



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection of the Cheyenne
VA Medical Center,
Wyoming



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Figure 1. Cheyenne VA Medical Center, Wyoming
(Source: <https://vaww.va.gov/directory/guide/>, accessed on April 9, 2019)

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
FPPE	focused professional practice evaluation
FY	fiscal year
LIP	licensed independent practitioner
MST	military sexual trauma
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UCC	urgent care center
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) review provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Cheyenne VA Medical Center (the facility). The inspection covers key clinical and administrative processes that are associated with promoting quality care.

CHIP 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 reviews 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 as well as areas affecting quality patient care. At the time of the review, the clinical areas of focus were

1. Quality, safety, and value;
2. Medical staff privileging;
3. Environment of care;
4. Medication management (specifically the controlled substances inspection program);
5. Mental health (focusing on military sexual trauma follow-up and staff training);
6. Geriatric care (spotlighting antidepressant use for elderly veterans);
7. Women's health (particularly abnormal cervical pathology result notification and follow-up); and
8. High-risk processes (specifically the emergency department and urgent care center operations and management).

This unannounced visit was conducted during the week of December 10, 2018. The OIG held interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a broad spectrum of clinical and administrative 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 this facility's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this facility and other Veterans Health Administration (VHA) facilities to identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Inspection Impact

Leadership and Organizational Risks

The facility leadership team consists of the director, chief of staff, associate director for Patient Care Services (ADPCS), and associate director. Organizational communication and accountability are carried out through a committee reporting structure, with the Executive Quality Board having oversight for several working groups. The leaders are members of the Executive Quality Board, which is responsible for tracking, identifying trends in, and monitoring quality of care and patient outcomes.

At the time of the OIG's visit, the leaders had been working together as a team since April 2018, when the associate director and chief of staff were appointed. The director and ADPCS were permanently assigned June 2016 and December 2015, respectively.

The OIG noted that selected employee satisfaction survey results indicated that employees appear generally satisfied with the director, chief of staff, and associate director, but opportunities exist to improve facility-wide employee satisfaction and provide an environment where employees feel encouraged to do the right thing. Patient experience survey results indicated that patients appeared generally satisfied with the leadership and care provided.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,¹ disclosures of adverse patient events, and patient safety indicator data and did not identify any substantial organizational risk factors.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is “a way to understand the similarities and differences between the top and bottom performers” within VHA.² Although the leadership team members were generally knowledgeable about selected SAIL metrics and community living center (CLC) measures, the leaders should continue to take actions to improve performance of the quality of care metrics and measures likely contributing to the facility's SAIL “2-star” and the CLC “3-star” Quality ratings.³

¹ The definition of sentinel event can be found within 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.”

² VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a “star rating” system to designate a facility's performance in individual measures, domains, and overall quality.

<http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938>. (The website was accessed on March 6, 2019, but is not accessible by the public.)

³ Based on fiscal year 2018, quarter 3 ratings at the time of the site visit.

The OIG noted findings of deficiencies in seven of the eight clinical areas reviewed and issued 17 recommendations that are attributable to the director, chief of staff, and associate director. These are briefly described below.

Quality, Safety, and Value

The facility generally complied with protected peer review requirements. However, the OIG identified deficiencies with utilization management data review and documentation of required content in root cause analyses and resuscitation episode reviews.

Medical Staff Privileging

The OIG team found there was general compliance with requirements for privileging and focused professional practice evaluation processes. However, the team noted improvement opportunities with service-specific data collection and provider with similar training and privileges conducting the evaluations in ongoing professional practice evaluations.⁴

Environment of Care

Safety and privacy requirements were generally in place at the facility. The inspection team did not note any issues with the availability of medical equipment and supplies. However, the team noted improvement opportunities with environmental cleanliness and infection prevention at the parent facility, personal protective equipment at the Rawlins VA Clinic, annual review of the hazard vulnerability analysis, and activation of the emergency operations plan for the facility's emergency management program.

Mental Health

Overall, the facility complied with mental health requirements, including the designation of a military sexual trauma (MST) coordinator and provision of clinical care. However, the inspection team identified noncompliance with establishing and monitoring MST-related staff training, communicating MST-related issues with local leaders, tracking and monitoring MST-related data, and providers completing MST mandatory training.

⁴ The definitions of ongoing professional practice evaluation and focused professional practice evaluations can be found within Office of Safety and Risk Awareness, Office of Quality and Performance, "*Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*," July 2016 (Revision 2). An ongoing professional practice evaluation is "the ongoing monitoring of privileged providers to confirm the quality of care delivered and ensures patient safety." A focused professional practice evaluation is "a time-limited process whereby the clinical leadership evaluates the privilege-specific competence of a provider who does not yet have documented evidence of competently performing the requested privilege(s) at the facility." A focused professional practice evaluation for cause is "a time-limited period during which the medical staff leadership assesses the provider's professional performance to determine if any action should be taken on the provider's privileges."

Geriatric Care

For geriatric patients, clinicians documented reasons for prescribing the medications, noted adverse drug reactions, and conducted medication reconciliation. However, the OIG team identified inadequate patient and/or caregiver education related to newly prescribed medications and inconsistent evaluations of their understanding when education was provided.

Women's Health

The OIG also noted the facility's compliance with indicators related to women's health, including requirements for a designated women veterans program manager, clinical oversight of the women's health program, tracking data related to cervical cancer screenings, communication of results to patients within required timeframe, and follow-up care when indicated. However, the Women Veterans Health Committee membership lacked consistent representation from the emergency department, business office/non-VA medical care, quality management, and the executive leadership team.

High-Risk Processes

The facility generally complied with many of the performance indicators used to assess the high-risk process of the operations and management of the emergency department. However, the OIG identified unlabeled open multi-dose insulin vials with no expiration date.

Summary

In reviewing key healthcare processes, the OIG issued 17 recommendations that are attributable to the facility director, chief of staff, ADPCS, and associate director. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this facility. The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network director and facility director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes F and G, pages 70–71, and the responses within the body of the report for the full text of the directors’ comments.) The OIG considers recommendations 9 and 10 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.



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Contents

Abbreviations	ii
Report Overview	iii
Results and Inspection Impact	iv
Contents	viii
Purpose and Scope	1
Methodology	3
Results and Recommendations	4
Leadership and Organizational Risks	4
Quality, Safety, and Value	20
Recommendation 1	23
Recommendation 2	24
Recommendation 3	24
Medical Staff Privileging	26
Recommendation 4	29
Recommendation 5	29
Recommendation 6	30
Environment of Care	31
Recommendation 7	33

Recommendation 8.....34

Recommendation 9.....35

Recommendation 10.....35

Medication Management: Controlled Substances Inspections36

Mental Health: Military Sexual Trauma Follow-Up and Staff Training39

Recommendation 11.....41

Recommendation 12.....41

Recommendation 13.....42

Recommendation 14.....42

Geriatric Care: Antidepressant Use among the Elderly44

Recommendation 15.....46

Women’s Health: Abnormal Cervical Pathology Results Notification and Follow-Up47

Recommendation 16.....49

High-Risk Processes: Operations and Management of Emergency Departments and Urgent
Care Centers50

Recommendation 17.....53

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings.....54

Appendix B: Facility Profile and VA Outpatient Clinic Profiles59

 Facility Profile.....59

 VA Outpatient Clinic Profiles.....61

Appendix C: Patient Aligned Care Team Compass Metrics63

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions
.....65

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Community
Living Center (CLC) Measure Definitions69

Appendix F: VISN Director Comments70

Appendix G: Facility Director Comments71

OIG Contact and Staff Acknowledgments72

Report Distribution73



Purpose and Scope

The purpose of the Office of Inspector General's (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to provide oversight of healthcare services to veterans. This focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Cheyenne VA Medical Center (the facility) is accomplished by examining a broad overview of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and facility leaders so that informed decisions can be made on improving care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a culture to sustain positive change.⁵ Investments in a culture of safety and quality improvement with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations.⁶ Figure 2 shows the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

To examine risks to patients and the organization when core processes are not performed well, the OIG focused on the following nine areas of clinical and administrative operations that support quality care at the facility:

1. Leadership and organizational risks
2. Quality, safety, and value (QSV)
3. Medical staff privileging
4. Environment of care
5. Medication management (specifically the controlled substances inspection program)
6. Mental health (focusing on military sexual trauma follow-up and staff training)
7. Geriatric care (spotlighting antidepressant use for elderly veterans)
8. Women's health (particularly abnormal cervical pathology results notification and follow-up)

⁵ Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/>. (The website was accessed on January 24, 2019.)

⁶ Institute for Healthcare Improvement, "How risk management and patient safety intersect: Strategies to help make it happen," March 24, 2015. <http://www.npsf.org/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen>. (The website was accessed on January 24, 2019.)

9. High-risk processes (specifically the emergency department and urgent care center operations and management).⁷

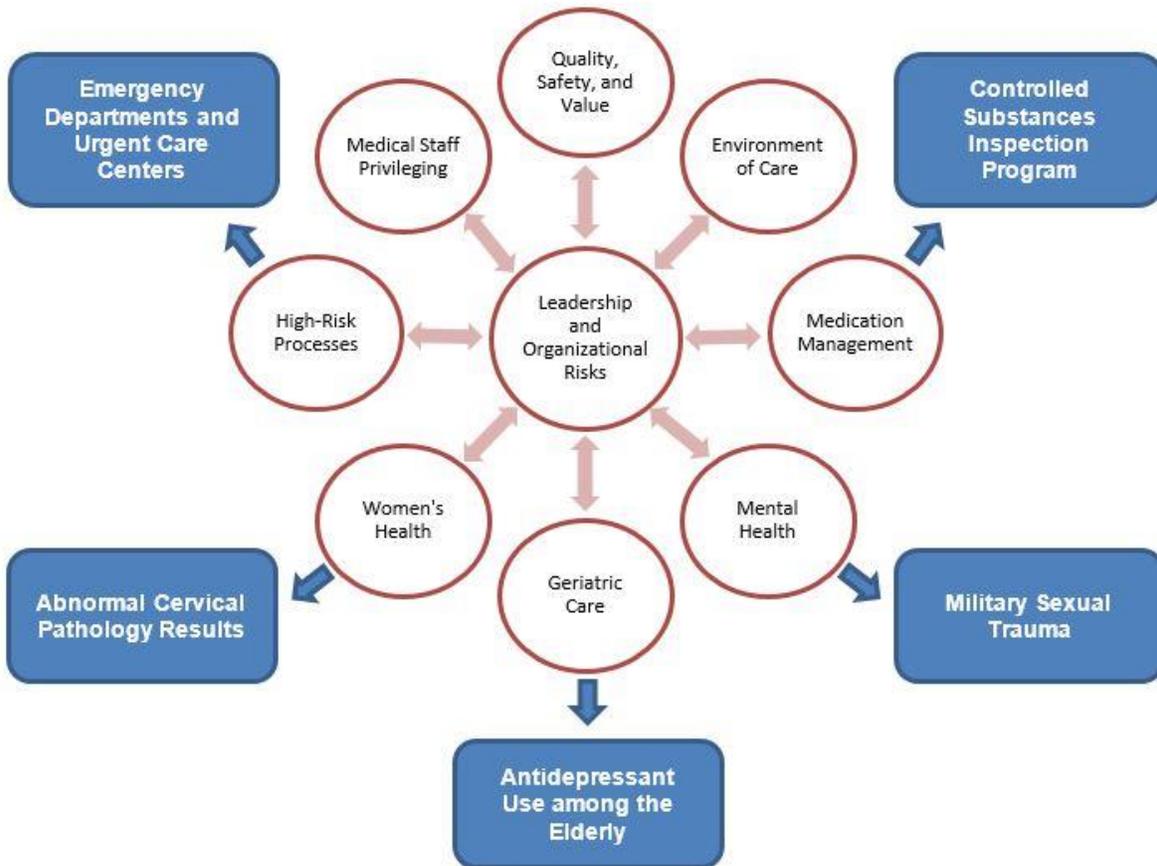


Figure 2. Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services
Source: VA OIG

⁷ See Figure 2. CHIP inspections address these processes during FY 2019 (October 1, 2018, through September 30, 2019); they may differ from prior years' focus areas.

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports;⁸ physically inspected OIG-selected areas; and discussed processes and validated findings with managers and employees. The OIG also interviewed members of the executive leadership team.

The inspection period examined operations from February 13, 2016, through December 14, 2018, the last day of the unannounced week-long site visit.⁹ While on site, the OIG did not receive any complaints beyond the scope of the CHIP review.

This report's recommendations for improvement target problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the facility completes corrective actions. The facility director's comments submitted in response to the recommendations appear within each topic area.

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

⁸ The OIG did not review VHA's internal survey results, instead focusing on OIG inspections and external surveys that affect facility accreditation status.

⁹ The range represents the time period from the last Combined Assessment Program review, which was performed prior to the comprehensive healthcare inspection, to the completion of the unannounced week-long CHIP site visit.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare facility. Leadership and organizational risks can impact the facility's ability to provide care in all of the selected clinical areas of focus.¹⁰ To assess the facility's risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Employee satisfaction
3. Patient experience
4. Accreditation and/or for-cause surveys and oversight inspections
5. Factors related to possible lapses in care
6. VHA performance data

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 that it serves, organizational charts may differ among facilities. Figure 3 illustrates the facility's reported organizational structure. The facility has 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 oversee patient care, which requires managing service directors and chiefs of programs and practices.

¹⁰ L. Botwinick, M. Bisognano, and C. Haraden, "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006. www.IHI.org. (The website was accessed on February 2, 2017.)

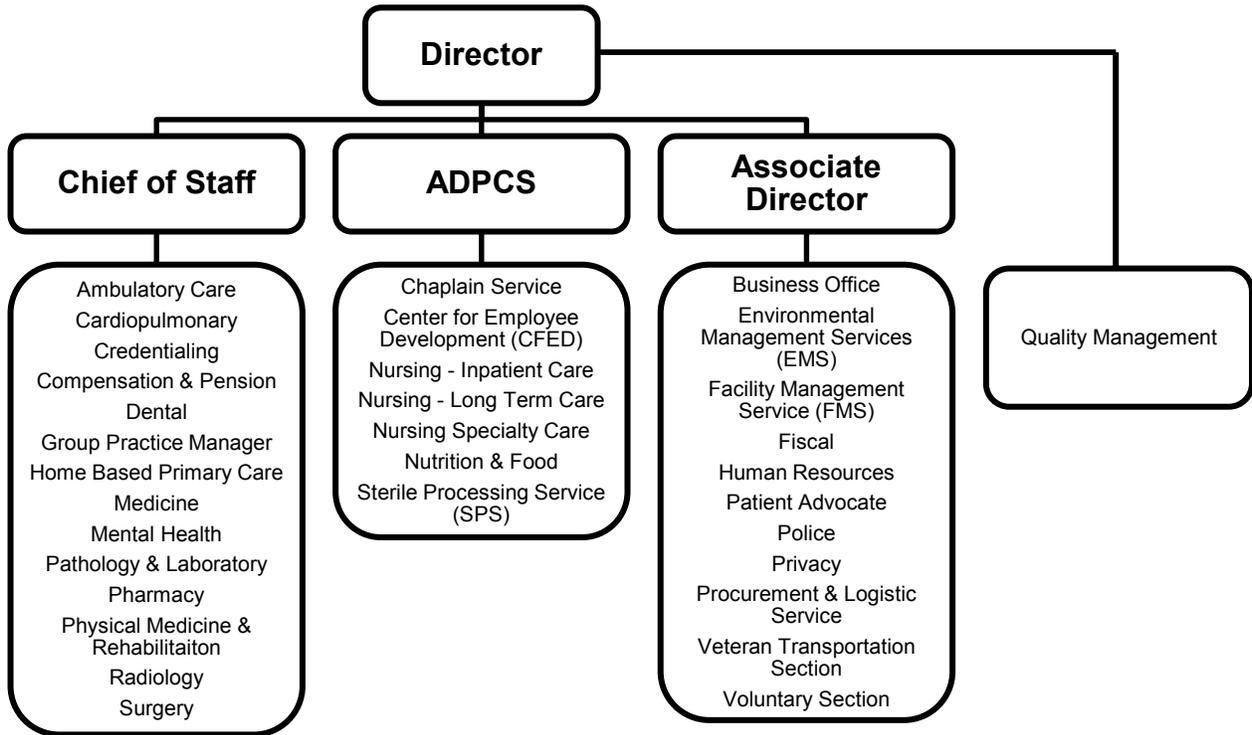


Figure 3. Facility Organizational Chart¹¹

Source: Cheyenne VA Medical Center (received December 10, 2018)

At the time of the OIG site visit, the executive team had been working together for seven months, although the director and the ADPCS had been in their positions for over two years and three years, respectively (see Table 1).

¹¹ At this facility, the director is responsible for Quality Management.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	June 16, 2016
Chief of staff	April 1, 2018
Associate director for Patient Care Services	December 13, 2015
Associate director	April 29, 2018 (term appointment) ¹²

Source: Cheyenne VA Medical Center human resources officer (received December 10, 2018)

To help assess facility 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.

In individual interviews, except for the recently-appointed chief of staff and associate director, the executive leadership team members generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, as well as employee and patient survey results. In addition, the executive leaders were generally knowledgeable within their tenure and scope of responsibilities about selected Strategic Analytics for Improvement and Learning (SAIL) metrics and community living center (CLC) measures. These are discussed more fully below.

The leaders are also engaged in monitoring patient safety and care through the Executive Quality Board, which is responsible for tracking, identifying trends, and monitoring quality of care and patient outcomes. The director serves as the chairperson, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Executive Quality Board oversees various working groups, such as the Administrative Executive Board, Medical Executive Board, and Patient Care Service Executive Board/Nurse Executive Board. See Figure 4.

¹² The associate director, who held a position within the facility prior to this assignment, was on term appointment. According to the US Office of Personnel Management, a term appointment lasts longer than one year but no more than four years. Office of Personnel Management, *The Guide to Processing Personnel Actions*, Chapter 10, *Non-status Appointments in the Competitive Service*, March 2017. <https://www.opm.gov/policy-data-oversight/data-analysis-documentation/personnel-documentation/processing-personnel-actions/gppa10.pdf>. (The website was accessed on March 15, 2019.)

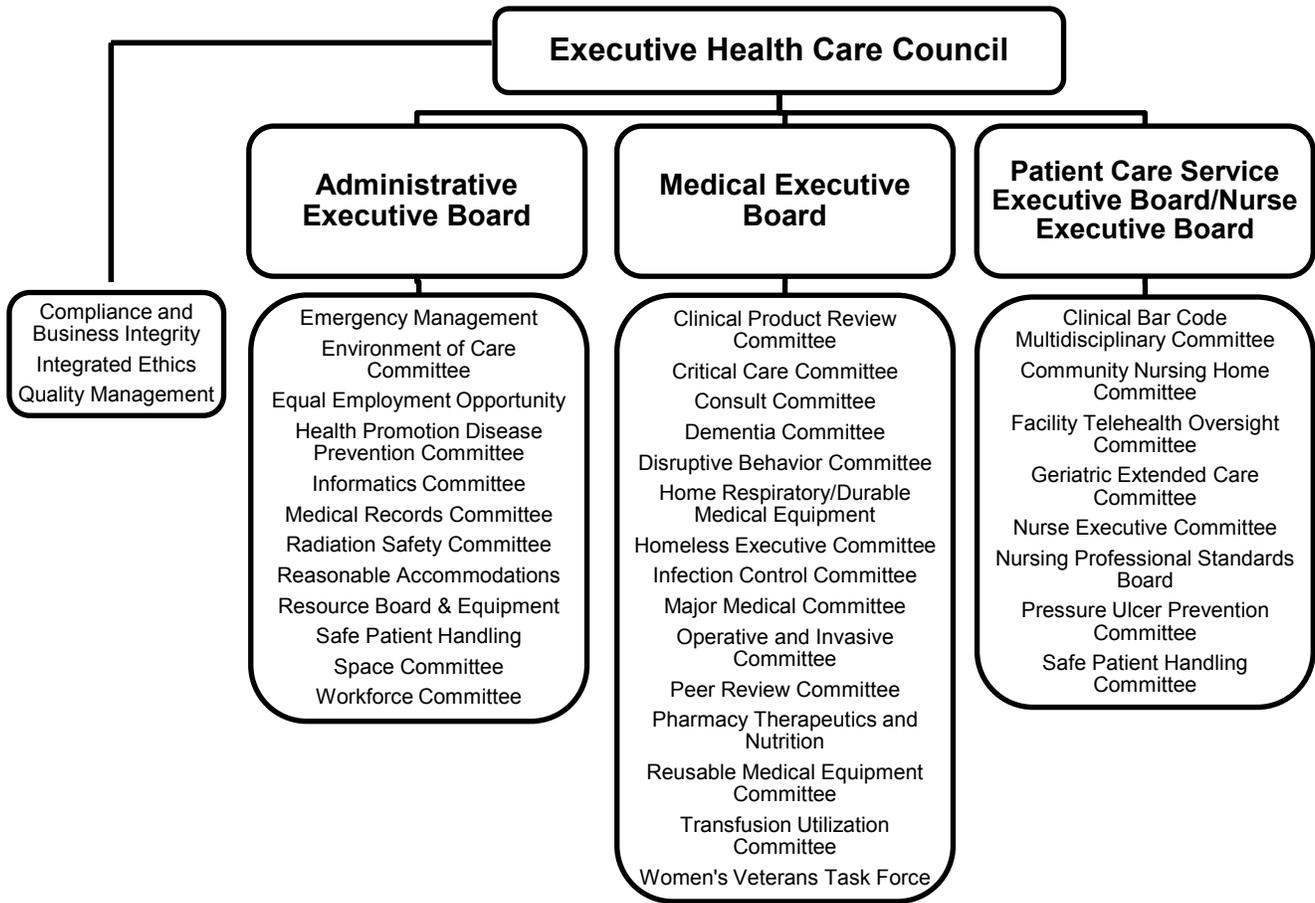


Figure 4. Facility Committee Reporting Structure¹³
 Source: Cheyenne VA Medical Center (received December 10, 2018)

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. 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 facility leadership.

To assess employee attitudes toward facility leaders, the OIG reviewed employee satisfaction survey results that relate to the period of October 1, 2017, through September 30, 2018.¹⁴ Table 2

¹³ The Executive Health Care Council oversees the Compliance and Business Integrity, Integrated Ethics, and Quality Management Committees.

¹⁴ Ratings are based on responses by employees who report to or are aligned under the director, chief of staff, ADPCS, and associate director.

provides relevant survey results for VHA, the facility, and selected facility executive leaders and summarizes employee attitudes toward selected facility leaders. The OIG found the facility average for selected survey leadership questions was lower than the VHA average.¹⁵ However, except for the ADPCS, the OIG noted results similar to or better than the VHA average for the members of the executive leadership team. Although employees appear generally satisfied with the director, chief of staff, and associate director, opportunities exist to improve facility-wide employee satisfaction.

Table 2. Survey Results on Employee Attitudes toward Facility Leadership (October 1, 2017, through September 30, 2018)

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: <i>Servant Leader Index Composite</i> ¹⁶	0–100 where HIGHER scores are more favorable	71.7	67.8	95.5	79.3	66.6	69.1
All Employee Survey: <i>In my organization, senior leaders generate high levels of motivation and commitment in the workforce?</i>	1 (Strongly Disagree)–5 (Strongly Agree)	3.3	3.2	4.9	3.9	2.8	3.4

¹⁵ 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.

¹⁶ According to the 2018 VA All Employee Survey Questions by Organizational Health Framework, Servant Leader Index, “is a summary measure of the work environment being a place where organizational goals are achieved by empowering others. This includes focusing on collective goals, encouraging contribution from others, and then positively reinforcing others’ contributions. Servant Leadership occurs at all levels of the organization, where individuals (supervisors, staff) put others’ needs before their own.”

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: <i>My organization's senior leaders maintain high standards of honesty and integrity.</i>	1 (Strongly Disagree)– 5 (Strongly Agree)	3.5	3.3	4.8	3.9	2.9	3.5
All Employee Survey: <i>I have a high level of respect for my organization's senior leaders.</i>	1 (Strongly Disagree)– 5 (Strongly Agree)	3.6	3.4	5.0	3.8	2.9	3.7

Source: VA All Employee Survey (accessed November 9, 2018)

Table 3 summarizes employee attitudes toward the workplace, also as expressed in VHA’s All Employee Survey. Although results for the director, chief of staff, and associate director were generally better than the VHA averages, opportunities exist to improve facility-wide employee workplace attitudes by providing an environment where employees feel encouraged to do the right thing.

**Table 3. Survey Results on Employee Attitudes toward the Workplace
(October 1, 2017, through September 30, 2018)**

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: <i>I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.</i>	1 (Strongly Disagree)– 5 (Strongly Agree)	3.8	3.5	4.9	4.2	3.3	3.8

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: <i>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).</i>	1 (Strongly Disagree)– 5 (Strongly Agree)	3.7	3.4	4.5	4.0	3.6	3.3
All Employee Survey: <i>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)?</i>	0 (Never)– 6 (Every Day)	1.5	1.7	1.1	1.8	1.9	1.9

Source: VA All Employee Survey (accessed November 9, 2018)

Patient Experience

To assess patient attitudes toward facility leaders, the OIG reviewed patient experience survey results that relate to the period of October 1, 2017, through July 31, 2018. VHA’s Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) 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 to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for facility leadership and compares the results to the overall VHA averages.¹⁷

VHA also collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. The OIG reviewed responses to four relevant survey questions that reflect

¹⁷ Ratings are based on responses by patients who received care at this facility.

patients’ attitudes toward facility leaders (see Table 4). For this facility, three patient survey results reflected higher care ratings than the VHA averages. Patients appeared generally satisfied with the leadership and care provided.

Table 4. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2017, through July 31, 2018)

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): <i>Would you recommend this hospital to your friends and family?</i>	The response average is the percent of “Definitely Yes” responses.	66.9	67.9
Survey of Healthcare Experiences of Patients (inpatient): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	84.2	89.4
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	76.1	74.2
Survey of Healthcare Experiences of Patients (outpatient specialty care): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	76.3	77.1

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed November 9, 2018)

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 respond to identified problems. Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint

Commission (TJC).¹⁸ Indicative of effective leadership, the facility has closed all recommendations for improvement.¹⁹

At the time of the site visit, the OIG also noted the facility’s current accreditation status with the Commission on Accreditation of Rehabilitation Facilities and College of American Pathologists.²⁰ Additional results included the Long Term Care Institute’s inspection of the facility’s community living center.²¹

Table 5. Office of Inspector General Inspections/The Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (<i>Combined Assessment Program Review of the Cheyenne VA Medical Center, Cheyenne, Wyoming, Report No. 16-00110-246, April 8, 2016</i>)	February 2016	11	0
OIG (<i>Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Cheyenne VA Medical Center, Cheyenne, Wyoming, Report No. 16-00019-249, April 14, 2016</i>)	February 2016	4	0

¹⁸ TJC 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. According to 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.”

¹⁹ A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by the accreditation organization or inspecting agency.

²⁰ According to 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 the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs; According to the College of American Pathologists, for 70 years it has “fostered excellence in laboratories and advanced the practice of pathology and laboratory science.” College of American Pathologists. <https://www.cap.org/about-the-cap>. (The website was accessed on February 20, 2019.); In accordance with 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.

²¹ The Long Term Care Institute states that it has been to over 4,000 healthcare facilities conducting quality reviews and external regulatory surveys since 1999. 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.” Long Term Care Institute. <http://www.ltcior.org/about-us/>. (The website was accessed on March 6, 2019.)

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
TJC	August 2016		
<ul style="list-style-type: none"> • Hospital Accreditation • Nursing Care Center Accreditation • Behavioral Health Care Accreditation • Home Care Accreditation 		<p>18</p> <p>2</p> <p>1</p> <p>6</p>	<p>0</p> <p>0</p> <p>0</p> <p>0</p>

Sources: *OIG and TJC (Inspection/survey results verified with the director on December 12, 2018)*

Factors Related to Possible Lapses in Care

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 6 lists the reported patient safety events from February 13, 2016 (the prior comprehensive OIG inspection date), through December 14, 2018.²²

²² 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. (Note that the Cheyenne VA Medical Center is a low complexity (3) affiliated facility as described in Appendix B.)

**Table 6. Summary of Selected Organizational Risk Factors
(February 13, 2016, through December 14, 2018)**

Factor	Number of Occurrences
Sentinel Events ²³	3
Institutional Disclosures ²⁴	7
Large-Scale Disclosures ²⁵	0

Source: Cheyenne VA Medical Center's patient safety and risk managers (received December 11, 2018)

The OIG also reviewed patient safety indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.²⁶ The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. Table 7 summarizes patient safety indicator data from July 1, 2016, through June 30, 2018.

²³ The definition of sentinel event can be found within 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.”

²⁴ According to 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 [his or her] 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.”

²⁵ According to VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, 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.”

²⁶ Agency for Healthcare Research and Quality. <https://www.qualityindicators.ahrq.gov/>. (The website was accessed on December 11, 2017.)

**Table 7. Patient Safety Indicator Data
(July 1, 2016, through June 30, 2018)**

Indicators	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN19	Facility
Pressure ulcers	0.76	0.63	0.00
Death among surgical inpatients with serious treatable conditions	114.89	90.91	0.00
Iatrogenic pneumothorax ²⁷	0.15	0.14	0.00
Central venous catheter-related bloodstream infection	0.16	0.04	0.00
In-hospital fall with hip fracture	0.09	0.12	0.00
Perioperative hemorrhage or hematoma	2.59	3.63	0.00
Postoperative acute kidney injury requiring dialysis	0.96	1.22	0.00
Postoperative respiratory failure	4.88	6.09	0.00
Perioperative pulmonary embolism or deep vein thrombosis	3.05	2.16	0.00
Postoperative sepsis	3.70	4.85	0.00
Postoperative wound dehiscence	0.93	0.47	0.00
Unrecognized abdominopelvic accidental puncture/laceration	1.07	2.05	0.00

Source: VHA Support Service Center

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

None of the 12 patient safety indicator measures show a reported rate per 1,000 hospital discharges in excess of the reported rates for VISN 19 and VHA.

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes “measures on healthcare quality, employee satisfaction, access to care, and efficiency.” It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to

²⁷ According to Northwestern Memorial Hospital, “A Pneumothorax is a type of lung injury that allows air to leak into the area between the lungs and the chest wall, which causes mild to severe chest pain and shortness of breath. An Iatrogenic Pneumothorax is caused by medical treatment, often as an incidental event during a procedure such as a pacemaker insertion.” Northwestern Medicine. <http://www.nmh.org/nm/quality-lung-injury-due-to-medical-care>. (The website was accessed on March 6, 2019.)

“understand the similarities and differences between the top and bottom performers” within VHA.²⁸

VA also uses a star-rating system where facilities with a “5-star” rating are performing within the top 10 percent of facilities and “1-star” facilities are performing within the bottom 10 percent of facilities. Figure 5 describes the distribution of facilities by star rating.²⁹ As of June 30, 2018, the facility was rated as “2-star” for overall quality.

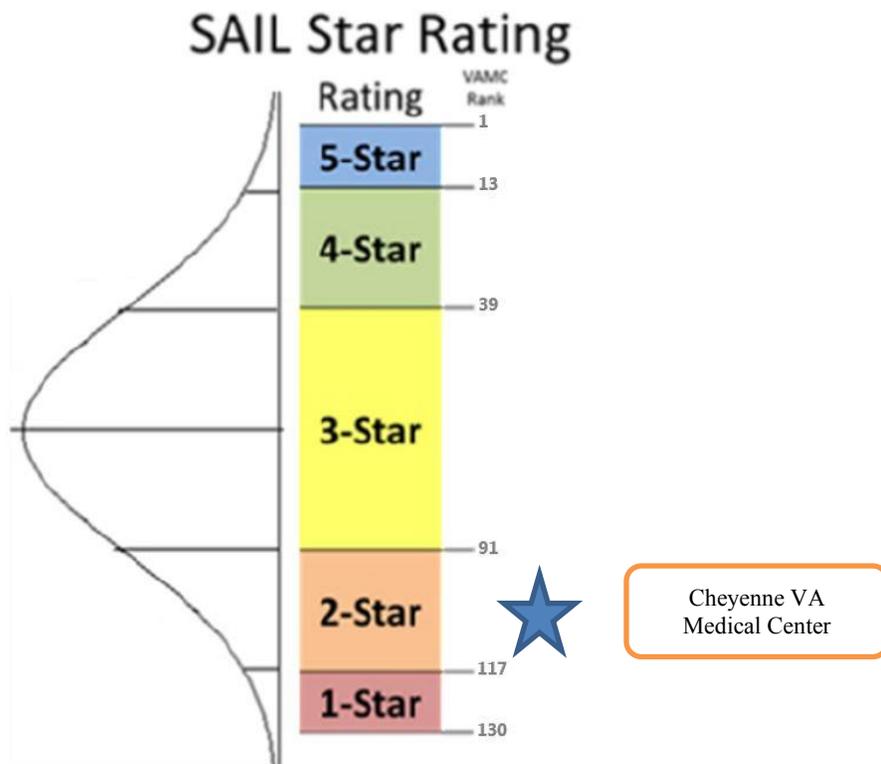


Figure 5. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)

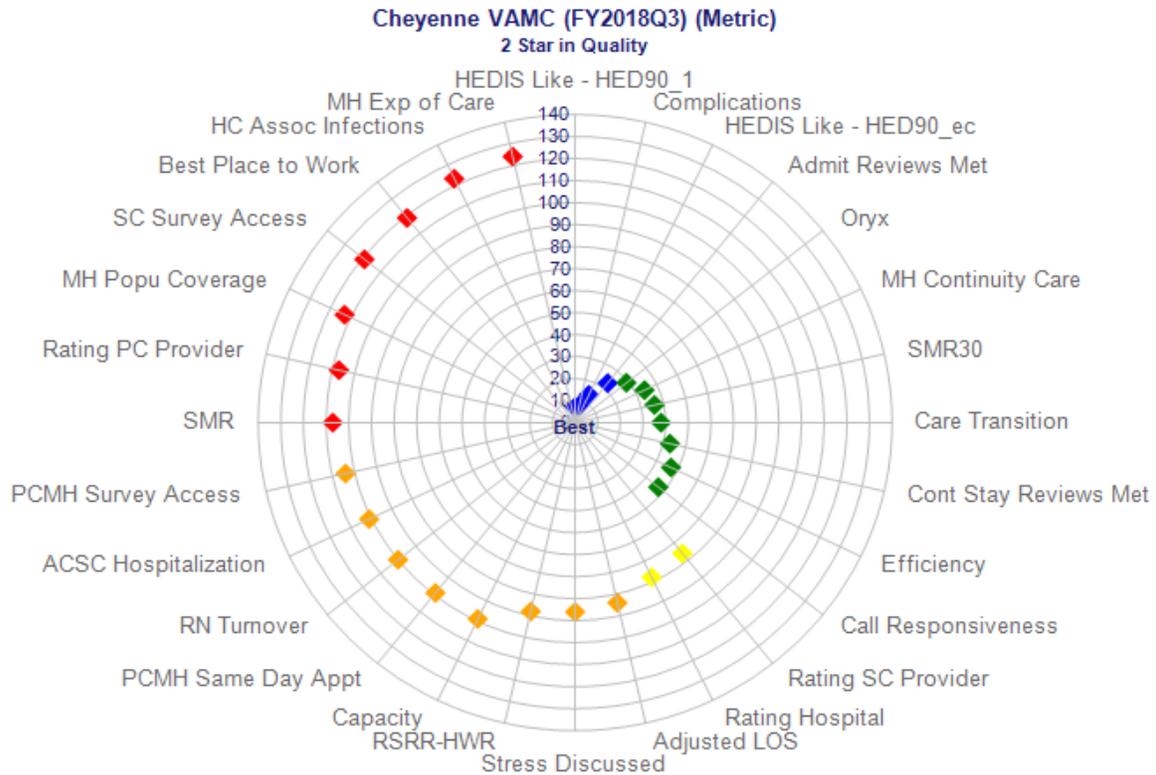
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed November 9, 2018)

Figure 6 illustrates the facility’s quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2018. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of complications, mental

²⁸ VHA Support Service Center (VSSC), The Strategic Analytics for Improvement and Learning (SAIL) Value Model, <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938>. (The website was accessed on March 7, 2019, but is not accessible by the public.)

²⁹ According to the methods established by the SAIL Model, this is based on normal distribution ranking of the quality domain for 130 VA Medical Centers.

health (MH) continuity care, care transition, and call responsiveness). Metrics that need improvement are denoted in orange and red (for example, capacity, registered nurse (RN) turnover, mental health (MH) population (Popu) coverage, and best place to work).³⁰



Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

Figure 6. Facility Quality of Care and Efficiency Metric Rankings (as of June 30, 2018)

Source: VHA Support Service Center

Note: The OIG did not assess VA’s data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). Data definitions are provided in Appendix D.

The SAIL Value Model also includes “SAIL CLC,” which is a tool to summarize and compare performance of CLCs in the VA. The SAIL model leverages much of the same data used in The

³⁰ For information on the acronyms in the SAIL metrics, please see Appendix D.

Centers for Medicare & Medicaid Services’ (CMS) *Nursing Home Compare*.³¹ The SAIL CLC provides a single resource to review quality measures and health inspection results. It includes star ratings for unannounced survey, staffing, quality, and overall results.³² Table 8 summarizes the rating results for the facility’s CLC as of June 30, 2018. Although the facility has an overall “5-star” rating, its rating for quality is only a “3-star.”

**Table 8. Facility CLC Star Ratings
(as of June 30, 2018)**

Domain	Star Rating
Unannounced Survey	★★★★★
Staffing	★★★★★
Quality	★★★
Overall	★★★★★

Source: VHA Support Service Center

In exploring the reasons for the “3-star” quality rating, the OIG considered the radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 7 illustrates the facility’s CLC quality rankings and performance compared with other VA CLCs as of June 30, 2018. The figure uses blue and green data points to indicate high performance (for example, in the areas of physical restraints–long stay (LS), newly received antipsychotic medications (meds)–short stay (SS), moderate-severe pain short stay (SS), and falls with major injury long stay (LS)). Metrics that need improvement and were likely the reasons why the facility had a “3-star” for quality are denoted in orange and red (for example, urinary tract infection (UTI) long stay (LS), moderate-severe pain long stay (LS), and catheter in bladder long stay (LS)).³³

³¹ According to Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, November 19, 2018, “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.”

³² *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated November 19, 2018). <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410>. (The website was accessed on March 6, 2019, but is not accessible by the public.)

³³ For data definitions of acronyms in the SAIL CLC measures, please see Appendix E.

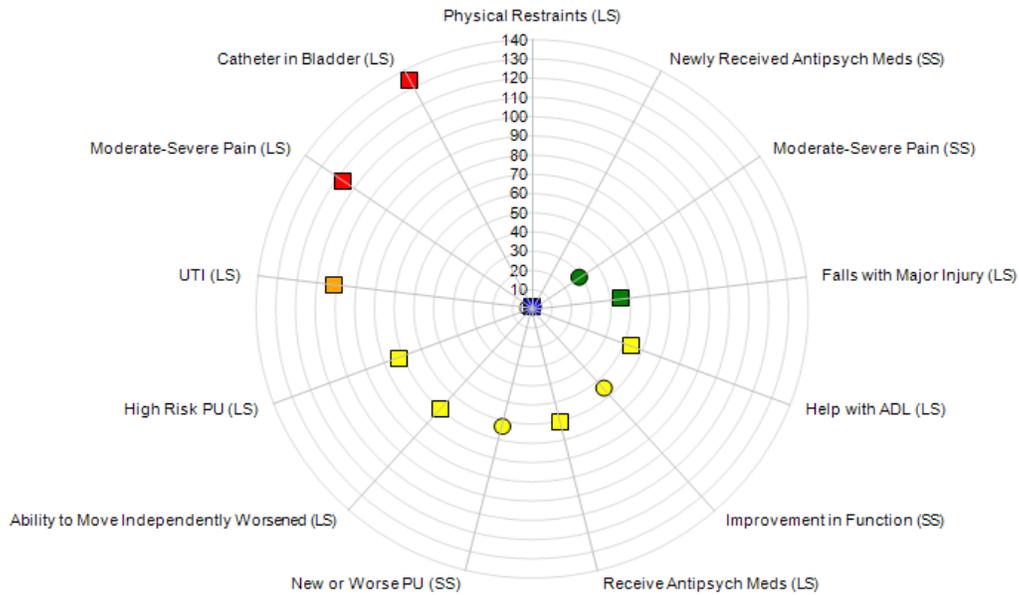


Figure 7. Facility CLC Quality Measure Rankings (as of June 30, 2018)

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. For data definitions, see Appendix E.

Leadership and Organizational Risks Conclusion

The facility’s executive leadership team appeared relatively stable, with all the positions permanently assigned for seven months at the time of the OIG’s on-site visit. Except for the ADPCS, selected survey scores related to employees’ satisfaction for the facility’s executive leaders were generally higher than VHA average. However, facility averages were lower than VHA averages, indicating that opportunities exist to improve facility-wide employee satisfaction and the workplace environment where employees feel encouraged to do the right thing. The OIG’s review of patient experience survey data indicates that patients seemed satisfied with the leadership and care provided. The leaders appeared to support efforts to improve and maintain patient safety, quality care, and other positive outcomes (such as initiating plans to maintain positive perceptions of the facility through active stakeholder engagement). The OIG’s review of the facility’s accreditation findings, sentinel events, disclosures, and patient safety indicator data did not identify any substantial organizational risk factors. The leadership team, except for the recently-appointed chief of staff and associate director, were generally knowledgeable, within their tenure and scope of responsibility, about selected SAIL and CLC measures but should continue to take actions to improve care and performance of metrics that are likely contributing to the current SAIL “2-star” and CLC “3-star” quality ratings.

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 that involves coordinating care among members of the healthcare team. To meet this goal, VHA must foster a culture of integrity and accountability in which personnel are vigilant and mindful, proactively risk-aware, and committed to consistently providing quality care, while seeking continuous improvement.³⁴ VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.³⁵ VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.³⁶

In determining whether the facility implemented and incorporated several OIG-selected key functions of VHA's enterprise framework for QSV into local activities, the inspection team evaluated protected peer reviews of clinical care,³⁷ utilization management (UM) reviews,³⁸ patient safety incident reporting with related root cause analyses,³⁹ and cardiopulmonary resuscitation (CPR) episode reviews.⁴⁰

When conducted systematically and credibly, protected peer reviews reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.⁴¹

³⁴ VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013. (This VHA directive was scheduled for recertification on or before the last working day of August 2018 and has not been recertified.)

³⁵ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 2014.

³⁶ VHA Directive 1026.

³⁷ The definition of a peer review can be found within 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, to identify learning opportunities for improvement, to provide confidential communication of the results back to the clinician, and to identify potential system or process improvements.

³⁸ According to VHA Directive 1117(1), *Utilization Management Program*, July 9, 2014 (amended January 18, 2018), UM reviews include evaluating the "appropriateness, medical need, and efficiency of health care services according to evidence-based criteria."

³⁹ The definition of a root cause analysis can be found within VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (This VHA Handbook was scheduled for recertification on or before the last working date of March 2016 and has not been recertified.) A root cause analysis is "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."

⁴⁰ VHA Directive 1177, *Cardiopulmonary Resuscitation*, August 28, 2018.

⁴¹ VHA Directive 1190.

The UM program, a key component of VHA's framework for quality, safety, and value, provides vital tools for managing the quality and the efficient use of resources. It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.⁴²

Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the facility.⁴³

VHA has also issued guidance to support its strategic priority of providing personalized, proactive, patient-driven care and to ensure that the provision of life-sustaining treatments, including CPR, is aligned with patients' values, goals, and preferences. VHA requires that each facility establishes a CPR Committee or equivalent that fully reviews each episode of care in which resuscitation was attempted. The ongoing review and analysis of high-risk healthcare processes is essential for ensuring patient safety and the provision of high-quality care. VHA also has established requirements for basic life support and advanced cardiac life support training and certification for clinicians responsible for administering life-sustaining treatments.⁴⁴

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:⁴⁵

- Protected peer reviews
 - Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
 - Implementation of improvement actions recommended by the Peer Review Committee
 - Completion of final reviews within 120 calendar days
 - Quarterly review of Peer Review Committee's summary analysis by the Medical Executive Committee

⁴² VHA Directive 1117(1).

⁴³ VHA Handbook 1050.01.

⁴⁴ VHA Directive 1177, VHA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences, January 11, 2017.

⁴⁵ For CHIP reviews, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

- 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 unit⁴⁶
- UM
 - Completion of at least 75 percent of all required inpatient reviews
 - Documentation of at least 75 percent of physician UM advisors' decisions in National UM Integration database
 - Interdisciplinary review of UM data
- Patient safety
 - Annual completion of a minimum of eight root cause analyses⁴⁷
 - Inclusion of required content in root cause analyses (generally)
 - Submission of completed root cause analyses to the National Center for Patient Safety within 45 days
 - Provision of feedback about root cause analysis actions to reporting employees
 - Submission of annual patient safety report to facility leaders
- Resuscitation episode review
 - Facility has a committee responsible for reviewing resuscitation episodes
 - Confirmation of actions taken during resuscitative events consistent with patients' wishes
 - Evidence of basic or advanced cardiac life support certification for code team responders
 - Evaluation of each resuscitation episode by the CPR Committee or equivalent

Quality, Safety, Value Conclusion

The OIG found general compliance with requirements for protected peer review. However, the OIG identified deficiencies with UM data review and documentation of required content in root

⁴⁶ VHA Directive 1190.

⁴⁷ According to VHA Handbook 1050.01, "the requirement for a total of eight [root cause analyses] and Aggregated Reviews is a minimum number, as the total number of [root cause analyses] is driven by the events that occur and the [Safety Assessment Code] SAC score assigned to them. At least four analyses per fiscal year must be individual [root cause analyses], with the balance being Aggregated Reviews or additional individual [root cause analyses]."

cause analyses and review of resuscitation episodes that warranted recommendations for improvement.

For UM, VHA requires that an interdisciplinary facility group review UM data. This group should include, but is not limited to, representatives from UM, medicine, nursing, social work, case management, mental health, and chief business office revenue utilization review (CBO-UR).⁴⁸ From January through November 2018, the UM interdisciplinary group lacked representation from CBO-UR. This resulted in a lack of expertise in the review and analysis of UM data. Facility managers were unaware of the requirement.

Recommendation 1

1. The facility director ensures the interdisciplinary group or committee that reviews utilization management data includes a representative from the chief business office revenue utilization review and monitors the committee's compliance.

Facility concurred.

Target date for completion: December 2019

Facility response: Utilization Manager will monitor attendance of interdisciplinary committee meetings. Attendance for utilization review/designee will be monitored until 100 percent compliance for six months. Results of review will be reported to Medical Executive Board.

To ensure credibility, VHA requires root cause analysis to include several factors, such as participation by leadership, exclusion of individuals involved in the event under review, consideration of relevant literature, and identification of at least one root cause with a corresponding action and outcome measure.⁴⁹ Of the five individual root cause analyses reviewed, the OIG found that all five did not include consideration of relevant literature and two had not fully implemented action items. Of the three that had completed actions, two had no outcome measures set to monitor implemented changes and one did not show sustained improvement of outcome measures. This resulted in insufficient evaluation of patient safety events and limited the analysis of system vulnerabilities that may lead to patient harm. The patient safety manager was unaware of how to enter relevant literature information into the National Center for Patient Safety database and cited a lack of support from involved services as the reasons for noncompliance.

⁴⁸ VHA Directive 1117(1).

⁴⁹ VHA Handbook 1050.01.

Recommendation 2

2. The facility director ensures the patient safety manager includes all required review elements in root cause analyses and monitors the patient safety manager's compliance.

Facility concurred.

Target date for completion: January 2020

Facility response: Orientation of the root cause analyses process has been completed with the patient safety manager. Audit of required elements of five root cause analyses or all root cause analyses through December 2019 will be completed by the VISN Patient Safety Officer.

Monitoring will be completed to obtain 100 percent compliance. Audit results will be reported to the Executive Quality Board (EQB).

For resuscitation episode reviews, VHA requires that the facility establish a committee for reviewing each resuscitative episode under the facility's responsibility and that each review includes elements such as identification of errors or deficiencies in technique or procedures, lack of availability or malfunction of equipment, and clinical or patient care issues.⁵⁰ The inspection team found that a cardiopulmonary resuscitation workgroup, under the leadership of an emergency department manager, reviewed resuscitation episodes; however, the team did not find evidence that the Critical Care Committee reviewed the required elements. This resulted in an incomplete analysis of resuscitation episodes and trends, which may impact patient safety. The chief of Quality Management and the Critical Care Committee chairperson were unaware of the requirements and believed current practice met requirements.

Recommendation 3

3. The facility director confirms that the Critical Care Committee conducts a complete analysis of resuscitation episodes by reviewing required elements and monitors the committee's compliance.

⁵⁰ VHA Directive 1177.

Facility concurred.

Target date for completion: October 2019

Facility response: The Critical Care Committee will conduct complete analysis of all resuscitation episodes as reported by the Cardiopulmonary Resuscitation (CPR) / Code Workgroup. The required elements will be recorded in the committee minutes and any discrepancies will be discussed in the Committee at large. This will be monitored by the Chair of the Critical Care Committee and of the CPR / Code Workgroup until a compliance of 90% is achieved for 6 consecutive months. A summary of discrepancies and interventions will be reported to the Medical Executive Committee.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of all healthcare professionals who are permitted by law and the facility to practice independently—"without supervision or direction, within the scope of the individual's license, and in accordance with individually granted clinical privileges." These healthcare professionals are also referred to as licensed independent practitioners (LIPs).⁵¹

Clinical privileges need to be specific, based on the individual's clinical competence. They are recommended by service chiefs and the Medical Staff Executive Committee and approved by the director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to their expiration.⁵²

VHA defines the focused professional practice evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance. The FPPE typically occurs at the time of initial appointment to the medical staff or the granting of new, additional privileges." "The on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation[s] (OPPE), [are] essential to confirm the quality of care delivered."⁵³

According to TJC, the "FPPE for Cause" should be used when a question arises regarding a privileged provider's ability to deliver safe, high-quality patient care. The "FPPE for Cause" is limited to a particular timeframe and customized to the specific provider and related clinical concerns.⁵⁴ Federal law requires VA facilities to report to the National Practitioner Data Bank when facilities take adverse clinical privileging actions, accept the surrender of clinical privileges, or restrict clinical privileges when the action is related to professional competence or professional conduct of LIPs.⁵⁵

To determine whether the facility complied with requirements for privileging, the OIG interviewed key managers and selected and reviewed the privileging folders of several medical staff members:

⁵¹ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (This VHA Handbook was scheduled for recertification on or before the last working date of October 2017 and has not been recertified.)

⁵² VHA Handbook 1100.19.

⁵³ VHA Handbook 1100.19.

⁵⁴ Office of Safety and Risk Awareness, Office of Quality and Performance, "Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance" July 2016 (Revision 2).

⁵⁵ VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports*, December 28, 2009. (This VHA Handbook was scheduled for recertification on or before the last working date of December 2014 and has not been recertified.)

- Ten solo or few (less than two in a specialty) practitioners hired within 18 months before the site visit or were privileged within the prior 12 months⁵⁶
- Ten LIPs hired within 18 months before the site visit
- Twenty LIPs re-privileged within 12 months before the visit
- No providers underwent a FPPE for cause within 12 months prior to the visit.

The OIG evaluated the following performance indicators:

- Privileging
 - Privileges requested by the provider
 - Facility-specific
 - Service-specific
 - Provider-specific⁵⁷
 - Approval of privileges for a period of less than, or equal to, two years
- Focused professional practice evaluations
 - Criteria defined in advance
 - Use of required criteria in FPPEs for selected specialty LIPs
 - Results and timeframes clearly documented
 - Evaluation by another provider with similar training and privileges
 - Medical Staff Executive Committee consideration of FPPE results in its decision to recommend continuing the initially granted privileges
- Ongoing professional practice evaluations
 - Criteria specific to the service or section
 - Use of required criteria in OPPEs for selected specialty LIPs

⁵⁶ The 18-month period was from June 10, 2017, through December 10, 2018. The 12-month review period was from December 10, 2017, through December 10, 2018; VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016, refers to a solo practitioner as being one provider in the facility that is privileged in a particular specialty. The OIG considers “few practitioners” as being fewer than three providers in the facility that are privileged in a particular specialty.

⁵⁷ According to VHA Handbook 1100.19, facility-specific means that privileges are granted only for procedures and types of services performed at the facility; service-specific refers to privileges being granted in a specific clinical service, such as neurology; and provider-specific means that the privileges should be granted to the individual provider based on their clinical competence and capabilities.

- Service chief's determination to recommend continuation of current privileges was based in part on the results of OPPE activities
- Evaluation by another provider with similar training and privileges
- Medical Staff Executive Committee's decision to recommend continuing privileges based on OPPE results
- Focused professional practice evaluations for cause
 - Clearly defined expectations/outcomes
 - Time-limited
 - Provider's ability to practice independently not limited for more than 30 days
 - Shared with the provider in advance
- Reporting of privileging actions to the National Practitioner Data Bank

Medical Staff Privileging Conclusion

The facility generally complied with privileging and FPPE requirements. However, the OIG identified noncompliance with service-specific data collection and providers with similar training and privileges completing the evaluations in OPPEs that warranted recommendations for improvement.

Specifically, VHA requires ongoing monitoring of privileged practitioners. Activities such as periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients can be included in the ongoing monitoring process. Data must be service and practitioner specific, reliable, easily retrievable, timely, justifiable, comparable, and risk adjusted where appropriate.⁵⁸ Additionally, VHA has defined the minimum-required specialty criteria for gastroenterology, pathology, nuclear medicine, and radiation oncology OPPEs.⁵⁹ This OPPE process is essential to confirm the quality of care delivered.⁶⁰

VHA also requires another provider with similar training and privileges to evaluate the privilege-specific competence of the practitioner and document evidence of competently performing the requested privileges of the facility.⁶¹

For four of eight solo or few (less than two in a specialty) practitioners who were privileged within the prior 12 months of the inspection, the OIG team found that the service chief's

⁵⁸ VHA Handbook 1100.19.

⁵⁹ VHA Memorandum, Requirements for Peer Review of Solo Practitioners, August 29, 2016.

⁶⁰ VHA Handbook 1100.19.

⁶¹ VHA Memorandum, Requirements for Peer Review of Solo Practitioners, August 29, 2016.

determination to continue current privileges was not based in part on results of OPPE activities. Further, the OIG noted that the OPPE data to be collected for the solo gastroenterology provider did not include the elements required by VHA. This resulted in insufficient evidence to confirm the quality of care delivered by providers. Clinical leaders were unaware of the requirement and cited lack of oversight as the reason for noncompliance.

Additionally, two of four solo or few (less than two in a specialty) practitioner profiles with OPPE activities had no evidence that providers with similar training and privileges completed the evaluations.⁶² This resulted in LIPs providing care without a thorough evaluation of their competency, which could impact quality of care and patient safety. The chief of staff attributed the noncompliance to misinterpretation of the requirement and believed that providers within the same service, regardless of training and privileges, were qualified to complete the evaluations.

Recommendation 4

4. The chief of staff ensures service chiefs collect, review, and use ongoing professional practice evaluation data in the determination to continue current privileges and monitors the service chiefs' compliance.

Facility concurred.

Target date for completion: December 2019

Facility response: The Chief of Staff or designee will review professional practice evaluation data to ensure relevant service-specific data for Ongoing Professional Practice Evaluations have been used to determine continuation of current privileges. This will be documented in the credentialing meeting minutes. Minutes will be audited by the Chief of Staff's office until 100 percent compliance is demonstrated for a minimum of six consecutive months or two quarters. Audit results will be reported to the Medical Executive Committee.

Recommendation 5

5. The chief of staff makes certain service chiefs include the minimum required specialty-specific criteria for ongoing professional practice evaluations of gastroenterology practitioners and monitors service chiefs' compliance.

⁶² VHA Memorandum, Requirements for Peer Review of Solo Practitioners, August 29, 2016.

Facility concurred.

Target date for completion: December 2019

Facility response: The Chief of Staff or designee will review service chiefs' documentation to ensure relevant service-specific data for Ongoing Professional Practice Evaluations have been used to determine continuation of current gastroenterology practitioners' privileges. This will be monitored by the Chief of Staff's office until 100 percent compliance is demonstrated for a minimum of six consecutive months or two quarters. Audit results will be reported to Medical Executive Committee.

Recommendation 6

6. The chief of staff makes certain that ongoing professional practice evaluations are completed by providers with similar training and privileges and monitors compliance.

Facility concurred.

Target date for completion: December 2019

Facility response: The Chief of Staff or designee will review service chiefs' documentation to ensure Ongoing Professional Practice Evaluations have been completed by providers with similar trainings and privileges. This will be monitored by the Chief of Staff's office until 100 percent compliance is demonstrated for a minimum of six consecutive months or two quarters. Audit results will be reported to Medical Executive Committee.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct environment of care inspection rounds and resolve issues in a timely manner. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional, but should also promote healing.⁶³

The purpose of this facet of the OIG inspection was to determine whether the facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, such as in the locked inpatient mental health unit. The inspection team also looked at facility compliance with emergency management processes.⁶⁴

VHA requires its facilities to have the “capacity for [providing] mental health services for veterans with acute and severe emotional and/or behavioral symptoms causing a safety risk to self or others, and/or resulting in severely compromised functional status. This level of care is typically provided in an inpatient setting;” however, for facilities that do not have inpatient mental health services, that “capacity” could mean facilitating care at a nearby VA or non-VA facility.⁶⁵

VHA requires managers to establish a comprehensive emergency management program to ensure the continuity of patient care and hospital operations in the event of a natural disaster or other emergency. This includes conducting a hazard vulnerability analysis and developing an emergency operations plan. These requirements are meant to support facilities’ efforts to identify and minimize harm from potential hazards, threats, incidents, and events related to healthcare and other essential services.⁶⁶ Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,

⁶³ VHA Directive 1608, Comprehensive Environment of Care (CEOC Program), February 1, 2016.

⁶⁴ Applicable requirements for high-risk areas and emergency management include those detailed in or by various VHA Directives, Joint Commission hospital accreditation standards, Occupational Safety and Health Administration, American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), and National Fire Protection Association (NFPA).

⁶⁵ VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (This VHA Handbook was scheduled for recertification on or before the last working date of September 2018 and has not been recertified.)

⁶⁶ VHA Directive 0320.01, Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures, April 6, 2017.

Occupational Safety and Health Administration,⁶⁷ and National Fire Protection Association standards.⁶⁸ The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.⁶⁹

In all, the OIG team inspected seven areas—the intensive care unit, a medical/surgical unit (3rd floor), community living center, post-anesthesia care unit, the emergency department, women’s clinic, and primary care clinic. The team also inspected the Rawlins VA Clinic. The inspection team reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent facility
 - General safety
 - Environmental cleanliness and infection prevention
 - General privacy
 - Women veterans program
 - Availability of medical equipment and supplies
- Community based outpatient clinic
 - General safety
 - Environmental cleanliness and infection prevention
 - General privacy
 - Women veterans program
 - Availability of medical equipment and supplies
- Locked inpatient mental health unit⁷⁰
 - Mental health environment of care rounds
 - Nursing station security
 - Public area and general unit safety

⁶⁷ The Occupational Safety and Health Administration (OSHA) is part of the US Department of Labor. OSHA’s Mission is to assure safe and healthy working conditions “by setting and enforcing standards and by providing training, outreach, education, and assistance.” <https://www.osha.gov/about.html> (This website was accessed on June 28, 2018.)

⁶⁸ The National Fire Protection Association (NFPA) is a global nonprofit organization “devoted to eliminating death, injury, property, and economic loss due to fire, electrical, and related hazards.” <https://www.nfpa.org/About-NFPA> (This website was accessed on June 28, 2018.)

⁶⁹ TJC. Environment of Care standard EC.02.05.07.

⁷⁰ The facility did not have an inpatient mental health unit.

- Patient room safety
- Infection prevention
- Availability of medical equipment and supplies
- Emergency management
 - Hazard vulnerability analysis (HVA)
 - Emergency operations plan (EOP)
 - Emergency power testing and availability

Environment of Care Conclusion

The parent facility generally met the performance indicators evaluated for safety and privacy. The OIG team did not note any issues with the availability of medical equipment and supplies. However, the team noted improvement opportunities with environmental cleanliness and infection prevention at the parent facility, personal protective equipment at the Rawlins VA Clinic, the annual review of the hazard vulnerability analysis, and the biannual activation of the emergency operations plan.

Specifically, TJC requires hospitals to identify “environmental deficiencies, hazards, and unsafe practices,”⁷¹ and to “keep furnishings and equipment safe and in good repair.”⁷² Of the seven patient care areas inspected at the parent facility, two areas had dirty ventilation grills;⁷³ two areas had dead insects in the light fixture covers;⁷⁴ four areas had walls in need of repair;⁷⁵ and two areas had stained ceiling tiles.⁷⁶ These findings may potentially affect the safety and physical well-being of patients, staff, and visitors. The associate director cited a shortage of staff and inattention to detail as reasons for noncompliance.

Recommendation 7

7. The associate director ensures managers maintain a safe and clean environment in patient care areas and monitors managers’ compliance.

⁷¹ TJC. Environment of Care standard EC.04.01.01.

⁷² TJC. Environment of care standard EC.02.06.01.

⁷³ Medical/surgical unit (3rd floor) and community living center.

⁷⁴ Intensive care and medical/surgical (3rd floor) units.

⁷⁵ Intensive care unit, medical/surgical unit (3rd floor), community living center, and the ED.

⁷⁶ Medical/surgical unit (3rd floor) and community living center.

Facility concurred.

Target date for completion: January 2020

Facility response: Maintaining a safe and clean environment in patient care areas will be monitored weekly/biannual by environment of care rounds. Work orders generated by the environment of care rounds will be completed within 14 days. This will be reported to Environment of Care Committee. Monitoring will be ongoing until 90% compliance is achieved for 6 months.

For infection prevention, Occupational Safety and Health Administration requires that appropriate personal protective equipment is readily accessible at the worksite.⁷⁷ At the Rawlins VA Clinic, the OIG found that gowns and masks were not readily accessible to employees. This may result in an increased potential for the spread of infection and may also compromise staff safety. The clinic manager and nursing staff attributed the noncompliance to lack of storage space for personal protective equipment throughout the clinic.

Recommendation 8

8. The associate director ensures managers make personal protective equipment readily accessible to employees at the Rawlins VA Clinic and monitors managers' compliance.

Facility concurred.

Target date for completion: October 2019

Facility response: Currently personal protective equipment is available at the Rawlins Clinic. Semi-Annually, Environment of Care rounds and/or Emergency Manager will monitor presence of appropriate personal protective equipment.

For emergency management, VHA requires facilities to have a comprehensive emergency management plan that includes an annual review of the hazard vulnerability analysis and emergency operations plan and an inventory of resources and assets that may be needed during emergencies.⁷⁸ This review must be documented, evaluated by the Emergency Management Committee, and approved by the executive leadership team.⁷⁹ Also, TJC requires facilities to test emergency operations plans twice a year to ensure effectiveness.

The OIG team found no evidence that the hazard vulnerability analysis was reviewed, and the facility activated its emergency operations plan only once during the previous 12 months. This resulted in a lack of assurance that the facility is prepared for contingency operations during

⁷⁷ OSHA 1910.1030(d)(3).

⁷⁸ VHA Directive 0320.01.

⁷⁹ VHA Directive 0320.01.

emergencies. Facility managers were aware of the requirements and cited the lack of a permanent facility emergency management specialist as the reason for noncompliance.

Recommendation 9

9. The associate director makes certain that the hazard vulnerability analysis is reviewed annually and monitors compliance.⁸⁰

Facility concurred.

Target date for completion: Completed

Facility response: Currently, the hazard vulnerability assessment has been reviewed and approved by the Emergency Management Committee, May 2019. Compliance of annual review has been added to the Environment of Care Committee reporting grid.

Recommendation 10

10. The associate director confirms that the emergency operations plan is activated twice a year and monitors compliance.⁸¹

Facility concurred.

Target date for completion: Completed

Facility response: The facility emergency operation plan has been revised, reviewed and approved by the Environment of Care Committee and the Medical Center Director. Currently three emergency operation plan activations have taken place in the previous six months. Quarterly review has been added to the Environment of Care Committee reporting grid.

⁸⁰ The OIG reviewed evidence sufficient to demonstrate that the facility had completed improvement actions and therefore closed the recommendation before the report's release.

⁸¹ The OIG reviewed evidence sufficient to demonstrate that the facility had completed improvement actions and therefore closed the recommendation before the report's release.

Medication Management: Controlled Substances Inspections

The Controlled Substances Act divides controlled drugs into five categories based on whether they have an accepted medical treatment use in the United States, their relative potential for abuse, and the likelihood of causing dependence if abused.⁸² Diversion of controlled substances by healthcare workers—the transfer of legally prescribed controlled substances from the prescribed individual to others for illicit use—remains a serious problem that can increase patient safety issues and elevate the liability risk to healthcare facilities.⁸³

VHA requires that facility managers implement and maintain a controlled substances inspection program to minimize the risk for loss and diversion and to enhance patient safety. Requirements include the appointment of controlled substances coordinator(s) and controlled substances inspectors, implementation of procedures for inventory control, and inspections of the pharmacy and clinical areas with controlled substances.⁸⁴

To determine whether the facility complied with requirements related to controlled substances security and inspections, the OIG team interviewed key managers and reviewed inspection reports; monthly summaries of findings, including discrepancies, provided to the facility director; inspection quarterly trend reports for the prior two completed quarters;⁸⁵ and other relevant documents. The OIG evaluated the following performance indicators:

- Controlled substances coordinator reports
 - Monthly summary of findings to the director
 - Quarterly trend report to the director
 - Quality Management Committee’s review of monthly and quarterly trend reports
 - Actions taken to resolve identified problems
- Pharmacy operations
 - Staff restrictions for monthly review of balance adjustments⁸⁶
- Requirements for controlled substances inspectors

⁸² Drug Enforcement Agency Controlled Substance Schedules. <https://www.deadiversion.usdoj.gov/schedules/>. (The website was accessed on March 7, 2019.)

⁸³ American Society of Health-System Pharmacists, “ASHP Guidelines on Preventing Diversion of Controlled Substances,” *American Journal of Health-System Pharmacists* 74, no. 5 (March 1, 2017): 325-348.

⁸⁴ VHA Directive 1108.02(1), *Inspection of Controlled Substances*, November 28, 2016 (amended March 6, 2017).

⁸⁵ The two quarters were from April 1, 2018, through September 30, 2018.

⁸⁶ Controlled substances balance adjustment reports list transactions in which the pharmacy vault inventory balance was manually adjusted.

- No conflicts of interest
- Appointed in writing by the director for a term not to exceed three years
- Hiatus of one year between any reappointment
- Completion of required annual competency assessment
- Controlled substances area inspections
 - Completion of monthly inspections
 - Rotations of controlled substances Inspectors
 - Patterns of inspections
 - Completion of inspections on day initiated
 - Reconciliation of dispensing between pharmacy and each dispensing area
 - Verification of controlled substances orders
 - Performance of routine controlled substances inspections
- Pharmacy inspections
 - Monthly physical counts of the controlled substances in the pharmacy
 - Completion of inspections on day initiated
 - Security and verification of drugs held for destruction⁸⁷
 - Accountability for all prescription pads in pharmacy
 - Verification of hard copy controlled substances prescriptions
 - Verification of 72-hour inventories of the main vault
 - Quarterly inspections of emergency drugs
 - Monthly checks of locks and verification of lock numbers
- Facility review of override reports⁸⁸

⁸⁷ According to VHA Directive 1108.02(1), The Destructions File Holding Report “lists all drugs awaiting local destruction or turn-over to a reverse distributor.” Controlled substances inspectors “must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report.”

⁸⁸ When automated dispensing cabinets are used, nursing staff can override and remove medications prior to the pharmacists’ review of medications ordered by the providers.

Medication Management Conclusion

Generally, the facility met requirements as reflected by the performance indicators above. The OIG made no recommendations.

Mental Health: Military Sexual Trauma Follow-Up and Staff Training

The Department of Veterans Affairs uses the term “military sexual trauma” (MST) to refer to a “psychological trauma, which in the judgment of a mental health professional employed by the Department [of Veterans Affairs], resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training.”⁸⁹ MST is an experience, not a diagnosis or a mental health condition. Although posttraumatic stress disorder is commonly associated with MST, other frequently associated diagnoses include depression and substance use disorders.⁹⁰

VHA requires that the facility director designates an MST coordinator to support national and VISN-level policies related to MST-related care and serve as a source of information; establish and monitor MST-related staff training and informational outreach; and communicate MST-related issues, services, and initiatives with leadership.⁹¹ Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.⁹²

VHA requires that all veterans and potentially eligible individuals seen in VHA facilities be screened for experiences of MST with the required MST clinical reminder in the computerized patient record system (CPRS).⁹³ Those who screen positive must have access to appropriate MST-related care.⁹⁴ VHA also requires that evidence-based mental health care be available to all veterans with mental health conditions related to MST. Patients requesting or referred for mental health services must receive an initial evaluation within 24 hours of the referral to identify urgent care needs and a more comprehensive diagnostic evaluation within 30 days.⁹⁵

The MST coordinator may provide clinical care to individuals experiencing MST and is thus subject to the same mandatory training requirements as mental health and primary care providers.⁹⁶ All mental health and primary care providers must complete MST mandatory

⁸⁹VHA Directive 1115, Military Sexual Trauma (MST) Program, May 8, 2018.

⁹⁰Military Sexual Trauma. https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf. (The website was accessed on November 17, 2017.)

⁹¹ VHA Directive 1115.

⁹² VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008 (amended November 16, 2015). (This VHA Handbook was scheduled for recertification on or before the last working date of September 2013 and has not been recertified.)

⁹³VHA Directive 1115 states that “MST-related care is not subject to the minimum active duty service requirement set forth in 38 U.S.C. 5303A; Veterans may therefore be able to receive MST-related care even if they are not eligible for VA health care under other treatment authorities.”

⁹⁴VHA Directive 1115.

⁹⁵ VHA Handbook 1160.01.

⁹⁶ VHA Directive 1115.

training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.⁹⁷

To determine whether the facility complied with the requirements related to MST follow-up and training, the OIG inspection team reviewed relevant documents and staff training records and interviewed key employees. The team also reviewed the electronic health records of 50 randomly selected outpatients who had a positive MST screen from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

- Designated facility MST coordinator
 - Establishes and monitors MST-related staff training
 - Establishes and monitors informational outreach
 - Communicates MST-related issues, services, and initiatives with local leaders
- Evidence of tracking MST-related data
- Provision of clinical care
 - Referral for MST-related care to patients with positive MST screens
 - Initial evaluation within 24 hours to patients referred for mental health services
 - Comprehensive diagnostic and treatment planning evaluation within 30 days to patients referred for mental health services
- Completion of MST mandatory training requirement for mental health and primary care providers

Mental Health Conclusion

The OIG team found many of the performance indicators were achieved, including the designation of an MST coordinator and provision of clinical care. The team noted concerns, however, with requirements for establishing and monitoring MST-related staff training, communicating MST-related issues with local leaders, tracking MST-related data, and providers completing MST mandatory training that warranted recommendations for improvement.

Specifically, VHA requires MST coordinators to establish and monitor MST-related staff training and communicate the status of MST services and initiatives with local leaders.⁹⁸ The OIG team determined that the facility had no process in place for establishing and monitoring

⁹⁷ VHA Directive 1115.01, *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017; Acting Deputy Under Secretary for Health for Operations and Management Memorandum, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers*, February 2, 2016.

⁹⁸ VHA Directive 1115.

MST-related staff training or communicating MST services and initiatives with leadership. This may hinder the MST coordinator's efforts to enhance staff training and leadership's ability to identify and address improvement opportunities. The MST coordinator and the acting chief of Mental Health Services attributed the lack of compliance to insufficient oversight and inattention to detail.

Recommendation 11

11. The facility director ensures the military sexual trauma coordinator establishes and monitors military sexual trauma-related staff training and monitors the coordinator's compliance.

Facility concurred.

Target date for completion: December 2019

Facility response: Compliance rates and appropriate assignment of training tracks for provider roles will be reviewed by the military sexual trauma coordinator monthly until 90 percent compliance is reached for a minimum of three consecutive months. When this goal is reached reviews will be completed quarterly and maintained by the military sexual trauma coordinator. Audit reviews will be reported to Medical Executive Board.

Recommendation 12

12. The facility director ensures the military sexual trauma coordinator communicates the status of military sexual trauma-related services and initiatives with leadership and monitors the coordinator's compliance.

Facility concurred.

Target date for completion: September 2019

Facility response: The military sexual trauma coordinator will communicate the status of military sexual trauma-related services and initiatives with leadership at the Medical Executive Board quarterly. This will include status of consults, individual and group therapy availability, use of Evidence Based Practice therapy, whole health initiatives and other services that may be available to veterans as well as changes within military sexual trauma program as directed by MST National office.

VHA also requires that MST-related data are tracked, including monitoring screening, referral, and treatment services provided to veterans.⁹⁹ The OIG found that the facility did not track and monitor MST-related data. This may result in ineffective program evaluation and missed

⁹⁹ VHA Handbook 1160.01.

opportunities for improvement. The MST coordinator and the acting chief of Mental Health Services cited insufficient oversight and inattention to detail as reasons for noncompliance.

Recommendation 13

13. The facility director makes certain that the military sexual trauma coordinator tracks and monitors military sexual trauma-related data and monitors the coordinator's compliance.

Facility concurred.

Target date for completion: September 2019

Facility response: The military sexual trauma coordinator will track and monitor military sexual trauma-related data and communicate this data at the Medical Executive Board quarterly. This report will include Military Sexual Trauma (MST) Dashboard, compliance of MST screenings, MST related care, provider training and accessibility of the MST coordinator through Answer the Call outcomes.

VHA requires that all mental health and primary care providers hired after July 1, 2012, complete MST mandatory training no later than 90 days after entering their position.¹⁰⁰ Of the 20 training records reviewed, the OIG team found that seven providers did not complete the required training within 90 days. This could prevent providers from administering appropriate counseling, care, and service to veterans who experienced MST. The MST coordinator and the acting chief of Mental Health Services cited insufficient oversight and inattention to detail as reasons for noncompliance.

Recommendation 14

14. The chief of staff ensures that providers complete military sexual trauma mandatory training within the required timeframe and monitors providers' compliance.

¹⁰⁰ VHA Directive 1115.01.

Facility concurred.

Target date for completion: December 2019

Facility response: Provider mandatory MST training will be tracked through TMS and reported quarterly to Medical Executive Board by the military sexual trauma coordinator. The MST Coordinator will identify barriers to non-compliance among providers and work with identified supervisors to ensure training is completed. Monthly auditing will be completed until 90 percent compliance with mandatory training requirements is reached. These audits will be reported to Medical Executive Board.

Geriatric Care: Antidepressant Use among the Elderly

VA's National Registry for Depression reported that "11 [percent] of veterans aged 65 years and older have a diagnosis of major depressive disorder."¹⁰¹ The VA/DoD (Department of Defense) Clinical Practice Guideline (CPG) describes depression as "a common mental disorder that presents with depressed mood, loss of interest or pleasure in regular activities, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration." This can lead to poor quality of life, decreased productivity, and increased mortality from suicide.¹⁰²

According to the Centers for Disease Control and Prevention, older adults are at increased risk for experiencing depression because "80 [percent] of older adults have at least one chronic health condition and 50 [percent] have two or more." Further, "most older adults see an improvement in [their] symptoms when treated with antidepressant drugs, psychotherapy, or a combination of both."¹⁰³

The American Geriatrics Society revised the Beers Criteria in 2015 to include lists of potentially inappropriate medications to be avoided. Potentially inappropriate medication use in older adults continues to be associated with confusion, falls, and mortality.¹⁰⁴ The criteria provide guidelines that help to improve the safety of prescribing certain medications including antidepressants for older adults.

TJC requires clinicians to educate patients and families about the "safe and effective use of medications."¹⁰⁵ In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.¹⁰⁶ Further, TJC requires clinicians to perform medication reconciliation by comparing the medication a patient is actually taking to the new medications that are ordered for the patient and resolving any discrepancies.¹⁰⁷ The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

¹⁰¹ Hans Peterson, "Late Life Depression," *U.S. Department of Veterans Affairs, Mental Health Featured Article*, March 1, 2011. https://www.mentalhealth.va.gov/featureArticle_Mar11LateLife.asp. (The website was accessed on March 8, 2019.)

¹⁰² VA/DoD *Clinical Practice Guideline for the Management of Major Depressive Disorder*, April 2016. <https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf> (The website was accessed November 20, 2018.)

¹⁰³ Centers for Disease Control and Prevention, "Depression is Not a Normal Part of Growing Older," January 31, 2017. <https://www.cdc.gov/aging/mentalhealth/depression.htm>. (The website was accessed on March 8, 2019.)

¹⁰⁴ American Geriatrics Society 2015 Beers Criteria Update Expert Panel, "American Geriatrics Society 2015 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults." http://www.sigot.org/allegato_docs/1057_Beers-Criteria.pdf (The website was accessed on March 22, 2018.)

¹⁰⁵ TJC. Provision of Care, Treatment, and Services standard PC 02.03.01.

¹⁰⁶ VHA Directive 1164, *Essential Medication Information Standards*, June 26, 2015.

¹⁰⁷ TJC. National Patient Safety Goal standard NPSG.03.06.01.

remission. Monitoring includes assessment of symptoms, adherence to medication and psychotherapy, and any adverse effects. The CPG also recommends that treatment planning includes patient education about treatment options, including risks and benefits.¹⁰⁸

To determine whether the facility complied with requirements concerning use of antidepressants among the elderly, the OIG inspection team interviewed key employees and managers. The team also reviewed the electronic health records of 39 randomly selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.¹⁰⁹ The OIG evaluated the following performance indicators:

- Justification for medication initiation
- Evidence of patient/caregiver education specific to the medication prescribed
- Clinician evaluation of patient/caregiver understanding of the education provided
- Medication reconciliation

Geriatric Care Conclusion

The OIG team found providers complied with requirements by justifying the reason for medication initiation and medication reconciliation. The inspection team found inadequate patient and/or caregiver education related to newly prescribed medications and inconsistent evaluation of the education provided that warranted recommendations for improvement.

Specifically, TJC requires education for patients and families about potential significant concerns, interactions, and side effects of new medication prior to administration,¹¹⁰ and that clinicians evaluate patient/caregiver understanding of the education provided.¹¹¹ The OIG estimated that clinicians provided this education to 64 percent of the patients at the facility, based on electronic health records reviewed.¹¹² In addition, the OIG estimated that clinicians assessed understanding of the education provided for 44 percent of the patients at the facility, based on records reviewed where education was provided.¹¹³ This resulted in patients and/or caregivers not having the essential information to safely manage their health. Program staff were aware of

¹⁰⁸ VA/DoD Clinical Practice Guidelines for the Management of Major Depressive Disorder.

¹⁰⁹ The seven selected antidepressant medications are Amitriptyline, Clomipramine, Desipramine, Doxepin (>6mg/day), Imipramine, Nortriptyline, and Paroxetine.

¹¹¹ TJC. Medication Management standard MM 06.01.01; TJC. Provision of Care, Treatment, and Services standard PC 02.03.01.

¹¹² The OIG is 95 percent confident that the true compliance rate is somewhere between 48.7 and 78.8 percent, which is statistically significantly below the 90 percent benchmark.

¹¹³ The OIG is 95 percent confident that the true compliance rate is somewhere between 25.0 and 64.0 percent, which is statistically significantly below the 90 percent benchmark.

the requirements and cited competing priorities due to staff and leadership vacancies, limited administrative time for clinicians, and gaps in communication as reasons for noncompliance.

Recommendation 15

15. The chief of staff confirms that clinicians provide and document patient/caregiver education and assess understanding of education provided about newly prescribed medications and monitors clinicians' compliance.

Facility concurred.

Target date for completion: January 2020

Facility response: The Chief of Staff or designee will review random patient records, a minimum of 30 monthly, for documentation of patient education when new medications are prescribed. Results will be audited by the Chief of Staff's office until 100 percent compliance is demonstrated for a minimum of three consecutive months or one quarter. Audit results will be reported to the Medical Executive Committee.

Women’s Health: Abnormal Cervical Pathology Results Notification and Follow-Up

Each year, about 12,000 women in the United States are diagnosed with cervical cancer.¹¹⁴ Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.¹¹⁵ In addition to HPV infection, other risk factors for cervical cancer include smoking, human immunodeficiency virus (HIV) infection, use of oral contraceptives for five or more years, and having given birth to three or more children.¹¹⁶ Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.¹¹⁷

VA is authorized to provide “gender-specific services, such as Papanicolaou tests (Pap smears),” to eligible women veterans. Further, VHA requires that all eligible and enrolled women veterans have access to appropriate services and preventative care. That care would include age-appropriate screening for cervical cancer.¹¹⁸

VHA requires that each facility have a “full-time Women Veterans Program Manager (WVPM) to execute comprehensive planning for women’s health care.” VHA also requires a medical director or clinical champion to be responsible for the clinical oversight of the women’s health program. Each facility must also have a “Women Veterans Health Committee (WVHC) comprised of appropriate facility leadership and program directors, which develops and implements a Women’s Health Program strategic plan.” The Women Veterans Health Committee must meet at least quarterly and report to the executive leadership. The facility must also have a process to ensure the collecting and tracking of data related to cervical cancer screenings.¹¹⁹

VHA has established timeframes for notifying patients of abnormal cervical pathology results. Abnormal cervical pathology results must be communicated to patients within seven calendar days from the date the results are available to the ordering provider. Communication of the

¹¹⁴ Centers for Disease Control and Prevention. “Cervical Cancer” *Inside Knowledge* fact sheet, December 2016. https://www.cdc.gov/cancer/cervical/pdf/cervical_facts.pdf. (The website was accessed on February 28, 2018.)

¹¹⁵ Center for Disease Control and Prevention. *Basic Information About Cervical Cancer*. February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019)

¹¹⁶ Centers for Disease Control and Prevention. *What Are the Risk Factors for Cervical Cancer?* February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/risk_factors.htm. (The website was accessed on March 8, 2019.)

¹¹⁷ Center for Disease Control and Prevention. *Basic Information About Cervical Cancer*. February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)

¹¹⁸ VHA Directive 1330.01(2), *Health Care Services for Women Veterans*, February 15, 2017 (amended July 24, 2018).

¹¹⁹ VHA Directive 1330.01(2).

results to patients must be documented. The facility must ensure that appropriate follow-up care is provided to patients with abnormal results.¹²⁰

To determine whether the facility complied with selected VHA requirements for the notification and follow-up care of abnormal cervical pathology results, the OIG inspection team reviewed relevant documents and interviewed selected employees and managers. The team also reviewed the electronic health records of five women veteran patients, between ages 21 and 65, who had an abnormal pap smear or test from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

- Appointment of a women’s veterans program manager
- Appointment of women’s health medical director or clinical champion
- Facility Women Veterans Health Committee
 - Core membership
 - Quarterly meetings
 - Reports to clinical executive leadership
- Collection and tracking of cervical cancer screening data
 - Notification of patients due for screening
 - Completed screenings
 - Results reporting
 - Follow-up care
- Communication of abnormal results to patient within required timeframe
- Provision of follow-up care for abnormal cervical pathology results, if indicated

Women’s Health Conclusion

Generally, the OIG inspection team found the facility attained many of the performance indicators, including requirements for a designated women’s veterans program manager and clinical champion, clinical oversight of the women’s health program, tracking of data related to cervical cancer screenings, communication of results to patients, and follow-up care if indicated. However, the inspection team noted a concern with the Women Veterans Health Committee membership that warranted a recommendation for improvement.

Specifically, VHA requires that the core membership of the Women Veterans Health Committee includes a women veterans program manager, a women’s health medical director,

¹²⁰ VHA Directive 1330.01(2).

“representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, emergency department, radiology, laboratory, quality management, business office/non-VA medical care, and a member from the executive leadership.”¹²¹ The team noted that the Women Veterans Health Committee membership lacked consistent representation from the emergency department, business office/non-VA medical care, quality management, and executive leadership. This resulted in a lack of expertise and oversight in the review and analysis of data to ensure appropriate clinical services are available to women veterans. The women’s health medical director cited turnover in key membership positions as the reason for noncompliance.

Recommendation 16

16. The facility director makes certain that the Women Veterans Health Committee includes required core members and monitors the committee’s compliance.

Facility concurred.

Target date for completion: January 2019

Facility response: The Women Veterans Program Manager will monitor attendance at each Women Veterans Health Committee meeting. Attendance will be monitored until 90 percent compliance is achieved for six consecutive months. This report will be sent to the Chief of Staff for action. Mandatory attendance compliance will be reported to the Medical Executive Committee.

¹²¹ VHA Directive 133.01(2).

High-Risk Processes: Operations and Management of Emergency Departments and Urgent Care Centers

VHA defines an emergency department as a “unit in a VA medical facility that has acute care medical and/or surgical inpatient beds and whose primary responsibility is to provide resuscitative therapy and stabilization in life-threatening situations.” An urgent care center (UCC) “provides acute medical care for patients without a scheduled appointment who are in need of immediate attention for an acute medical or mental health illness and/or minor injuries.”¹²² A variety of emergency services may exist, dependent on “capability, capacity, and function of the local VA medical facility;” however, emergency care must be uniformly available in all VHA emergency departments and UCCs.¹²³

Because the emergency department or UCC is often the first point of contact for patients seeking treatment of unexpected medical issues, a care delivery system with appropriate resources and services must be available to deliver prompt, safe, and appropriate care. VHA requires that each emergency department provide “unrestricted access to appropriate and timely emergency medical and nursing care 24 hours a day, 7 days a week.” VHA UCCs are also required to provide access and timely care during established operational hours. VHA also requires that “evaluation, management, and treatment [are] provided by qualified personnel with the knowledge and skills appropriate to treat those seeking emergency care.”¹²⁴

TJC noted that patient flow problems pose a persistent risk to quality and safety and established standards for the management of the flow of patients in the emergency department and the rest of the hospital. Managing the flow of patients prevents overcrowding, which can “undermine the timeliness of care and, ultimately, patient safety.” Effective management processes that “support patient flow [in the ED or UCC settings] (such as admitting, assessment and treatment, patient transfer, and discharge) can minimize delays in the delivery of care.”¹²⁵

The VHA national director of Emergency Medicine developed the Emergency Medicine Improvement (EMI) initiative to improve the quality of emergent and urgent care provided through VA emergency departments and UCCs. As part of this initiative, all VA emergency departments and UCCs must use the Emergency Department Integration Software (EDIS) tracking program to document and manage the flow of patients.¹²⁶

¹²² VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016 (amended March 7, 2017).

¹²³ VHA Directive 1101.05(2).

¹²⁴ VHA Directive 1101.05(2).

¹²⁵ TJC. Leadership standard LD.04.03.11.

¹²⁶ VHA Directive 1101.05(2); The Emergency Medicine Management Tool (EMMT) uses data collected from EDIS to generate productivity metrics. The use of EDIS and EMMT are key tools in accomplishing EMI initiative goals.

VA emergency departments and UCCs must also be designed to promote a safe environment of care.¹²⁷ Managers must ensure medications are securely stored,¹²⁸ a psychiatric intervention room is available,¹²⁹ and equipment and supplies are readily accessible to provide gynecologic and resuscitation services. VHA also requires emergency departments to have communication systems available to accept requests by local emergency medical services for transporting unstable patients to VA emergency departments.¹³⁰

The OIG team examined the clinical risks of the emergency department/UCC areas by evaluating the staffing; the provision of care, including selected aspects of mental health and women's health; and the reduction of patient safety risks to optimize quality care and outcomes in those areas. In addition to conducting manager and staff interviews, the team reviewed emergency department staffing schedules, committee minutes, and other relevant documents. The OIG evaluated the following performance indicators:

- General
 - Presence of an emergency department and UCC
 - Availability of acute care medical and/or surgical inpatient beds in facilities with emergency departments
 - Emergency department/UCC operating hours
 - Workload capture process
- Staffing for emergency department/UCC
 - Dedicated medical director
 - At least one licensed physician privileged to staff the department at all times
 - Minimum of two registered nurses on duty during all hours of operation
 - Back-up call schedules for providers
- Support services for emergency department/UCC
 - Access during regular hours, off hours, weekends, and holidays
 - On-call list for staff required to respond

¹²⁷ VHA Directive 1101.05(2).

¹²⁸ TJC. Medication Management standard MM.03.01.01.

¹²⁹ A psychiatric intervention room is where individuals experiencing a behavioral health crisis, including serious disturbances, agitation, or intoxication may be taken immediately on arrival.

¹³⁰ VHA Directive 1101.05(2).

- Licensed independent mental health provider available as required for the facility's complexity level
- Telephone message system during non-operational hours
- Inpatient provider available for patients requiring admission
- Patient flow
 - EDIS tracking program
 - Emergency department patient flow evaluation
 - Diversion policy
 - Designated bed flow coordinator
- General safety
 - Directional signage to after hours emergency care
 - Fast tracks¹³¹
- Medication security and labeling
- Management of patients with mental health disorders
- Emergency department participation in local/regional emergency medical services (EMS) system, if applicable
- Women veteran services
 - Capability and equipment for gynecologic examinations
- Life support equipment

High-Risk Processes Conclusion

The facility generally complied with many of the performance indicators used to assess the operations and management of the emergency department. However, the OIG team identified a concern with unlabeled open medication vials in the emergency department that warranted a recommendation for improvement.

Specifically, VHA requires multi-dose medications to be labeled with an expiration date upon opening the product (to include, but not limited to parenterals (injectable), insulin, and eye drops) that does not exceed 28 days or a shorter expiration date recommended by the

¹³¹ The emergency department fast track is a designated care area within the emergency department domain where lower acuity patients are assessed and treated.

manufacturer.¹³² The OIG found open and undated multi-dose insulin vials in the medication refrigerator. Failure to label opened medication vials may result in unsafe medication administration. Facility managers were aware of the requirement and acknowledged that clinical staff failed to follow medication safety procedures as the reason for noncompliance.

Recommendation 17

17. The associate director for Patient Care Services makes certain that staff label multi-dose medication vials with an expiration date upon opening and monitors clinical staff's compliance.

Facility concurred.

Target date for completion: October 2019

Facility response: Nurse Managers will monitor compliance with multi-dose vial medication labeling a minimum of three times weekly. Reports of these audits will be presented to Nurse Executive Committee. Monitoring will be ongoing for a minimum of three months or until 90% compliance is reached.

¹³² VHA Directive 1108.06, *Inpatient Pharmacy Services*, February 8, 2017.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	<ul style="list-style-type: none"> • Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Accreditation and/or for-cause surveys and oversight inspections • Factors related to possible lapses in care • VHA performance data 	Seventeen OIG recommendations ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events are attributable to the director, chief of staff, ADPCS, and associate director. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> • Protected peer reviews • UM reviews • Patient safety • Resuscitation episode review 	<ul style="list-style-type: none"> • The Critical Care Committee conducts a complete analysis of resuscitation episodes by reviewing required elements. 	<ul style="list-style-type: none"> • The interdisciplinary group or committee that reviews UM data includes a representative from the chief business office revenue utilization review. • The patient safety manager includes all required review elements in root cause analyses.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Privileging	<ul style="list-style-type: none"> • Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank 	<ul style="list-style-type: none"> • Service chiefs collect and review OPPE data. • Service chiefs include the minimum required specialty-specific criteria for OPPEs of gastroenterology practitioners. • OPPEs are completed by providers with similar training and privileges. 	<ul style="list-style-type: none"> • None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
<p>Environment of Care</p>	<ul style="list-style-type: none"> • Parent facility <ul style="list-style-type: none"> ○ General safety ○ Environmental cleanliness and infection prevention ○ General privacy ○ Women veterans program ○ Availability of medical equipment and supplies • Community based outpatient clinic <ul style="list-style-type: none"> ○ General safety ○ Environmental cleanliness and infection prevention ○ General privacy ○ Women veterans program ○ Availability of medical equipment and supplies • Emergency management <ul style="list-style-type: none"> ○ Hazard vulnerability analysis (HVA) ○ Emergency operations plan (EOP) ○ Emergency power testing and availability 	<ul style="list-style-type: none"> • Managers maintain a clean and safe environment in patient care areas. • Personal protective equipment is readily accessible to employees at the Rawlins VA Clinic. 	<ul style="list-style-type: none"> • The hazard vulnerability analysis is reviewed annually. • The emergency operations plan is activated twice a year.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Controlled Substances Inspections	<ul style="list-style-type: none"> • Controlled substances coordinator reports • Pharmacy operations • Controlled substances inspector requirements • Controlled substances area inspections • Pharmacy inspections • Facility review of override reports 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training	<ul style="list-style-type: none"> • Designated facility MST coordinator • Evidence of tracking MST-related data • Provision of clinical care • Completion of MST mandatory training requirement for mental health and primary care providers 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • The MST coordinator establishes and monitors MST-related staff training. • The MST coordinator communicates the status of MST-related services and initiatives with leadership. • The MST coordinator tracks and monitors MST-related data. • Providers complete MST mandatory training within the required timeframe.
Geriatric Care: Antidepressant Use among the Elderly	<ul style="list-style-type: none"> • Justification for medication initiation • Evidence of patient and/or caregiver education specific to the medication prescribed • Clinician evaluation of patient and/or caregiver understanding of the education provided • Medication reconciliation 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Clinicians provide and document patient and/or caregiver education and assess understanding of education provided about newly prescribed medications.
Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up	<ul style="list-style-type: none"> • Appointment of a women veterans program manager • Appointment of a women's health medical director or clinical champion 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • The Women Veterans Health Committee includes core members.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	<ul style="list-style-type: none"> • Facility Women Veterans Health Committee • Collection and tracking of cervical cancer screening data • Communication of abnormal results to patients within required timeframe • Provision of follow-up care for abnormal cervical pathology results, if indicated 		
<p>High-Risk Processes: Operations and Management of Emergency Departments and UCCs</p>	<ul style="list-style-type: none"> • General • Staffing for emergency department/UCC • Support services for emergency department/UCC • Patient flow • General safety • Medication security and labeling • Management of patients with mental health disorders • Emergency department participation in local/regional EMS system • Women veteran services • Life support equipment 	<ul style="list-style-type: none"> • Staff label multi-dose medication vials with an expiration date upon opening. 	<ul style="list-style-type: none"> • None

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this low complexity (3) affiliated¹³³ facility reporting to VISN 19.¹³⁴

**Table B.1. Facility Profile for Cheyenne (442)
(October 1, 2015, through September 30, 2018)**

Profile Element	Facility Data FY 2016 ¹³⁵	Facility Data FY 2017 ¹³⁶	Facility Data FY 2018 ¹³⁷
Total medical care budget dollars	\$163,181,031	\$180,205,118	\$184,955,681
Number of:			
• Unique patients	23,913	24,698	24,662
• Outpatient visits	283,574	296,001	286,184
• Unique employees ¹³⁸	795	807	804
Type and number of operating beds:			
• Community living center	42	41	41
• Domiciliary	10	10	10
• Medicine	20	20	20
• Surgery	2	2	2
Average daily census:			
• Community living center	34	36	36
• Domiciliary	3	8	8
• Medicine	11	12	12
• Rehabilitation medicine	0	0	—

¹³³ Associated with a medical residency program.

¹³⁴ The VHA medical centers 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.

¹³⁵ October 1, 2015, through September 30, 2016.

¹³⁶ October 1, 2016, through September 30, 2017.

¹³⁷ October 1, 2017, through September 30, 2018.

¹³⁸ Unique employees involved in direct medical care (cost center 8200).

Profile Element	Facility Data FY 2016 ¹³⁵	Facility Data FY 2017 ¹³⁶	Facility Data FY 2018 ¹³⁷
<ul style="list-style-type: none"> Surgery 	2	2	3

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

VA Outpatient Clinic Profiles¹³⁹

The VA outpatient clinics in communities within the catchment area of the facility provide primary care integrated with women’s health, mental health, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table B.2. provides information relative to each of the clinics.

Table B.2. VA Outpatient Clinic Workload/Encounters and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2017, through September 30, 2018)¹⁴⁰

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services ¹⁴¹ Provided	Diagnostic Services ¹⁴² Provided	Ancillary Services ¹⁴³ Provided
Sidney, NE	442GB	2,202	322	Endocrinology Nephrology Rheumatology	n/a	Nutrition
Rawlins, WY	442QA	3,284	370	Nephrology Rheumatology General surgery GYN Orthopedics	n/a	Nutrition

¹³⁹ Includes all outpatient clinics in the community that were in operation as of August 15, 2018. The OIG omitted Sterling (442QE), CO as no data were reported.

¹⁴⁰ VHA Directive 2010-049, *Encounter and Workload Capture for Therapeutic and Supported Employment Services Vocational Programs*, October 14, 2010. “An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient’s condition.”

¹⁴¹ Specialty care services refer to non-primary care and non-mental health services provided by a physician.

¹⁴² Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

¹⁴³ Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

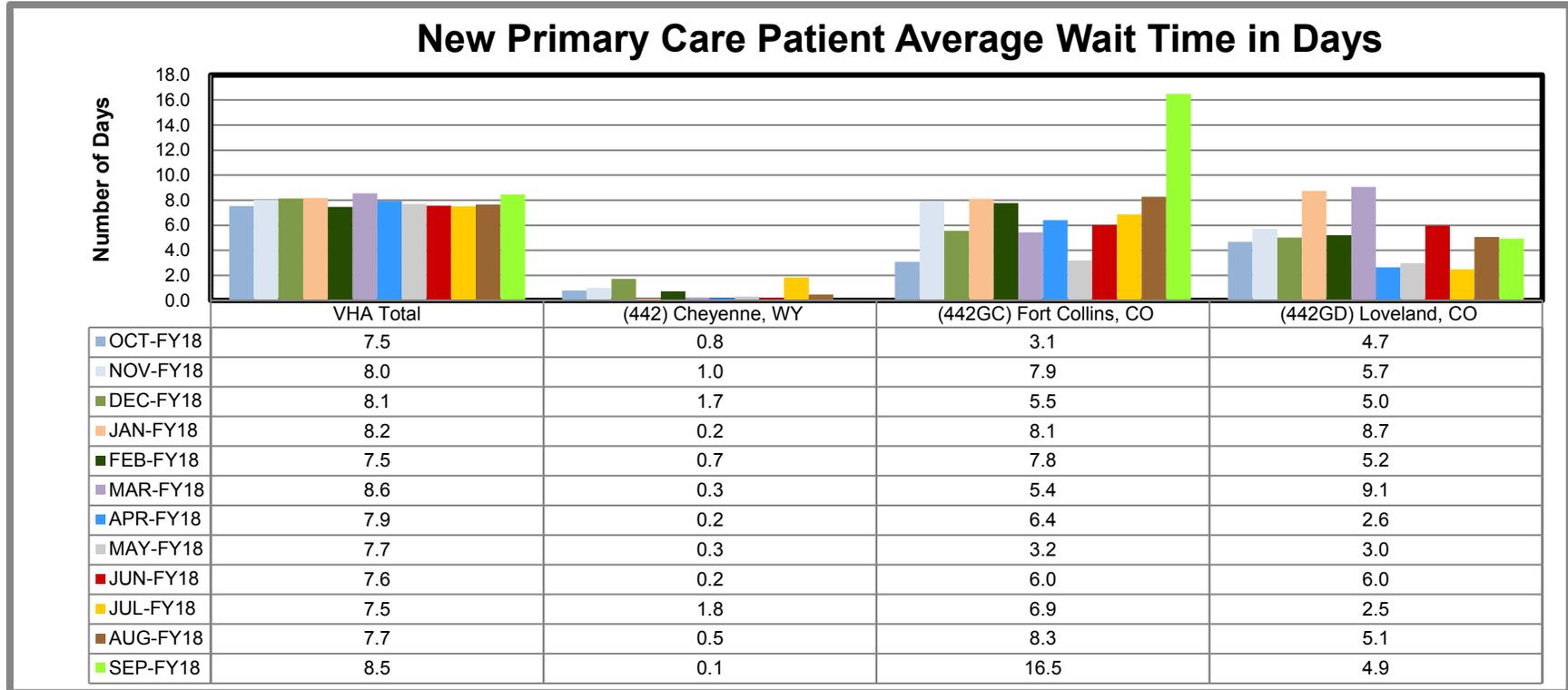
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services ¹⁴¹ Provided	Diagnostic Services ¹⁴² Provided	Ancillary Services ¹⁴³ Provided
Fort Collins, CO	442GC	9,617	6,226	Dermatology Endocrinology Nephrology Rheumatology Poly-Trauma Eye GYN Orthopedics Podiatry Urology	n/a	Pharmacy Social work Weight management Nutrition
Loveland, CO	442GD	8,264	5,490	Dermatology Endocrinology Nephrology Rheumatology Eye GYN Podiatry	n/a	Pharmacy Social work Weight management Nutrition

Source: VHA Support Service Center and VA Corporate Data Warehouse

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

n/a = not applicable

Appendix C: Patient Aligned Care Team Compass Metrics¹⁴⁴



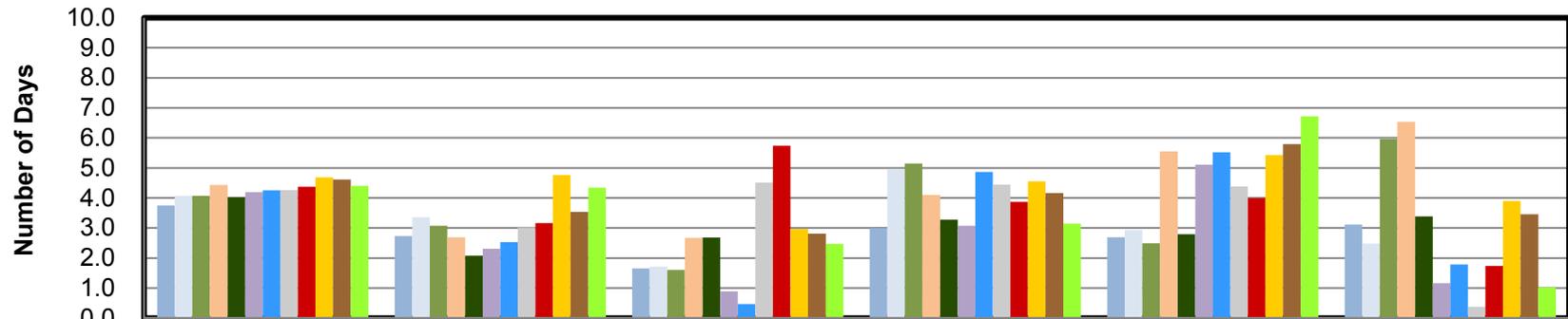
Source: VHA Support Service Center

Note: The OIG did not assess VA’s data for accuracy or completeness. The OIG omitted Sidney, NE (442GB); Rawlins, WY (442QA); and Sterling, CO (442QE), as no data were reported.

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.” Note that prior to FY15, this metric was calculated using the earliest possible create date.

¹⁴⁴ Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 13, 2018.

Established Primary Care Patient Average Wait Time in Days



	VHA Total	(442) Cheyenne, WY	(442GB) Sidney, NE	(442GC) Fort Collins, CO	(442GD) Loveland, CO	(442QA) Rawlins, WY
OCT-FY18	3.7	2.7	1.7	3.0	2.7	3.1
NOV-FY18	4.1	3.4	1.7	5.0	2.9	2.5
DEC-FY18	4.1	3.1	1.6	5.2	2.5	6.0
JAN-FY18	4.4	2.7	2.7	4.1	5.5	6.5
FEB-FY18	4.0	2.1	2.7	3.3	2.8	3.4
MAR-FY18	4.2	2.3	0.9	3.1	5.1	1.2
APR-FY18	4.3	2.5	0.5	4.9	5.5	1.8
MAY-FY18	4.3	3.0	4.5	4.4	4.4	0.4
JUN-FY18	4.4	3.2	5.7	3.9	4.0	1.7
JUL-FY18	4.7	4.8	3.0	4.6	5.4	3.9
AUG-FY18	4.6	3.5	2.8	4.2	5.8	3.5
SEP-FY18	4.4	4.3	2.5	3.1	6.7	1.0

Source: VHA Support Service Center

Note: The OIG did not assess VA’s data for accuracy or completeness. The OIG omitted Sterling CO (442QE), as no data were reported.

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.”

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions¹⁴⁵

Measure	Definition	Desired Direction
ACSC hospitalization	Ambulatory care sensitive conditions hospitalizations	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit reviews met	Percent acute admission reviews that meet interqual criteria	A higher value is better than a lower value
APP capacity	Advanced practice provider capacity	A lower value is better than a higher value
Best place to work	All employee survey best places to work score	A higher value is better than a lower value
Call responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Care transition	Care transition (Inpatient)	A higher value is better than a lower value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Comprehensiveness	Comprehensiveness (PCMH)	A higher value is better than a lower value
Cont stay reviews met	Percent acute continued stay reviews that meet interqual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Efficiency/capacity	Efficiency and physician capacity	A higher value is better than a lower value
Employee satisfaction	Overall satisfaction with job	A higher value is better than a lower value

¹⁴⁵ VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL)* (last updated December 26, 2018). <http://vawww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938>. (The website was accessed on March 7, 2019, but is not accessible by the public.)

Measure	Definition	Desired Direction
HC assoc infections	Health care associated infections	A lower value is better than a higher value
HEDIS like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
HEDIS like – HED90_1	HEDIS-EPRP based PRV TOB BHS	A higher value is better than a lower value
HEDIS like – HED90_ec	HEDIS-eOM based DM IHD	A higher value is better than a lower value
MH wait time	Mental health care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH continuity care	Mental health continuity of care (FY14Q3 and later)	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	ORYX	A higher value is better than a lower value
PC routine care appt	timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC urgent care appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PCMH care coordination	PCMH care coordination	A higher value is better than a lower value
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
Physician capacity	Physician capacity	A lower value is better than a higher value
PC wait time	PC wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value

Measure	Definition	Desired Direction
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
RN turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-COPD	30-day risk standardized mortality rate for COPD	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-COPD	30-day risk standardized readmission rate for COPD	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value

Measure	Definition	Desired Direction
SC care coordination	SC (specialty care) care coordination	A higher value is better than a lower value
SC routine care appt	Timeliness in getting a SC routine care appointment (specialty care)	A higher value is better than a lower value
SC survey access	Timely appointment, care and information (specialty care)	A higher value is better than a lower value
SC urgent care appt	Timeliness in getting a SC urgent care appointment (specialty care)	A higher value is better than a lower value
Seconds pick up calls	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty care wait time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value
Telephone abandonment rate	Telephone abandonment rate	A lower value is better than a higher value

Source: VHA Support Service Center

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) Measure Definitions¹⁴⁶

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.
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.
Physical restraints (LS)	Long-stay measure: percent of residents who were physically restrained.
Receive antipsych meds (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.
UTI (LS)	Long-stay measure: percent of residents with a urinary tract infection.

¹⁴⁶ *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated November 19, 2018). <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410>. (The website was accessed on March 6, 2019, but is not accessible by the public.)

Appendix F: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 17, 2019

From: Director, Rocky Mountain Network (10N19)

Subj: Comprehensive Healthcare Inspection of the Cheyenne VA Medical Center, WY

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

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

1. I have reviewed the findings, recommendations and action plan of the Cheyenne VA Medical Center, WY. I am in agreement with the above.

(Original signed by:)

Ralph T. Gigliotti
Network Director

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

Appendix G: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: June 17, 2019

From: Director, Cheyenne VA Medical Center (442/00)

Subj: Comprehensive Healthcare Inspection of the Cheyenne VA Medical Center, WY

To: Director, Rocky Mountain Network (10N19)

1. We appreciate the opportunity to work with the Office of Inspector General as we continuously strive to improve the quality of healthcare for America's Veterans.
2. I have reviewed and concur with the findings and recommendations in the Comprehensive Healthcare Inspection of the Cheyenne VA Medical Center, WY.
3. Please find attached our response to each recommendation provided in this report.

(Original signed by:)

Paul Roberts, MHA, FACHE

Director, Cheyenne VA Medical Center (442/00)

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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