DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Sheridan VA Medical Center

Wyoming

CHIP REPORT | REPORT #18-04681-228 | SEPTEMBER 26, 2019

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Figure 1. *Sheridan VA Medical Center, Wyoming (Source: https://vaww.va.gov/directory/guide/, accessed on April 10, 2019)*

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
EDIS	Emergency Department Integration Software
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) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Sheridan VA Health Care 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

At the time of the OIG's visit, the facility leadership team consisted of the director, chief of staff, associate director for Patient Care Services (ADPCS), and associate director. Organizational communications and accountability were managed through a committee reporting structure, with the Executive Leadership Board having oversight for several working groups. The director chaired the Executive Leadership Board and Quality, Safety, Value Board, which was responsible for tracking, identifying trends in, and monitoring quality of care and patient outcomes.

The facility's leadership team had been working together for about four months. The director was permanently assigned August 16, 2017. The chief of staff, ADPCS, and associate director were permanently assigned May 13, 2018; June 10, 2018; and August 19, 2018, respectively.

The OIG noted that selected employee satisfaction survey results indicated that facility leaders were engaged and promoted a culture of safety. In the review of patient experience survey results related to the facility, opportunities appear to exist for leadership to improve the customer service experience in both inpatient and outpatient settings.

Additionally, the OIG reviewed accreditation surveys and oversight inspections, 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 knowledgeable within their areas of responsibility about selected SAIL metrics and community living center (CLC) measures, the leaders should continue to take actions

[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.)

to sustain and improve care and performance of the quality of care metrics and measures likely contributing to the facility's SAIL "4-star" and CLC "1-star" quality ratings.[3]

The OIG noted deficiencies in seven of the eight clinical areas reviewed and issued 22 recommendations that are attributable to the director, associate director, and chief of staff. These are briefly described below.

Medical Staff Privileging

The OIG found there was general compliance with requirements for privileging. However, the OIG noted concerns with the focused professional practice evaluation (FPPE) and ongoing professional practice evaluation (OPPE) processes. Additionally, the OIG identified a repeat finding in medical staff privileging related to OPPEs data collection.[4]

Environment of Care

The OIG found that general safety and privacy measures were in place at the parent facility and the representative community based outpatient clinic. The OIG did not identify any issues with the availability of medical equipment and supplies in any areas except the urgent care center (UCC); this issue is further discussed in the High Risk: Emergency Department and UCC results section. However, the OIG noted concerns with environmental cleanliness, inpatient mental health patient safety, and emergency management that warranted recommendations for improvement.

Medication Management

Overall, the facility complied with requirements for some of the performance indicators evaluated, including the controlled substances coordinator reports, pharmacy operations, and requirements for controlled substances inspectors. However, the OIG identified noncompliance with the reconciliations of dispensing and return of stock for one day, verification of controlled substances orders during area inspections, and controlled substances coordinators routinely conducting inspections which warranted recommendations for improvement.

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

[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."

Mental Health

The OIG team also found the facility complied with many of the performance indicators, including the designation of a military sexual trauma (MST) coordinator, tracking of MST-related data, and completion of initial evaluations within 24 hours for patients referred to mental health services. The OIG noted a concern, however, with providers completing MST mandatory training.

Geriatric Care

For geriatric patients, clinicians documented reasons for prescribing medications, ensured patient and/or caregiver understanding when education was provided, and reconciled medications. However, the OIG identified inadequate patient/caregiver education related to newly prescribed medications.

Women's Health

The OIG also noted the facility performed adequately on indicators related to women's health, including requirements for a designated women veterans program manager, tracking data related to cervical cancer screenings, communicating results to patients within the required time frame, and providing follow-up care when indicated. However, the Women Veterans Health Committee membership lacked representation from the women's health medical director, gynecology, business office, and executive leadership.

High-Risk Processes

The facility director and chief of staff acknowledged that the facility was not compliant with the requirements for the UCC. The OIG found that facility managers were operating the UCC 24 hours per day without a waiver and required staff, had no backup call schedule for providers, and did not implement the Emergency Department Integration Software tracking program. The OIG also noted insufficient signage to direct patients to the UCC and the lack of necessary patient care equipment and supplies.

Summary

In reviewing key healthcare processes, the OIG issued 22 recommendations for improvement directed to the facility director, associate director, and chief of staff. 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 inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes F and G, pages 76–77, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to provide oversight of healthcare services to veterans. This focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Sheridan 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:

- Leadership and organizational risks
- Quality, safety, and value (QSV)
- Medical staff privileging
- Environment of care
- Medication management (specifically the controlled substances inspection program)
- Mental health (focusing on military sexual trauma follow-up and staff training)
- Geriatric care (spotlighting antidepressant use for elderly veterans)
- 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.)

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

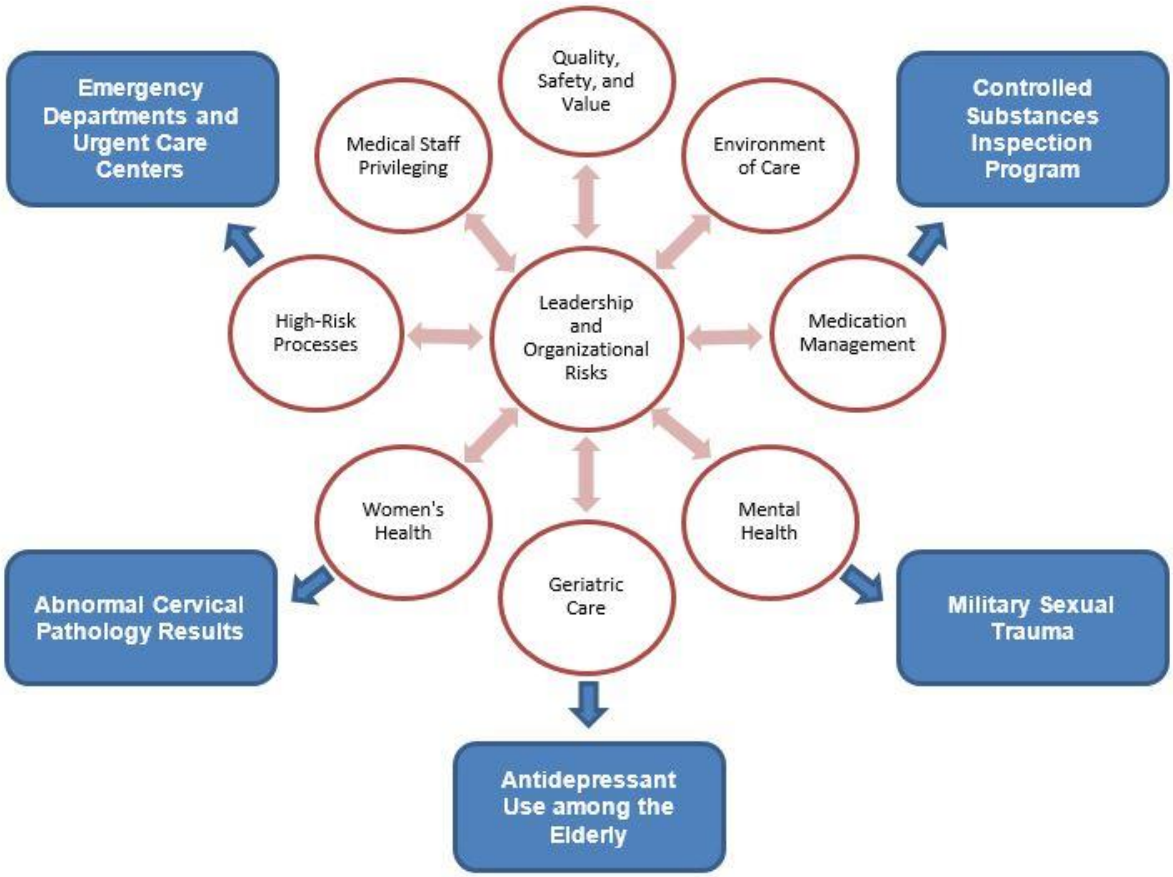

Figure 2. *Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

[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 November 7, 2015, 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 report 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 Clinical 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 it serves, organizational charts may differ across facilities. Figure 3 illustrates this 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 are responsible for overseeing patient care and service directors, as well as program and practice chiefs.

At the time of the OIG site visit, the executive team had been working together for about four months (see Table 1). It is important to note that the chief of staff position had been vacant for over three years, due to difficulties in recruiting for the facility's location, and was filled by a clinical psychologist through a waiver approved by VHA Central Office.

[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.)

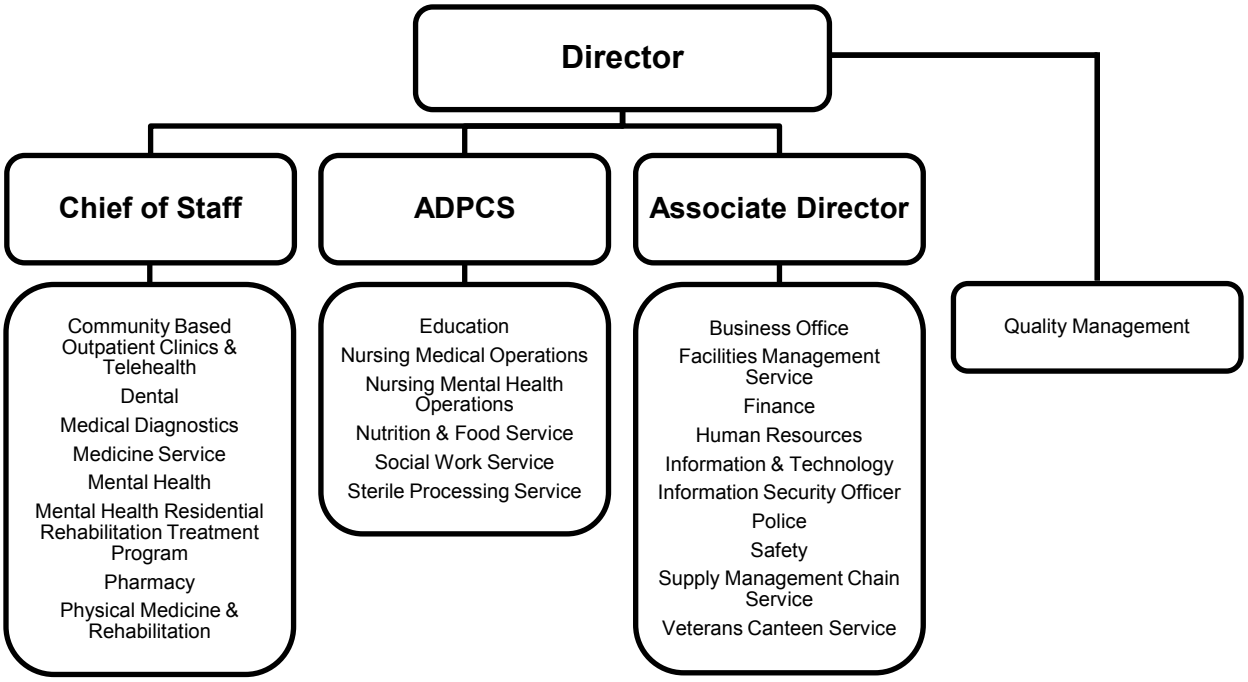

Figure 3. *Facility Organizational Chart*[11]
Source: Sheridan VA Medical Center (received December 10, 2018)

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	August 16, 2017
Chief of staff	May 13, 2018
Associate director for Patient Care Services	June 10, 2018
Associate director	August 19, 2018

Source: Sheridan 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, these 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 scope of responsibilities about selected

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

Strategic Analytics for Improvement and Learning (SAIL) metrics and SAIL community living center (CLC) measures. These are discussed in greater detail below.

The director serves as chairperson of the Executive Leadership Board with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Executive Leadership Board has oversight of various working groups, such as the QSV, Medical Executive, and Patient Care Executive Boards.

These leaders are also engaged in monitoring patient safety and care through the Quality, Safety, and Value (QSV) Board, for which the director is the chair. The QSV Board is responsible for tracking, trending, and monitoring quality of care and patient outcomes. See Figure 4.

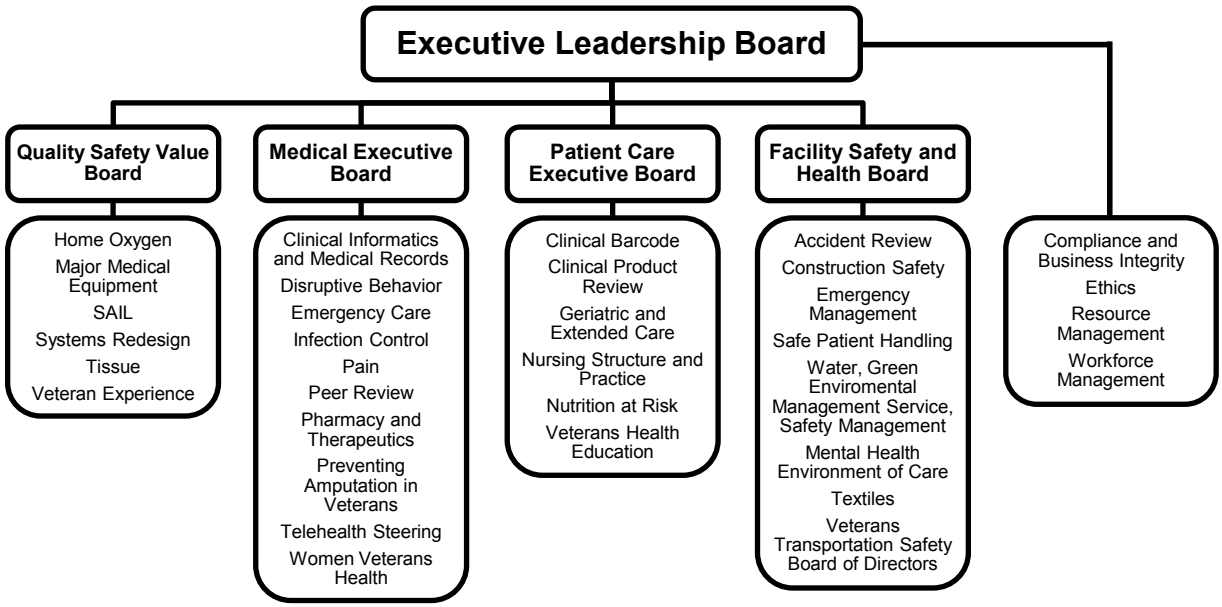

Figure 4. *Facility Committee Reporting Structure*[12]
Source: Sheridan VA Medical Center (December 10, 2018)

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

[12] The Executive Leadership Board oversees Compliance and Business Integrity, Ethics, Resource Management, and Workforce Management.

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.[13] Table 2 provides relevant survey results for VHA, the facility, and selected facility executive leaders. It summarizes employee attitudes toward these selected facility leaders as expressed in VHA's All Employee Survey. The OIG found the facility average for the selected survey questions was higher than the VHA average.[14] The same trend was noted for the members of the executive leadership team. In all, employees appear generally satisfied with facility leaders.

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: *Servant Leader Index Composite*[15]	0–100 where HIGHER scores are more favorable	71.7	72.7	84.3	93.8	83.0	74.3
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.3	3.5	4.1	4.6	4.0	4.1
All Employee Survey: *My organization's senior leaders maintain high*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.6	4.5	4.5	3.8	4.3

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

[14] 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.

[15] 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
standards of honesty and integrity.							
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.7	4.4	4.5	3.8	4.3

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

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. Note that the facility and executive leadership team averages for the selected survey questions were similar to or better than the VHA average.

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 can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.8	4.3	4.3	3.8	4.3
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.6	4.0	4.2	3.6	3.7

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.5	1.6	1.3	1.1	0.6	1.4

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.[16]

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 patients' attitudes toward facility leaders (see Table 4). For this facility, one of four patient survey results reflected higher care ratings compared to the VHA average, and three surveys reflected lower care ratings than the VHA average. Opportunities appear to exist for leadership to improve patient experiences in multiple inpatient and outpatients settings.

[16] Ratings are based on responses by patients who received care at this facility.

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): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	66.9	70.2
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.2	77.6
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.1	75.9
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.3	72.3

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed November 8, 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.[17] Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint

[17] The Joint Commission (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.

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] The OIG also noted the facility's results from the Long Term Care Institute's inspections of the facility's CLC.[21]

[18] 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.ltciorg.org/about-us/. (The website was accessed on March 6, 2019.)

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 (*Combined Assessment Program Review of the Sheridan VA Healthcare System, Sheridan, Wyoming, Report No. 15-04697-105, February 10, 2016*)	November 2015	14	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics, Sheridan VA Healthcare System, Sheridan, Wyoming, Report No. 15-05154-271, April 21, 2016*)	March 2016	12	0
TJC	September 2016		
• Hospital Accreditation		14	0
• Nursing Care Center Accreditation		1	0
• Behavioral Health Care Accreditation		1	0
• Home Care Accreditation		0	n/a

Sources: OIG and TJC (Inspection/survey results verified with the chief, Quality Safety and Value on December 5, 2018)
n/a = Not applicable

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 November 7, 2015 (the prior comprehensive OIG inspection), 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 Sheridan VA Medical Center is a low complexity (3) facility as described in Appendix B.)

Table 6. Summary of Selected Organizational Risk Factors (November 7, 2015, through December 14, 2018)

Factor	Number of Occurrences
Sentinel Events[23]	3
Institutional Disclosures[24]	1
Large-Scale Disclosures[25]	0

Source: Sheridan VA Medical Center's patient safety manager and risk manager (received December 10, 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.

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

Indicators	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 19	Facility
Pressure ulcer	0.76	0.63	0.00
Death among surgical inpatients with serious treatable conditions	114.89	90.91	n/a

[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.)

Indicators	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 19	Facility
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	n/a
Postoperative respiratory failure	4.88	6.09	n/a
Perioperative pulmonary embolism or deep vein thrombosis	3.05	2.16	0.00
Postoperative sepsis	3.70	4.85	n/a
Postoperative wound dehiscence (rupture along incision)	0.93	0.47	0.00
Unrecognized abdominopelvic accidental puncture or 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.
n/a = Not applicable because during the review period, there were no surgical discharges with serious treatable complications (death among surgical inpatients with serious treatable conditions, postoperative acute kidney injury requiring dialysis, or postoperative sepsis).

As noted, four of 12 patient safety indicator measures (death among surgical inpatients with serious treatable conditions, postoperative acute kidney injury requiring dialysis, postoperative respiratory failure, and postoperative sepsis) were not applicable to this facility. The eight remaining patient safety indicator measures show a lower reported rate than VHA and VISN 19.

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 "4-star" for overall quality.

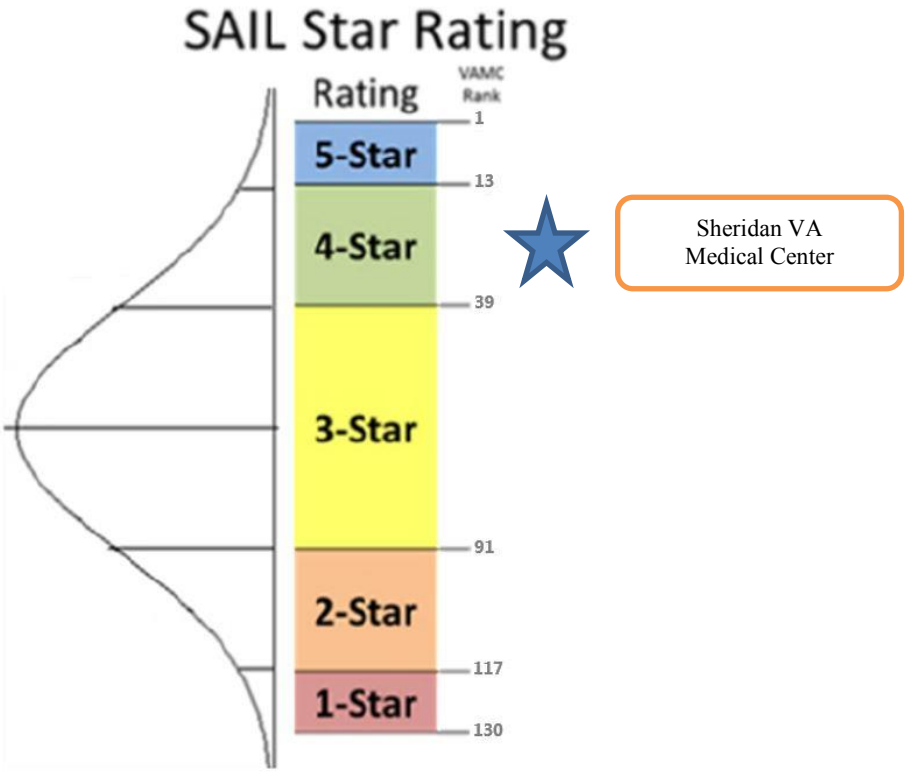

Figure 5. *Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)*
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed November 9, 2018)

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 acute care 30-day

[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.

standardized mortality ratio (SMR 30), call responsiveness, and best place to work). Metrics that need improvement are denoted in orange and red (for example, registered nurse (RN) turnover, rating (of) specialty care (SC) provider, and mental health (MH) continuity (of) care).[30]

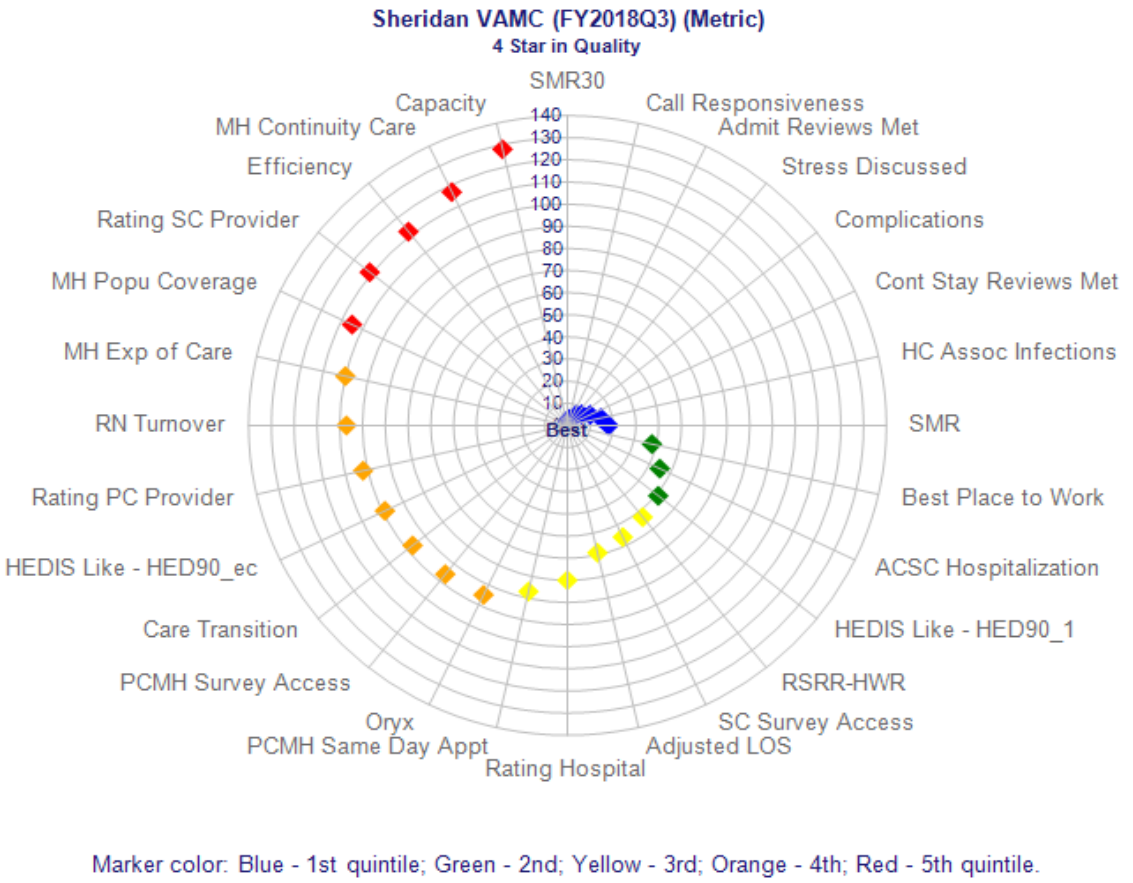

Figure 6. *Facility Quality of Care and Efficiency Metric Rankings (as of June 30, 2018)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait 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 the performance of CLCs in the VA. The SAIL model leverages much of the same data used in

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

The 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 an 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 "4-star" rating, its rating for quality is only a "1-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 "1-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. Figure 7 uses blue and green data points to indicate high performance (for example, in the areas of physical restraints–long stay (LS), improvement in function–short stay (SS), and high risk pressure ulcer (PU) (LS)). Metrics that need improvement and were likely the reasons why the facility had a "1-star" for quality are denoted in orange and red (for example, falls with major injury (LS), urinary tract infection (UTI) (LS), and catheter in bladder (LS)).[33]

[31] According to the Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, August 22, 2019, "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 August 22, 2019). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410. (The website was accessed on September 3, 2019, but is not accessible by the public.)

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

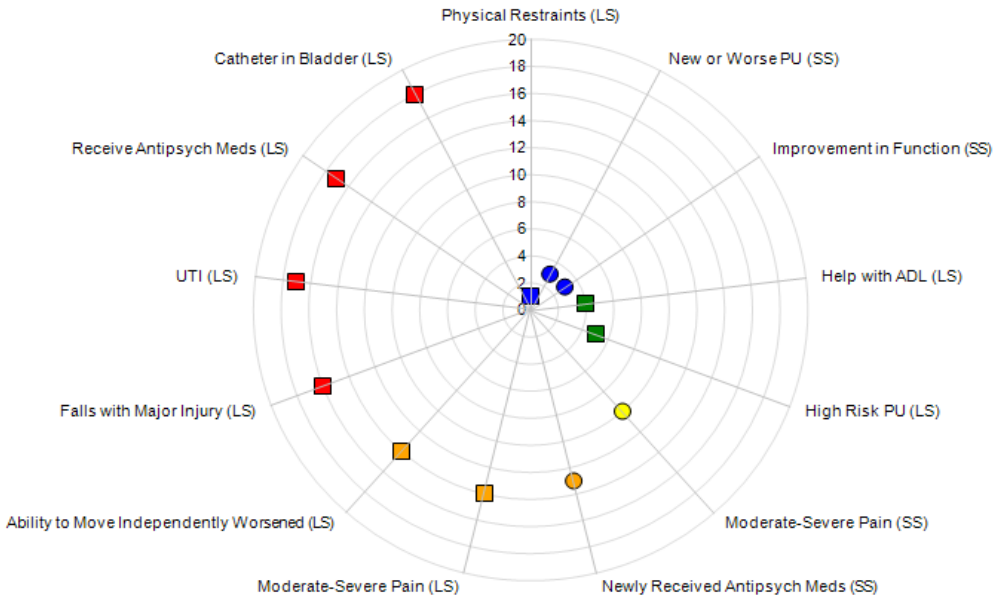

Figure 7. *Facility CLC Quality Measure Rankings (as of June 30, 2018)*
LS = Long-Stay Measure SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix E.

Leadership and Organizational Risks Conclusion

The facility has stable executive leadership and active engagement with employees and patients as evidenced by high satisfaction scores. Organizational leaders support patient safety, quality care, and other positive outcomes (such as initiating processes and plans to maintain positive perceptions of the facility through active stakeholder engagement). The OIG's review of this low complexity facility's accreditation organization findings, sentinel events, disclosures, and patient safety indicators did not identify any substantial organizational risk factors; however, it is important to note that the OIG identified a repeat finding from the previous Combined Assessment Program inspection in medical staff privileging related to the collection of ongoing professional practice evaluation (OPPE) data (which is discussed in Medical Staff Privileging). The senior leadership team was actively engaged and knowledgeable about selected SAIL and CLC metrics but should continue to take actions to sustain and improve performance of measures contributing to the SAIL "4-star" and CLC "1-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

[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." This directive was in effect at the time of the review but was replaced by VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019); this directive expired on July 31, 2019.

[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.

nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[41]

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

[41] VHA Directive 1190.

[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.

  - Quarterly review of Peer Review Committee's summary analysis by the Medical Executive Committee
  - Peer review of all applicable deaths within 24 hours of admission to the hospital
  - Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[46]
- UM
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Annual completion of a minimum of eight root cause analyses[47]
  - 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[48]
  - Evidence of a committee responsible for reviewing resuscitation episodes
  - Confirmation of actions taken during resuscitative events being 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

[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 analysis per fiscal year must be individual [root cause analyses], with the balance being Aggregated Reviews or additional individual [root cause analyses]."

[48] The facility did not have any resuscitation episodes during the previous 12 months.

Quality, Safety, Value Conclusion

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

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).[49]

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.[50]

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."[51]

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 time frame and customized to the specific provider and related clinical concerns.[52] 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.[53]

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:

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[49] 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.)

[50] VHA Handbook 1100.19.

[51] VHA Handbook 1100.19.

[52] 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).

[53] 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.)

- Four 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 months[54]
- Three LIPs hired within 18 months before the site visit
- Two 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-specific[55]
  - 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 time frames 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

[54] The 18-month period was from June 9, 2017, through December 9, 2018. The 12-month review period covered December 9, 2017, through December 9, 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.

[55] 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 National Practitioner Data Bank

Medical Staff Privileging Conclusion

The OIG found general compliance with requirements for privileging. However, the OIG identified concerns with the FPPE and OPPE processes, including a repeat finding (from the previous Combined Assessment Program inspection) related to OPPE data collection.

Specifically, VHA requires the criteria for the FPPE process "to be defined in advance, using objective criteria accepted by the practitioner."[56] Three applicable practitioners' profiles lacked evidence that providers were aware of the criteria for evaluation before initiation of the FPPE process. This could result in providers' misunderstanding of the FPPE expectations. The program specialist and chief of staff stated that they gave the providers the medical center bylaw's cover letter about the FPPE process and communicated the expectations to providers when first credentialed.

Recommendation 1

1. The chief of staff ensures that clinical managers define and communicate expectations for focused professional practice evaluations in advance and maintain appropriate documentation of the processes, and monitors the clinical managers' compliance.

[56] VHA Handbook 1100.19.

Facility concurred.

Target date for completion: December 31, 2019

Facility response: Focused Professional Practice Evaluations (FPPE) forms were changed to include a review and signature by the employee and supervisor at the onset of the FPPE. The revised FPPE form was approved on January 29, 2019 at the Executive Committee of Medical Staff (ECOMS) committee, which reports to the Medical Executive Board (MEB). The process was changed effective January 29, 2019; all service lines were notified of the new review and signature requirement. Since then, 100 percent (9/9) of new providers have used the modified form and process. This will continue to be monitored monthly through ECOMS to maintain 100 percent compliance (number of new providers using the new FPPE forms/number of new providers) through December 31, 2019.

For OPPEs, VHA requires that at the time of reprivileging, service chiefs consider relevant service- and practitioner-specific data utilizing defined criteria when recommending the continuation of licensed independent practitioners' privileges to the Executive Committee of the Medical Staff. Such data are maintained as part of the practitioner's provider profile and may include direct observations, clinical discussions, and clinical record reviews.[57] VHA has also identified minimum-required specialty criteria for the professional practice evaluation of four specialty provider types, including pathology and laboratory medicine.[58] The OPPE process is essential to confirm the quality of care delivered and "allows the facility to identify professional practice trends that impact the quality of care and patient safety."[59]

For four of six practitioners' profiles, there was no evidence of service-specific OPPE criteria. As a result, providers delivered care without a thorough evaluation of their practice. The chief of staff stated that the primary care providers had different review forms and thought that this difference between primary and specialty care providers met the requirement for service/section specific elements for the medical staff.

For three of six LIPs who were re-privileged, the facility's Executive Committee of the Medical Staff recommended continuation of privileges even though the OPPE results were incomplete. The three LIPs were all solo providers and included a pathologist whose OPPE did not include the minimum-required pathology and laboratory medicine criteria. This resulted in these providers continuing to deliver care without evaluation of their professional practice trends. The chief of staff reported that these are solo providers, that the facility had requested assistance from VISN 19 and other facilities with completing the OPPEs without success, and that the privileges

[57] VHA Handbook 1100.19.

[58] 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 less than three providers in the facility that are privileged in a particular specialty.

[59] VHA Handbook 1100.19.

were approved without the OPPE data to ensure veterans continued to have access to care at the facility. The chief of staff also stated an OPPE was not completed for the solo pathologist because the provider, does not have direct patient care responsibilities, provides only clinical oversight for laboratory services, and therefore did not think the criteria was required for this provider. Incomplete OPPE data collection represents a repeat finding from the November 2015 Combined Assessment Program review.[60]

Recommendation 2

2. The chief of staff ensures ongoing professional practice evaluations include service-specific criteria and monitors compliance.

Facility concurred.

Target date for completion: March 31, 2020

Facility response: All service lines were immediately asked to conduct a review of current ongoing professional practice evaluations (OPPE) forms to ensure criteria are specific to the service/section. Once the service lines complete the reviews, the amended OPPEs will be reviewed by Executive Committee of the Medical Staff (ECOMS) for approval and implementation. Compliance with utilizing the new OPPE forms will be 100 percent, (OPPE using service specific criteria/all specialty providers) monitored through monthly Executive Committee of Medical Staff committee for two quarters.

Recommendation 3

3. The chief of staff makes certain that service chiefs collect and review ongoing professional practice evaluation data and that the facility's Executive Committee of the Medical Staff reviews the data in the consideration to continue provider privileges, and monitors compliance.

[60] VA Office of Inspector General, *Combined Assessment Program Review of the Sheridan VA Healthcare System,* Report No. 15-04697-105, February 10, 2016.

Facility concurred.

Target date for completion: March 31, 2020

Facility response: The Chief of Staff through the credentialing and privileging office will review and verify 100 percent (number of service chief signed OPPE forms for providers/number of OPPE providers on staff) signatures confirming that the service chiefs have reviewed ongoing professional practice evaluation data on a biannual basis, as per medical staff by-laws. Compliance with the 100 percent benchmark will be validated through the Executive Committee of the Medical Staff. Further, the Chief of Staff will assure clear documentation of OPPE review in the service chief brief which is utilized to inform the service chief prior to obtaining their approval to refer to ECOMS for reappointment. This is maintained in each provider file prior to review and approval of re-credentialing in the Executive Committee of the Medical Staff minutes.

Recommendation 4

4. The chief of staff confirms that the solo pathologist's ongoing professional practice evaluation includes the minimum required specialty criteria and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: The Chief of Staff will meet with the Supervisory Lab Manager to review ongoing professional practice evaluation (OPPE) and develop criteria for OPPE review completion by VHA peers. Once OPPE criteria have been developed, the OPPE for Pathology will be reviewed by the Executive Committee of the Medical Staff (ECOMS) for approval and implementation. Once approved, the OPPE will be completed monthly and reviewed by the service chief bi-annually as per medical center bylaws. Oversight monitoring will be performed through ECOMS. Compliance will be illustrated by 100 percent completion of the pathologists OPPE for the next six months.

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.[61]

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.[62]

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.[63]

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.[64] Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,

[61] VHA Directive 1608, *Comprehensive Environment of Care (CEOC Program)*, February 1, 2016.

[62] 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).

[63] 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.)

[64] VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

Occupational Safety and Health Administration,[65] and National Fire Protection Association standards.[66] The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.[67]

In all, the OIG team inspected three inpatient areas—Mountain View CLC (building 86, south unit), medicine (building 71, 3rd floor), inpatient mental health (building 8, north and south)—in addition to the urgent care center and the outpatient primary care center. The team also reviewed the emergency management program and inspected the Rock Springs VA Clinic. The OIG 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 unit
  - Mental health environment of care rounds
  - Nursing station security
  - Public area and general unit safety

[65] 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.)

[66] 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.)

[67] TJC. Environment of Care standard EC.02.05.07.

  - 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 OIG noted general safety and privacy measures were in place at the parent facility and the representative Community Based Outpatient Clinic. The OIG did not identify any issues with the availability of medical equipment and supplies in any areas except the urgent care center (UCC); this issue is further discussed in the High Risk: Emergency Department and UCC results section. Although not an area inspected during this OIG site visit, it was identified by OIG through review of the performance logic[68] inspection count report that the Cody VA Clinic, operated by contracted staff, was not listed as a site for rounds or inspected as required. The OIG noted deficiencies in environmental cleanliness, inpatient mental health patient safety, and emergency management that warranted recommendations for improvement.

Specifically, VHA[69] and TJC[70] require hospitals to identify environmental deficiencies, hazards, and unsafe practices and keep furnishings and equipment safe and in good repair. The OIG noted problems with cleanliness and maintenance throughout the facility and at the Rock Springs VA Clinic. These conditions potentially affect the safety and physical well-being of patients, staff, and visitors.

At the parent facility, the OIG noted that three patient care areas had damaged or stained ceiling tiles[71] and dirty ventilation grills[72] and two areas had damaged or dirty floor tiles and damaged walls or window sills.[73] The associate director stated that facility staff involved in the identification, reporting, data entry, and tracking were not communicating with leaders when

[68] Performance logic is the database that VHA was using to collect all data associated with environment of care rounds.

[69] VHA Directive 1608.

[70] TJC. Environment of Care standard EC.02.06.01.

[71] Mountain View CLC (building 86, south); medical unit (building 71, 3rd floor); outpatient primary care (building 71, 1st floor).

[72] Mountain View CLC (building 86, south); medical unit (building 71, 3rd floor); inpatient mental health (building 8, north and south).

[73] Mountain View CLC (building 86, south); inpatient mental health (building 8, north and south).

deficiencies were not corrected timely. The facility staff tasked to perform the environment of care rounds lacked proper training for their assigned roles.

At the Rock Springs VA Clinic, the OIG noted deficiencies in six inspected rooms. The OIG found stained ceiling tiles and dirty floors. The environmental management services staff stated that the property owners do not respond in a timely manner to environmental concerns.

Recommendation 5

5. The associate director validates that the environment of care rounds team is trained to identify and record all environment of care deficiencies during environment of care rounds, and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: The Associate Director will implement an Environment of Care (EOC) training session starting first quarter of FY2020 and continue quarterly until 100 percent of the EOC team members are trained. After the first wave of training, new EOC members will be trained individually on an as needed basis. Percentage of compliance with the training plan (those trained/members of the EOC team) will be monitored through the Facility Safety and Health Board (FSHB) which reports to the Executive Leadership Board. Competency validation will be completed by the EOC Coordinator or the Associate Director (competency validated/those trained) until 90 percent are competency validated. This will be monitored through quarterly reporting to FSHB for two quarters.

Recommendation 6

6. The facility director works with the VISN director and contracting officer to make certain that the Rock Springs VA Clinic property owners correct deficiencies and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: The Community Based Outpatient Clinic (CBOC) Director or designee will follow up with the property owner to ensure that all deficiencies are addressed in a timely manner. The facility Environment of Care team will continue to perform biannual inspections of the CBOC facility and track timely completion of deficiencies. 95 percent of all identified findings will be resolved or have an action plan identified within 14 days (findings resolved or with action plans/findings during EOC rounds). This data (findings resolved or with action plans/findings during EOC rounds), along with tracking to complete correction of 100 percent of EOC findings (findings resolved/findings during EOC rounds) will be tracked to completion through Facility Safety and Health Board.

Additionally, VHA requires that VA police test and document response time to panic alarms in locked inpatient mental health units.[74] The OIG found that the VA police completed the required monthly panic alarm testing, but facility staff could not provide any documented evidence of the officers' response time. This may result in an unsafe environment for patients, visitors, and staff since timely police responses greatly impact the overall success of intervention and reduce organizational risks. VA police were not aware of the requirement to annotate officer response time during testing. Furthermore, the chief, VA police, stated that the support position tasked with monitoring the inpatient mental health panic alarm system had been vacant since November 2017.

Recommendation 7

7. The associate director ensures the VA police document response time to panic alarm testing at the locked inpatient mental health unit and monitors compliance.

Facility concurred.

Target date for completion: March 31, 2020

Facility response: The VA police will document panic alarm testing and response times throughout the facility and will conduct separate panic alarm tests in the locked inpatient mental health unit as a part of the required rapid response drills. Documentation will be on the Rapid Response Drill form and monitored for 95 percent compliance (number of documented response times/the number of completed panic alarm tests) will reported through Facility Safety and Health Board for two quarters.

[74] VHA Mental Health Environment of Care Checklist, December 8, 2016

VHA requires inpatient mental health seclusion rooms be designed to prevent patient injury. "Flooring material should have some cushioning to decrease the risk of injury in a fall."[75] The OIG found the floor in two seclusion rooms lacked cushioning. This could result in harm to patients or staff in the event of a fall. The facility had self-identified the deficiency and requested funding for renovation.

Recommendation 8

8. The associate director ensures flooring that provides cushioning is installed in the mental health seclusion rooms.

Facility concurred.

Target date for completion: October 1, 2019 to determine if funding has been granted, and August 1, 2020 for installation of the flooring.

Facility response: This was submitted to the Strategic Capital Investment Planning for funding. The Associate Director and Chief of Facilities Management anticipate award of funding in FY2020. Once funding is obtained, the flooring will be corrected to provide a cushioned surface in the mental health seclusion rooms.

VHA also requires that facilities develop and annually review their emergency operations plan.[76] TJC requires that the plan includes "how the hospital will manage the activities required as part of patient scheduling, triage, assessment, treatment, admission, transfer, and discharge" during an emergency.[77] The OIG found the facility's emergency operations plan lacked information about how the facility manages patient scheduling, treatments, and admissions.[78] This resulted in a lack of assurance that the facility is prepared for contingency operations during emergencies. The emergency manager was new to the position and being trained, but there was no reason provided for the missing elements.

Recommendation 9

9. The associate director validates that the facility's emergency operations plan includes all required elements and monitors compliance.

[75] VHA Mental Health Environment of Care Checklist, December 8, 2016.

[76] VHA Directive 0320.01.

[77] TJC. Emergency Management standard EM.02.02.11.

[78] TJC. Emergency Management standard EM.02.02.11.

Facility concurred.

Target date for completion: December 31, 2019

Facility response: The facility's Emergency Operations Plan (EOP) was updated to include all required elements on January 31, 2019. Approval was indicated by obtaining wet signatures of each member of the Executive Leadership Team at that time. By the end of quarter one of FY 2020, the Emergency Manager will perform the yearly update, review and have approved the EOP through the Emergency Management Committee.

Lastly, VHA requires facilities to have an emergency electrical distribution system that operates safely, reliably, and efficiently.[79] TJC also requires all facility emergency generators be tested at least monthly, for a minimum of 30 minutes and with a dynamic load that is at least 30 percent of the nameplate rating or the manufacturer's recommended exhaust gas temperature and that this is documented.[80,81] The OIG found that monthly emergency generator test records did not include documentation of the percent of dynamic load or exhaust gas temperature. This could result in lack of assurance of operational readiness and reliability of the generators when needed. The OIG observed that the facility staff documented on their emergency generator testing form, however they did not complete the section for the percent load and there was no supervisor review noted.

Recommendation 10

10. The associate director makes certain that monthly emergency generator testing includes documentation of dynamic load used and monitors compliance.

[79] VHA Directive 1028, *Electrical Power Distribution Systems,* July 25, 2014.

[80] A dynamic load involves "switching the emergency loads over to a generator and performing a test to verify that the system does indeed power its emergency loads," Hospital Safety Center, September 1, 2007, "*The Joint Commission clarifies its generator testing requirements.*" http://www.hospitalsafetycenter.com/content/74955/topic/WS_HSC_HSC.html. (The website was accessed on May 28, 2019.)

[81] TJC. Environment of Care standard EC.02.05.07.

Facility concurred.

Target date for completion: January 31, 2020

Facility response: Per the Joint Commissions Standard EP.02.05.07, "If the organization does not meet either the 30% of nameplate rating or the recommended exhaust gas temperature during any test in EC.02.05.07, EP 5, then it must test the emergency generator once every 12 months using supplemental (dynamic or static) loads of 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes, for a total of 1½ continuous hours." Because the facility cannot meet the 30% of nameplate rating during testing, Facilities Management Services contracted to have a vendor perform the annual generator test, which was completed April 2019. This will be repeated by December 2019, so that the facility is back on its regular schedule.

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 reports 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 adjustments[86]
- 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 destruction[87]
  - 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 reports[88]

Medication Management Conclusion

The OIG found general compliance with requirements for some of the performance indicators evaluated, including the controlled substances coordinator reports, pharmacy operations, and

[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.

requirements for controlled substances inspectors. However, the OIG identified deficiencies with the reconciliations of dispensing and return of stock for one day, verification of controlled substances orders during area inspections, and controlled substances coordinators routinely conducting inspections which warranted recommendations for improvement.

Specifically, VHA requires controlled substance inspection program staff to reconcile one random day's stocking/refilling from the pharmacy to every automated dispensing unit and one random day's return of stock to pharmacy from every automated dispensing unit during controlled substances area inspections.[89] The OIG found during April to September 2018, four of eight areas lacked reconciliation of one-day dispensing from the pharmacy to the automated dispensing cabinet. All eight areas lacked reconciliation of one-day's return of stock to the pharmacy from every automated dispensing cabinet. Failure to reconcile dispensing and returns in all controlled substances areas may cause delays in identifying potential drug diversion activities. The controlled substance coordinator reported a lack of awareness and oversight of the requirements.

Recommendation 11

11. The facility director makes certain that monthly reconciliation of one day dispensing from pharmacy to every automated dispensing cabinet and one day return of stock to pharmacy from every automated dispensing cabinet is performed during controlled substances inspections and monitors compliance.

[89] VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: March 31, 2020

Facility response: Immediate correction for complete monthly facility-wide reconciliation of one day dispensing from every automated dispensing cabinet and one day return of stock to pharmacy across all eight dispensing areas was implemented on December 18, 2018 and replicated monthly thereafter. All inspection forms were updated to reflect the new requirements and education was provided by the Controlled Substances Coordinator (CSC) to each of the inspection teams prior to implementation. Controlled Substances Coordinator now has access to and pulls reports monthly to eliminate possible errors in this process. Further examination revealed that the process needed improvement. On May 1, 2019 a newly created spreadsheet tracking all controlled substances was implemented by the Controlled Substance and Quality Program Manager in Pharmacy. Moving forward, as of September 1, 2019 the CSC will meet regularly with the Controlled Substance and Quality Program Manager in Pharmacy to complete the restock and return reconciliation for the month. The CSC will maintain a copy of the pharmacy spreadsheet. Compliance will be monitored at 100 percent (monthly reconciliation across all areas/areas surveyed) for six months and reported during Quarterly Controlled Substance Program Report review sessions and reported quarterly through the Quality Safety Value Board.

In addition, VHA requires that controlled substances inspectors "verify [that] there is a hard copy order (electronic or written) in the patient's medical record, there is documentation of administration, and documentation of two signatures for any wasting of partial doses for five randomly selected dispensing activities" on a monthly basis.[90] The OIG noted that during April to September 2018, one of the eight areas lacked the controlled substance inspector's verification of five randomly selected dispensing activities. Failure to verify orders may cause delays in identifying any potential drug diversion activities. The ambulatory care clinic did not have the Bar Code Medication Administration system, and the controlled substance coordinator advised not being aware of how to conduct the review without that system.

Recommendation 12

12. The facility director ensures that controlled substances inspectors verify controlled substances orders on a monthly basis and monitors the inspectors' compliance.

[90] VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: December 31, 2020

Facility response: The Controlled Substances Coordinator (CSC) adapted monthly procedures to include the monitoring of controlled substances via electronic or written copy in the Ambulatory Care Clinic, which was identified as the outlier during survey. This process was changed in December 2018 and replicated monthly thereafter. All inspection forms were updated to reflect the new requirements and education was provided by the CSC to each of the inspection teams prior to implementation. The CSC now has access to and pulls reports monthly to clearly verify that monitoring is occurring across all eight areas. In circumstances where an individual area has less than 5 narcotics dispensed for the time frame selected, the inspector will verify all controlled substances orders against medications dispensed in that area for the same time frame. If less than 5 orders are verified the CSC will annotate this on the inspection sheet. Compliance will be monitored at 100 percent (verification of up to 5 controlled substance orders for each dispensing area/the 8 dispensing areas) for six months and reported during Quarterly Controlled Substance Program Report review sessions and reported quarterly through the Quality Safety Value Board.

Despite VHA requiring that controlled substance coordinators refrain from conducting routine monthly inspections,[91] the OIG found that from April to September 2018, the controlled substance coordinator conducted routine monthly inspections in all eight non-pharmacy areas and in the pharmacy. When controlled substances coordinators conduct routine monthly inspections, program oversight may be compromised. The controlled substances coordinator stated there had been staffing challenges during one month but provided no reason for the other months.

Recommendation 13

13. The facility director affirms that controlled substances coordinators refrain from conducting routine inspections and monitors the coordinators' compliance.

[91] VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: December 31, 2020

Facility response: The Controlled Substances Coordinator (CSC) and alternate were immediately removed from the schedule of teams assigned to complete monthly inspections. In circumstances where the CSC or alternate are covering inspections related to training, competency validation, emergency or to further investigate trend data, there will be an annotation on the inspection worksheet and a memo submitted to the Medical Center Director outlining the reason. Since the process change, the CSC or alternate has not had any instance where they have had to perform inspections. Compliance will be monitored at 5 percent or less (number of times CSC or alternate performs inspections/number of inspections completed YTD) for six months and reported during Quarterly Controlled Substance Program Report review session then reported quarterly through the Quality Safety Value Board.

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."[92] 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.[93]

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.[94] Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.[95]

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.[96] Those who screen positive must have access to appropriate MST-related care.[97] 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.[98]

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.[99] All mental health and primary care providers must complete MST mandatory

[92]VHA Directive 1115, Military Sexual Trauma (MST) Program, May 8, 2018.

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

[94] VHA Directive 1115.

[95] 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.).

[96] VHA 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."

[97] VHA Directive 1115.

[98] VHA Handbook 1160.01.

[99] 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.[100]

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 22 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 of referral for mental health services
  - Comprehensive diagnostic and treatment planning evaluation within 30 days of referral for mental health services
- Completion of MST mandatory training requirement for mental health and primary care providers

Mental Health Conclusion

Generally, the OIG found compliance with many of the performance indicators, including the designation of an MST coordinator, tracking of MST-related data, and initial evaluations within 24 hours for patients referred to mental health services. However, the OIG identified a concern with providers completing MST mandatory training that warranted a recommendation for improvement.

Specifically, VHA requires that all primary care and mental health care providers complete the MST mandatory training. Providers hired after July 1, 2012, must complete this training no later

[100] 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, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers,* February 2, 2016.

than 90 days after entering their position.[101] The OIG found that 8 of 20 providers had not completed the training. Four of these eight providers were hired after July 1, 2012. Without MST training, providers could lack the ability to provide appropriate counseling, care, and services to veterans. The ADPCS and MST coordinator failed to ensure that monitoring processes captured all staff who are required to complete training.

Recommendation 14

14. The facility director makes certain that providers complete military sexual trauma mandatory training within the required time frame and monitors compliance.

Facility concurred.

Target date for completion: December 31, 2019

Facility response: By January 2019, Military Sexual Trauma (MST) Trainings were assigned to staff members identified as deficient and processes to assign MST training to newly hired employees were verified. On a weekly basis, a Talent Management System (TMS) report on the completion status of the MST Trainings will be sent to the MST coordinator by Education staff to aid with tracking. The MST coordinator will be tasked with notifying the supervisors of deficient employees of the requirement to complete training. 95 percent (number of staff completing/number of staff requiring training per quarter) of staff required to have this training will complete it within the required timeframe. This data will be reported to the Patient Care Executive Board (PCEB) on a quarterly basis for two quarters.

[101] VHA Directive 1115.01 and Acting Deputy Under Secretary for Health for Operations and Management, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers,* February 2, 2016.

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."[102] The VA/DoD 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.[103]

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 antidepression drugs, psychotherapy, or a combination of both."[104]

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.[105] 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."[106] In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.[107] 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.[108] The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

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[102] 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.)

[103] 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.)

[104] 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.)

[105] 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.)

[106] TJC. Provision of Care, Treatment, and Services standard PC 02.03.01.

[107] VHA Directive 1164, *Essential Medication Information Standards*, June 26, 2015.

[108] 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.[109]

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 22 patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.[110] The OIG evaluated the following performance indicators:

- 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

Geriatric Care Conclusion

The OIG found compliance with many of the performance indicators, including documented justification for initiating the medication, patient/caregiver understanding of education when provided, and medication reconciliation. However, the OIG identified inadequate patient/caregiver education related to newly prescribed medications that warranted a recommendation for improvement.

TJC requires that clinicians educate patients and families about "safe and effective use of medications" and that the patient's "medical record contains information that reflects the patient's care, treatment, and services."[111] The OIG determined that clinicians provided this education in 32 percent of the electronic health records reviewed.[112] Without medication education, patients would not have the necessary information to manage their own health at home.[113] The chief of Pharmacy stated that the providers were following an old process where the patients would bring the non-VA prescription to their VA provider and the provider would place the order for the medication. Providers were unaware of a change in process that allows patients to bring their prescriptions written by non-VA providers directly to the pharmacy where the pharmacist would have provided patient education.

[109] VA/DoD Clinical Practice Guidelines for the Management of Major Depressive Disorder.

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

[111] TJC. Provision of Care standard PC.02.03.01 and Record of Care, Treatment, and Services standard RC.02.01.01.

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

[113] TJC Introduction to Standard PC.02.03.01.

Recommendation 15

15. The chief of staff ensures clinicians provide and document patient/caregiver education for newly prescribed medications and monitors the clinicians' compliance.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: Education was provided immediately at a Medical Grand Rounds presentation on December 13, 2018. Educational statements will be added to provider documentation and medication reconciliation templates. Once template updates are complete, Medical and Mental Health Grand Rounds presentations will be repeated, and each prescribing provider will receive an email with education requirements outlined. Compliance with educational requirements to geriatric patients will be monitored with 100 percent chart review done monthly and results will be presented to the Pharmacy and Therapeutics Committee. Any providers that are not completing education will be contacted by either the Associate Chief of Staff of Medicine or the Psychiatry Lead for corrective action. Chart reviews will be monitored until 90 percent compliance (number of veterans greater than age 65 with documented education on newly prescribed medications/number of newly prescribed antidepressants in Veterans greater than age 65) has been maintained for six months.

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 leaders. The facility must also have a process to ensure the collecting and tracking of data related to cervical cancer screenings.[119]

VHA has established time frames 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 February 28, 2018.)

[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 record of one woman veteran, 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 veterans program manager
- Appointment of a women's health medical director or clinical champion
- Facility Women Veterans Health Committee
  - Core membership
  - Quarterly meetings
  - Reports to clinical executive leaders
- 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 patients within required time frame
- Provision of follow-up care for abnormal cervical pathology results, if indicated

Women's Health Conclusion

Generally, the OIG found compliance with many of the performance indicators, including requirements for a designated women veterans program manager, tracking data related to cervical cancer screenings, communicating results to patients within the required time frame, and providing follow-up care if indicated. However, the OIG identified a concern with the core membership for the Women Veterans Health Committee 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 executive leadership."[121] From October 2017 through October 2018, the committee lacked representation from the women's health medical director, gynecology, business office, and executive leadership. This resulted in a lack of expertise in the review and analysis of data as the committee planned and carried out improvements for quality and equitable care for women veterans.[122] The women veterans program manager stated the women's health medical director position was recently filled. Representatives from gynecology and the business office were not on the charter. Additionally, the chief of staff was permanently assigned in May 2018 and identified as a member per the committee charter but had not attended any meetings.

Recommendation 16

16. The facility director ensures the Women Veterans Health Committee includes required core members and monitors the committee's compliance.

Facility concurred.

Target date for completion: March 31, 2020

Facility response: The Women Veterans Health Committee meeting is held at least quarterly and will be rescheduled to reduce conflicts with other meetings. The Women's Health Medical Director will be advised of the meeting ahead of time and schedule adjusted or a designee will be sent. All committee members will be reminded of the requirement to attend at least 75 percent of meetings either in person or by sending a designee in their absence. Attendance will be documented on the Women Veterans Health Committee minutes, which are submitted to the Medical Executive Board (MEB). MEB will monitor compliance for six months. The Sheridan VA does not have a gynecologist on staff.

[121] VHA Directive 1330.01(2).

[122] VHA Directive 1330.01(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." A 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."[123] 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.[124]

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."[125]

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."[126]

The VHA national director of Emergency Medicine developed the Emergency Medicine Improvement 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.[127]

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

[124] VHA Directive 1101.05(2).

[125] VHA Directive 1101.05(2).

[126] TJC. Leadership standard LD.04.03.11.

[127] 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.[128] Managers must ensure medications are securely stored,[129] a psychiatric intervention room is available,[130] 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.[131]

The OIG examined the clinical risks of the 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 OIG team reviewed UCC staffing schedules, committee minutes, and other relevant documents. The OIG evaluated the following performance indicators:

- General
  - Presence of an emergency department or 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
  - Backup 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

[128] VHA Directive 1101.05(2).

[129] TJC. Medication Management standard MM.03.01.01.

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

[131] 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 tracks[132]
- 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 was not compliant with the requirements for the UCC. The OIG found that facility managers were operating the UCC 24 hours per day without a waiver and required staff, had no backup call schedule for providers, and did not implement the EDIS tracking program. The OIG also noted insufficient signage to direct patients to the UCC and the lack of necessary patient care equipment and supplies. The facility director and chief of staff acknowledged that the facility was not compliant with the UCC requirements but had been working with VISN 19 and the national program office since August 2018 on a restructuring plan. The chief of staff

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

provided the OIG with a clinical restructuring proposal, sent to the VISN 19 December 11, 2018.[133]

Specifically, VHA requires that VA medical facilities operating a UCC 24 hours a day, seven days a week, must request and receive approval for a waiver from the national director of Emergency Medicine.[134] The OIG found the facility did not have a waiver to operate the UCC with continuous hours. This resulted in a lack of assurance that the facility provides urgent care with proper staffing and support. The chief of Quality Management stated that the UCC has been operating for 24 hours a day, seven days a week, since the facility transitioned from an emergency department to a UCC in 2008.

Recommendation 17

17. The facility director must seek a waiver should the facility continue to operate the urgent care center 24 hours a day, seven days a week.

Facility concurred.

Target date for completion: November 1, 2019 for the proposal to be routed to VA Central Office, full implementation of the plan by August 1, 2020

Facility response: Sheridan Veterans Administration Health Care System will continue to work with VISN 19 to create and route for formal concurrence, a revised Business Plan for Proposed Restructuring of Clinical Programs to be in alignment with the Veterans Health Administration Directive 1101.05(2). This will include a request for waiver to continue to operate the urgent care center 24 hours a day, seven days a week.

Additionally, VHA requires that a UCC has appropriately educated and qualified emergency care professionals physically present in the UCC during all hours of operation. This includes a licensed physician and a minimum of two registered nurses.[135] The OIG found that the UCC did not have a provider or the minimum two registered nurses present in the UCC during all hours of operation. This resulted in a lack of appropriate staff to care for patients with urgent needs. The chief of staff provided the OIG with an unsigned and undated business plan for the proposed restructuring of the UCC.[136]

[133] VHA 1101.05(2).
[134] VHA 1101.05(2).
[135] VHA 1101.05(2).
[136] VHA 1101.05(2).

Recommendation 18

18. The facility director ensures that the urgent care center is staffed with a licensed physician and a minimum of two registered nurses at all times of operation and monitors compliance.

Facility concurred in principle.

Target date for completion: August 30, 2020. Recruitment package for seven Urgent Care RNs was submitted to local Resource Management Committee on August 30, 2019. The posting of Urgent Care vacancies will remain open and active until all positions are filled. By November 1, 2019 the request for provider waiver as outlined below will be routed to VA Central Office.

Facility response: Prior to the OIG visit in December 2018, the Sheridan Veterans Administration Health Care System (SVAHCS) spent 15 months working actively to find the most realistic and fiscally responsible solution to meeting VHA Directive 1101.05(2) Emergency Medicine. At the time of the OIG visit, the SVAHCS had created a clinical restructuring proposal that included decreasing urgent care hours to 7:30am-4:00pm Monday through Friday. Unfortunately, conversations from December 2018 through July 2019 had yet to reveal a mutually satisfactory plan for implementing the clinical restructuring plan and meeting the directive. Discussions with VISN and local leadership finally culminated in a local decision to change directions from the original business plan which included decreased hours to the current plan for seeking a waiver to maintain 24 hour a day 7 day a week availability of Urgent Care services for all Veterans in our community. This in large part has been driven by our expertise in providing appropriate and timely mental health and substance abuse services to our Veterans. Further compounding this decision was the lack of Urgent Care services available to Veterans in our community under the Mission Act. The focus on this new direction commenced at the beginning of August. The SVAHCS has continued to engage in conversations with the national Emergency Management office to discuss the most realistic and fiscally responsible way to provide nursing and medical coverage for Urgent Care Veterans.

Since the beginning of August, the SVAHCS has worked to create action plans to address the Registered Nurse (RN) staffing requirements of VHA Directive 1101.05(2). Following is the current state for RN staffing in the Urgent Care: there are a total of four dedicated Urgent Care RN staff members; two RNs are staffed Monday through Friday 7:30am-4:00pm; one dedicated RN is staffed 7:30am-8:00pm Saturday and Sunday. The Monday through Friday staffing is supported by data analysis indicating peak hours of utilization. Any Veteran presenting after 4:00pm Monday through Friday or 8:00pm on Saturday and Sunday are currently being triaged by one of the two RNs assigned to the medical unit which is located two floors above the Urgent Care. Current data analysis indicates 4 Veterans are seen per week from 8:00pm-7:30am. Utilizing this current care model, there have been no adverse outcomes for any Veteran requiring Urgent Care. It is estimated that the SVAHCS will need to hire seven RNs to allow for 24 hour

per day 7 days per week staffing with two RNs in Urgent Care. A recruitment package for seven Urgent Care nurses was completed and submitted to the Resource Management Committee on August 30, 2019. Nursing leadership will initiate conversations with Human Resources regarding recruitment bonuses for qualified applicants. Executive Leadership fully supports efforts at providing high quality care to our Veterans 24 hours per day 7 days per week. Executive Leadership will move the recruitment package to posting as quickly as Human Resources can accommodate this request. Timely filling of Urgent Care vacancies will be highly dependent upon the pool of qualified nurses who apply. The posting for Urgent Care nurses will remain open and active until all seven nurses have been hired. Active recruitment will begin immediately and continue until staffing par levels are achieved.

The facility will implement Emergency Department Integration Software (EDIS) which will allow for accurate tracking of throughput for Veterans coming into the Urgent Care System. This data will be reviewed monthly at the Emergency Care Committee, which reports to the Medical Executive Board. The Urgent Care volume at this time is limited: currently the Urgent Care serves on average about 4 Veterans during the hours of 7:30am-4:00pm, on average about 1 Veteran from 4:00pm-8:00pm and, as previously mentioned, on average 4 Veterans per week from 8:00pm-7:30am. EDIS implementation will allow the facility to document efficiency in the current provider model of the Urgent Care being covered by the Medical Officer of the day (MOD). A clinical back up schedule for MOD coverage has been created and includes utilization of three other MD/DO staff who reside on station and can be available to the facility within 15 minutes. Discussions on August 6, 2019 with the VA National Emergency Management office included a potential request for a waiver to allow this model of care to continue until the Urgent Care reaches 6 Veterans per shift, at which point a dedicated Advanced Practice Registered Nurse (APRN) will be hired for Urgent Care Coverage. For compliance with VHA Directive 1101.05(2) Emergency Medicine, the APRN functioning in the Urgent Care setting will have physician coverage immediately available within the hospital.

In October 2019, the VA National Emergency Management office staff have committed to performing a site visit to the SVAHCS to better understand the challenges of a frontier medical environment, recruitment challenges and fiscal responsibility. The SVAHCS Associate Chief Nurse of Medical Operations is an active participant on the national task force to re-examine VHA Directive 1101.05(2) Emergency Medicine and its impact on small, highly rural, level three facilities with Urgent Care needs. The SVAHCS will continue to work with VISN 19 to create and route for formal concurrence, request for waiver for provider staffing as outlined above. This will be routed to the Office of Emergency Management by November 1, 2019.

Adequate staffing during all hours of operation requires an effective backup call process as well. VHA requires that "all ED and UCC facilities have written provider staffing contingency plans that includes a backup call schedule to address situations where expedient mobilization of

provider resources are needed."[137] The OIG found that the UCC lacked a backup call schedule, which could potentially impact the facility's ability to provide uninterrupted and timely patient care. The chief of staff provided the OIG with an unsigned and undated business plan for the proposed restructuring of the UCC.[138]

Recommendation 19

19. The chief of staff ensures that a backup call schedule is maintained for urgent care providers and monitors compliance.

Facility concurred.

Target date for completion: March 31, 2020

Facility response: The Sheridan Veterans Administration Health Care System will create a backup call schedule for Urgent Care coverage, this will be created by the Medicine service line and disseminated throughout the facility with other coverage and leave calendars on a monthly basis. Compliance will be monitored at 100 percent (number of back up schedules/six months) for six months through the Quality Safety Value Board.

VHA policy states that "all VA EDs and UCCs must fully implement and utilize the EDIS tracking program for data entry, to capture patient data including ED/UCC flow metrics and to utilize that information for flow improvement."[139] The OIG found that the facility was not using the EDIS tracking program. This resulted in the lack of data regarding patient flow and timeliness in the UCC. The associate chief nurse reported that they do not use EDIS, as it is difficult to train the many staff members at different locations where urgent care patients are seen.

Recommendation 20

20. The chief of staff ensures the emergency department integration software tracking program is fully implemented for data entry and that the information is utilized for improvement and monitors compliance.

[137] VHA Directive 1101.05(2).
[138] VHA Directive 1101.05(2).
[139] VHA Directive 1101.05(2).

Facility concurred.

Target date for completion: Implementation of EDIS by December 1, 2019; Data collection for staff utilization numbers through June 30, 2020

Facility response: Sheridan Veterans Administration Health Care System will educate necessary staff and stakeholders in the application of emergency department integration software (EDIS) and will implement the use in the Urgent Care Clinic (UCC) by December 1, 2019.

Utilization will be monitored for 90 percent compliance by utilizing EDIS data reliability metrics. For six months after implementation, the data will be reported to Emergency Care Committee. Process improvement will be initiated based upon opportunities identified by data analysis.

Measures of Veteran throughput will also be monitored utilizing the Emergency Medicine Management Tool Process Analysis tool (time in minutes from entry into the system until Veteran is discharged from UCC) to document timely response by Licensed Independent Providers. Data analysis will be completed by the Associate Chief of Staff of Medicine, and process improvement will be initiated based upon opportunities identified. Data will be reviewed and monitored through the Medical Executive Board.

VHA requires facilities to have "appropriate signage at all entrances" directing patients to the emergency department and/or UCC.[140] The OIG found that the facility had only one sign outside the UCC and no interior signs directing patients to the UCC area. Signage is important for patients presenting for care at the UCC. The chief of staff provided the OIG with an unsigned and undated business plan for the proposed restructuring of the UCC.[141]

Recommendation 21

21. The facility director ensures appropriate signage directs patients to the urgent care center and monitors compliance.

[140] VHA Directive 1101.05(2).

[141] VHA Directive 1101.05(2).

Facility concurred.

Target date for completion: April 1, 2020

Facility response: Extensive review of the exterior of the Sheridan Veterans Administration Health Care System parent facility revealed at least seven exterior wayfinding signs directing Veterans to the Urgent Care Clinic beginning at the entry to the main campus and throughout the remainder of the campus. Urgent Care clinic directional signage will be posted at main building entrances to the facility, as well as on interior way finding signs. An internal wayfinding signage project is currently in contracting and will include Urgent Care Clinic signage.

Lastly, VHA requires that "equipment and supplies necessary to care for patients expected to be seen in the ED/UCC must be readily available in the facility at all times," including pediatric/neonatal resuscitation and obstetric equipment, and that all medical staff must be trained to use these items.[142] The OIG found that the facility lacked pediatric/neonatal basic life support equipment and an obstetric delivery kit. This may result in a lack of timely and appropriate care for patients presenting for care. The chief of staff provided the OIG with an unsigned and undated business plan for the proposed restructuring of the UCC.[143]

Recommendation 22

22. The facility director ensures that equipment and supplies necessary to care for patients are readily available at all times in the urgent care center and monitors compliance.

Facility concurred.

Target date for completion: October 1, 2019

Facility response: Pediatric resuscitation equipment and an Obstetrical emergency kit will be obtained by Medical Supply staff and stocked in the Urgent Care Clinic. Once obtained, training will be provided to nursing and Licensed Independent Providers in the Urgent Care Clinic by the Nurse Manager via staff meeting. Pediatric ambu-bag is stocked on the Urgent Care Clinic crash cart, which is continuously monitored by the Reusable Medical Equipment technician every six months and when the seal is broken as the crash cart is used. Par levels and expiration dates on the disposable OB equipment will be continuously monitored by logistics Medical Supply staff as they restock the rooms.

[142] VHA Directive 1101.05(2).

[143] VHA Directive 1101.05(2).

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	• 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	Twenty-two OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the director, chief of staff, and associate director. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer reviews • UM reviews • Patient safety • Resuscitation episode review	• None	• None
Medical Staff Privileging	• Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank	• Clinical managers define and communicate expectations for FPPEs in advance and maintain appropriate documentation of the processes.	• OPPEs include service-specific criteria. • Service chiefs collect and review OPPE data and the facility's Executive Committee of the Medical Staff reviews the data in the consideration to continue provider privileges. • The solo pathologist's OPPE includes the minimum required specialty criteria.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• 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 unit
	  ○ Mental health environment of care rounds
	  ○ Nursing station security
	  ○ Public area and general unit safety
	  ○ Patient room safety
	  ○ Infection prevention
	  ○ Availability of medical equipment and supplies
	• Emergency management
	  ○ Hazard vulnerability analysis (HVA)
	  ○ Emergency operations plan (EOP)
		• Environment of care rounds team is trained to identify and record all environment of care deficiencies.
		• Director works with the VISN director and contracting officer toward correction of Rock Springs VA Clinic deficiencies.
		• Monthly emergency generator testing includes documentation of dynamic load used.
			• VA police document response time to panic alarm testing at the locked inpatient mental health unit.
			• Flooring that provides cushioning is installed in the mental health seclusion rooms.
			• The emergency operations plan includes all required elements.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	○ Emergency power testing and availability		
Medication Management: Controlled Substances Inspections	• Controlled substances coordinator reports • Pharmacy operations • Controlled substances inspector requirements • Controlled substances area inspections • Pharmacy inspections • Facility review of override reports	• None	• Monthly reconciliation of one day dispensing from pharmacy to every automated dispensing cabinet and one day return of stock to pharmacy from every automated dispensing cabinet is performed during controlled substances inspections. • Controlled substances inspectors verify controlled substances orders on a monthly basis. • Controlled substances coordinators refrain from conducting routine inspections.
Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training	• 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	• Providers complete military sexual trauma mandatory training within the required time frame.	• None
Geriatric Care: Antidepressant Use among the Elderly	• 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	• Clinicians provide and document patient/caregiver education for newly prescribed medications.	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up	• Appointment of a women veterans program manager • Appointment of a women's health medical director or clinical champion • Facility Women Veterans Health Committee • Collection and tracking of cervical cancer screening data • Communication of abnormal results to patients within required time frame • Provision of follow-up care for abnormal cervical pathology results, if indicated	• None	• The Women Veterans Health Committee includes required core members.
High-Risk Processes: Operations and Management of Emergency Departments and UCCs	• 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	• The UCC is staffed with a licensed physician and a minimum of two registered nurses at all times of operation. • Equipment and supplies necessary to care for patients are readily available at all times in the UCC.	• The facility director seeks a waiver to continue to operate the UCC 24 hours a day, seven days a week. • A backup call schedule is maintained for UCC providers. • The emergency department integration software tracking program is fully implemented for data entry and the information is utilized for improvement. • Signage directs patients to the UCC.

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this low complexity (3) facility reporting to VISN 19.[144]

Table B.1. Facility Profile for Sheridan VA Medical Center (666) (October 1, 2015, through September 30, 2018)

Profile Element	Facility Data FY 2016[145]	Facility Data FY 2017[146]	Facility Data FY 2018[147]
Total medical care budget dollars	$97,455,519	$108,871,158	$121,561,371
Number of:			
• Unique patients	12,877	12,680	12,521
• Outpatient visits	116,976	121,320	124,325
• Unique employees[148]	466	470	543
Type and number of operating beds:			
• Community living center	40	40	40
• Domiciliary	71	115	101
• Medicine	10	10	10
• Mental health	50	20	20
Average daily census:			
• Community living center	34	30	30
• Domiciliary	49	62	67
• Medicine	5	5	4
• Mental health	27	12	8

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.

[144] 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."

[145] October 1, 2015, through September 30, 2016.

[146] October 1, 2016, through September 30, 2017.

[147] October 1, 2017, through September 30, 2018.

[148] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[149]

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)[150]

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[151] Provided	Diagnostic Services[152] Provided	Ancillary Services[153] Provided
Casper, WY	666GB	6,069	2,262	Cardiology Dermatology Endocrinology Gastroenterology Nephrology Poly-trauma Rehab physician Anesthesia General surgery Orthopedics	EKG	Pharmacy Social work Weight management

[149] Includes all outpatient clinics in the community that were in operation as of August 15, 2018.

[150] The definition of an "encounter" can be found in VHA Directive 2010-049, *Encounter and Workload Capture for Therapeutic and Supported Employment Services Vocational Programs*, October 14, 2010. (This directive expired on October 31, 2015 and has not been updated.) An encounter is a "professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition."

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

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

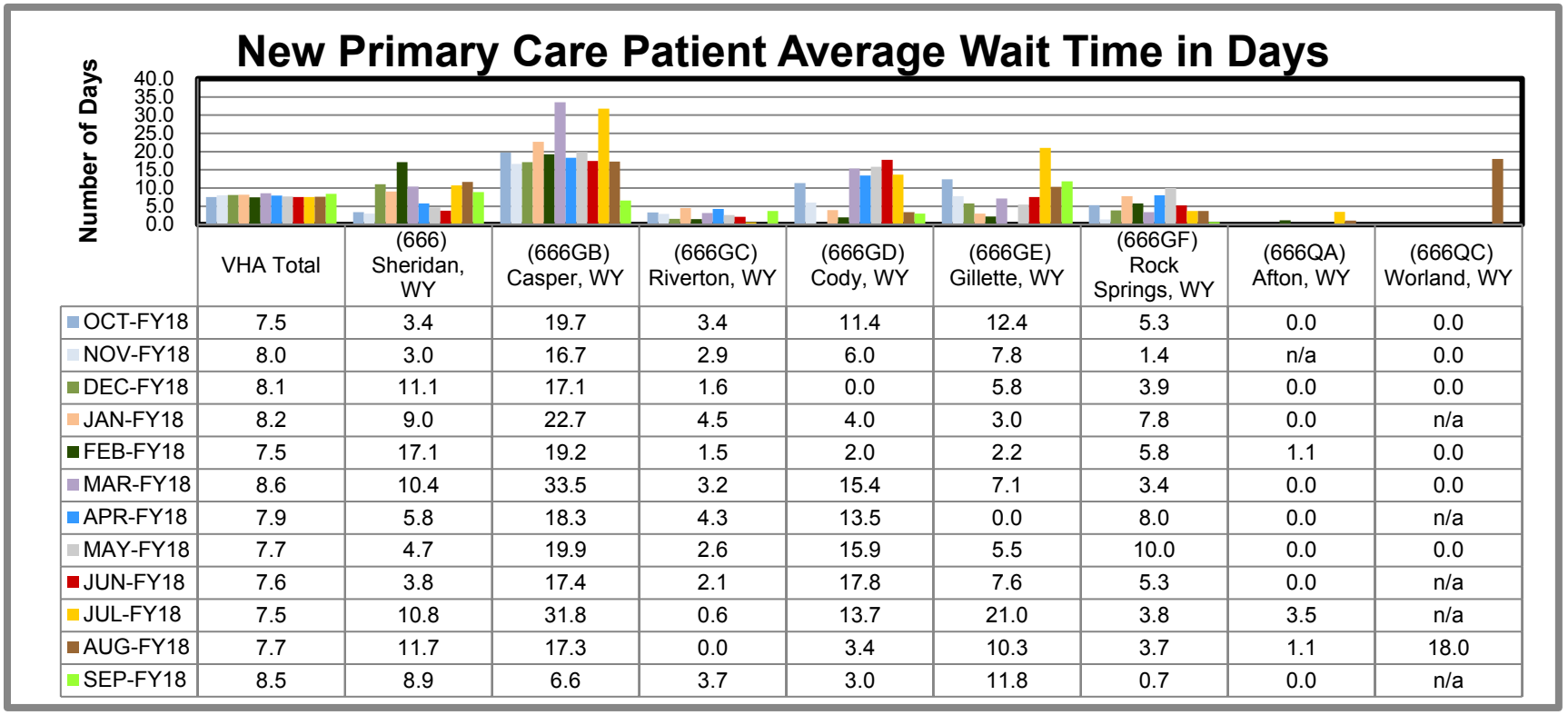
[153] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[151] Provided	Diagnostic Services[152] Provided	Ancillary Services[153] Provided
Riverton, WY	666GC	3,119	1,073	Cardiology Dermatology Endocrinology Gastroenterology Neurology Poly-trauma Rehab physician Anesthesia General surgery Orthopedics	EKG EMG	Pharmacy Social work Weight management
Cody, WY	666GD	3,345	483	Cardiology Endocrinology Gastroenterology Nephrology Poly-trauma Rehab physician Anesthesia General surgery Orthopedics	EKG	Pharmacy Social work Weight management
Gillette, WY	666GE	3,170	714	Cardiology Dermatology Endocrinology Gastroenterology Nephrology Rehab physician General surgery Orthopedics	EKG	Pharmacy Social work Weight management

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[151] Provided	Diagnostic Services[152] Provided	Ancillary Services[153] Provided
Rock Spring, WY	666GF	3,132	1,094	Cardiology Dermatology Endocrinology Gastroenterology Orthopedics	EKG	Pharmacy Social work Weight management
Afton, WY	666QA	1,104	111	Cardiology Gastroenterology Nephrology Poly-trauma Rehab physician Anesthesia	EKG	Pharmacy Social work Weight management
Evanston, WY	666QB	497	119	Cardiology Dermatology Gastroenterology Anesthesia	EKG	Pharmacy Social work Weight management
Worland, WY	666QC	483	111	Cardiology Dermatology Endocrinology Rehab physician Anesthesia Orthopedics	EKG	Pharmacy Social work Weight management

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

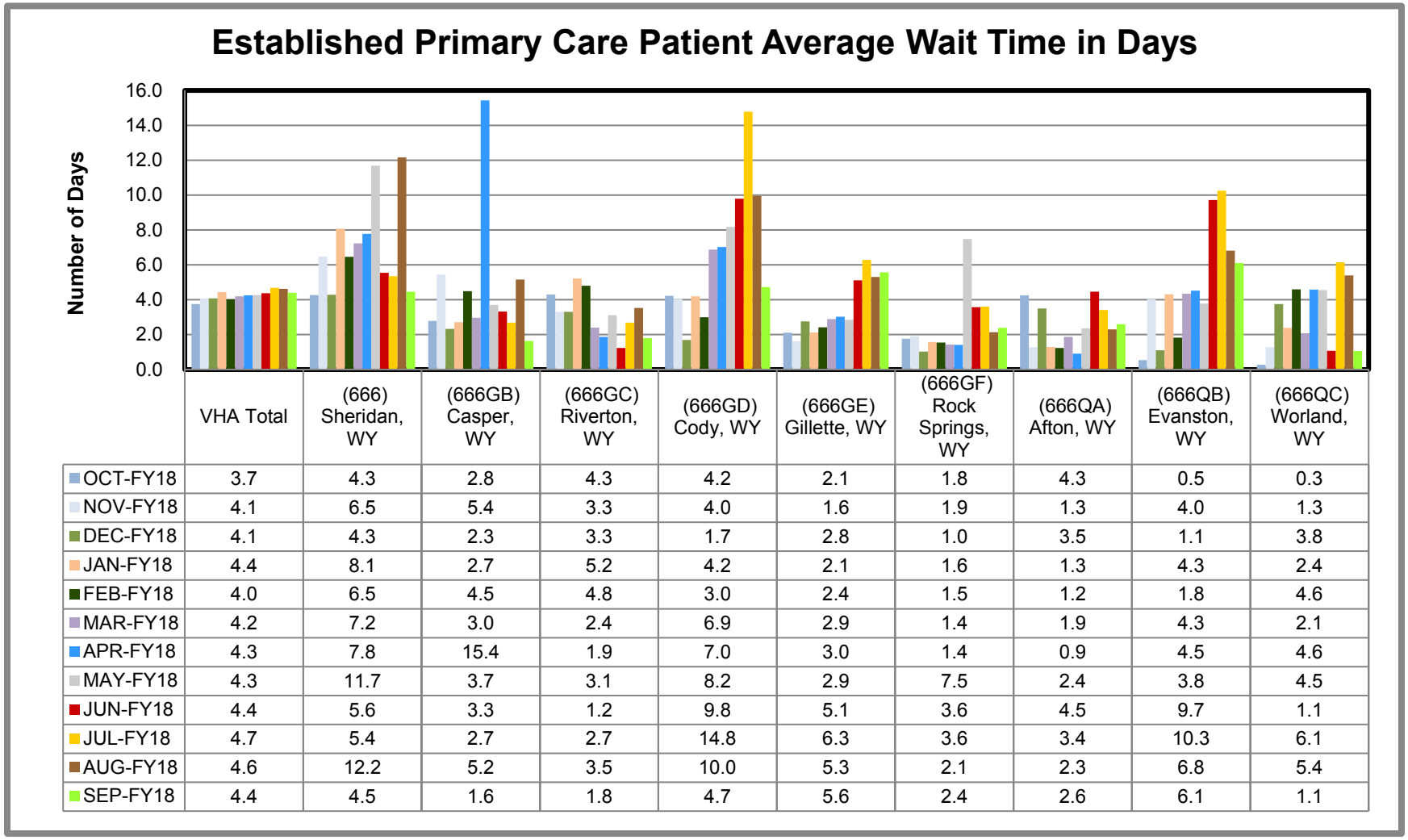
Appendix C: Patient Aligned Care Team Compass Metrics[154]



	VHA Total	(666) Sheridan, WY	(666GB) Casper, WY	(666GC) Riverton, WY	(666GD) Cody, WY	(666GE) Gillette, WY	(666GF) Rock Springs, WY	(666QA) Afton, WY	(666QC) Worland, WY
OCT-FY18	7.5	3.4	19.7	3.4	11.4	12.4	5.3	0.0	0.0
NOV-FY18	8.0	3.0	16.7	2.9	6.0	7.8	1.4	n/a	0.0
DEC-FY18	8.1	11.1	17.1	1.6	0.0	5.8	3.9	0.0	0.0
JAN-FY18	8.2	9.0	22.7	4.5	4.0	3.0	7.8	0.0	n/a
FEB-FY18	7.5	17.1	19.2	1.5	2.0	2.2	5.8	1.1	0.0
MAR-FY18	8.6	10.4	33.5	3.2	15.4	7.1	3.4	0.0	0.0
APR-FY18	7.9	5.8	18.3	4.3	13.5	0.0	8.0	0.0	n/a
MAY-FY18	7.7	4.7	19.9	2.6	15.9	5.5	10.0	0.0	0.0
JUN-FY18	7.6	3.8	17.4	2.1	17.8	7.6	5.3	0.0	n/a
JUL-FY18	7.5	10.8	31.8	0.6	13.7	21.0	3.8	3.5	n/a
AUG-FY18	7.7	11.7	17.3	0.0	3.4	10.3	3.7	1.1	18.0
SEP-FY18	8.5	8.9	6.6	3.7	3.0	11.8	0.7	0.0	n/a

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Evanston, WY (666QB), 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. The absence of reported data is indicated by "n/a."

[154] Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 06, 2018.



	VHA Total	(666) Sheridan, WY	(666GB) Casper, WY	(666GC) Riverton, WY	(666GD) Cody, WY	(666GE) Gillette, WY	(666GF) Rock Springs, WY	(666QA) Afton, WY	(666QB) Evanston, WY	(666QC) Worland, WY
OCT-FY18	3.7	4.3	2.8	4.3	4.2	2.1	1.8	4.3	0.5	0.3
NOV-FY18	4.1	6.5	5.4	3.3	4.0	1.6	1.9	1.3	4.0	1.3
DEC-FY18	4.1	4.3	2.3	3.3	1.7	2.8	1.0	3.5	1.1	3.8
JAN-FY18	4.4	8.1	2.7	5.2	4.2	2.1	1.6	1.3	4.3	2.4
FEB-FY18	4.0	6.5	4.5	4.8	3.0	2.4	1.5	1.2	1.8	4.6
MAR-FY18	4.2	7.2	3.0	2.4	6.9	2.9	1.4	1.9	4.3	2.1
APR-FY18	4.3	7.8	15.4	1.9	7.0	3.0	1.4	0.9	4.5	4.6
MAY-FY18	4.3	11.7	3.7	3.1	8.2	2.9	7.5	2.4	3.8	4.5
JUN-FY18	4.4	5.6	3.3	1.2	9.8	5.1	3.6	4.5	9.7	1.1
JUL-FY18	4.7	5.4	2.7	2.7	14.8	6.3	3.6	3.4	10.3	6.1
AUG-FY18	4.6	12.2	5.2	3.5	10.0	5.3	2.1	2.3	6.8	5.4
SEP-FY18	4.4	4.5	1.6	1.8	4.7	5.6	2.4	2.6	6.1	1.1

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.
Data Definition: "The average number of calendar days between an Established Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date."

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[155]

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

[155] VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL)* (last updated December 26, 2018). 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.)

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 Definitions[156]

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.

[156] *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated August 22, 2019). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410. (The website was accessed on September 3, 2019, but is not accessible by the public.)

Appendix F: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: August 14, 2019

From: Director, Rocky Mountain Network (10N19)

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

To: Director, Bay Pines Office of Healthcare Inspections (54CH03)

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

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

(Original signed by:)

Ralph Giglotti

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: July 16, 2019

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

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

To: Director, Rocky Mountain Network (10N19)

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

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

(Original signed by:)

Pamela S. Crowell, MPA

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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