Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-00110-246

Combined Assessment Program Review of the Cheyenne VA Medical Center Cheyenne, Wyoming

April 8, 2016

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: www.va.gov/oig/hotline)

Glossary

AD	advance directive
CAP	Combined Assessment Program
CSP	compounded sterile product
CT	computed tomography
EHR	electronic health record
EOC	environment of care
facility	Cheyenne VA Medical Center
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
OR	operating room
QSV	quality, safety, and value
VHA	Veterans Health Administration

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of February 8, 2016.

Review Results: The review covered seven activities. We made no recommendations in the Medication Management activity. The facility's reported accomplishment was the telephone access initiative.

Recommendations: We made recommendations in the following six activities:

Quality, Safety, and Value: Consistently review Ongoing Professional Practice Evaluation data every 6 months. Ensure Physician Utilization Management Advisors document their decisions in the National Utilization Management Integration database.

Environment of Care: Properly cover medical waste/biohazard containers.

Coordination of Care: Develop a policy that addresses temporary bed locations.

Computed Tomography Radiation Monitoring: Revise the Radiation Safety Program policy to include required elements.

Advance Directives: Consistently use the required advance directive note titles.

Suicide Prevention Program: Implement a process for responding to referrals from the Veterans Crisis Line and tracking patients who are at high risk for suicide. Implement a process to follow up on high-risk patients who missed mental health appointments. Require that new clinical employees complete suicide risk management training within the required timeframe. Ensure patients and/or caregivers receive a copy of the Suicide Prevention Safety Plan. Review patients' high-risk flags at least every 90 days.

Comments

The Veterans Integrated Service Network Director and Acting Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 24–29, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- QSV
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Suicide Prevention Program

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2015 and FY 2016 through February 8, 2016, and inspectors conducted the review in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide

the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Cheyenne VA Medical Center, Cheyenne, Wyoming,* Report No. 13-02312-304, September 11, 2013).

During this review, we presented crime awareness briefings for 78 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. We distributed an electronic survey to all facility employees and received 223 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

Reported Accomplishment

Telephone Access Initiative

In 2014, the facility implemented the telephone access initiative. The facility identified two primary challenges with the telephone system. The technology and telephone routing systems were antiquated and failed to capture real-time data. In addition, employees couldn't manage the call volume, and abandonment rates were very high.

A multidisciplinary workgroup consisting of veterans, front-line telephone employees, and subject matter experts in telephone systems identified all sources of variation, researched new and emerging technology available to VHA, and developed a plan for implementing an automated call distribution/agent system. A committed effort was made for employee education and training in customer service, telephone courtesy, and warm hand-off procedures at the Medical Support Assistant level. By November 2015, the facility had achieved an answer rate of 3,871 of 4,090 calls (95 percent) and an abandonment rate of 219 of 4,090 calls (5 percent). The cumulative abandonment rate improved from 22 percent in January 2015 to 11 percent in October 2015.

The facility now monitors and evaluates these efforts weekly and provides performance data to front-line employees and managers to gauge and improve performance by area or service queue. The data is also reported to the Executive Quality Board and will be shared with veterans during the open town hall forums in 2016.

Results and Recommendations

QSV

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.[a]

We conversed with senior managers and key QSV employees, and we evaluated meeting minutes, 20 licensed independent practitioners' profiles, 10 protected peer reviews, 5 root cause analyses, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key QSV functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data.		
X	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws addressed a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data. • Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws. • The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated. • The facility followed its policy when employees' licenses expired.	• Three profiles did not contain evidence that clinical managers reviewed Ongoing Professional Practice Evaluation data every 6 months.	**1.** We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Protected peer reviews met selected requirements: • Peer reviewers documented their use of important aspects of care in their review such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions.		
X	Utilization management met selected requirements: • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • The facility had designated an interdisciplinary group to review utilization management data.	• There was no evidence that Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database.	**2.** We recommended that Physician Utilization Management Advisors document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.
	Patient safety met selected requirements: • The Patient Safety Manager entered all reported patient incidents into the WEBSPOT database. • The facility completed the required minimum of eight root cause analyses. • The facility provided feedback about the root cause analysis findings to the individual or department who reported the incident. • At the completion of FY 2015, the Patient Safety Manager submitted an annual patient safety report to facility leaders.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in QSV activities.		
	The facility met any additional elements required by VHA or local policy.		

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. We also determined whether the facility met selected requirements in the dental clinic and the OR.[b]

We inspected the medical/surgical and intensive care units, the community living center and hospice units, the Emergency Department, the OR and post-anesthesia care unit, and the dental and primary care outpatient clinics. Additionally, we reviewed relevant documents and eight employee training records, and we conversed with key employees and managers. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment between patients.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		
	The facility met fire safety requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met environmental safety requirements.		
X	The facility met infection prevention requirements.	• In three of six patient care areas, medical waste/biohazard containers were not properly covered.	**3.** We recommended that facility managers ensure medical waste/biohazard containers are properly covered and monitor compliance.
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Dental Clinic		
	Dental clinic employees completed bloodborne pathogens training within the past 12 months.		
	Dental clinic employees received hazard communication training on chemical classification, labeling, and safety data sheets.		
NA	Designated dental clinic employees received laser safety training in accordance with local policy.		
	The facility tested dental water lines in accordance with local policy.		
	The facility met environmental safety and infection prevention requirements in the dental clinic.		
NA	The facility met laser safety requirements in the dental clinic.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

NM	Areas Reviewed for the OR	Findings	Recommendations
	The facility had emergency fire policy/procedures for the OR that included alarm activation, evacuation, and equipment shutdown with responsibility for turning off room or zone oxygen.		
	The facility had cleaning policy/procedures for the OR and adjunctive areas that included a written cleaning schedule and methods of decontamination.		
	OR housekeepers received training on OR cleaning/disinfection in accordance with local policy.		
	The facility monitored OR temperature, humidity, and positive pressure.		
	The facility met fire safety requirements in the OR.		
	The facility met environmental safety requirements in the OR.		
	The facility met infection prevention requirements in the OR.		
	The facility met medication safety and security requirements in the OR.		
	The facility met laser safety requirements in the OR.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for the safe preparation of CSPs.[c]

We reviewed relevant documents and the competency assessment/testing records of 10 pharmacy employees (6 pharmacists and 4 technicians). Additionally, we inspected one area where sterile products are compounded. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy on preparation of CSPs that included required components: • Pharmacist CSP preparation or supervision of preparation except in urgent situations • Hazardous CSP preparation in an area separate from routine CSP preparation or in a compounding aseptic containment isolator • Environmental quality and control of ante and buffer areas • Hood certification initially and every 6 months thereafter • Cleaning procedures for all surfaces in the ante and buffer areas		
	The facility established competency assessment requirements for employees who prepare CSPs that included required elements, and facility managers assessed employee competency at the required frequency based on the facility's risk level.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	If the facility used an outsourcing facility for CSPs, it had a policy/guidelines/a plan that included required components for the outsourcing facility: • Food and Drug Administration registration • Current Drug Enforcement Agency registration if compounding controlled substances		
	The facility had a safety/competency assessment checklist for preparation of CSPs that included required steps in the proper order to maintain sterility.		
	All International Organization for Standardization classified areas had documented evidence of periodic surface sampling, and the facility completed required actions when it identified positive cultures.		
	The facility had a process to track and report CSP medication errors, including near misses.		
	The facility met design and environmental safety controls in compounding areas.		
	The facility used a laminar airflow hood or compounding aseptic isolator for preparing non-hazardous intravenous admixtures and any sterile products.		
	The facility used a biological safety cabinet in a physically separated negative pressure area or a compounding aseptic containment isolator for hazardous medication compounding and had sterile chemotherapy type gloves available for compounding these medications.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	If the facility prepared hazardous CSPs, a drug spill kit was available in the compounding area and during transport of the medication to patient care areas.		
	Hazardous CSPs were physically separated or placed in specially identified segregated containers from other inventory to prevent contamination or personnel exposure.		
	An eyewash station was readily accessible near hazardous medication compounding areas, and there was documented evidence of weekly testing.		
	The facility documented cleaning of compounding areas, and employees completed cleaning at required frequencies.		
	During the past 12 months, the facility initially certified new hoods and recertified all hoods minimally every 6 months.		
	Prepared CSPs had labels with required information prior to delivery to the patient care areas: • Patient identifier • Date prepared • Admixture components • Preparer and checker identifiers • Beyond use date		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Coordination of Care

The purpose of this review was to evaluate selected aspects of the facility's patient flow process over the inpatient continuum (admission through discharge).[d]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 35 randomly selected patients who had an acute care inpatient stay of at least 3 days from July 1, 2014, through June 30, 2015. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy that addressed patient discharge and scheduling discharges early in the day.		
X	The facility had a policy that addressed temporary bed locations, and it included: • Priority placement for inpatient beds given to patients in temporary bed locations • Upholding the standard of care while patients are in temporary bed locations • Medication administration • Meal provision	• The facility did not have a policy that addressed temporary bed locations.	**4.** We recommended that the facility develop a policy that addresses temporary bed locations.
	The Facility Director had appointed a Bed Flow Coordinator with a clinical background.		
	Physicians or acceptable designees completed a history and physical exam within 1 day of the patient's admission or referenced a history and physical exam completed within 30 days prior to admission. • When resident physicians completed the history and physical exams, the attending physicians provided a separate admission note or addendum within 1 day of the admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• When the facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete history and physical exams, they were properly documented.		
	Nurses completed admission assessments within 1 day of the patient's admission.		
	When patients were transferred during the inpatient stay, physicians or acceptable designees documented transfer notes within 1 day of the transfer. • When resident physicians wrote the transfer notes, attending physicians documented adequate supervision. • Receiving physicians documented transfers.		
	When patients were transferred during the inpatient stay, sending and receiving nurses completed transfer notes.		
	Physicians or acceptable designees documented discharge progress notes or instructions that included patient diagnoses, discharge medications, and follow-up activity levels. • When resident physicians completed the discharge notes/instructions, attending physicians documented adequate supervision. • When facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete discharge notes/instructions, they were properly documented.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians provided discharge instructions to patients and/or caregivers and documented patients and/or caregiver understanding.		
	The facility complied with any additional elements required by VHA or local policy.		

CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for 10 CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 50 randomly selected patients who had a CT scan January 1–December 31, 2014. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
X	The facility had a CT/imaging/radiation safety policy or procedure that included: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans	The facility's Radiation Safety Program policy did not include: • A CT quality control program with program monitoring by a medical physicist at least annually and image quality monitoring • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans	**5.** We recommended that the facility revise the Radiation Safety Program policy to include a computed tomography quality control program with annual monitoring by a medical physicist and image quality monitoring, protocol monitoring and a method for identifying and reporting excessive doses to the Radiation Safety Officer, a process for managing/reviewing protocols and procedures to follow when revising protocols, and radiologist review of appropriateness of orders and specification of protocol prior to scans.

NM	Areas Reviewed (continued)	Findings	Recommendations
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		
	A medical physicist tested a sample of CT protocols at least annually.		
	A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service.		
NA	If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review and documented the dose in the required application(s), and any summary reports provided by teleradiology included dose information.		
	CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification.		
	There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring.		
	If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used.		
	The facility complied with any additional elements required by VHA or local policy.		

ADs

The purpose of this review was to determine whether the facility complied with selected requirements for ADs for patients.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 34 randomly selected patients who had an acute care admission July 1, 2014–June 30, 2015. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles		
	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.		
	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.		
X	Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. • When inpatients requested a discussion, employees documented the discussion and used the required AD note titles.	• For three of the eight AD discussion notes, employees did not use the required note titles.	**6.** We recommended that employees consistently use the required advance directive note titles and that facility managers monitor compliance.
	The facility met any additional elements required by VHA or local policy.		

Suicide Prevention Program

The purpose of this review was to evaluate the extent the facility's MH providers consistently complied with selected suicide prevention program requirements.[g]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 40 patients assessed to be at risk for suicide during the period October 1, 2014–September 30, 2015, plus those who died from suicide during this same timeframe. We also reviewed the training records of 15 new employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

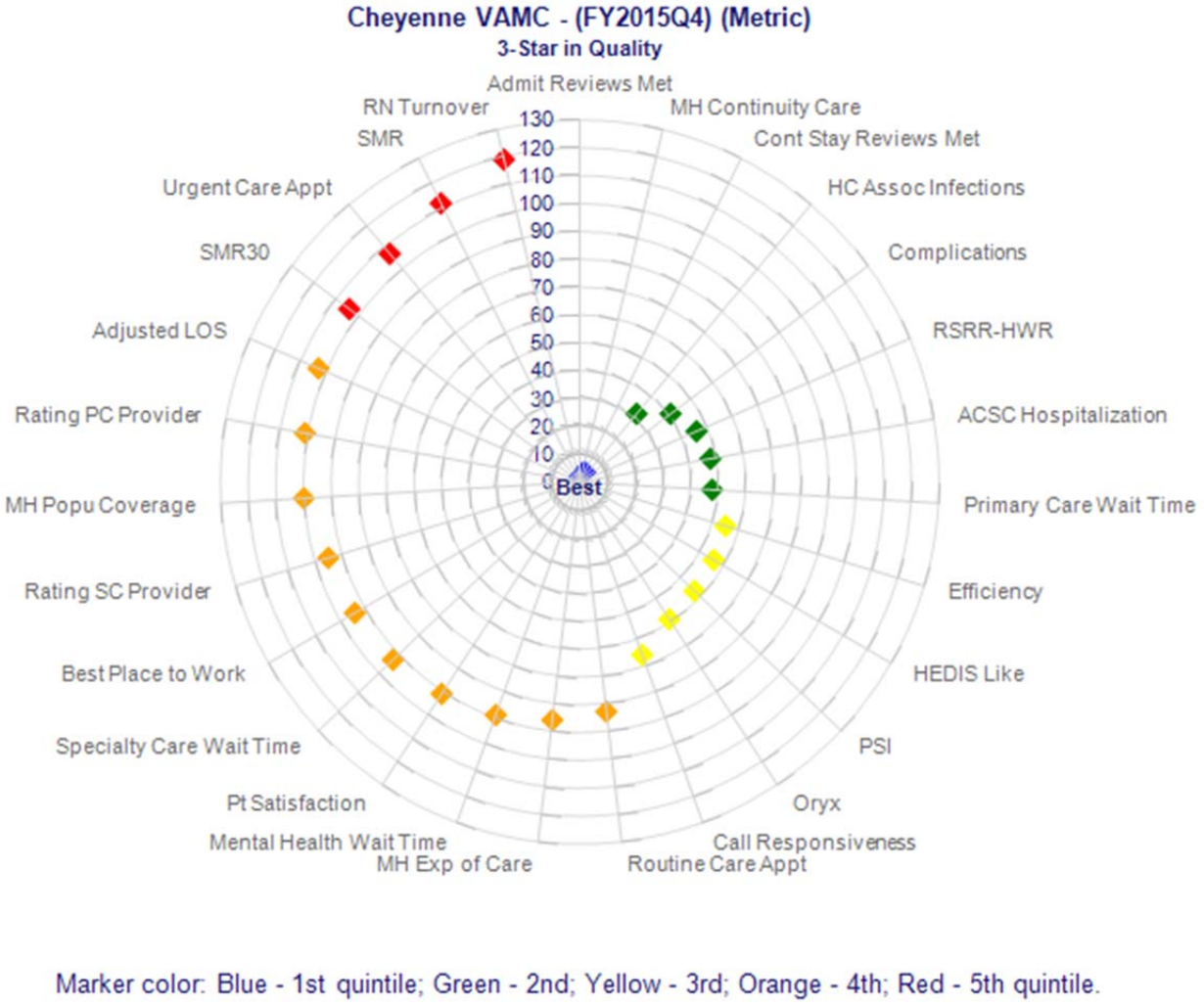
NM	Areas Reviewed	Findings	Recommendations
	The facility had a full-time Suicide Prevention Coordinator.		
X	The facility had a process for responding to referrals from the Veterans Crisis Line and for tracking patients who are at high risk for suicide.	• The facility did not have a documented process for responding to referrals from the Veterans Crisis Line and tracking patients who are at high risk for suicide.	**7.** We recommended that the facility implement a process for responding to referrals from the Veterans Crisis Line and tracking patients who are at high risk for suicide.
X	The facility had a process to follow up on high-risk patients who missed MH appointments.	• The facility did not have a documented process to follow up on high-risk patients who missed MH appointments.	**8.** We recommended that the facility implement a process to follow up on high-risk patients who missed mental health appointments and that facility managers monitor compliance.
X	The facility provided training within required timeframes: • Suicide prevention training to new employees • Suicide risk management training to new clinical employees	• Thirteen of the 15 training records indicated that clinicians did not complete suicide risk management training within 90 days of being hired.	**9.** We recommended that the facility ensure new clinical employees complete suicide risk management training within the required timeframe and that facility managers monitor compliance.
	The facility provided at least five suicide prevention outreach activities to community organizations each month.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility completed required reports and reviews regarding patients who attempted or completed suicide.		
	Clinicians assessed patients for suicide risk at the time of admission.		
	Clinicians appropriately placed Patient Record Flags: • High-risk patients received Patient Record Flags. • Moderate- and low-risk patients did not receive Patient Record Flags.		
	Clinicians documented Suicide Prevention Safety Plans that contained the following required elements: • Identification of warning signs • Identification of internal coping strategies • Identification of contact numbers of family or friends for support • Identification of professional agencies • Assessment of available lethal means and how to keep the environment safe		
X	Clinicians documented that they gave patients and/or caregivers a copy of the safety plan.	• In 12 of the 23 applicable EHRs, clinicians did not document that they gave patients and/or caregivers a copy of the plan.	**10.** We recommended that clinicians ensure patients and/or caregivers receive a copy of the Suicide Prevention Safety Plan and that facility managers monitor compliance.
X	The treatment team evaluated patients as follows: • At least four times during the first 30 days after discharge • Every 90 days to review Patient Record Flags	• Twenty-seven of the 40 applicable EHRs (68 percent) did not contain evidence that the treatment team reviewed patients' high-risk flags at least every 90 days.	**11.** We recommended that treatment teams review patients' high-risk flags at least every 90 days and that facility managers monitor compliance.
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Cheyenne/442) FY 2016 through February 2016[1]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$48.1
Number of:	
• **Unique Patients**	16,926
• **Outpatient Visits**	96,361
• **Unique Employees**[2]	756
Type and Number of Operating Beds (as of January 2016):	
• **Hospital**	22
• **Community Living Center**	42
• **Domiciliary**	10
Average Daily Census (as of January 2016):	
• **Hospital**	11
• **Community Living Center**	32
• **Domiciliary**	0
Number of Community Based Outpatient Clinics	3
Location(s)/Station Number(s)	Sidney/442GB Fort Collins/442GC Greeley/442GD
Veterans Integrated Service Network Number	19

[1] All data is for FY 2016 through February 2016 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

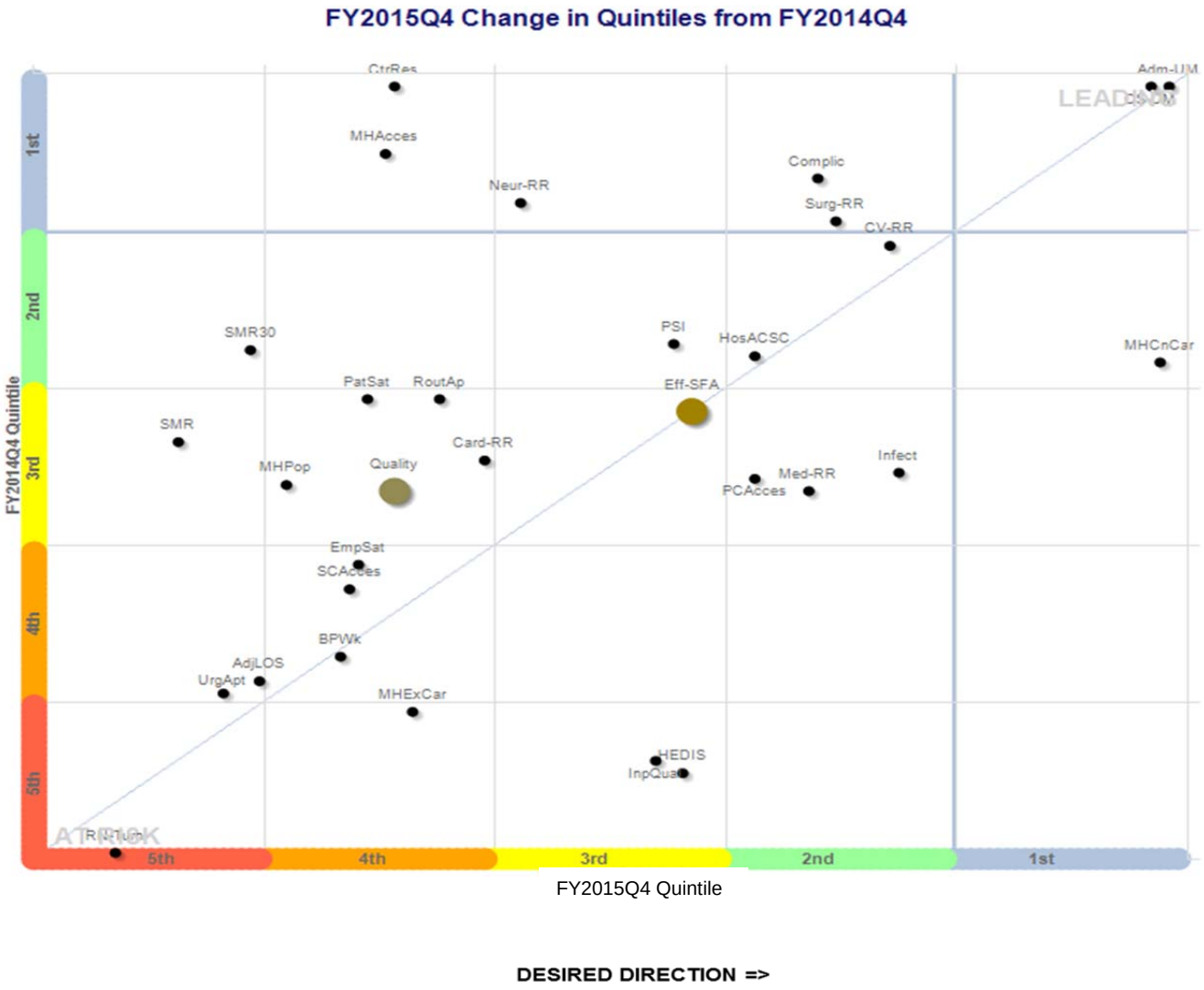
Strategic Analytics for Improvement and Learning (SAIL)[3]



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

[3] Metric definitions follow the graphs.

Scatter Chart



DESIRED DIRECTION =>

NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	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
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	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
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	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-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-CHF	30-day risk standardized readmission rate for congestive heart failure	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
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 and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

Appendix C

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: March 18, 2016

From: Director, Rocky Mountain Network (10N19)

Subject: **CAP Review of the Cheyenne VA Medical Center, Cheyenne, WY**

To: Director, Denver Office of Healthcare Inspections (54DV)

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. I have received the response from the Cheyenne VA Health Care System and concur with the response.

2. If you have any questions or concerns, please contact Ruth Hammond, VISN 19, Quality Management Specialist, 303-639-7016.

for Ralph T. Gigliotti, FACHE
Director, VA Rocky Mountain Network (10N19)

Acting Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: March 15, 2016

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

Subject: **CAP Review of the Cheyenne VA Medical Center, Cheyenne, WY**

To: Director, Rocky Mountain Network (10N19)

1. The Cheyenne VAMC would like to express our appreciation for the opportunity to work with the Office of Inspector General and to review and comment regarding the recommendations for improvement contained in this report.

2. Please find attached our response to each recommendation provided in this report.

3. If there are any questions regarding the response to the recommendations or any additional information is required, please contact Ms. Lisa Adamson, Chief of Quality Management, (307) 433-3621 or at Lisa.Adamson@va.gov.

Paul Roberts, MHA, FACHE
Acting Director, Cheyenne VA Medical Center (442/00)

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2016

Facility response: Facility will assign each service line to track completion of Ongoing Professional Practice Evaluations timely, and Chief of Staff office will monitor tracking and completion.

Recommendation 2. We recommended that Physician Utilization Management Advisors document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: Education has been completed to each Physician Utilization Management Advisor. The Utilization Management Nurse will monitor completion of decisions being documented in the National Utilization Management Integration database.

Recommendation 3. We recommended that facility managers ensure medical waste/biohazard containers are properly covered and monitor compliance.

Concur

Target date for completion: June 30, 2016

Facility response: Nurse Managers on all units will provide education to staff regarding waste/biohazard containers being properly covered at all times. Tracers will be conducted in all areas for three months to monitor compliance.

Recommendation 4. We recommended that the facility develop a policy that addresses temporary bed locations.

Concur

Target date for completion: April 20, 2016

Facility response: The facility will develop a policy that addresses temporary bed locations.

Recommendation 5. We recommended that the facility revise the Radiation Safety Program policy to include a computed tomography quality control program with annual monitoring by a medical physicist and image quality monitoring, protocol monitoring and a method for identifying and reporting excessive doses to the Radiation Safety Officer, a process for managing/reviewing protocols and procedures to follow when revising protocols, and radiologist review of appropriateness of orders and specification of protocol prior to scans.

Concur

Target date for completion: April 20, 2016

Facility response: The Chief of Radiology and Radiologist are revising the Radiation Safety Program policy to include all the required elements listed in the recommendation.

Recommendation 6. We recommended that employees consistently use the required advance directive note titles and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2016

Facility response: Social workers will use the required advance directive note titles in CPRS to document discussions with the Veterans Electronic health record. Reviews will be conducted for three months to monitor compliance.

Recommendation 7. We recommended that the facility implement a process for responding to referrals from the Veterans Crisis Line and tracking patients who are at high risk for suicide.

Concur

Target date for completion: May 30, 2016

Facility response: Suicide Prevention Program staff and those that may provide coverage will be educated on the process for responding to and tracking referrals from the Veteran's Crisis Line and high risk patients. The Suicide Prevention Coordinator will report quarterly to the Mental Health Executive Council and Medical Executive Board on

the number and type of referrals received from the Veteran's Crisis Line and actions taken for follow up.

Recommendation 8. We recommended that the facility implement a process to follow up on high-risk patients who missed mental health appointments and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: The "No Show" Mental Health Service Line appointment procedure will be revised to include a process for follow-up on high-risk patients who missed Mental Health appointments. Audits will be completed to ensure compliance.

Recommendation 9. We recommended that the facility ensure new clinical employees complete suicide risk management training within the required timeframe and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: The Suicide Prevention Coordinator will receive reports through the Talent Management System through the Center for Employee Development. The Suicide Prevention Coordinator will notify providers and respective Program Managers monthly of needed completion. Reports will be provided quarterly to the Mental Health Executive Council and the Medical Executive Board.

Recommendation 10. We recommended that clinicians ensure patients and/or caregivers receive a copy of the Suicide Prevention Safety Plan and that facility managers monitor compliance.

Concur

Target date for completion: August 31, 2016

Facility response: A policy memorandum will be developed to include safety plans and process for developing, documenting, and providing a copy to the patient. Education will be provided to staff on requirements, and audits will be conducted to ensure compliance.

Recommendation 11. We recommended that treatment teams review patients' high-risk flags at least every 90 days and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: A policy memorandum will be developed to include implementation of a Suicide Risk Management Committee/team to review Category 1 Patient Record Flags. The committee will meet monthly to determine, in consultation with the patient's provider(s), whether to continue or remove a Patient Record Flag. A tracking tool will be used to document Patient Record Flag actions, and the Suicide Risk Management Committee will report compliance to the Mental Health Executive Committee quarterly.

Office of Inspector General
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Endnotes

[a] The references used for this topic were:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Directive 1117, *Utilization Management Program*, July 9, 2014.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[b] The references used for this topic included:
- VHA Directive 2005-037, *Planning for Fire Response*, September 2, 2005.
- VHA Directive 2009-026; *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; May 13, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, National Fire Protection Association, Association of perioperative Registered Nurses, U.S. Pharmacopeial Convention, American National Standards Institute.

[c] The references used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of VA Pharmacy Benefits Management Services, The Joint Commission, the United States Pharmacopeial Convention, the American Society of Health-System Pharmacists, the Institute for Safe Medication Practices, the Food and Drug Administration, and the American National Standards Institute.

[d] The references used for this topic included:
- VHA Directive 1009, *Standards for Addressing the Needs of Patients Held in Temporary Bed Locations*, August 28, 2013.
- VHA Directive 1063, *Utilization of Physician Assistants (PA)*, December 24, 2013.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[e] The references used for this topic included:
- VHA Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, "Radiation risks of diagnostic imaging," Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, "Online Guide," updated October 4, 2011.
- The American College of Radiology, "ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT, Revised 2012.

[f] The references used for this topic included:
- VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[g] The references used for this topic included:
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010 (corrected 2/3/11).
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VHA Handbook 1160.06, *Inpatient Health Services*, September 16, 2013.
- Various Deputy Under Secretary for Health for Operations and Management memorandums and guides.
- *VA Suicide Prevention Coordinator Manual*, August 2014.
- Various requirements of The Joint Commission.