DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

# Comprehensive Healthcare Inspection of the Cheyenne VA Medical Center in Wyoming

CHIP REPORT | REPORT #21-00245-256 | SEPTEMBER 20, 2021

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***Figure 1.*** *Cheyenne VA Medical Center in Wyoming.*
*Source: https://vaww.va.gov/directory/guide/* (*accessed January 6, 2021*).

# Abbreviations

| | |
|---|---|
| ADPCS | Associate Director for Patient Care Services |
| CHIP | Comprehensive Healthcare Inspection Program |
| CLC | community living center |
| COVID-19 | coronavirus disease |
| DBRS | Disruptive Behavior Reporting System |
| FDA | Food and Drug Administration |
| FY | fiscal year |
| OIG | Office of Inspector General |
| QSV | quality, safety, and value |
| RN | registered nurse |
| SAIL | Strategic Analytics for Improvement and Learning |
| TJC | The Joint Commission |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Report Overview

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

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

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

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

The OIG conducted an unannounced virtual review of the Cheyenne VA Medical Center during the week of November 30, 2020. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the medical center's performance within the identified focus areas at the time of the OIG review. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this medical center and other Veterans Health Administration (VHA) facilities

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

identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

## Inspection Results

The OIG noted opportunities for improvement in several areas reviewed and issued seven recommendations to the Director and Chief of Staff. These opportunities for improvement are briefly described below.

### Leadership and Organizational Risks

At the time of the OIG's virtual review, the medical center's leadership team consisted of the Director, Chief of Staff, Associate Director for Patient Care Services, and Associate Director. Organizational communications and accountability were managed through the Executive Quality Board, which was also responsible for tracking and trending quality of care and patient outcomes.

When the OIG conducted this inspection, the medical center's leaders had worked as a team for approximately 14 months. The Associate Director for Patient Care Services was the most tenured leader, permanently assigned in December 2015. The Associate Director was the newest member of the leadership team, assigned in September 2019. The Medical Center Director and Chief of Staff had served in their positions since June 2016 and March 2018, respectively.

Employee satisfaction survey results showed that the Associate Director had opportunities to improve employee satisfaction, attitudes toward the workplace, and feelings of workplace respect and the ability to bring up problems and tough issues. The Associate Director for Patient Care Services could reduce staff feelings of moral distress at work.[2] However, patients generally appeared satisfied with the care provided.

The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and did not identify any substantial organizational risk factors.[3]

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

[2] "2019 VA All Employee Survey (AES): Questions by Organizational Health Framework," VA Workforce Surveys Portal, VHA Support Service Center, accessed June 7, 2021, http://aes.vssc.med.va.gov/documents/05_AES_Instrument_ItemThemes.pdf. The All Employee Survey defines moral distress as being "unsure about the right thing to do or could not carry out what you believed to be the right thing."

[3] 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."

way to understand the similarities and differences between the top and bottom performers within VHA.[4]

The Director was knowledgeable, and the Chief of Staff and Associate Director for Patient Care Services were minimally knowledgeable, within their scope of responsibilities, about VHA data and/or system-level factors contributing to specific poorly performing SAIL measures. The Chief of Staff and Associate Director for Patient Care Services verbalized limited understanding of selected poorly performing Community Living Center SAIL measures.[5] In individual interviews, executive leaders were generally able to speak about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. However, all leaders should continue actions to improve and sustain quality and efficiency.

## COVID-19 Pandemic Readiness and Response

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[6]

## Quality, Safety, and Value

The medical center complied with requirements for a committee responsible for quality, safety, and value oversight functions; the Systems Redesign and Improvement Program; and protected peer reviews.[7] However, the OIG identified weaknesses in Surgical Work Group processes.

## Medication Management

The OIG team observed compliance with many elements of expected performance, including the availability of staff to receive remdesivir shipments, use of proper names for medication orders,

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

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

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

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

and provision of required testing prior to medication administration. However, the OIG found deficiencies with patient and caregiver education.

## Care Coordination

The medical center complied with requirements for a policy addressing inter-facility transfers. However, the OIG identified deficiencies with the monitoring and evaluation of inter-facility transfers, completion of the transfer form or note prior to the transfer, and transmission of patients' active medication lists and advance directives to receiving facilities.

## High-Risk Processes

The medical center met many of the requirements for the management of disruptive and violent behavior. However, the OIG noted concerns with the development of a disruptive behavior policy, use of the Disruptive Behavior Reporting System, and staff completion of required training.

## Conclusion

The OIG conducted a detailed inspection across eight key areas (two administrative and six clinical) and subsequently issued seven recommendations for improvement to the Medical Center Director and Chief of Staff. However, the number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. The intent is for medical center leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues and other less-critical findings that may eventually interfere with the delivery of quality health care.

## Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 55–56, and the responses within the body of the report for the full text of the directors' comments.) The OIG considers recommendations 1–5 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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# Contents

# Purpose and Scope

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

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

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

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

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

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

[2] Anam Parand et al., "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9, (September 5, 2014): https://doi.org/10.1136/bmjopen-2014-005055.

[3] Danae Sfantou et al., "Importance of Leadership Style Towards Quality of Care Measures in Healthcare Settings: A Systematic Review," *Healthcare (Basel)* 5, no. 4, (October 14, 2017): 73, https://doi.org/10.3390/healthcare5040073.

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

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

5. Medication management (targeting remdesivir use)
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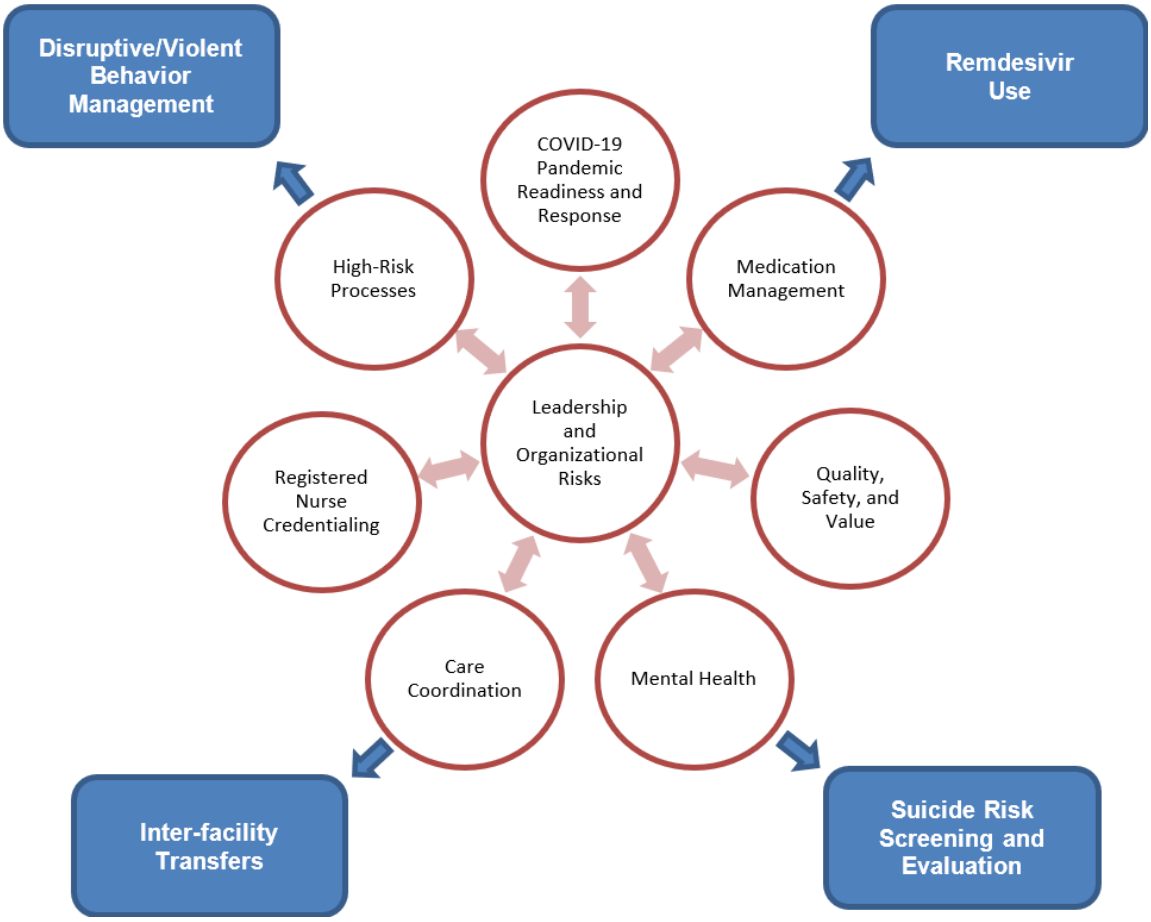



***Figure 2***. *Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services.*
*Source: VA OIG.*

# Methodology

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

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality and clinical functions, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports.[6] The team also interviewed executive leaders and discussed processes, validated findings, and explored reasons for noncompliance with staff.

The inspection examined operations from December 14, 2018, through December 4, 2020, the last day of the unannounced multiday evaluation.[7] During the virtual site visit, the OIG did not receive any complaints beyond the scope of the inspection.

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[8]

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[9] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

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

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

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

[9] Pub. L. No. 95-452, 92 Stat 1101, as amended (codified at 5 U.S.C. App. 3).

# Results and Recommendations

## Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA medical center. Leadership and organizational risks can affect a medical center's ability to provide care in the clinical focus areas.[10] To assess this medical center's risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Staffing
4. Employee satisfaction
5. Patient experience
6. Accreditation surveys and oversight inspections
7. Identified factors related to possible lapses in care and the medical center response
8. VHA performance data (medical center)
9. VHA performance data (community living center (CLC))[11]

### Executive Leadership Position Stability and Engagement

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

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

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

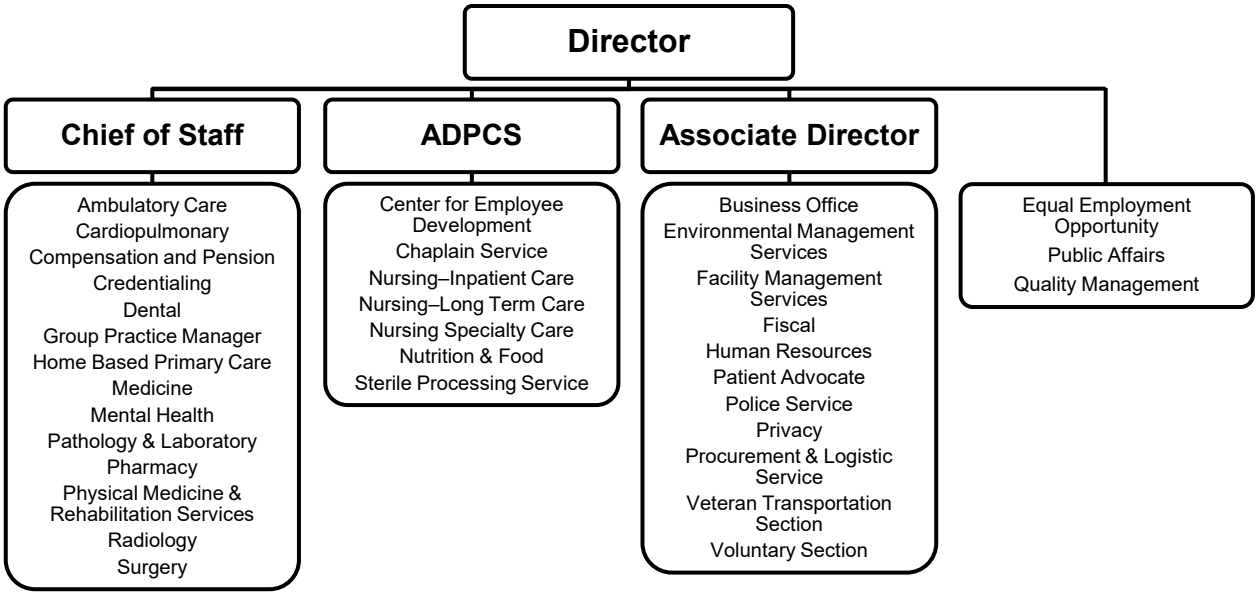



***Figure 3.*** *Medical center organizational chart.*
*Source: Cheyenne VA Medical Center (received December 1, 2020).*

At the time of the OIG virtual review, the executive team had worked together for approximately 14 months. The ADPCS had served in the role since December 2015, and the Director and Chief of Staff had been in their positions for more than two years. The Associate Director was the newest member of the team (see table 1

**Table 1. Executive Leader Assignments**

| Leadership Position | Assignment Date |
|---|---|
| Medical Center Director | June 26, 2016 |
| Chief of Staff | March 18, 2018 |
| Associate Director for Patient Care Services | December 13, 2015 |
| Associate Director | September 15, 2019 |

*Source: Cheyenne Senior Strategic Business Partner (received November 30, 2020).*

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

The Director was most knowledgeable, and the Chief of Staff and ADPCS were minimally knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific Strategic Analytics for Improvement and Learning (SAIL) measures. The Chief of Staff and ADPCS verbalized limited understanding of selected

poorly performing CLC SAIL measures. In individual interviews, the executive leadership team members were generally able to speak about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

The Director serves as the chairperson of the Executive Quality Board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Quality Board oversaw various working groups such as the Administrative Executive, Medical Executive, and Patient Care Service Executive Boards. The Executive Quality Board also monitored patient safety and care and was responsible for tracking and trending quality of care and patient outcomes (see figure 4).

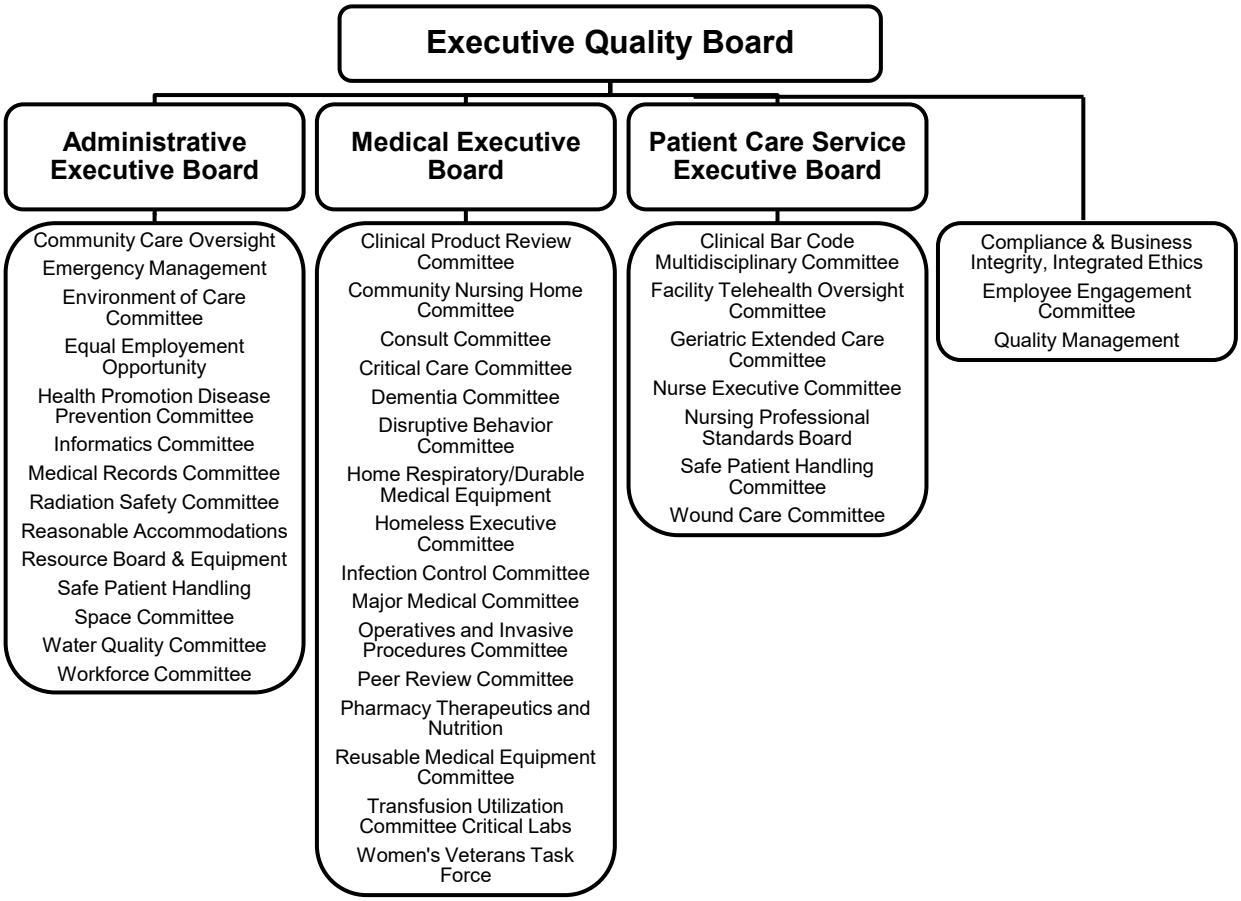



***Figure 4.*** *Medical center committee reporting structure.*

*Source: Cheyenne VA Medical Center (received December 1, 2020).*

## Budget and Operations

The medical center's FY 2020 annual medical care budget of $250,941,958 increased over 15 percent from the previous year's budget of $217,143,751.[12] When asked about the effect of this change on the medical center's operations, the Director indicated that the budget increase allowed for additional full-time employees and allocations for purchased care in the community. Additionally, the Director stated that a new "Super Clinic" was opening in 2022, so another budget increase was expected for the upcoming fiscal year. The new clinic would replace the existing Fort Collins and Loveland clinics. Existing services for mental health, physical therapy, optometry, audiology, social work, pharmacy, and chaplaincy would remain available, while services like radiology and dental would be added, and home-based primary care and telehealth would be expanded with an increased total number of staff.

## Staffing

The Veterans Access, Choice, and Accountability Act of 2014 required the OIG to determine, on an annual basis, the VHA occupations with the largest staffing shortages.[13] Under the authority of the VA Choice and Quality Employment Act of 2017, the OIG conducts annual determinations of clinical and nonclinical VHA occupations with the largest staffing shortages within each medical facility.[14] In addition, the OIG has demonstrated a link between staffing shortages and negative effects on patient care delivery.[15]

Table 2 provides the top facility-reported clinical and nonclinical occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[16] The Director and Associate Director confirmed that occupations listed in table 2 remained the top clinical and nonclinical shortages at the time of the OIG inspection. However, the ADPCS indicated that nurse practitioners for psychiatry should be added to the list of clinical staffing shortages. Additionally, the Chief of Staff stated that surgical specialty providers should be added to the list; medical center leaders had been trying to hire urologists and ophthalmologists, who had been hard to find and recruit. Leaders also reported that while current staffing was able to meet patient care needs, there were ongoing efforts to attract and

[12] VHA Support Service Center.

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

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

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

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

retain staff by conducting salary surveys, administering career progression programs, and offering special pay and repayment of education loans.

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

| Top Clinical Staffing Shortages | Top Nonclinical Staffing Shortages |
|---|---|
| 1. Registered Respiratory Therapist | 1. Custodial Worker |
| 2. Diagnostic Radiologic Technologist | 2. Cook |
| 3. Nursing Assistant | 3. Food Service Worker |
| 4. Medical Technologist | 4. Medical Support Assistance |
| 5. Pharmacy Technician | 5. Electrician |

*Source: VA OIG.*

## Employee Satisfaction

The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[17] Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[18] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical center leaders.

To assess employee attitudes toward medical center leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2018, through September 30, 2019.[19] Table 3 provides relevant survey results for VHA, the medical center, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG found the medical center averages for the selected survey leadership questions were similar to the VHA averages.[20] The Director, Chief of Staff, and ADPCS's scores were consistently higher than VHA and medical center averages. However, the Associate Director appeared to have an opportunity to model servant leadership.[21]

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

[18] "AES Survey History."

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

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

[21] The All Employee Survey scores are not reflective of the current Associate Director, who assumed the role after the survey was administered.

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

| Questions/ Survey Items | Scoring | VHA Average | Medical Center Average | Director Average | Chief of Staff Average | ADPCS Average | Assoc. Director Average |
|---|---|---|---|---|---|---|---|
| All Employee Survey: *Servant Leader Index Composite.** | 0–100 where higher scores are more favorable | 72.6 | 70.5 | 89.0 | 87.9 | 89.4 | 66.5 |
| All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.* | 1 (Strongly Disagree)–5 (Strongly Agree) | 3.4 | 3.3 | 4.6 | 3.9 | 4.1 | 3.8 |
| All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.* | 1 (Strongly Disagree)–5 (Strongly Agree) | 3.6 | 3.5 | 4.6 | 3.9 | 4.1 | 3.8 |
| All Employee Survey: *I have a high level of respect for my organization's senior leaders.* | 1 (Strongly Disagree)–5 (Strongly Agree) | 3.6 | 3.5 | 4.6 | 4.0 | 4.1 | 3.8 |

*Source: VA All Employee Survey (accessed October 28, 2020).*

**The Servant Leader Index is a summary measure based on respondents' assessments of their supervisors' listening, respect, trust, favoritism, and response to concerns.*

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[22] The medical center average for the selected survey questions was similar to the VHA average. Scores for the Director and Chief of Staff were consistently better than those for VHA and the medical center, while those for the Associate Director were similar to or better than VHA and the medical center. However, opportunities appeared to exist for the ADPCS to

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

reduce employee feelings of moral distress at work (uncertainty about the right thing to do or inability to carry out what you believed to be the right thing).

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

| Questions/Survey Items | Scoring | VHA Average | Medical Center Average | Director Average | Chief of Staff Average | ADPCS Average | Assoc. Director Average |
|---|---|---|---|---|---|---|---|
| All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.* | 1 (Strongly Disagree)–5 (Strongly Agree) | 3.8 | 3.6 | 4.8 | 4.0 | 4.5 | 4.1 |
| 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 | 3.7 | 4.4 | 4.2 | 4.3 | 3.9 |
| All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?* | 0 (Never)–6 (Every Day) | 1.4 | 1.5 | 1.0 | 1.3 | 2.0 | 1.5 |

*Source: VA All Employee Survey (accessed October 28, 2020).*

VHA leaders have articulated that the agency "is committed to a harassment-free healthcare environment."[23] To this end, leaders initiated the "End Harassment" and "Stand Up to Stop Harassment Now!" campaigns to help create a culture of safety where staff and patients feel secure and respected.[24]

The Director reported implementing strategies from VA's "Stand Up to Stop Harassment Now!" campaign.[25] To demonstrate commitment to a culture of safety, medical center leaders evaluated and improved their Equal Employment Opportunity Program by hiring a new manager who redesigned the program and implemented the Just Culture Model. Additionally, the Director reported that a Diversity Committee was chartered to address diversity issues.

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. The medical center and executive leader averages were generally similar to or better than the VHA average. Leaders appeared to maintain an environment where staff felt respected and safe and discrimination was not tolerated. However, the Associate Director appeared to have opportunities to improve employee feelings of workplace respect and the ability to bring up problems and tough issues.[26]

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

| Questions/Survey Items | Scoring | VHA Average | Medical Center Average | Director Average | Chief of Staff Average | ADPCS Average | Assoc. Director Average |
|---|---|---|---|---|---|---|---|
| All Employee Survey: *People treat each other with respect in my workgroup.* | 1 (Strongly Disagree)–5 (Strongly Agree) | 3.8 | 3.8 | 4.8 | 4.4 | 4.5 | 3.4 |
| All Employee Survey: *Discrimination is not tolerated at my workplace.* | 1 (Strongly Disagree)–5 (Strongly Agree) | 4.0 | 4.1 | 4.8 | 4.6 | 4.8 | 4.0 |

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

[24] "Stand Up to Stop Harassment Now!"

[25] Executive in Charge, Office of Under Secretary for Health Memorandum, *Stand Up to Stop Harassment Now*.

[26] The All Employee Survey scores are not reflective of the current Associate Director, who assumed the role after the survey was administered.

| Questions/Survey Items | Scoring | VHA Average | Medical Center Average | Director Average | Chief of Staff Average | ADPCS Average | Assoc. Director Average |
|---|---|---|---|---|---|---|---|
| All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.* | 1 (Strongly Disagree)–5 (Strongly Agree) | 3.8 | 3.6 | 4.8 | 4.5 | 4.5 | 3.5 |

*Source: VA All Employee Survey (accessed October 28, 2020).*

## Patient Experience

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

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 6 provides relevant survey results for VHA and the medical center.[27] Patients generally appeared satisfied with the care provided.

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

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

| Questions | Scoring | VHA Average | Medical Center Average |
|---|---|---|---|
| Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?* | The response average is the percent of "Definitely Yes" responses. | 69.6 | 65.9 |
| Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?* | The response average is the percent of "Very satisfied" and "Satisfied" responses. | 82.8 | 82.6 |
| Survey of Healthcare Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?* | The response average is the percent of "Very satisfied" and "Satisfied" responses. | 84.9 | 88.8 |

*Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed October 29, 2020).*

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans by 2048.[28] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant questions that reflect patients' experiences by gender, including those for Inpatient, Patient-Centered Medical Home, and Specialty Care surveys (see tables 7–9). The Patient-Centered Medical Home and Specialty Care survey results for male respondents were generally less favorable than the corresponding VHA averages, while those for female respondents were generally more positive than female VHA patients nationally.

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

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

| Questions | Scoring | VHA* | | Medical Center | |
|---|---|---|---|---|---|
| | | Male Average | Female Average | Male Average | Female Average‡ |
| *Would you recommend this hospital to your friends and family?* | The measure is calculated as the percentage of responses in the top category (Definitely yes). | 69.8 | 64.9 | 67.2 | – |
| *During this hospital stay, how often did doctors treat you with courtesy and respect?* | The measure is calculated as the percentage of responses that fall in the top category (Always). | 84.5 | 85.5 | 92.2 | – |
| *During this hospital stay, how often did nurses treat you with courtesy and respect?* | The measure is calculated as the percentage of responses that fall in the top category (Always). | 85.1 | 82.9 | 92.0 | – |

*Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed October 29, 2020).*

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

*The medial center averages are based on 198–202 male and nine female respondents, depending on the question.*

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

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

| Questions | Scoring | VHA* | | Medical Center | |
|---|---|---|---|---|---|
| | | Male Average | Female Average | Male Average | Female Average |
| *In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?* | The measure is calculated as the percentage of responses that fall in the top category (Always). | 51.6 | 44.7 | 47.8 | 51.3 |

| Questions | Scoring | VHA* | | Medical Center | |
|---|---|---|---|---|---|
| | | Male Average | Female Average | Male Average | Female Average |
| *In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?* | The measure is calculated as the percentage of responses that fall in the top category (Always). | 60.0 | 53.2 | 58.0 | 74.0 |
| *Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?* | The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10). | 74.1 | 69.6 | 70.0 | 60.2 |

*Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed October 29, 2020).*

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

*The medial center averages are based on 249–821 male and 28–69 female respondents, depending on the question.*

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

| Questions | Scoring | VHA* | | Medical Center | |
|---|---|---|---|---|---|
| | | Male Average | Female Average | Male Average | Female Average |
| *In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?* | The measure is calculated as the percentage of responses that fall in the top category (Always). | 50.8 | 46.2 | 44.6 | 57.0 |
| *In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?* | The measure is calculated as the percentage of responses that fall in the top category (Always). | 57.7 | 54.0 | 55.4 | 61.4 |

| Questions | Scoring | VHA* | | Medical Center | |
|---|---|---|---|---|---|
| | | Male Average | Female Average | Male Average | Female Average |
| *Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?* | The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10). | 75.1 | 72.1 | 72.9 | 94.8 |

*Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed October 29, 2020).*

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

*The medial center averages are based on 235–721 male and 18–36 female respondents, depending on the question.*

## Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders responded to identified problems.[29] Table 10 summarizes the relevant medical center inspections most recently performed by the OIG and The Joint Commission (TJC).[30] At the time of the OIG review, the medical center had closed all but one recommendation for improvement issued since the previous CHIP site visit conducted in December 2018. The Chief, Quality Management reported working with medical center managers to address the open recommendation related to antidepressant use among the elderly.

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

[30] 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."

The OIG team also noted the medical center's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[31] Additional results included the Long Term Care Institute's inspection of the medical center's CLC.[32]

**Table 10. 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 (*Delay in Care and Care Coordination Concerns at the Cheyenne VA Medical Center and the Iowa City VA Health Care System, Wyoming and Iowa*, Report No. 18-00693-41, December 19, 2018) | April 2018 | 7 | 0 |
| OIG (*Comprehensive Healthcare Inspection of the Cheyenne VA Medical Center, Wyoming*, Report No. 18-04680-162, July 24, 2019) | December 2018 | 17 | 1* |
| TJC Hospital Accreditation | July 2019 | 41 | 0 |
| TJC Behavioral Health Care Accreditation | | 3 | 0 |
| TJC Home Care Accreditation | | 10 | 0 |

*Source: OIG and TJC (inspection/survey results received from the Accreditation Manager on December 1–2, 2020).*

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

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

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be

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

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

able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms.

Table 11 lists the reported patient safety events from December 14, 2018 (the prior OIG CHIP site visit), through November 30, 2020.[33]

**Table 11. Summary of Selected Organizational Risk Factors (December 14, 2018, through November 30, 2020)**

| Factor | Number of Occurrences |
|---|---|
| Sentinel Events | 4 |
| Institutional Disclosures | 1 |
| Large-Scale Disclosures | 0 |

*Source: Cheyenne VA Medical Center Quality Management Staff (received November 30–December 10, 2020).*

The Director spoke knowledgeably about serious adverse event reporting and stated that all adverse events are reported immediately, and quality management staff contact the Director by phone if needed. Sentinel event determinations are made through discussion between the Chief of Staff, ADPCS, quality management staff, and the Patient Safety Manager using the VA National Center for Patient Safety Handbook as a guide. Institutional disclosure determinations are also decided during adverse event discussions. The Director described consulting with the Chief of Quality Management to determine if institutional disclosures are warranted. Further, the medical center's process to follow up on serious events includes bimonthly reporting of investigation status and ongoing actions, implementation, and closure to the Executive Quality Board.

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

## Veterans Health Administration Performance Data for the Medical Center

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency."[34] Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[35]

Figure 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2020. Figure 5 shows the Cheyenne VA Medical Center's performance in the first through fifth quintiles. Those in the first quintile (blue data points) are better-performing measures (for example, in the areas of health care associated (HC assoc) infections and mental health (MH) continuity (of) care). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red, respectively (for example, specialty care (SC) care coordination, rating (of) SC provider, and rating (of) primary care (PC) provider).[36] Leaders appeared to have multiple opportunities to improve and sustain performance.

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

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

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

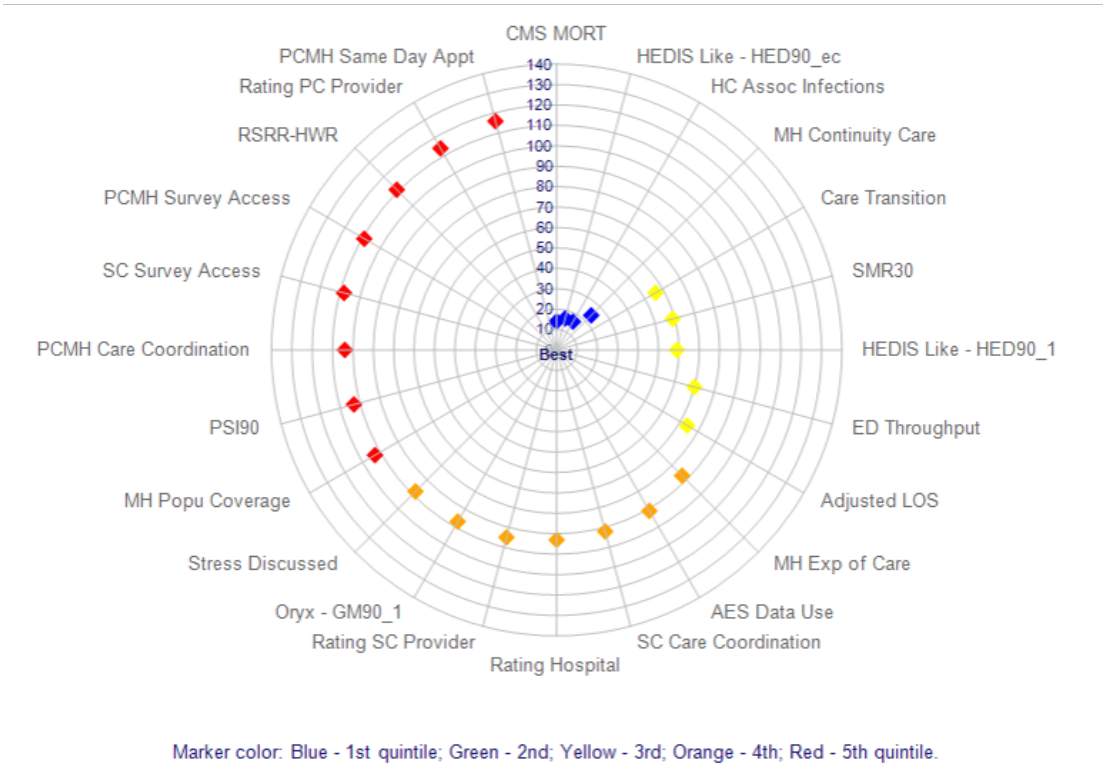



***Figure 5.*** *Medical center quality of care and efficiency metric rankings, FY 2020 quarter 3 (as of June 30, 2020).*

*Source: VHA Support Service Center.*

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

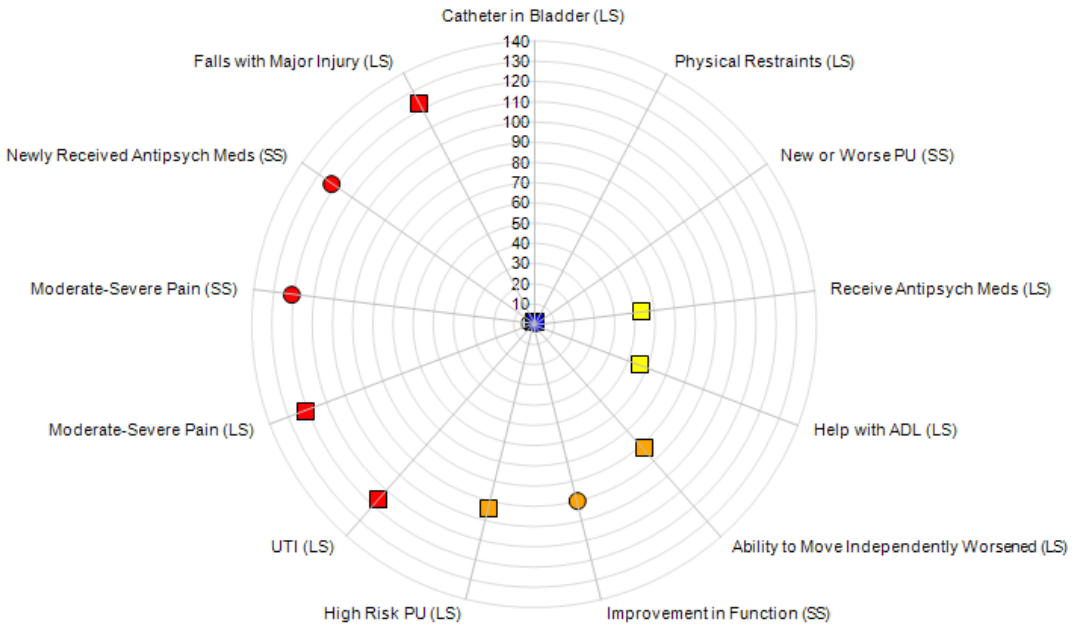
## Veterans Health Administration Performance Data for the Community Living Center

The CLC SAIL Value Model is a tool to "summarize and compare performance of CLCs in the VA."[37] The model "leverages much of the same data" used in the Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[38]

[37] Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC): A tool to examine Quality Using Internal VA Benchmarks,* July 16, 2021. "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."

[38] Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC): A tool to examine Quality Using Internal VA Benchmarks.*

Figure 6 illustrates the medical center's CLC quality rankings and performance compared with other VA CLCs as of June 30, 2020. Figure 6 displays the Cheyenne VA Medical Center's CLC metrics with high performance (blue data points) in the first quintile (for example, in the areas of catheter in bladder–long-stay (LS) and new or worse pressure ulcer (PU)–short-stay (SS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, improvement in function (SS), urinary tract infections (UTI) (LS), and falls with major injury (LS)).[39] CLC SAIL metrics also suggest that leaders have various opportunities to improve and sustain performance.




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

***Figure 6.*** *Cheyenne CLC quality measure rankings, FY 2020 quarter 3 (as of June 30, 2020).*
*LS = Long-Stay Measure.* *SS = Short-Stay Measure.*
*Source: VHA Support Service Center.*
*Note: The OIG did not assess VA's data for accuracy or completeness.*

## Leadership and Organizational Risks Findings and Recommendations

The medical center's executive team had worked together for 14 months at the time of the virtual review. The ADPCS had served in the role since December 2015, and the Director and Chief of Staff had been in their positions for more than two years. The Associate Director was the newest member of the team, assigned in September 2019. The medical center managed organizational

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

communications and accountability through a committee reporting structure, with the Executive Quality Board overseeing several working groups. The Executive Quality Board also monitors patient safety and care and is responsible for tracking and trending quality of care and patient outcomes.

The Director discussed how the medical center's FY 2020 budget increase allowed for additional staffing and allocation of funds for purchased care in the community. Executive leaders were able to discuss interim strategies to address occupational shortages.

Selected employee satisfaction survey responses demonstrated general satisfaction with leaders and maintenance of an environment where discrimination was not tolerated. Responses also highlighted opportunities for the Associate Director to model servant leadership and to improve staff's perception of workplace respect and their ability to bring up problems and tough issues. Additionally, the scores for the ADPCS presented an opportunity to reduce staff's feelings of moral distress. Patient experience survey data indicated general satisfaction with the care provided, and selected results for female respondents were more favorable than those for female VHA patients nationally.

The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. However, the Chief of Staff and ADPCS had opportunities to improve their understanding of selected VHA SAIL data, and all leaders should continue actions to improve and sustain quality and efficiency.

The OIG made no recommendations.

## COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic.[40] VHA subsequently issued its *COVID-19 Response Plan* on March 23, 2020, which presents strategic guidance on prevention of viral transmission among veterans and staff and appropriate care for sick patients.[41]

During this time, VA continued providing care to veterans and engaged its fourth mission, the "provision of hospital care and medical services during certain disasters and emergencies" to persons "who otherwise do not have VA eligibility for such care and services."[42] "In effect, VHA facilities provide a safety net for the nation's hospitals should they become overwhelmed—for veterans (whether previously eligible or not) and non-veterans."[43]

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

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

The OIG also surveyed medical center staff to solicit their feedback and potentially identify any problematic trends and/or issues that may require follow-up.

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[44]

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

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

[42] 38 U.S.C. § 1785. VA's missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA's fourth mission, the provision of hospital care and medical services during certain disasters and emergencies: "During and immediately following a disaster or emergency…VA under 38 U.S.C. § 1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency."

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

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

## Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high quality, safe, reliable, and veteran-centered care.[45] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[46] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."[47]

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

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

The OIG reviewers also assessed the medical center's processes for its Systems Redesign and Improvement Program, which support "VHA's transformation journey to become a High Reliability Organization."[48] Systems redesign and improvement processes drive organizational change toward the goal of "zero harm" and can create strong cultures of safety. VHA implemented systems redesign and improvement programs to "optimize Veterans' experience by providing services to develop self-sustaining improvement capability."[49] The OIG team examined various requirements related to systems redesign and improvement:

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

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

Next, the OIG assessed the medical center's processes for conducting protected peer reviews of clinical care.[50] Protected peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[51] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[52] The OIG team examined the completion of the following elements:

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[53]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[54]
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed the medical center's surgical program. The VHA National Surgery Office provides oversight for surgical programs and "promotes systems and practices that enhance high quality, safe, and timely surgical care."[55] The National Surgery Office's principles, which guide the delivery of comprehensive surgical services at local, regional, and national levels, include "(1) Operational oversight of surgical services and quality improvement activities;

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

[51] VHA Directive 1190.

[52] VHA Directive 1190.

[53] VHA Directive 1190.

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

[55] "NSO Reporting, Resources, & Tools," VA Surgical Quality Improvement Program, accessed November 21, 2020, https://vaww.nso.med.va.gov/apps/VASQIP/Pages/Default.aspx. (This is an internal VA website not publicly accessible.)

(2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select specialty programs."[56] The medical center's performance was assessed on several dimensions:

- Assignment and duties of a chief of surgery
- Assignment and duties of a surgical quality nurse (registered nurse)
- Establishment of a surgical work group with required members who meet at least monthly
- Surgical work group tracking and review of quality and efficiency metrics
- Investigation of adverse events[57]

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, National Surgery Office reports, and other relevant information.[58]

## Quality, Safety, and Value Findings and Recommendations

The medical center complied with requirements for a committee responsible for QSV oversight functions, the Systems Redesign and Improvement Program, and protected peer reviews. However, the OIG identified deficiencies in Surgical Work Group processes.

VHA requires medical directors to ensure that facilities with surgery programs have a surgical work group that meets at least monthly and includes the Chief of Surgery, Chief of Staff, Surgical Quality Nurse, and Operating Room Nurse Manager as core members.[59] The OIG reviewed Surgical Work Group (a subcommittee of the Operatives and Invasive Committee) meeting minutes from December 18, 2019, through November 18, 2020, and found that the Chief of Staff, Surgical Quality Nurse, and Operating Room Nurse Manager did not consistently attend the meetings. Lack of leaders' involvement resulted in the review and analysis of surgery program data without the perspectives of key staff. The Chief of Surgery stated that failure to assign alternates for required members contributed to noncompliance.

[56] "NSO Reporting, Resources, & Tools."

[57] VHA Directive 1102.01(1), *National Surgery Office,* April 24, 2019, amended May 22, 2019.

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

[59] VHA Directive 1102.01(1).

## Recommendation 1

1. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that all core members consistently attend Surgical Work Group meetings.[60]

Medical center concurred.

Target date for completion: Completed

Medical center response: The Cheyenne VAHCS [VA Health Care System] Surgical Workgroup Charter was revised to allow for mandatory attendees to send alternates to meetings. This included adapting the minutes attendance list to reflect alternates. The target is 90 percent compliance for two consecutive quarters.

[60] The OIG reviewed evidence sufficient to demonstrate that medical center staff had completed improvement actions, and therefore, closed the recommendation before publication of the report.

## Registered Nurse Credentialing

VHA has defined procedures for the credentialing of registered nurses (RNs) that include verification of "professional education, training, licensure, certification, registration, previous experience, including documentation of any gaps (greater than 30 days) in training and employment, professional references, adverse actions, or criminal violations, as appropriate."[61] Licensure is defined by VHA as "the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State in the form of a license and/or registration."[62]

VA requires all RNs to hold at least one active, unencumbered license.[63] Individuals who hold a license in more than one state are not eligible for RN appointment if a state has terminated the license for cause or if the RN voluntarily relinquished the license after written notification from the state of potential termination for cause.[64] When an action has been "taken against [an] applicant's sole license or against any of the applicant's licenses, a review by the Chief, Human Resources Management Service, or the Regional Counsel, must be completed to determine whether the applicant satisfies VA's licensure requirements," and documented as required.[65] Additionally, all current and previously held licenses must be verified from the primary or original source and documented in VetPro, VHA's electronic credentialing system, prior to appointment to a VA medical facility.[66]

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

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

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

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

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

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

[64] 38 U.S.C. § 7402.

[65] VHA Directive 2012-030.

[66] VHA Directive 2012-030.

## Registered Nurse Credentialing Findings and Recommendations

The medical center generally complied with the requirements listed above. Therefore, the OIG made no recommendations.

## Medication Management: Remdesivir Use in VHA

On May 1, 2020, the Food and Drug Administration (FDA) authorized the emergency use of remdesivir. At that time, remdesivir was an unapproved, investigational antiviral medication for the treatment of adults and children hospitalized with severe COVID-19.[67] The FDA provided information on specific laboratory tests to be ordered prior to and during the administration of remdesivir. Additionally, the FDA required providers to report potentially related adverse events.[68]

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.[69] Due to the limited supply and specific storage requirements of remdesivir, VA needed someone to be available 24 hours a day, 7 days a week to accept overnight, cold-chain shipments of the drug and report any unused medication to the Emergency Pharmacy Services group.[70]

On August 28, 2020, the FDA amended the Emergency Use Authorization criteria for remdesivir to include "suspected or laboratory-confirmed COVID-19 in all hospitalized adult and pediatric patients."[71] The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.[72]

To determine whether VHA facilities complied with requirements related to the administration of remdesivir, the OIG interviewed key employees and managers and reviewed electronic health records of six patients who were administered remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. The OIG assessed the following performance indicators:

- Staff availability to receive medication shipments
- Medication orders used proper name

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[67] Gilead Sciences, *Fact Sheet for Health Care Providers: Emergency Use Authorization (EUA) of Veklury (remdesivir)*, May 1, 2020, revised August 2020. Food and Drug Administration, *Frequently Asked Questions for Veklury (remdesivir),* updated February 4, 2021.

[68] Gilead Sciences, *Fact Sheet for Health Care Providers: Emergency Use Authorization (EUA) of Veklury (remdesivir)*.

[69] Assistant Under Secretary for Health for Operations Memorandum, *Remdesivir Distribution for Department of Veterans Affairs (VA) Patients*, May 8, 2020.

[70] Centers for Disease Control and Prevention, *Vaccine Storage and Handling Kit*, May 2014. "The cold chain begins with the cold storage unit at the manufacturing plant, extends through transport of vaccine(s) to the distributor, then delivery and storage at the provider facility, and ends with administration of vaccine to the patient. Appropriate storage conditions must be maintained at every link in the cold chain." Assistant Under Secretary for Health for Operations Memorandum, *Remdesivir Distribution for Department of Veterans Affairs (VA) Patients*.

[71] Food and Drug Administration, "FDA News Release: COVID-19 Update: FDA Broadens Emergency Use Authorization for Veklury (remdesivir) to Include All Hospitalized Patients for Treatment of COVID-19," August 28, 2020.

[72] Food and Drug Administration, "FDA News Release: FDA Approved First Treatment for COVID-19," October 22, 2020.

- Staff determined patients met criteria for receiving medication prior to administration
- Required testing completed prior to medication administration for
  - Potential pregnancy
  - Kidney assessment (estimated glomerular filtration rate)[73]
  - Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)[74]
- Patient/caregiver education provided
- Staff reported any adverse events to the FDA

## Medication Management Findings and Recommendations

The medical center complied with many elements of expected performance, including staff availability to receive remdesivir shipments, medication orders, and required testing prior to medication administration. However, the OIG found deficiencies with patient and caregiver education.

At the time of the review, under the Emergency Use Authorization, VA Pharmacy Benefits Management Services required healthcare providers to provide the "Fact Sheet for Patients and Parents/Caregivers," inform patients and/or caregivers that remdesivir was not an FDA-approved medication, provide the option to refuse the medication, and advise patients and/or caregivers of known risks, benefits, and alternatives to remdesivir prior to administration.[75] The OIG determined that three of six patients and/or caregivers were not provided with the "Fact Sheet for Patients and Parents/Caregivers." As a result, these patients and/or their caregivers may not have been aware of the potential risks, which could have altered their decision to receive the medication. The Chief of Pharmacy stated that the lack of clarity regarding who was responsible for the distribution of the document led to the noncompliance.

[73] "Estimated Glomerular Filtration Rate (eGFR)," National Kidney Foundation, accessed December 9, 2020, https://www.kidney.org/atoz/content/gfr. "Estimated glomerular filtration rate [eGFR] is the best test to measure your level of kidney function and determine your stage of kidney disease."

[74] "Alanine transferase," National Cancer Institute, accessed December 9, 2020, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/alanine-transferase. Alanine transferase, also referred to as serum glutamate pyruvate transaminase, is "an enzyme found in the liver and other tissues," of which a high level may be indicative of liver damage.

[75] VA Pharmacy Benefits Management Services, *Remdesivir Emergency Use Authorization (EUA) Requirements*, May 2020.

Given the FDA's approval of remdesivir for use in adult patients hospitalized with COVID-19, the OIG made no recommendation related to Emergency Use Authorization requirements.[76]

[76] Food and Drug Administration, "FDA News Release: FDA Approves First Treatment for COVID-19," October 22, 2020.

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

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.[77] The suicide rate for veterans was 1.5 times greater than for nonveteran adults and estimated to represent approximately 13.8 percent of all suicide deaths in the United States during 2018.[78] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[79]

VHA has implemented various evidence-based approaches to reduce veteran suicides. In addition to expanded mental health services and community outreach, VHA has adopted a three-phase process to screen and assess for suicide risk in most clinical settings. The phases include primary and secondary screens and a comprehensive assessment. However, screening for patients seen in emergency departments or urgent care centers begins with the secondary screen, the Columbia-Suicide Severity Rating Scale, and subsequent completion of the Comprehensive Suicide Risk Assessment when screening is positive.[80] The OIG examined whether staff initiated the Columbia-Suicide Severity Rating Scale and completed all required elements.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from the emergency department or urgent care center.[81] The medical center was assessed for its adherence to the following requirements for suicide safety plans:

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

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

- relevant documents;

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

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

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

[80] Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum, *Suicide Risk Screening and Assessment Requirements*, May 23, 2018; Department of Veterans Affairs, *Department of Veterans Affairs (VA) Suicide Risk Identification Strategy: Minimum Requirements by Setting*, December 18, 2019.

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

- the electronic health records of 45 randomly selected patients who were seen in the emergency department/urgent care center from December 1, 2019, through August 31, 2020; and
- staff training records.

## Mental Health Findings and Recommendations

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

## Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.[82]

VHA medical facility directors are "responsible for ensuring that a written policy is in effect that ensures the safe, appropriate, orderly, and timely transfer of patients."[83] Further, VHA staff are required to use the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record to monitor and evaluate all transfers.[84]

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

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

To determine whether the medical center complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 50 patients who were transferred from the medical center due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

### Care Coordination Findings and Recommendations

The medical center complied with requirements for a policy addressing inter-facility transfers. However, the OIG found deficiencies with patient transfer monitoring and evaluation, transfer forms/notes, and active medication list and advance directive transmission to receiving facilities.

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

[83] VHA Directive 1094.

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

VHA requires that "transfers are monitored and evaluated as part of VHA's Quality Management Program."[85] The OIG did not find evidence that medical center staff monitored or evaluated patient transfers from October 1, 2019, through September 30, 2020. This could have hindered ongoing performance improvement activities. The Chief of Medicine acknowledged that the medical center lacked a process to monitor and evaluate inter-facility transfers.

## Recommendation 2

2. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that medical center staff monitor and evaluate inter-facility patient transfers.[86]

| |
|---|
| Medical center concurred. |
| Target date for completion: Completed |
| Medical center response: An auditing process for monitoring Interfacility Patient Transfers from Inpatient Units and from the Emergency Department was established in December 2020, modeled after the OIG Audit template. Audits have been completed at 100% from January 2021 to July 2021. The target is 90 percent compliance for two consecutive quarters. |

VHA requires that staff use the VA *Inter-Facility Transfer Form* or an equivalent note in the electronic health record to monitor and evaluate the transfer.[87] The OIG estimated that providers did not complete the required form or note for 44 percent of inter-facility patient transfers.[88] Further, the OIG estimated that 28 percent of transfer forms or notes did not include patients' informed consent.[89] Failure to complete all elements of the required transfer form or note results in incomplete health records and the inability to monitor and evaluate the transfer process. The Chief of Medicine and Emergency Department Section Chief attributed noncompliance to providers selecting a note template with a similar title that lacked the required elements.

[85] VHA Directive 1094.

[86] The OIG reviewed evidence sufficient to demonstrate that medical center staff had completed improvement actions, and therefore, closed the recommendation before publication of the report.

[87] VHA Directive 1094.

[88] The OIG estimated that 95 percent of the time, the true compliance rate is between 42.0 and 70.0 percent, which is statistically significantly below the 90 percent benchmark.

[89] The OIG estimated that 95 percent of the time, the true compliance rate is between 60.0 and 84.0 percent, which is statistically significantly below the 90 percent benchmark.

## Recommendation 3

3. The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that providers complete all elements of the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note prior to patient transfers.[90]

Medical center concurred.

Target date for completion: Completed

Medical center response: Tracking and Auditing of Inter-facility transfers from Cheyenne VAHCS. From January 2021 to July 2021, compliance of completing the 10-2649A form or the equivalent has been 98%. The target is 90 percent compliance for two consecutive quarters.

VHA requires transferring providers to "send all pertinent medical records available, including an active patient medication list and…advance directive " to the receiving facility.[91] The OIG estimated that transferring providers did not send the patient's active medication list to the receiving facility for 42 percent of inter-facility transfers.[92] The OIG also determined that providers did not send a copy of the advanced directive to the receiving facility for 17 of the 18 applicable patients.[93] As a result, there was no assurance that receiving facility staff could determine patients' current medications or preferences regarding their health care. The Chief of Medicine and Emergency Department Section Chief explained that providers used a note template with a similar title that lacked the required elements. Due to the small number of patients identified for the advance directive requirement, the OIG made no recommendation.

## Recommendation 4

4. The Medical Center Director determines the reasons for noncompliance and ensures that transferring providers send patients' active medication lists to receiving facilities during inter-facility transfers.[94]

[90] The OIG reviewed evidence sufficient to demonstrate that medical center staff had completed improvement actions, and therefore, closed the recommendation before publication of the report.

[91] VHA Directive 1094.

[92] The OIG estimated that 95 percent of the time, the true compliance rate is between 44.0 and 72.0 percent, which is statistically significantly below the 90 percent benchmark.

[93] The OIG estimated that 95 percent of the time, the true compliance rate is between 0.0 and 18.2 percent, which is statistically significantly below the 90 percent benchmark.

[94] The OIG reviewed evidence sufficient to demonstrate that medical center staff had completed improvement actions, and therefore, closed the recommendation before publication of the report.

Medical center concurred.

Target date for completion: Completed

Medical center response: Tracking and Auditing of Inter-facility transfers from Cheyenne VAHCS. From January 2021 to July 2021, compliance of sending active medication lists to receiving facilities with transfer has been 98%. The target is 90 percent compliance for two consecutive quarters.

## High-Risk Processes: Management of Disruptive and Violent Behavior

VHA defines disruptive behavior as "behavior by any individual that is intimidating, threatening, dangerous, or that has, or could, jeopardize the health or safety of patients, Department of Veterans Affairs (VA) employees, or individuals at the facility."[95] Balancing the rights and healthcare needs of violent and disruptive patients with the health and safety of other patients, visitors, and staff poses a significant challenge for VHA facilities. VHA has "committed to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety."[96] The OIG examined various requirements for the management of disruptive and violent behavior:

- Development of a policy for reporting and tracking disruptive behavior
- Implementation of an employee threat assessment team[97]
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[98]
- Use of the Disruptive Behavior Reporting System (DBRS) to document the decision to implement an Order of Behavioral Restriction[99]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[100]

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

[96] VHA Directive 2012-026.

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

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

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

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

VHA also requires that all staff complete part 1 of the prevention and management of disruptive behavior training within 90 days of hire. The Workplace Behavioral Risk Assessment results are used to assign additional levels of training. When the assessment results deem a facility location as low or moderate risk, staff working in the area are also required to complete part 2 of the training. When results indicate high risk, staff are required to complete parts 1, 2, and 3 of the training.[101] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[102] The OIG assessed staff compliance with the completion of required training.

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

### High-Risk Processes Findings and Recommendations

The medical center addressed many of the performance indicators above. However, the OIG noted concerns with the development of a disruptive behavior policy, use of the DBRS, and staff completion of required training.

VHA requires each facility to have a written policy for reporting and tracking disruptive behavior.[103] The OIG found that the medical center's policy expired on September 6, 2020, and had not been updated. As a result, staff lacked current guidance on how to manage behavior that could jeopardize the health or safety of patients, staff, and visitors; undermine a culture of safety in VHA; or otherwise interfere with the delivery of health care. The Disruptive Behavior Committee Chair did not provide a reason for noncompliance but shared that medical center staff are updating the policy to align with VHA guidance.

## Recommendation 5

5. The Medical Center Director determines the reasons for noncompliance and makes certain that the medical center has a current policy for reporting and tracking disruptive behavior.[104]

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

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

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

[104] The OIG reviewed evidence sufficient to demonstrate that medical center staff had completed improvement actions, and therefore, closed the recommendation before publication of the report.

Medical center concurred.

Target date for completion: Completed

Medical center response: The Disruptive Behavior Policy has been revised and published. Delay in revision and publication was to assure alignment with the new Committee Charter.

VHA requires disruptive behavior committees or boards to document the decision to implement an Order of Behavioral Restriction and the patient's notification of the order and right to appeal in the DBRS.[105] The OIG found that the Disruptive Behavior Committee did not document patient notification in the DBRS for four of nine Orders of Behavioral Restriction issued from September 2019 through September 2020. This resulted in lack of evidence that patients were notified of restriction orders or provided the opportunity to appeal. The Disruptive Behavior Committee Chair reported being unclear of the requirement to use the DBRS to document patient notifications.

## Recommendation 6

6. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures the Disruptive Behavior Committee documents patient notification of an Order of Behavioral Restriction and right to appeal in the Disruptive Behavior Reporting System.[106]

Medical center concurred.

Target date for completion: December 31, 2021

Medical center response: 100% of Veterans that have Orders of Behavioral Restrictions (OBR) have been documented in the Disruptive Behavior Reporting System (DBRS) from December 2020 to July 2021. The target is 90 percent compliance for two consecutive quarters.

VHA requires that staff are assigned the prevention and management of disruptive behavior part 1 training at hire and "additional levels of PMDB [prevention and management of disruptive behavior] training based on the risk for exposure to disruptive behaviors as determined in the facility Workplace Behavioral Risk Assessment."[107] The OIG reviewed 30 selected staff and found that 4 (13 percent) did not complete part 1 training and 22 (73 percent) did not complete part 2 training. Additionally, none of the three staff who were identified by the facility as

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

[106] The action plan lacks specific detail. The OIG will monitor implementation during the follow-up process until identified deficiencies are resolved.

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

working in a high-risk area completed part 3 training. This could result in staff's lack of awareness, preparedness, and precautions when responding to disruptive behavior. The training specialist reported not being aware that the training was required for fee basis physicians and also reported that parts 2 and 3 of the training were suspended due to COVID-19.

## Recommendation 7

7. The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.[108]

Medical center concurred.

Target date for completion: December 31, 2021

Medical center response: Skill Levels II and III were paused during the pandemic. They were re-started at the end of June 2021. The maximum number of participants is 20 per skills check-off. These classes are being scheduled based on Instructor availability. (100% of Fee Basis, Transitory, Part-Time, and Intermittent Clinical Staff are compliant)

TMS VA 20152 Mandatory Training for Transitory, Part-Time, and Intermittent Clinical Staff. PMDB is a portion of this mandatory training for those staff members. (100% of Fee Basis, Transitory, Part-Time, and Intermittent Clinical Staff are compliant)

TMS VA 37659 Prevention and Management of Disruptive Behavior (95% of Full time Staff designated to need this are compliant)

Levels II & III Prevention and Management of Disruptive Behavior training will be completed for applicable staff and reported to the Executive Quality Board.

Numerator: number of staff completed Level II & III training/Denominator: number of staff needing Level II & III training

The target is 90 percent compliance for two consecutive quarters.

[108] The OIG recognizes that COVID-19 has affected facility operations and makes no comment on the timeline for safely accomplishing this important training.

## Report Conclusion

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

# Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines seven OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Director and Chief of Staff. The intent is for these leaders to use the 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.

**Table A.1. Summary Table of Recommendations**

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

| Healthcare Processes | Review Elements | Critical Recommendations for Improvement | Recommendations for Improvement |
|---|---|---|---|
| Quality, Safety, and Value | • QSV committee<br>• Systems redesign and improvement<br>• Protected peer reviews<br>• Surgical program | • None | • All core members consistently attend Surgical Work Group meetings. |
| RN Credentialing | • RN licensure requirements<br>• Primary source verification | • None | • None |
| Medication Management: Remdesivir Use in VHA | • Staff availability for medication shipment receipt<br>• Medication order naming<br>• Satisfaction of inclusion criteria prior to medication administration<br>• Required testing prior to medication administration<br>• Patient/caregiver education<br>• Adverse event reporting to the FDA | • None | • None |
| Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation | • Columbia-Suicide Severity Rating Scale initiation and note completion<br>• Suicide safety plan completion<br>• Staff training requirements | • None | • None |

| Healthcare Processes | Review Elements | Critical Recommendations for Improvement | Recommendations for Improvement |
|---|---|---|---|
| Care Coordination: Inter-facility Transfers | • Inter-facility transfer policy<br>• Inter-facility transfer monitoring and evaluation<br>• Inter-facility transfer form/facility-defined equivalent with all required elements completed by the appropriate provider(s) prior to patient transfer<br>• Patient's active medication list and advance directive sent to receiving facility<br>• Communication between nurses at sending and receiving facilities | • Providers complete all elements of the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note prior to patient transfers.<br>• Transferring providers send patients' active medication lists to receiving facilities during inter-facility transfers. | • Medical center staff monitor and evaluate inter-facility patient transfers. |
| High-Risk Processes: Management of Disruptive and Violent Behavior | • Policy for reporting and tracking of disruptive behavior<br>• Employee threat assessment team implementation<br>• Disruptive behavior committee or board establishment<br>• Disruptive Behavior Reporting System use<br>• Patient notification of an Order of Behavioral Restriction<br>• Annual Workplace Behavioral Risk Assessment with involvement from required participants<br>• Mandatory staff training | • None | • The medical center has a current policy for reporting and tracking disruptive behavior.<br>• The Disruptive Behavior Committee documents patient notification of an Order of Behavioral Restriction and right to appeal in the Disruptive Behavior Reporting System.<br>• Staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas. |

# Appendix B: Medical Center Profile

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

**Table B.1. Profile for Cheyenne VA Medical Center (442)**
**(October 1, 2017, through September 30, 2020)**

| Profile Element | Medical Center Data FY 2018* | Medical Center Data FY 2019 | Medical Center Data FY 2020‡ |
|---|---|---|---|
| Total medical care budget | $184,955,681 | $217,143,751 | $250,941,958 |
| Number of: | | | |
| • Unique patients | 24,662 | 25,357 | 24,050 |
| • Outpatient visits | 286,184 | 291,356 | 260,285 |
| • Unique employees§ | 804 | 874 | 869 |
| Type and number of operating beds: | | | |
| • Community living center | 41 | 42 | 42 |
| • Domiciliary | 10 | 10 | 10 |
| • Medicine | 20 | 20 | 20 |
| • Surgery | 2 | 2 | 2 |
| Average daily census: | | | |
| • Community living center | 32 | 34 | 26 |
| • Domiciliary | 8 | 8 | 4 |
| • Medicine | 11 | 12 | 10 |
| • Surgery | 3 | 2 | 1 |

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

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

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

[1] "Facility Complexity Model," VHA Office of Productivity, Efficiency & Staffing (OPES), accessed August 20, 2021, http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx. (This is an internal website not publicly accessible.) An affiliated medical center is associated with a medical residency program. 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."

# Appendix C: VA Outpatient Clinic Profiles

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

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

| Location | Station No. | Primary Care Workload/ Encounters | Mental Health Workload/ Encounters | Specialty Care Services Provided | Diagnostic Services Provided | Ancillary Services Provided |
|---|---|---|---|---|---|---|
| Sidney, NE | 442GB | 1,445 | 146 | Endocrinology<br>Nephrology | – | Nutrition |
| Fort Collins, CO | 442GC | 5,620 | 7,190 | Dermatology<br>Endocrinology<br>General surgery<br>Nephrology<br>Orthopedics<br>Poly-trauma | – | Nutrition<br>Pharmacy<br>Social work<br>Weight management |

[1] VHA Directive 1230(4), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended June 17, 2021. An encounter is a "professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient's condition."

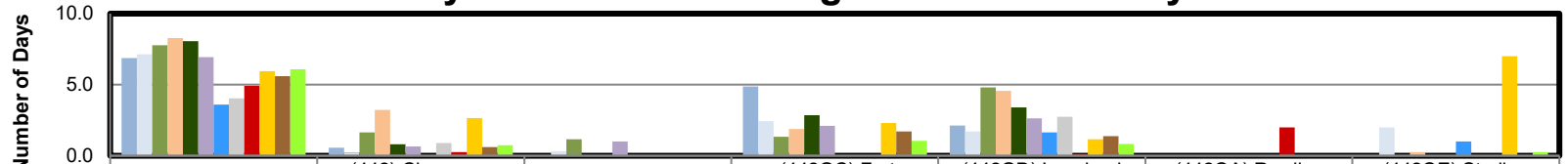
| Location | Station No. | Primary Care Workload/ Encounters | Mental Health Workload/ Encounters | Specialty Care Services Provided | Diagnostic Services Provided | Ancillary Services Provided |
|---|---|---|---|---|---|---|
| Loveland, CO | 442GD | 7,296 | 4,644 | Anesthesia<br>Cardiology<br>Dermatology<br>Endocrinology<br>Eye<br>General surgery<br>GYN<br>Nephrology<br>Podiatry<br>Poly-trauma<br>Urology | – | Nutrition<br>Pharmacy<br>Social work<br>Weight management |
| Rawlins, WY | 442QA | 1,815 | 87 | Nephrology<br>Orthopedics | – | Nutrition |
| Sterling, CO | 442QE | 815 | 79 | – | – | – |

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

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

# Appendix D: Patient Aligned Care Team Compass Metrics

## New Primary Care Patient Average Wait Time in Days



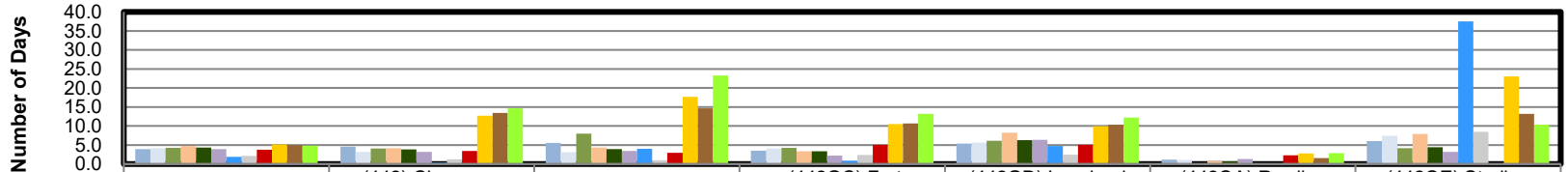

| | VHA All | (442) Cheyenne, WY | (442GB) Sidney, NE | (442GC) Fort Collins, CO | (442GD) Loveland, CO | (442QA) Rawlins, WY | (442QE) Sterling, CO |
|---|---|---|---|---|---|---|---|
| OCT-FY20 | 6.9 | 0.6 | 0.0 | 4.9 | 2.1 | 0.0 | 0.0 |
| NOV-FY20 | 7.1 | 0.2 | 0.3 | 2.4 | 1.7 | 0.0 | 2.0 |
| DEC-FY20 | 7.8 | 1.6 | 1.2 | 1.3 | 4.8 | 0.0 | 0.0 |
| JAN-FY20 | 8.3 | 3.2 | 0.0 | 1.9 | 4.6 | 0.0 | 0.3 |
| FEB-FY20 | 8.1 | 0.8 | 0.0 | 2.8 | 3.4 | 0.0 | 0.0 |
| MAR-FY20 | 6.9 | 0.7 | 1.0 | 2.1 | 2.6 | 0.0 | 0.0 |
| APR-FY20 | 3.6 | 0.0 | n/a | n/a | 1.6 | n/a | 1.0 |
| MAY-FY20 | 4.0 | 0.9 | n/a | 0.0 | 2.8 | 0.0 | 0.0 |
| JUN-FY20 | 4.9 | 0.3 | 0.0 | 0.0 | 0.1 | 2.0 | n/a |
| JUL-FY20 | 5.9 | 2.6 | 0.0 | 2.3 | 1.2 | 0.0 | 7.0 |
| AUG-FY20 | 5.6 | 0.6 | 0.0 | 1.7 | 1.4 | 0.0 | 0.0 |
| SEP-FY20 | 6.1 | 0.7 | 0.0 | 1.0 | 0.8 | 0.0 | 0.3 |

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

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

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

## Established Primary Care Patient Average Wait Time in Days




| | VHA All | (442) Cheyenne, WY | (442GB) Sidney, NE | (442GC) Fort Collins, CO | (442GD) Loveland, CO | (442QA) Rawlins, WY | (442QE) Sterling, CO |
|---|---|---|---|---|---|---|---|
| OCT-FY20 | 3.9 | 4.6 | 5.6 | 3.5 | 5.4 | 1.2 | 6.1 |
| NOV-FY20 | 4.2 | 3.2 | 3.1 | 4.1 | 5.6 | 1.1 | 7.4 |
| DEC-FY20 | 4.2 | 4.1 | 8.0 | 4.3 | 6.2 | 0.1 | 4.2 |
| JAN-FY20 | 4.8 | 4.1 | 4.3 | 3.4 | 8.2 | 0.8 | 7.9 |
| FEB-FY20 | 4.3 | 3.9 | 4.0 | 3.4 | 6.3 | 0.7 | 4.4 |
| MAR-FY20 | 3.9 | 3.2 | 3.4 | 2.2 | 6.4 | 1.3 | 3.2 |
| APR-FY20 | 1.9 | 0.3 | 4.0 | 0.8 | 4.7 | 0.0 | 37.5 |
| MAY-FY20 | 2.1 | 1.2 | 1.0 | 2.4 | 2.4 | 0.1 | 8.5 |
| JUN-FY20 | 3.7 | 3.4 | 3.0 | 5.0 | 5.0 | 2.3 | 0.0 |
| JUL-FY20 | 5.1 | 12.7 | 17.7 | 10.5 | 9.9 | 2.8 | 23.0 |
| AUG-FY20 | 5.0 | 13.4 | 14.7 | 10.6 | 10.4 | 1.5 | 13.2 |
| SEP-FY20 | 4.9 | 14.7 | 23.3 | 13.2 | 12.2 | 2.9 | 10.3 |

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

*Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the medical center's explanation for the increased wait times for the Sterling CBOC.*

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

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

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

*Source: VHA Support Service Center.*

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

| Measure | Definition |
|---|---|
| Ability to move independently worsened (LS) | Long-stay measure: percentage of residents whose ability to move independently worsened. |
| Catheter in bladder (LS) | Long-stay measure: percent of residents who have/had a catheter inserted and left in their bladder. |
| 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. |

*Source: VHA Support Service Center.*

# Appendix G: VISN Director Comments

## Department of Veterans Affairs Memorandum

Date: August 5, 2021

From: Director, Rocky Mountain Network (10N19)

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

To: Director, Office of Healthcare Inspections (54CH02)

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

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

*(Original signed by:)*

Ralph Gigliotti

VISN 19 Network Director

# Appendix H: Medical Center Director Comments

## Department of Veterans Affairs Memorandum

Date: July 26, 2021

From: Paul L. Roberts, Medical Center Director, Cheyenne VA Medical Center (442/00)

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

To: Director, Rocky Mountain Network (10N19)

We appreciate the opportunity to work with the Office of Inspector General as we continuously strive to improve the quality of healthcare for America's Veterans.

Supporting documents are attached where appropriate.

*(Original signed by:)*

Paul L. Roberts, MHA, FACHE

Medical Center Director

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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