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VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Cheyenne VA Medical Center in Wyoming

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Figure 1. *Cheyenne VA Medical Center in Wyoming.*
Source: https://www.benefits.va.gov/CHEYENNE/directions.asp (accessed February 1, 2024).

Abbreviations

ADPCS/NE	Associate Director for Patient Care Services/Nurse Executive
CHIP	Comprehensive Healthcare Inspection Program
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
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 the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following five areas of clinical and administrative operations:

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on suicide prevention initiatives)

The OIG initiated an unannounced inspection of the Cheyenne VA Medical Center the week of June 5, 2023. 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 inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted opportunities for improvement and issued five recommendations to the Medical Center Director and Chief of Staff in the following areas of review: Medical Staff Privileging, Environment of Care, and Mental Health. 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 leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the

delivery of quality health care. The results are detailed throughout the report, and the recommendations are summarized in appendix A on page 18.

VA 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 C and D, pages 20–21, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the Cheyenne VA Medical Center 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 they can make informed decisions 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]

To examine risks to patients and the organization, the OIG focused on core processes in the following five areas of clinical and administrative operations:[4]

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on suicide prevention initiatives)

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

[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): 13, https://doi.org/10.1136/bmjopen-2014-005055.

[3] Danae F. 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] CHIP site visits addressed these processes during fiscal year (FY) 2023 (October 1, 2022, through September 30, 2023); they may differ from prior years' focus areas.

Methodology

The Cheyenne VA Medical Center also provides care through multiple outpatient clinics in Colorado, Nebraska, and Wyoming. General information about the medical center can be found in appendix B.

The OIG inspected the Cheyenne VA Medical Center during the week of June 5, 2023.[5] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[6] 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 medical center leaders complete corrective actions. The Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that 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.

[5] The OIG's last comprehensive healthcare inspection of the Cheyenne VA Medical Center occurred in November 2020. The Joint Commission performed a hospital and behavioral health care and human services review in August 2022.

[6] Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Results and Recommendations

Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.[7] High-impact leaders should be person-centered and transparent, engage front-line staff members, have a "relentless focus" on their organization's vision and strategy, and "practice systems thinking and collaboration across boundaries."[8] When leaders fully engage and inspire employees, create psychological safety, develop trust, and apply organizational values to all decisions, they lay the foundation for a culture and system focused on clinical and patient safety.[9]

To assess this medical center's leadership and risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Employee satisfaction
4. Patient experience
5. Identified factors related to possible lapses in care and medical center leaders' responses

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The medical center had a leadership team consisting of the Medical Center Director (Director), Chief of Staff, Associate Director for Patient Care Services/Nurse Executive (ADPCS/NE), and two Associate Directors. The Chief of Staff and ADPCS/NE oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive team had worked together for almost two years. The ADPCS/NE was assigned in December 2015, followed by the Director in June 2016. The Chief of Staff was appointed in April 2018, and the Associate Directors were appointed in September 2021 and July 2022.

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[7] Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

[8] Swensen et.al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs.*

[9] Allan Frankel et al., *A Framework for Safe, Reliable, and Effective Care,* Institute for Healthcare Improvement White Paper, 2017.

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

Budget and Operations

The OIG noted that the medical center's fiscal year (FY) 2022 annual medical care budget of $300,999,584 had increased by over 15 percent compared to the previous year's budget of $261,299,005.[10] The Director and Associate Director reported the budget was adequate. However, the Director stated that care in the community expenditures consumed most of the additional funding, especially for cardiology and emergency services.[11] The Associate Director shared that due to the fast-growing northern Colorado population who receive care at the medical center, leaders spent increased funding on additional staff and overtime costs.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[12] 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 facility leaders.

To assess employee viewpoints, the OIG reviewed results from VA's All Employee Survey from FYs 2020 through 2022 regarding their perceived ability to disclose a suspected violation without fear of reprisal.[13] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the medical center over time.

The medical center's scores were lower than VHA's for all three years, indicating staff were less comfortable disclosing suspected violations compared to VHA employees overall. To improve scores, the Director reported conducting patient safety forums with each unit whereby staff could discuss safety concerns related to their work. In response to concerns staff reported during the forums, the Director stated that logistics staff began attending daily surgery meetings to ensure the teams had the items they needed in the operating room.

The Chief of Staff reported that daily communication through huddles with key personnel, service chiefs, and executive leaders to share information and issues affecting healthcare

[10] Veterans Health Administration (VHA) Support Service Center.

[11] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," VA, accessed November 20, 2023, https://www.va.gov/communitycare/.

[12] "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center.

[13] The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only.

operations was paramount in increasing employees' engagement and perceived ability to disclose suspected violations.

Table 1. All Employee Survey Question: Ability to Disclose a Suspected Violation (FYs 2020 through 2022)

All Employee Survey Group	FY 2020	FY 2021	FY 2022
VHA	3.8	3.9	3.9
Cheyenne VA Medical Center	3.6	3.8	3.8

Source: VA All Employee Survey (accessed December 27, 2022).

Note: Respondents scored this survey item from 1 (Strongly disagree) through 6 (Do not know).

Patient Experience

VHA uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to assess patients' healthcare experiences and compare them to the private sector. VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[14] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the medical center from FYs 2020 through 2022. Table 2 provides survey results for VHA and the medical center over time.

The medical center's survey scores indicated patients were generally less satisfied with their inpatient and primary care experiences but more satisfied with their specialty care when compared to VHA patients nationally. The ADPCS/NE attributed the lower inpatient satisfaction to the medical center's limited services, causing patients to be referred to community care or transferred to the VA facility in Denver, Colorado for many acute services. Regarding primary care, the ADPCS/NE stated that patients' satisfaction may have declined because providers delivered care through telehealth rather than in-person. The ADPCS/NE added that, in December 2022, leaders started a program allowing patients a choice between waiting for appointments with their regular providers or choosing same-day appointments with any available providers.

[14] "Patient Experiences Survey Results," VHA Support Service Center.

Table 2. Survey of Healthcare Experiences of Patients (FYs 2020 through 2022)

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Medical Center	VHA	Medical Center	VHA	Medical Center
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	64.3	69.7	68.5	68.9	65.6
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?*†	82.5	82.6	81.9	81.3	81.7	81.6
Specialty Care: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*†	84.8	88.3	83.3	84.5	83.1	83.4

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 8 and 14, 2022).

**The response average is the percent of "Definitely yes" responses.*

†The response average is the percent of "Very satisfied" and "Satisfied" responses.

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

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[15] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[16] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

[15] Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," VA, accessed January 20, 2023, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

[16] The Joint Commission, *Standards Manual*, E-dition, January 1, 2022. A culture of safety is "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management." "Hospital Survey on Patient Safety Culture: User's Guide," Agency for Healthcare Research and Quality, July 2018, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[17]

"A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)."[18] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's 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."[19] Lastly, a large-scale disclosure is "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."[20] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[21]

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred during FY 2022 and reviewed the information staff provided. The Director stated the Chief, Quality and Safety determines whether adverse events need further review. The Chief, Quality and Safety discussed reviewing adverse events entered in the Joint Patient Safety Reporting system with the Risk Manager, who then discusses whether they need an institutional disclosure with the Chief of Staff, who makes the final decision.[22]

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

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[17] Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events (2nd ed.)*, Institute for Healthcare Improvement White Paper, 2011.

[18] The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, Sentinel Event Policy (SE), July 2023. VHA incorporates The Joint Commission's definition of a sentinel event in VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

[19] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[20] VHA Directive 1004.08.

[21] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024. The new directive contains similar language regarding patient safety as the rescinded handbook.)

[22] VHA uses the Joint Patient Safety Reporting system for data management of patient safety events such as medical errors and close calls. "VHA National Center for Patient Safety Frequently Asked Questions," VA, accessed January 25, 2024, https://www.patientsafety.va.gov/about/faqs.asp.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[23] To achieve this goal, VHA requires that its medical facility leaders implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[24] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[25]

VHA implemented the National Center for Patient Safety program to develop a range of patient safety methodologies and practices. VHA's Patient Safety program includes staff assessing system vulnerabilities that may result in patient harm, reporting adverse patient safety events, and focusing on prevention.[26] According to The Joint Commission's standards for performance improvement, staff must analyze data to monitor performance and identify trends and improvement opportunities, then implement actions to enhance patient safety.[27]

The OIG assessed the medical center's processes for conducting peer reviews of clinical care.[28] 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."[29] Peer reviews are "intended to promote confidential and non-punitive assessments of care" that consistently contribute to quality management efforts at the individual provider level.[30]

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports. The team also reviewed one death that occurred within 24 hours of inpatient admission during FY 2022.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

[23] VA, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

[24] VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.

[25] VHA Directive 1100.16.

[26] VHA Handbook 1050.01; VHA Directive 1050.01(1).

[27] The Joint Commission, *Standards Manual*, E-dition, PI.03.01.01, PI.04.01.01, January 1, 2022.

[28] 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. VHA Directive 1190.

[29] VHA Directive 1190.

[30] VHA Directive 1190.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of “all health care professionals who are permitted by law and the facility to practice independently.”[31] These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care “without supervision or direction, within the scope of the individual’s license, and in accordance with individually-granted clinical privileges.”[32]

Privileges need to be specific and based on the individual practitioner’s clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP’s credentials and service chief’s recommendation to determine whether “clinical competence is adequately demonstrated to support the granting of the requested privileges,” and submits the final recommendation to the facility director.[33] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[34]

VHA states the Focused Professional Practice Evaluation (FPPE) is a defined period during which service chiefs assess LIPs’ professional performance. The FPPE process occurs when an LIP is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP’s performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.[35]

VHA’s credentialing process involves the assessment and verification of healthcare practitioners’ qualifications to provide care and is the first step in ensuring patient safety.[36] Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office under the chief of staff. VHA also requires facilities to have credentialing and

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[31] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded this handbook and replaced it with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

[32] VHA Handbook 1100.19.

[33] VHA Handbook 1100.19.

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[37]

The OIG interviewed key managers and selected and reviewed the privileging folders of 23 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

VHA requires medical staff to review and document FPPE results and report them to an executive committee of the medical staff.[38] The OIG found that medical staff did not report results for some FPPEs to the Medical Executive Board.[39] Failure to report FPPE results may lead to the board recommending LIPs' privileges without evidence of competency, potentially affecting safe patient care. The Chief of Staff stated credentialing and privileging staff did not provide effective oversight of the privileging process.

Recommendation 1

1. The Chief of Staff ensures medical staff review and document licensed independent practitioners' Focused Professional Practice Evaluation results and report them to the Medical Executive Board.

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: The Chief of Staff will ensure the medical staff review and document all required Focused Professional Practice Evaluation results. The Credentialing and Privileging Manager will track and monitor Focused Professional Practice Evaluation results reported to the Medical Executive Board every month. The numerator equals the number of complete Focused Professional Practice Evaluations presented to Medical Executive Board monthly. The denominator equals the total number of required Focused Professional Practice Evaluations monthly. The Credentialing and Privileging Manager will report the compliance results monthly to the Medical Executive Board, chaired by the Chief of Staff, until 90 percent compliance is achieved and sustained for two consecutive quarters.

[37] Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo, "Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020," December 16, 2020.

[38] VHA Handbook 1100.19; VHA Directive 1100.21(1).

[39] The executive committee of the medical staff is called the Medical Executive Board at this medical center.

VHA requires service chiefs to regularly monitor LIPs' performance through Ongoing Professional Practice Evaluations.[40] The OIG found that privileging folders did not consistently have evidence of completed Ongoing Professional Practice Evaluations. Failure to complete the evaluations could result in LIPs providing care without a thorough review of their performance, which could jeopardize patient care. The Credentialing and Privileging Manager attributed the deficiency to vacancies in service chief positions, and the Chief of Staff concurred.

Recommendation 2

2. The Chief of Staff ensures service chiefs monitor licensed independent practitioners' performance by regularly conducting Ongoing Professional Practice Evaluations.

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: The Chief of Staff will ensure the service chiefs monitor licensed independent practitioners' performance through Ongoing Professional Practice Evaluations. The Credentialing and Privileging Manager will track and monitor completion of Ongoing Professional Practice Evaluations every month. The numerator equals the number of complete Ongoing Professional Practice Evaluations presented to the Medical Executive Board monthly. The denominator equals the total number of required Ongoing Professional Practice Evaluations monthly. The Credentialing and Privileging Manager will report the compliance results monthly to the Medical Executive Board, chaired by the Chief of Staff, until 90 percent compliance is achieved and sustained for two consecutive quarters.

[40] VHA Handbook 1100.19; VHA Directive 1100.21(1).

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of VHA's environment of care program is to ensure "a safe, clean health care environment that provides the highest standards in the health care setting."[41] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[42]

The purpose of this inspection was to determine whether staff at VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG inspected selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.[43]

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected five patient care areas:

- Community living center (CLC East)
- Emergency Department
- Inpatient Unit (medical and surgical)
- Intensive Care Unit
- Primary Care Clinic

Environment of Care Findings and Recommendations

VHA requires staff to conduct environment of care inspections at "a minimum of once per fiscal year in non-patient care areas, and twice per fiscal year in all areas where patient care is delivered."[44] The OIG found that in FY 2022, staff did not inspect all patient care areas twice,

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[41] VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. (This directive was in effect at the time of the inspection. VHA amended it September 7, 2023.)

[42] VHA Directive 1608. The supply chain management system must meet the needs of its customers, which involves ensuring availability of the right product in the right place and at the right time. VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[43] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (VHA rescinded and replaced this handbook with VHA Directive 1160.06, *Inpatient Mental Health Services,* September 27, 2023.) VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024.)

[44] VHA Directive 1608.

which could have prevented them from proactively identifying unsafe conditions.[45] The Safety and Occupational Health Specialist reported staff misidentified one area as a non-patient care area and inspected it only once, and did not inspect three areas because these areas were not consistently open during regular work hours.

Recommendation 3

3. The Medical Center Director ensures staff conduct environment of care inspections in patient care areas at the required frequency.

Medical center concurred.

Target date for completion: July 1, 2024

Medical center response: The Medical Center Director will ensure that facility staff complete and document the number of environment of care inspections required for patient care areas. Areas where patient care is delivered will have the minimum required twice per fiscal year environment of care inspections. The Safety and Occupational Health Specialist will track and monitor the number of environment of care inspections completed each month using an electronic data base. The numerator equals the number of environment of care inspections completed each month in patient care areas. The denominator is the total number of environment of care inspections expected to be completed each month in patient care areas. The Safety and Occupational Health Specialist will report the compliance rate monthly to the Comprehensive Environment of Care Committee. The minutes of the Comprehensive Environment of Care Committee will be reviewed for compliance by the Medical Center Director until 90 percent compliance is achieved and sustained for six consecutive months.

VHA requires staff to separate soiled and contaminated supplies from clean and sterile supplies.[46] The OIG found clean and dirty equipment stored together in the Emergency Department and Intensive Care Unit. This posed a risk of infection to patients and staff. The Chief, Environmental Management Service reported staff did not request removal of the unnecessary clean equipment and instead used the soiled utility room as temporary storage. The OIG observed that staff removed the clean equipment from the soiled utility room during the site visit and therefore made no recommendation.

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[45] The OIG found that staff did not inspect all patient care areas twice in FY 2022, including Compensation and Pension examination rooms, Mobile Clinic Laramie, Telehealth-Torrington, and Telehealth-Wheatland.

[46] VHA Directive 1131(5), *Management of Infectious Diseases and Infection Prevention and Control Programs*, November 7, 2017, amended June 4, 2021. (VHA rescinded and replaced this directive with VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs*, November 27, 2023.)

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[47] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[48] The suicide rate for veterans was higher than for nonveteran adults during 2020.[49] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[50]

Due to the prevalence of suicide among at-risk veterans, VHA implemented a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.[51] VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.[52]

VHA requires each medical center and very large community-based outpatient clinic to have a full-time suicide prevention coordinator to track and follow up with high-risk veterans, conduct community outreach activities, and inform leaders of suicide-related events.[53]

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and reviewed relevant documents and the electronic health records of 45 randomly selected patients who had a positive suicide screen in FY 2022 and received primary care services.

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[47] VA Secretary memo, "Agency-Wide Required Suicide Prevention Training," October 15, 2020.

[48] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed March 14, 2022.

[49] VA Office of Mental Health and Suicide Prevention, *2022 National Veteran Suicide Prevention Annual Report*, September 2022.

[50] Congressional Research Service, "Veteran Suicide Prevention," IF11886 version 2, July 29, 2021.

[51] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," November 13, 2020. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," November 23, 2022.)

[52] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy). Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Suicide Behavior and Overdose Reporting," July 20, 2021. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Suicide Behavior and Overdose Reporting," May 9, 2023.)

[53] VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021. "Very large CBOCs [community-based outpatient clinics] are those that serve more than 10,000 unique veterans each year." VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. (VHA rescinded and replaced this handbook with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.)

Mental Health Findings and Recommendations

VHA requires suicide prevention coordinators to report suicide-related events monthly to "local mental health leadership and quality management."[54] The OIG found the Suicide Prevention Coordinator did not report suicide-related events to mental health leaders in four months, or to quality management staff in three months of FY 2022. The lack of frequent reporting could hinder leaders' oversight and result in missed opportunities for them to improve suicide prevention practices. The acting Chief, Mental Health was recently assigned to the position and explained being unable to speak about the reporting of any suicide-related events in FY 2022. The Suicide Prevention Coordinator said the position's workload made monthly reporting difficult. The Chief, Quality and Safety stated the reporting was intermittent.

Recommendation 4

4. The Medical Center Director ensures the Suicide Prevention Coordinator reports suicide-related events to mental health leaders and quality management staff at least monthly.

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: The Medical Center Director will ensure the Suicide Prevention Coordinator reports suicide related events monthly to mental health leaders and quality management staff by monthly reporting to the Healthcare Delivery Council, attended by the Chief, Mental Health and quality management staff. The Suicide Prevention Coordinator will complete a monthly audit for tracking. The numerator equals the number of months suicide related events are reported to the Healthcare Delivery Council. The denominator equals total number of months of Healthcare Delivery Council meetings. The Suicide Prevention Coordinator will complete the audit and report compliance quarterly to the Healthcare Delivery Council. The minutes of the Healthcare Delivery Council will be reviewed for compliance by the Medical Center Director until 90 percent compliance is achieved and sustained for two consecutive quarters.

VHA requires providers to complete the Comprehensive Suicide Risk Evaluation following a patient's positive suicide risk screen.[55] The OIG estimated that providers did not complete the evaluation after a positive screen for 44 (95% CI: 30 to 59) percent of patients, which is

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[54] VHA Directive 1160.07.

[55] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy);" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)."

statistically significantly above the OIG's 10 percent deficiency benchmark.[56] Failure to evaluate patients for suicidal behavior could result in missed opportunities for providers to identify patients who are at imminent risk for suicide and intervene. The Associate Chief of Staff, Ambulatory Care reported believing providers asked patients the evaluation questions during their appointments but forgot to complete the formal evaluation in the electronic health record. A director of one of the medical center's northern Colorado outpatient clinics cited one of the reasons as differing patient handoff procedures among rotating staff contributing to missed communication of positive screens to providers.

Recommendation 5

5. The Medical Center Director ensures providers complete the Comprehensive Suicide Risk Evaluation following a patient's positive suicide risk screen.

Medical center concurred.

Target date for completion: October 31, 2024

Medical center response: The Suicide Prevention Coordinator will run a daily electronic health record report identifying all positive Columbia-Suicide Severity Rating Scale screens. The Suicide Prevention Coordinator will conduct a daily audit of all electronic health records containing a positive Columbia-Suicide Severity Risk Screen, for completion of a timely Comprehensive Suicide Risk Evaluation. The numerator equals the number of completed Comprehensive Suicide Risk Evaluations per month. The denominator is the total number of electronic health records with a positive Columbia-Suicide Severity Rating Scale screen per month. The Suicide Prevention Coordinator will present the numerator, denominator, and compliance rate monthly to the Healthcare Delivery Council. The minutes of the Healthcare Delivery Council will be reviewed for compliance by the Medical Center Director until 90 percent compliance is achieved and sustained for two consecutive quarters.

[56] A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. The 95% confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence intervals 95 percent of the time.

Report Conclusion

To assist leaders in evaluating the quality of care at their medical center, the OIG conducted a detailed inspection of five clinical and administrative areas and provided five recommendations on systemic issues that may adversely affect patient care. The total number of recommendations does not necessarily reflect the overall quality of all services delivered within this medical center. However, the OIG's findings highlight areas of concern, and the recommendations are intended to help guide improvement efforts. The OIG appreciates the participation and cooperation of VHA staff during this inspection process. A summary of the recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines five OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Medical Center Director and Chief of Staff. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care.

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• None
Medical Staff Privileging	• Medical staff review and document licensed independent practitioners' Focused Professional Practice Evaluation results and report them to the Medical Executive Board. • Service chiefs monitor licensed independent practitioners' performance by regularly conducting Ongoing Professional Practice Evaluations.
Environment of Care	• Staff conduct environment of care inspections in patient care areas at the required frequency.
Mental Health: Suicide Prevention Initiatives	• The Suicide Prevention Coordinator reports suicide-related events to mental health leaders and quality management staff at least monthly. • Providers complete the Comprehensive Suicide Risk Evaluation following a patient's positive suicide risk screen.

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, 2019, through September 30, 2022)

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Total medical care budget	$250,941,958	$261,299,005	$300,999,584
Number of: • Unique patients	24,051	25,160	25,851
• Outpatient visits	260,285	285,254	264,606
• Unique employees§	869	873	889
Type and number of operating beds: • Community living center	42	42	42
• Domiciliary	10	10	10
• Medicine	20	20	20
• Surgery	2	2	2
Average daily census: • Community living center	24	23	21
• Domiciliary	4	2	6
• Medicine	9	10	11
• Surgery	1	1	1

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

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

**October 1, 2019, through September 30, 2020.*
†*October 1, 2020, through September 30, 2021.*
‡*October 1, 2021, through September 30, 2022.*
§*Unique employees involved in direct medical care (cost center 8200).*

[1] VHA medical facilities are classified according to a 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." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: February 28, 2024

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

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

To: Director, Office of Healthcare Inspections (54CH06)

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General Comprehensive Healthcare Inspection draft report of the Cheyenne VA Medical Center. I concur with the recommendations in the report.
2. The Rocky Mountain Network and the Cheyenne VA Medical Center are committed to honoring our Veterans by ensuring they receive high-quality healthcare services and I support the Director's response and action plan.
3. I appreciate the Office of Inspector General's partnership in our continuous improvement efforts.

(Original signed by:)

Sunaina Kumar-Giebel
Director, Rocky Mountain Network

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: February 16, 2024

From: Director, Cheyenne VA Medical Center (442)

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

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

1. The Cheyenne VA Healthcare System would like to thank the Office of the Inspector General Team for the thorough review and assessment during the Comprehensive Healthcare Inspection Program review.
2. I appreciate the opportunity to review the draft report and concur with the recommendations and submitted action plans. These recommendations will be used to strengthen our processes and improve the care that is provided to our Veterans.
3. The partnership between the Office of Inspector General and the Cheyenne VA Healthcare System to ensure Veterans receive worldclass healthcare is appreciated.

(Original signed by:)

Paul L. Roberts, MHA, FACHE
Director, Cheyenne VA Healthcare System

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