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VETERANS HEALTH ADMINISTRATION

Deficiencies in Oversight and Leadership Response to Optometry Concerns at the Cheyenne VA Medical Center in Wyoming

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Cheyenne VA Medical Center (facility) in Wyoming to review facility and Veterans Integrated Service Network (VISN) 19 leaders' response to allegations received on October 6, 2022, that an optometrist "misses diagnoses" and was not practicing to the standard of care or completing documentation in the electronic health record. The complainant provided a list of 16 patients allegedly adversely affected by the optometrist's care.

The OIG reviewed the allegations and sent a request on November 4, 2022, to the VISN for a response. VISN 19 leaders responded to the OIG request on May 11, 2023, and substantiated the care concerns regarding the optometrist, specifically that the optometrist failed to appropriately diagnose patients and delayed testing for 15 of the 16 patient cases provided in the original allegation. The OIG determined the VISN leaders' response lacked important information, such as the current employment status of the optometrist and a plan to review the care of other patients who may have been adversely affected. The OIG therefore initiated a healthcare inspection on June 6, 2023.

The OIG found that in January 2023, the facility ophthalmology section chief reviewed the care provided to the 16 patients and substantiated that these patients received substandard care. Based on that review, the Facility Director issued a summary suspension letter to the optometrist and removed the optometrist from direct patient care. The Facility Director also initiated a focused clinical care review (FCCR) at the time of the summary suspension; however, the OIG found deficiencies in facility leaders' implementation and interpretation of results from the FCCR.[1]

When developing an FCCR, the Veterans Health Administration (VHA) requires facility leaders to use randomly selected cases within a specifically identified time frame. Facility leaders should instruct reviewers with the same expertise to determine if the provider being reviewed met the standard of care and, if the standard was not met, to provide support in the results report.[2] The results are reported to facility leaders and the medical executive committee to review and consider any findings and recommendations for next steps.[3]

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[1] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. An FCCR is a comprehensive and retrospective review of a provider's practice to determine if any privileging actions will be taken.

[2] VHA Medical Staff Affairs Quality, Safety and Value, "Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance," January 2018. Potential results of an FCCR are: finding no evidence to support the allegations and returning the provider back to full medical practice; returning the provider back to full medical practice but with close clinical supervision; or taking privileging action that reduces or removes the ability for the provider to return to full medical practice.

[3] VHA Medical Staff Affairs Quality, Safety and Value, "Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance," January 2018.

The OIG learned that three optometry expert reviewers (expert reviewers), two from outside VISN 19 and one from within VISN 19, completed the FCCR. The OIG interviewed the expert reviewers and each expressed significant concerns with the care provided by the optometrist. However, facility leaders told the OIG that the results of the FCCR were mixed and that one expert reviewer was highly critical, one expert reviewer was complementary, and one expert reviewer was neutral. The OIG reviewed documentation of facility leaders' analysis of the results of the FCCR, which concluded that the "Provider did not meet the standard of care the majority of the time," with 58 percent of cases not meeting the accepted standard of care.[4] Despite these results, the medical executive committee voted to return the optometrist's privileges to allow the provider to demonstrate improvement because facility leaders interpreted the FCCR results as mixed. They also initiated a focused professional practice evaluation (FPPE) for cause in March 2023.[5] In June 2023, the medical executive committee determined the optometrist's performance had improved based on the results of the FPPE for cause and approved the optometrist to return to an ongoing professional performance evaluation.[6] The optometrist then retired from the facility in July 2023.

The OIG found that, although the results of both the initial review of patients identified in the allegation and the FCCR indicated the optometrist provided substandard care, facility leaders did not perform a review to evaluate risk and potential harm to patients not included in the initial group of 16 patients. When the OIG asked the Chief of Staff about reviewing past and current patient care for the optometrist, the Chief of Staff reported, "I would not say that we've closed that discussion, but we've sort of not come up with a good way to do that."

The OIG was concerned that a review of all the optometrist's patients to identify potential additional incidents of substandard care and to assess for harm was neither performed nor planned.

The OIG also determined that facility leaders failed to comply with VHA's state licensing board (SLB) reporting policy.[7] Reporting to SLBs is required by VHA when a licensed healthcare professional is found to have "substantially failed to meet generally accepted standards of

[4] The OIG found no evidence outlining the calculation process used by facility leaders to determine the FCCR result conclusion of 58 percent. When asked, the facility and VISN credentialing and privileging managers were unable to explain the standards used to interpret the FCCR results.

[5] VHA Medical Staff Affairs Quality, Safety and Value, "Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance," January 2018. An FPPE for cause is a specified time period in which "medical staff leadership" assess the provider's performance and allow for an opportunity for the provider to show the ability to perform as expected.

[6] VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. "Ongoing professional performance evaluation (OPPE) is the ongoing monitoring of privileged LIPs [licensed independent providers] to identify clinical practice trends that may impact the quality and safety of care."

[7] VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021. The five stages of the SLB reporting process include "(1) Initial Review Stage; (2) Comprehensive Review Stage; (3) Decision Stage; (4) Privacy Officer Review Stage; and (5) The Reporting Stage."

clinical practice" and there is a concern for patient safety.[8] The OIG found no documentation that the optometrist underwent the SLB review stages as required after facility leaders substantiated concerns that the optometrist was not meeting the generally accepted standard of care. Ultimately, facility directors make the decision to report healthcare professionals to an SLB. Through interviews, facility leaders demonstrated a lack of understanding of the need to initiate the SLB reporting process.

The OIG determined that the optometrist's supervisors failed to complete annual proficiency reports as required in two of the years leading up to the OIG inspection. VHA requires that supervisors annually evaluate the proficiency of employees, provide the report to employees no later than 60 calendar days after the end of the rating period, counsel employees to improve and correct deficiencies if needed, and take action if performance does not improve.[9]

The OIG reviewed the optometrist's annual proficiency reports from June 2018 through June 2023, and found no evidence that the proficiency reports for the 2021 and 2023 rating periods were completed as required. The optometrist's supervisor at the time of the June 2020–2021 rating cycle could not provide a reason for the missing proficiency report and stated, "that was probably an oversight." The optometrist's supervisor (ophthalmology section chief) at the time of the June 2022–2023 rating cycle was new to the facility and reported the reason for the missing proficiency report may have been lack of response to the report by the optometrist as well as the ophthalmology section chief's inexperience with the process to complete proficiency reports.

Upon document reviews of the three completed optometrist proficiency reports (2019, 2020, and 2022), the OIG learned that two of the completed proficiency reports (2020 and 2022) indicated the optometrist required improvement on assessments and planning, care management, and documentation. Despite optometry and ophthalmology leaders noting areas for practice improvement on two separate proficiency reports, the OIG found no documentation to support that leaders took actions to address the deficiencies.

The OIG made one recommendation to the VISN Director to conduct a comprehensive review of the quality of care provided by the optometrist and take action as warranted, and two recommendations to the Facility Director related to compliance with VHA requirements for SLB reporting, and optometry service proficiency processes.

[8] VHA Directive 1100.18.

[9] VHA Handbook 5013/1 Part II, *Performance Management Systems*, November 18, 2003; VHA Handbook 5013/11 Part II, *Performance Management Systems,* October 3, 2012.

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

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Contents

Abbreviations

FCCR	focused clinical care review
FPPE	focused professional practice evaluation
OIG	Office of Inspector General
OPPE	ongoing professional performance evaluation
SLB	state licensing board
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Cheyenne VA Medical Center (facility) in Wyoming to review facility and Veterans Integrated Service Network (VISN) 19 leaders' response to allegations of poor patient care by an optometrist.

Background

The facility, part of VISN 19, operates the main campus in Cheyenne and three outpatient clinics across Colorado and Nebraska.[1] The Veterans Health Administration (VHA) classifies the facility as level 3, low complexity.[2] From October 1, 2022, through September 30, 2023, the facility served 25,409 unique patients and provided primary and secondary care, including medicine, surgery, ophthalmology, and optometry.

Through an interview with an ophthalmology leader and document review, the OIG learned that the facility ophthalmology and optometry service fall under Surgery Service. The ophthalmology section chief is the direct supervisor for providers in the eye clinic, which include optometrists and technicians, and reports to the chief of surgery. The chief of surgery is supervised by the Chief of Staff.

Optometrists are doctors of optometry and complete four years of optometry school. They are licensed to practice optometry, which primarily involves performing eye exams and vision tests, prescribing and dispensing corrective lenses, detecting eye abnormalities, prescribing medications in some states, and performing certain surgical procedures.

Ophthalmologists are medical doctors who specialize in eye and vision care. Ophthalmologists complete over 10 years of training and education, including medical school, and practice medicine and surgery. According to the American Academy of Ophthalmology, ophthalmologists "diagnose and treat a wider range of conditions than optometrists. An ophthalmologist diagnoses and treats all eye diseases, performs eye surgery, and prescribes and fits eyeglasses and contact lenses to correct vision problems."

[1] The Cheyenne VA Medical Center is located in Cheyenne, Wyoming; with VA clinics in Fort Collins and Loveland, Colorado; and Sidney, Nebraska; and VA mobile clinics in Torrington, Wheatland, and Laramie, Wyoming; and Sterling, Colorado.

[2] VHA Office of Productivity, Efficiency, & Staffing (OPES), "Fact Sheet Facility Complexity Model." The Facility Complexity Model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex. A level 3 facility has "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs."

Prior OIG Reports

An OIG report was published on March 26, 2024, that included two recommendations related to medical staff privileging.[3] The OIG found medical staff were not reporting all focused and ongoing professional practice evaluation results to the Medical Executive Board, which may lead to privileging of providers without evidence of competency. The OIG recommended the Chief of Staff ensure completion and documentation of all focused and ongoing professional practice evaluations to the Medical Executive Board. As of April 10, 2024, these recommendations remained open.

Allegations and Related Concerns

On October 6, 2022, the OIG received a complaint alleging that an optometrist at the facility "misses diagnoses" and was not practicing to the standard of care or completing documentation in the electronic health record. The complainant stated that the optometrist was a safety concern to patients and provided a list of 16 patients allegedly affected by the optometrist's delivery of care.

The OIG reviewed the allegations and sent a request on November 4, 2022, to the VISN for a response. VISN 19 leaders responded to the OIG request on May 11, 2023. The VISN response included a review by the facility ophthalmology section chief that substantiated the care concerns regarding the optometrist, specifically that the optometrist failed to appropriately diagnose patients and delayed testing for 15 of the 16 patient cases provided in the original allegation. The OIG determined the VISN leaders' response lacked important information, such as the current employment status of the optometrist and a plan to review the care of other patients who may have been adversely affected.

The OIG initiated a healthcare inspection to review actions taken by facility and VISN leaders upon discovering the optometrist's care concerns.

Scope and Methodology

The OIG initiated the inspection on June 6, 2023, and conducted a site visit July 31–August 2, 2023. Virtual interviews began July 5, 2023, and were completed September 7, 2023. The OIG

[3] VA OIG, *Comprehensive Healthcare Inspection of the Cheyenne VA Medical Center in Wyoming*, Report No. 23-00122-118, March 26, 2024.

interviewed VISN and facility leaders, relevant providers and staff, and three optometry subject matter experts.[4]

In addition, the OIG reviewed VHA and facility policies and procedures related to ophthalmology, quality and proficiency reviews, committee meeting minutes, relevant emails, and other related documents.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

Inspection Results

The OIG identified deficiencies with facility leaders' response to the optometrist's quality of care concerns, including facility leaders' failure to initiate a review of the magnitude of impact of the optometrist's substandard care and failures in reporting the optometrist to the state licensing board (SLB) and in completing proficiency reports for the optometrist.

[4] Interviews included VISN and facility executive leaders; VISN and facility service leaders; the complainant; the identified optometrist; and relevant staff in the areas of ophthalmology, optometry, quality management, risk management, patient safety, and human resources. After the OIG site visit, a facility leader told the OIG that the Chief of Staff retired.

1. Deficiencies in Facility Leaders' Response to Concerns with the Optometrist's Care

The OIG discovered through document review that the Facility Director issued a summary suspension letter to the optometrist in January 2023 stating that the allegations of substandard care had been substantiated and required further review, and removed the optometrist from direct patient care from late January to mid-March 2023.[5]

VHA specifies that when "privileges are summarily suspended, the comprehensive review of the reason for summary suspension" should be completed and recommendations for reducing or rescinding clinical privileges presented to the facility director for "consideration and action."[6] Further, once aware that a "licensed health care professional" has possibly failed to achieve the "generally acceptable standards of care," the facility director is responsible for ensuring the start of the SLB reporting process, "beginning with the initial review stage to establish whether there is substantial evidence of the failure to meet standard of care."[7]

Focused Clinical Care Review

The OIG learned through document review the Facility Director initiated a focused clinical care review (FCCR) at the time of the summary suspension in January 2023 to determine if the optometrist met the standard of care.[8] The OIG found deficiencies in facility leaders' implementation and interpretation of results from the FCCR.

When developing an FCCR, VHA requires facility leaders to review a clinical provider's care using randomly selected cases within a specifically identified time frame. Per VHA, cases "can be split between the three reviewers with each reviewer given the same 2–3 cases" to demonstrate a reliable rating of the provider's care.[9] Further, VHA guidance specifies facility leaders should instruct reviewers with the same expertise to determine if the provider being reviewed met the standard of care and, if the standard was not met, to provide support in the

[5] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. This handbook was in effect for a portion of the time frame of the events discussed in this report. It was rescinded and replaced by VHA Directive 1100.21(1) *Privileging*, March 2, 2023, and amended April 26, 2023. A summary suspension of privileges may occur when "the failure to take such action may result in an imminent danger to the health of any individual."

[6] VHA Handbook 1100.19.

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

[8] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. An FCCR is a comprehensive and retrospective review of a provider's practice to determine if any privileging actions will be taken.

[9] VHA Medical Staff Affairs Quality, Safety and Value, "Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance," January 2018.

results report.[10] Also per VHA, after the reviews are completed by the reviewers with the same expertise, the results are reported to facility leaders and the medical executive committee to review and consider any findings and recommendations for next steps.[11]

The OIG found the documentation provided by facility leaders did not include how the patient cases were chosen by facility leaders for the expert reviewers, including the time frame of the sample and whether the cases were randomly selected. When asked by the OIG about the details of the process used to choose the FCCR patient cases, the Chief of Staff and credentialing and privileging manager were unable to provide clarifying information on the process used to determine the random sample of patient cases, or how the FCCR was developed and executed. During the interview, the Chief of Staff reported consulting with the VISN credentialing and privileging officer about which cases to review and being advised to pull random cases, but did not report being advised on the development of the FCCR. Without such details, the OIG was unable to determine whether the FCCR sample was a representational sample.

Through a review of documents, the OIG learned that three optometry expert reviewers (expert reviewers), two from outside VISN 19 and one from within VISN 19, completed the FCCR. Additionally, the chief of surgery, chief of ophthalmology, and credentialing and privileging manager developed review elements for 26 unique patient cases. The review elements focused on clinical assessment, diagnosis, and documentation. The facility credentialing and privileging manager instructed the expert reviewers to provide "yes" or "no" answers to address whether or not the optometrist met the standard of care but did not give instructions to specify the rationale if the optometrist did not meet the standard of care. The OIG reviewed documentation of facility leaders' analysis of the results of the FCCR obtained from the credentialing and privileging manager, which concluded that the "Provider did not meet the standard of care the majority of the time," with 58 percent of cases not meeting the accepted standard of care. The three expert reviewers told the OIG during interviews that competent optometrists should only fail to meet accepted standards in 5–10 percent of cases. In the same interviews, the expert reviewers also told the OIG of having significant concerns about the care reviewed, and believing the optometrist to be performing worse than expected of a competent optometrist. The FCCR subject matter experts found deficiencies in basic optometry care such as obtaining a complete history for a complaint of double vision, diagnosis and care of glaucoma patients, and accurate identification of findings on physical examination.

[10] VHA Medical Staff Affairs Quality, Safety and Value, "Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance," January 2018. Potential results of an FCCR are: finding no evidence to support the allegations and returning the provider back to full medical practice; returning the provider back to full medical practice but with close clinical supervision; or taking privileging action that reduces or removes the ability for the provider to return to full medical practice.

[11] VHA Medical Staff Affairs Quality, Safety and Value, "Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance," January 2018.

During document review, the OIG found no evidence outlining the calculation process used by facility leaders to determine the FCCR result conclusion of 58 percent. When asked during OIG interviews, the facility and VISN credentialing and privileging managers were unable to explain the standards used to interpret the FCCR results.

Additionally, the OIG learned that the Chief of Staff and chief of surgery did not include the ophthalmology section chief when the facility credentialing and privileging manager analyzed the results of the FCCR. The Chief of Staff and chief of surgery had reported limited knowledge about optometry and relied on experts, such as the ophthalmology section chief, to advise facility leaders on optometry care.

The OIG determined that the facility leaders' characterization of the expert reviewers' opinions was inconsistent with the expert reviewers. Facility leaders stated that the results were mixed and that one expert reviewer was highly critical, one expert reviewer was complementary, and one expert reviewer was neutral. When the OIG talked with the expert reviewers, all three stated that they would not want to be in practice with or have family taken care of by the optometrist. All three also said that no one from the facility had contacted them for their opinions about the reviewed care.

During review of the medical executive committee meeting minutes, the OIG found that the results of the optometrist's FCCR were reviewed by the committee and the committee voted to return the optometrist's privileges and initiated a focused professional practice evaluation (FPPE) for cause to monitor performance in March 2023.[12] An FPPE for cause is a customized review for a provider to demonstrate improvement in knowledge and skills that were identified as a concern in an FCCR and is typically initiated for concerns that can be corrected without risk to patients. The Chief of Staff told the OIG during an interview that the mixed results of the optometrist's FCCR received from the expert reviewers were a factor in the decision to return the optometrist to patient care on an FPPE for cause.

At the conclusion of the FPPE for cause in June 2023, the medical executive committee determined that the optometrist's provision of care had improved and approved the optometrist to return to an ongoing professional performance evaluation (OPPE).[13] The optometrist then retired from the facility in July 2023.

[12] VHA Medical Staff Affairs Quality, Safety and Value, "Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance," January 2018. An FPPE for cause is a specified time period in which "medical staff leadership" assess the provider's performance and allow for an opportunity for the provider to show the ability to perform as expected.

[13] VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. "Ongoing professional performance evaluation (OPPE) is the ongoing monitoring of privileged LIPs [licensed independent providers] to identify clinical practice trends that may impact the quality and safety of care."

The OIG concluded that the facility leaders' implementation and interpretation of the FCCR process and results demonstrated a poor understanding of the requirements to complete the FCCR. The facility leaders were unable to describe the methodology used for the FCCR review and analysis of the results. Facility leaders should have considered the FCCR results concerning, given the instances of substandard care, but did not. Facility leaders demonstrated through two completed reviews that the optometrist delivered problematic care pre-suspension, but ultimately returned the optometrist to full privileges.

Failure to Evaluate Patients At Risk from Substandard Optometry Care

The OIG found that, although the results of both the initial review of patients identified in the allegation and the FCCR indicated the optometrist provided substandard care, facility leaders did not perform a review to evaluate risk and potential harm to patients not included in the initial group of 16.

Upon review of the results of the original OIG request for information and the FCCR, the OIG determined that VISN and facility leaders had evidence that patients received substandard care across the optometrist's practice. In interviews with the expert reviewers that conducted the FCCR, the OIG learned the reviewers found that these lapses in care were characterized as basic optometry care and involved several clinical areas that included glaucoma care, interpretation of retinal imaging, and treatment of macular degeneration.

When asked during OIG interviews about identifying patient harm in the FCCR review, one of the expert reviewers commented that the reviews were intended to evaluate the provider's care and not to identify patient harm, which would require a more extensive review of the record. During OIG interviews, the expert reviewers mentioned the risks of substandard care. One expert reviewer stated that the potential for patient harm such as visual loss was one of the reasons it is important to follow standards. Another expert reviewer stated that it was important to be consistent and detailed in optometric assessments because of the risk of severe, permanent consequences from untreated disease.

When the OIG asked the Chief of Staff about reviewing past and current patient care for the optometrist, the Chief of Staff reported, "I would not say that we've closed that discussion, but we've sort of not come up with a good way to do that." While the optometrist subsequently passed an FPPE for cause, the OIG was concerned to learn that a review of all the optometrist's patients to identify potential additional incidents of substandard care and to assess for harm was neither performed nor planned.

The OIG concluded that facility leaders failed to respond to a pattern of substandard care provided by the optometrist and did not conduct further quality of care reviews; therefore, they were unable to identify the need for disclosure.[14]

Noncompliance with State Licensing Board Reporting Policy

The OIG determined that facility leaders failed to comply with VHA's SLB reporting policy. The OIG found no documentation that the optometrist underwent the review stages within VHA's SLB reporting process after facility leaders and the first- and second-line supervisors substantiated concerns that the optometrist was not meeting the generally accepted standard of care.

Reporting to SLBs is required by VHA when a licensed healthcare professional is found to have "substantially failed to meet generally accepted standards of clinical practice" and there is a concern for patient safety.[15] VHA established a five-stage process that includes facility initial and comprehensive reviews, a facility director decision, and, if appropriate, reporting to SLBs, which should be completed in less than 100 calendar days.[16] The SLB reporting process should occur at the same time as any personnel or privileging actions.[17] Ultimately, the facility director makes the decision to report a healthcare professional to an SLB.[18]

VHA requires that a "first- or second-line supervisor must initiate the SLB reporting process within 5-business days of obtaining objective evidence that the licensed health care professional failed to meet the generally acceptable standards of care."[19] Through interviews, facility leaders demonstrated a lack of understanding of the need to initiate the SLB reporting process. By the time that the FCCR results were available, the OIG considered that the optometrist had "substantially failed to meet generally accepted standards of clinical practice" and raised concerns for patient safety.[20] The ophthalmology section chief did not recall discussions related to beginning the SLB reporting process. The surgery chief reported being unsure of the SLB reporting process and told the OIG during an interview that the process is to begin with a peer review. During an interview with the OIG, the Chief of Staff recalled some discussion of SLB

[14] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. A disclosure is a discussion between providers and patients when a potentially harmful adverse event occurs during the course of a patient's care. Adverse events are "untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers."

[15] VHA Directive 1100.18.

[16] VHA Directive 1100.18. The five stages of the SLB reporting process include "(1) Initial Review Stage; (2) Comprehensive Review Stage; (3) Decision Stage; (4) Privacy Officer Review Stage; and (5) The Reporting Stage."

[17] VHA Directive 1100.18.

[18] VHA Directive 1100.18.

[19] VHA Directive 1100.18.

[20] VHA Directive 1100.18.

reporting but stated the situation "never triggered that process" because the optometrist did not withdraw from employment while being investigated. The Facility Director did not recall discussions relating to SLB reporting when asked during an OIG interview.

When a provider leaves employment, VHA policy requires the first- or second-line supervisor to complete a review of a provider's care within seven business days of the employee's separation date to ensure that clinical practice met the generally accepted standard of care and document the review on the Provider Exit Review form. If the supervisor determines the provider did not meet the generally accepted standard of care based on substantial documented evidence, the SLB reporting process is required to be initiated within seven business days of the supervisor signing the Provider Exit Review form.[21]

The OIG reviewed the Provider Exit Review form and found the chief of surgery (the optometrist's second-line supervisor) completed documentation within seven business days as required.

The OIG concluded that facility leaders were unclear about the requirements for SLB reporting and therefore did not consider initiating the SLB reporting process. The OIG would have expected initiation of the SLB reporting process to occur at the time of the VISN response when the chief of ophthalmology determined 15 of the 16 patient cases showed substandard patient care. The facility leaders and second-line supervisor also were required to initiate the SLB reporting process after the summary suspension of privileges and FCCR results indicated the optometrist did not meet the standard of care.

2. Deficiencies in Oversight of Proficiency Reviews

The OIG determined that the optometrist's supervisors failed to complete annual proficiency reports as required in two of the years leading up to the OIG inspection.

VHA requires that supervisors annually evaluate the proficiency of employees, provide the report to employees no later than 60 calendar days after the end of the rating period, counsel employees to improve and correct deficiencies if needed, and take action if performance does not improve.[22] The proficiency rating system is designed for supervisors to provide continual systematic evaluation of an employee's effectiveness in the assigned role.[23]

The OIG reviewed the optometrist's annual proficiency reports from June 2018 through June 2023, and found no evidence that the proficiency reports for the rating periods ending June 2021 and June 2023 were completed as required. When asked by the OIG, a facility quality

[21] VHA Directive 1100.18.

[22] VHA Handbook 5013/1 Part II, *Performance Management Systems*, November 18, 2003; VHA Handbook 5013/11 Part II, *Performance Management Systems,* October 3, 2012.

[23] VHA Directive 5013/3, *Performance Management Systems*, January 27, 2011.

management staff member confirmed that no performance reports for the 2021 and 2023 rating cycles were recorded in the performance management system.[24] During an interview with the OIG, the optometrist's supervisor at the time of the June 2020–2021 rating cycle could not provide a reason for the missing proficiency report and stated, "that was probably an oversight." The optometrist's supervisor (ophthalmology section chief) at the time of the June 2022–June 2023 rating cycle was new to the facility and reported the reason for the missing proficiency report may have been lack of response to the report by the optometrist as well as the ophthalmology section chief's inexperience with the process to complete proficiency reports.

Upon document reviews of the three completed optometrist proficiency reports (2019, 2020, and 2022), the OIG learned that two of the completed proficiency reports (2020 and 2022) indicated the optometrist required improvement on assessments and planning, care management, and documentation. In an interview, the ophthalmology section chief reported counseling the optometrist about glaucoma care but, while documentation on the 2022 proficiency report indicated "some concern for substandard management in. . . some conditions," no documentation was found that the concerns were discussed with the optometrist. The former optometry supervisor also reported to the OIG that there were concerns about the optometrist's care, including incorrect diagnoses and poor documentation, and speaking to the optometrist about the concerns.

Despite optometry and ophthalmology leaders noting areas for practice improvement on two separate proficiency reports and identified deficient care in 2020 and 2022, the OIG found no documentation to support that leaders took actions to address the deficiencies.

The OIG concluded that without consistent annual oversight of the optometrist's proficiency, leaders did not fully assess the optometrist's ongoing performance and competence.

Conclusion

The facility ophthalmology section chief substantiated that an optometrist provided substandard care based on a review of 16 patients provided by an OIG complainant. The optometrist was summarily suspended while facility leaders initiated an FCCR to understand the optometrist's practice. The OIG found that these initial actions were appropriate.

However, the OIG found facility leaders could not describe the methodology used for the FCCR review. Additionally, facility leaders' interpretation of the FCCR differed from the three independent subject matter experts from outside the facility, who conducted the review and

[24] VACO Human Capital Information Systems, *Enterprise Performance Management System (ePerformance)*, October 1, 2022. "Enterprise Performance Management System (EPMS) ePerformance is a performance management system used for VA employees for their yearly performance plans to reduce need to have manual processes and printing and automatically moves employees plans over to the Federally required eOPF [electronic official personnel folder]."

shared significant concerns about the care reviewed, which showed that the "Provider did not meet the standard of care the majority of the time," with 58 percent of cases not meeting the accepted standard of care. Further, because the results of both the initial review of patients identified in the allegation and the FCCR indicated the optometrist provided substandard care, facility leaders should have performed a review to evaluate risk and potential harm to patients.

Despite these results, the medical executive committee voted to return the optometrist's privileges and facility leaders conducted an FPPE for cause after completion of the FCCR, which the optometrist successfully completed. The optometrist returned to practice for a few months before retiring from the VA in July 2023.

The OIG identified facility leaders' failures in the process for SLB reporting, and the optometrist's supervisors' failures in completing proficiency reports for the optometrist.

Facility leaders failed to comply with VHA's SLB reporting policy. Facility leaders substantiated concerns that the optometrist was not meeting the generally accepted standard of care; however, the OIG found no documentation that the optometrist underwent the review stages within VHA's SLB reporting process. The OIG further determined that facility leaders were confused about SLB reporting requirements, erroneously concluding that SLB reporting did not apply in the optometrist's circumstances.

In two of the years leading up to the OIG inspection, the optometrist's supervisors failed to complete annual proficiency reports as required. The OIG concluded that without consistent annual oversight of the optometrist's proficiency, leaders did not fully assess the optometrist's ongoing performance and competence.

Recommendations 1–3

1. The Veterans Integrated Service Network Director, in conjunction with facility leaders and optometry service leaders, conducts a comprehensive review of the quality of care provided by the optometrist, identifies deficiencies, and takes action as indicated.
2. The Cheyenne VA Medical Center Director ensures compliance with Veterans Health Administration requirements for state licensing board reporting of the care provided by the optometrist and takes action, including training, as indicated.
3. The Cheyenne VA Medical Center Director reviews optometry service proficiency processes, identifies deficiencies, and takes action as indicated.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 30, 2024

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

Subj: Healthcare Inspection—Deficiencies in Oversight and Leadership Response to Optometry Concerns at the Cheyenne VA Medical Center in Wyoming

To: Director, Office of Healthcare Inspections (54HL02)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. The Rocky Mountain Network, VISN 19, is committed to honoring our Veterans and ensuring they receive high-quality healthcare services. We regret any circumstance that results in a Veteran receiving less than stellar support and care. We appreciate the assessment provided by the Office of Inspector General and the opportunity to review and comment on the report "Deficiencies in Oversight and Leadership Response to Optometry Concerns at the Cheyenne VA Medical Center in Wyoming."

2. Based on the thorough review of the report by myself and VISN 19 Leadership, I concur with the recommendations and submitted actions plans from Cheyenne VA Health Care System and VISN 19.

3. If there are any questions regarding responses or additional information required, please contact the VISN 19 Quality Management Officer.

(*Original signed by:*)

Sunaina Kumar-Giebel, MHA
Director, VA Rocky Mountain Network (10N19)

VISN Director Response

Recommendation 1

The Veterans Integrated Service Network Director, in conjunction with facility leaders and optometry service leaders, conducts a comprehensive review of the quality of care provided by the optometrist, identifies deficiencies, and takes action as indicated.

_X _Concur

____Nonconcur

Target date for completion: October 31, 2024

Director Comments

The VISN CMO [Chief Medical Officer] office will oversee a comprehensive review of the optometrist's encounters to determine veteran harm and arrange future care needs. Initial reviews were completed during a six-month period of evaluation prior to separation, as well as a modest retrospective review. Additional reviews will target care since the last successful OPPE in 2020 and include a comprehensive review of a high-risk diabetes cohort of non-deceased veterans who have not had subsequent eye care. Additional review criteria will be developed if severe delinquencies are found.

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 19, 2024

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

Subj: Healthcare Inspection—Deficiencies in Oversight and Leadership Response to Optometry Concerns at the Cheyenne VA Medical Center in Wyoming

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

1. Cheyenne VA Healthcare System deeply regrets the circumstances that led to the investigation by the Office of Inspector General (OIG). We take such incidents with utmost seriousness, as the well-being of our patients is our top priority. We appreciate the thoroughness of the OIG's investigation and express our gratitude for the opportunity to review and comment on the Office of Inspector General's report, Deficiencies in Oversight and Leadership Response to Optometry Concerns at the Cheyenne VA Medical Center in Wyoming.

2. Based on the thorough review of the report, I concur with the recommendations and have provided action plans to each recommendation.

3. If there are any questions regarding responses or additional information required, please contact Chief of Quality Management for the Cheyenne VA Health Care System.

(*Original signed by*:)

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

Facility Director Response

Recommendation 2

The Cheyenne VA Medical Center Director ensures compliance with Veterans Health Administration requirements for state licensing board reporting of the care provided by the optometrist and takes action, including training, as indicated.

_X _Concur

____Nonconcur

Target date for completion: September 30, 2024

Director Comments

Medical center response: The Cheyenne VA Medical Center Director will ensure compliance with Veterans Health Administration requirements for state licensing board reporting of the care provided by the optometrist. This will be evidenced by confirmation from the appropriate state board of licensure. Training will be provided to the Medical Executive Committee regarding the state licensing board reporting process. The numerator equals the number of members completing training and the denominator equal the total number of members. Completion of training will be reported in the Medical Executive Committee minutes and reviewed by the Medical Center Director until 90% compliance.

Recommendation 3

The Cheyenne VA Medical Center Director reviews optometry service proficiency processes, identifies deficiencies, and takes action as indicated.

_X _Concur

____Nonconcur

Target date for completion: September 30, 2024

Director Comments

Medical center response: The Cheyenne VA Medical Center Director will review the optometry service proficiency process and ensure completion of proficiencies and action is taken for deficiencies as indicated by reviewing an audit of current optometry employees through ePerformance. The numerator equals the number of proficiencies completed, denominator equals the number of proficiencies expected. This will be reported to Executive Leadership Board monthly until 90% compliance is met. Deficiencies will be tracked for completed actions as

indicated. The numerator equals deficiencies with open action items, denominator equals the total number of deficiencies..

OIG Contact and Staff Acknowledgments

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