DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Providence VA Medical Center in Rhode Island

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Figure 1. *Providence VA Medical Center in Rhode Island.*
Source: https://vaww.va.gov/directory/guide/ (accessed January 29, 2021).

Abbreviations

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

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Providence VA Medical Center and associated community-based outpatient clinics in Massachusetts and Rhode Island. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

1. COVID-19 pandemic readiness and response[1]

2. Quality, safety, and value

3. Registered nurse credentialing

4. Medication management (targeting remdesivir use)

5. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)

6. Care coordination (spotlighting inter-facility transfers)

7. High-risk processes (examining the management of disruptive and violent behavior)

The OIG conducted an unannounced review of the Providence VA Medical Center during the week of February 1, 2021. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the medical center's performance within the identified focus areas at the time of the OIG review. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this medical center and other Veterans Health Administration (VHA) facilities

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

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

Inspection Results

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

Leadership and Organizational Risks

At the time of the OIG's virtual review, the medical center's leadership team consisted of the Director, Chief of Staff, Associate Director for Patient Care/Nurse Executive, and Associate Director for Operations. Organizational communications and accountability were managed through the Executive Governing Board. In addition, the Quality, Safety, and Value Committee was responsible for tracking and trending quality of care and patient outcomes.

When the OIG conducted this inspection, medical center's leaders had worked together for over seven months. The Director had served in the role since June 2020, and the other team members had been in their positions for more than two years.

Employee satisfaction survey responses demonstrated satisfaction with leaders and maintenance of an environment where staff felt respected and discrimination was not tolerated, but responses also pointed to opportunities for the Chief of Staff and Director to improve feelings of servant leadership and reduce moral distress at work, respectively.[2] However, selected patient experience survey scores generally reflected similar or higher care ratings than the VHA average. Patients appeared satisfied with the care provided.

The inspection team also reviewed accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors.

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

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[2] "2020 VA All Employee Survey (AES): Questions by Organizational Health Framework," VA Workforce Surveys Portal, VHA Support Service Center, accessed July 29, 2021, http://aes.vssc.med.va.gov/SurveyInstruments/_layouts/15/DocIdRedir.aspx?ID=QQVSJ65U5ZMQ-229890423-174. (This is an internal website not publicly accessible.). The 2020 All Employee Survey defines the Servant Leader Index as a summary measure based on respondents' assessments of their supervisors' listening, respect, trust, favoritism, and response to concerns, and moral distress as being "unsure about the right thing to do or could not carry out what you believed to be the right thing."

way to understand the similarities and differences between the top and bottom performers within VHA.[3]

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific SAIL measures. In addition, leaders were able to speak about actions taken during the previous 12 months to maintain or improve organizational performance.

COVID-19 Pandemic Readiness and Response

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

Quality, Safety, and Value

The medical center complied with requirements for a committee responsible for quality, safety, and value oversight functions and protected peer reviews.[4] However, the OIG identified weaknesses in the Systems Redesign and Improvement Program and Surgical Work Group.

Medication Management

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

Care Coordination

Generally, the medical center met expectations for an inter-facility transfer policy, as well as monitoring and evaluation of inter-facility transfers. However, the OIG identified deficiencies with the transmission of patients' advance directives to receiving facilities and communication between nurses at sending and receiving facilities.

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

[4] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a "critical review of care, performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements.

Conclusion

The OIG conducted a detailed inspection across eight key areas (two administrative and six clinical) and subsequently issued three recommendations for improvement to the Director, Chief of Staff, and Associate Director for Patient Care. However, the number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. The intent is for medical center leaders to use the recommendations to help guide improvements in operations and clinical care. The recommendations address issues that may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes F and G, pages 51-52, 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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Contents

Purpose and Scope

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

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

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

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

1. Leadership and organizational risks

2. COVID-19 pandemic readiness and response[5]

3. Quality, safety, and value (QSV)

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

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

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

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

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

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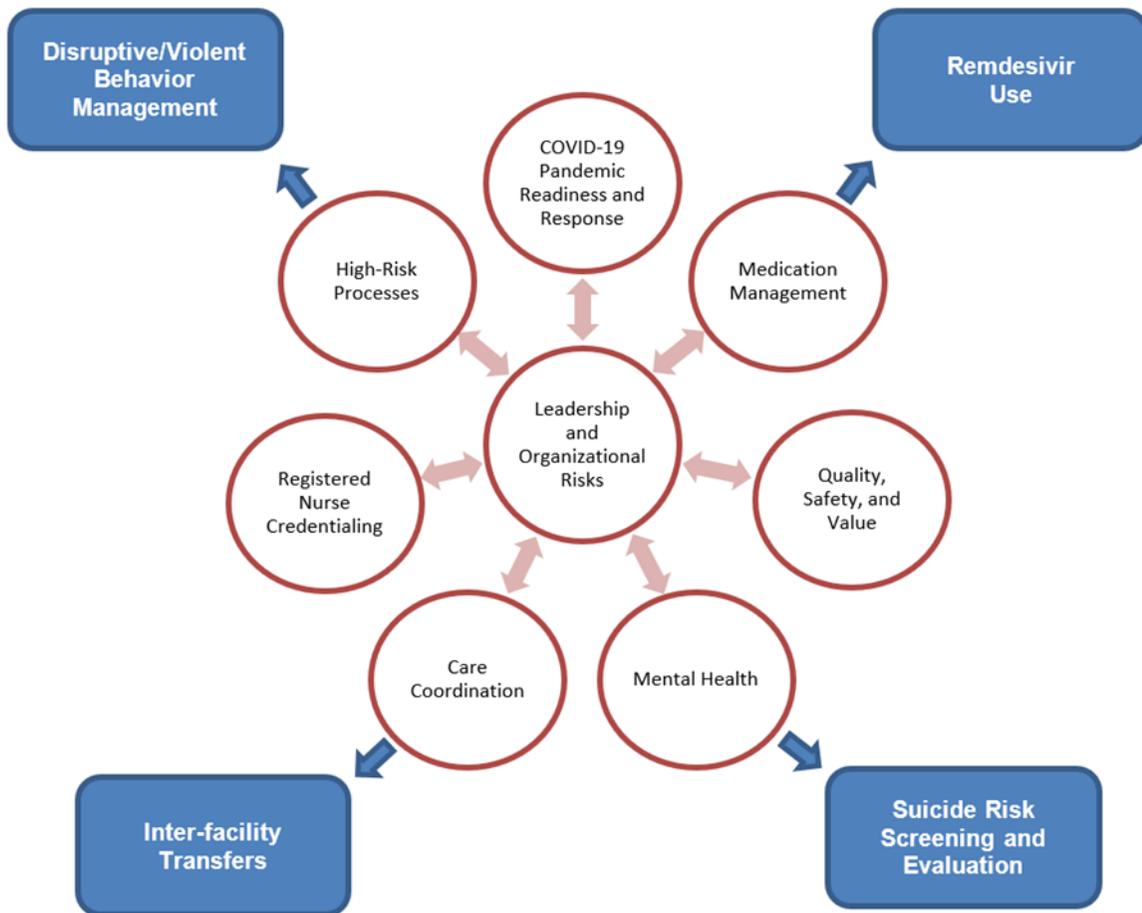

Figure 2*. Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services. Source: VA OIG.*

Methodology

The Providence VA Medical Center also provides care through multiple outpatient clinics in Massachusetts and Rhode Island. Additional details about the types of care provided by the medical center can be found in appendixes B and C.

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

The inspection examined operations from August 19, 2017, through February 5, 2021, the last day of the unannounced multiday evaluation.[7] During the virtual site visit, the OIG referred concerns that were beyond the scope of this inspection to the OIG's hotline management team for further review.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[8] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

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

[7] The range represents the time period from the prior CHIP site visit to the completion of the unannounced, multiday virtual CHIP visit in February 2021.

[8] Pub. L. No. 95-452, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3).

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA medical center. Leadership and organizational risks can affect a medical center's ability to provide care in the clinical focus areas.[9] To assess this medical center's risks, the OIG considered several indicators:

- Executive leadership position stability and engagement

- Budget and operations

- Staffing

- Employee satisfaction

- Patient experience

- Accreditation surveys and oversight inspections

- Identified factors related to possible lapses in care and the medical center's response

- VHA performance data (medical center)

Executive Leadership Position Stability and Engagement

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

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[9] Laura Botwinick, Maureen Bisognano, and Carol Haraden, *Leadership Guide to Patient Safety*, Institute for Healthcare Improvement, Innovation Series White Paper, 2006.
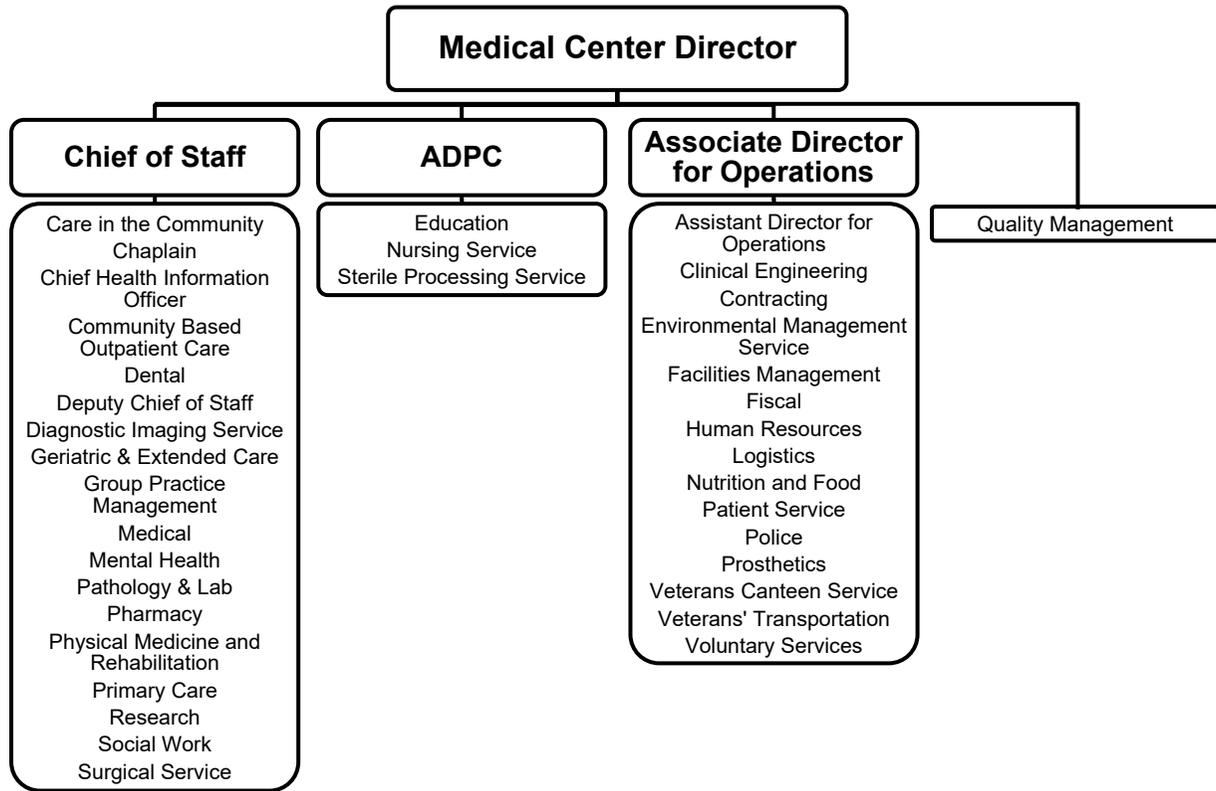
Figure 3. *Medical center organizational chart.*

Source: Providence VA Medical Center (received February 2, 2021).

At the time of the OIG inspection, the executive team had worked together for over seven months. The Director was the newest member of the executive team and had served in the role since June 2020. The other team members had been in their positions for more than two years (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	June 21, 2020
Chief of Staff	March 8, 2015
Associate Director for Patient Care	October 14, 2018
Associate Director	April 7, 2013

Source: Providence VA Medical Center, Senior Strategic Partner (received February 1, 2021).

To help assess the medical center executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, ADPC, and Associate Director regarding their knowledge of various

performance metrics and their involvement and support of actions to improve or sustain performance.

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific Strategic Analytics for Improvement and Learning (SAIL) measures. In individual interviews, the executive leadership team members were able to speak about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

The Director served as the chairperson of the Executive Governing Board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Governing Board oversaw various working groups such as the Administrative Leadership, Clinical Leadership, and Strategic Planning Committees. These leaders monitored patient safety and care through the Quality, Safety, and Value Committee, which was responsible for tracking and trending quality of care and patient outcomes and reported to the Executive Governing Board (see figure 4).

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                        ┌─────────────────────────────────┐
                        │   Executive Governing Board     │
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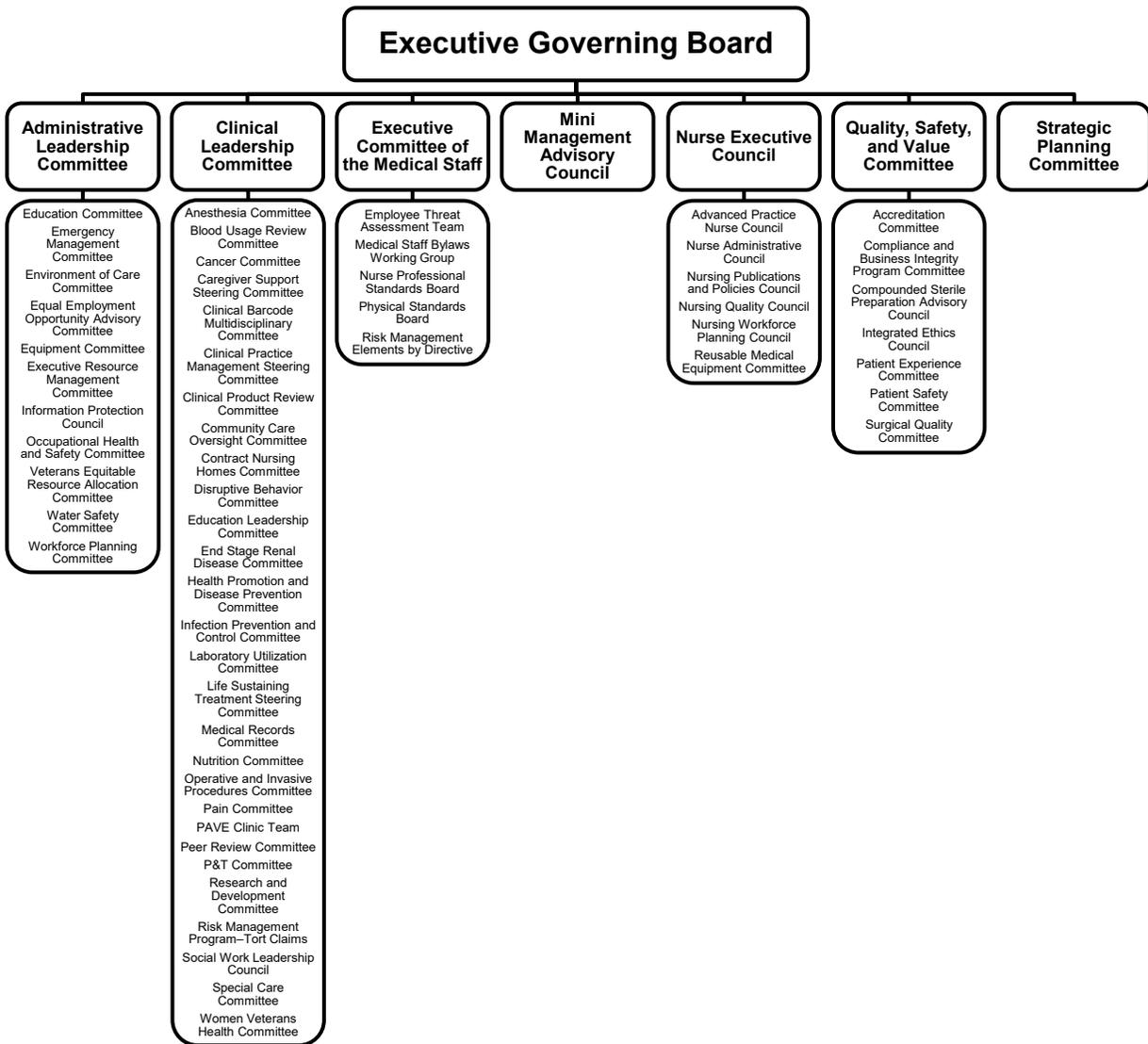| Administrative Leadership Committee	Clinical Leadership Committee	Executive Committee of the Medical Staff	Mini Management Advisory Council	Nurse Executive Council	Quality, Safety, and Value Committee	Strategic Planning Committee
Education Committee	Anesthesia Committee	Employee Threat Assessment Team		Advanced Practice Nurse Council	Accreditation Committee	
Emergency Management Committee	Blood Usage Review Committee	Medical Staff Bylaws Working Group		Nurse Administrative Council	Compliance and Business Integrity Program Committee	
Environment of Care Committee	Cancer Committee	Nurse Professional Standards Board		Nursing Publications and Policies Council	Compounded Sterile Preparation Advisory Council	
Equal Employment Opportunity Advisory Committee	Caregiver Support Steering Committee	Physical Standards Board		Nursing Quality Council	Integrated Ethics Council	
Equipment Committee	Clinical Barcode Multidisciplinary Committee	Risk Management Elements by Directive		Nursing Workforce Planning Council	Patient Experience Committee	
Executive Resource Management Committee	Clinical Practice Management Steering Committee			Reusable Medical Equipment Committee	Patient Safety Committee	
Information Protection Council	Clinical Product Review Committee				Surgical Quality Committee	
Occupational Health and Safety Committee	Community Care Oversight Committee					
Veterans Equitable Resource Allocation Committee	Contract Nursing Homes Committee					
Water Safety Committee	Disruptive Behavior Committee					
Workforce Planning Committee	Education Leadership Committee					
	End Stage Renal Disease Committee					
	Health Promotion and Disease Prevention Committee					
	Infection Prevention and Control Committee					
	Laboratory Utilization Committee					
	Life Sustaining Treatment Steering Committee					
	Medical Records Committee					
	Nutrition Committee					
	Operative and Invasive Procedures Committee					
	Pain Committee					
	PAVE Clinic Team					
	Peer Review Committee					
	P&T Committee					
	Research and Development Committee					
	Risk Management Program–Tort Claims					
	Social Work Leadership Council					
	Special Care Committee					
	Women Veterans Health Committee					

Figure 4. Medical center committee reporting structure.

Source: Providence VA Medical Center (received February 4, 2021).

P&T = Pharmacy & Therapeutics Committee.
PAVE = Prevention of Amputation in Veterans Everywhere.

Budget and Operations

The medical center's FY 2020 annual medical care budget of $351,790,821 increased almost 20 percent compared to the previous year's budget of $293,932,825.[10] When asked about the effect of this change on the medical center's operations, the Director indicated that 70 additional staff were hired in support of COVID-19 relief.

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[10] VHA Support Service Center.

Staffing

The Veterans Access, Choice, and Accountability Act of 2014 required the OIG to determine, on an annual basis, the VHA occupations with the largest staffing shortages.[11] Under the authority of the VA Choice and Quality Employment Act of 2017, the OIG conducts annual determinations of clinical and nonclinical VHA occupations with the largest staffing shortages within each medical facility.[12] In addition, the OIG has demonstrated a linkage between staffing shortages and negative effects on patient care delivery.[13]

Table 2 provides the top facility-reported clinical and nonclinical occupational shortages as reported in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[14] However, at the time of the virtual review, the Director indicated there were no critical staffing shortages. The Chief of Staff also reported that primary care physicians and psychiatrists were in high demand and described how moving expense reimbursements and recruitment bonuses were authorized to compete with the private sector for these professionals.

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Medical Officer	1. Medical Records Technician
2. Anesthesiology	2. Human Resources Management
3. Primary Care	3. Food Service Worker
4. Psychiatry	4. Human Resources Assistance
5. NP–Primary Care*	5. Medical Supply Aide and Technician

Source: VA OIG.

*NP = nurse practitioner.

Employee Satisfaction

The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." Since 2001, the instrument has been refined several

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

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

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

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

times in response to VA leaders' inquiries on VA culture and organizational health.[15] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical center leaders.

To assess employee attitudes toward medical center leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2019, through September 30, 2020.[16] Table 3 provides relevant survey results for VHA, the medical center, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG found the medical center averages for the selected survey leadership questions were similar to the VHA averages.[17] The medical center leaders' averages for the selected questions were similar to or higher than the VHA average, except for the Chief of Staff's score related to servant leadership.

Table 3. Survey Results on Employee Attitudes toward Medical Center Leaders (October 1, 2019, through September 30, 2020)

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPC Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	73.8	72.5	77.1	70.7	80.3	85.3
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.5	3.4	3.8	3.7	4.0	3.8

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

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

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

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPC Average	Assoc. Director Average
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.5	4.0	3.6	4.3	3.7
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.7	3.6	3.8	3.7	3.9	4.1

Source: VA All Employee Survey (accessed January 4, 2021).

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

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[18] The medical center averages for the selected survey questions were similar to the VHA averages. The leaders' averages were generally better than those for VHA and the medical center; however, opportunities appeared to exist for the Director to reduce employee feelings of moral distress at work (uncertainty about the right thing to do or inability to carry out what you believed to be the right thing).

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

**Table 4. Survey Results on Employee Attitudes toward the Workplace
(October 1, 2019, through September 30, 2020)**

Questions/Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPC Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree)– 5 (Strongly Agree)	3.8	3.8	4.2	3.9	4.1	4.5
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree)– 5 (Strongly Agree)	3.8	3.8	4.1	4.3	4.5	4.1
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never)– 6 (Every Day)	1.4	1.3	1.6	1.3	1.3	1.3

Source: VA All Employee Survey (accessed January 4, 2021).

VHA leaders have articulated that the agency "is committed to a harassment-free healthcare environment." To this end, leaders initiated the "End Harassment" and "Stand Up to Stop

Harassment Now!" campaigns to help create a culture of safety where staff and patients feel secure and respected.[19]

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. The medical center and executive leadership team averages for the selected survey questions were similar to or better than the VHA average. Leaders appeared to maintain an environment where staff felt respected and safe and discrimination was not tolerated.

Table 5. Survey Results on Employee Attitudes toward Workgroup Relationships (October 1, 2019 through September 30, 2020)

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPC Average	Assoc. Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree)– 5 (Strongly Agree)	3.9	4.0	4.4	4.4	4.1	4.2
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree)– 5 (Strongly Agree)	4.1	4.2	4.6	4.8	4.3	4.4
Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree)– 5 (Strongly Agree)	3.8	3.8	4.2	4.3	3.9	4.1

Source: VA All Employee Survey (accessed January 4, 2021).

Patient Experience

To assess patient experiences with the medical center, which directly reflect on its leaders, the OIG team reviewed survey results from October 1, 2019, through September 30, 2020. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and support benchmarking its performance against the private sector.

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

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 6 provides relevant survey results for VHA and the medical center.[20] Patients appeared satisfied with the care provided.

**Table 6. Survey Results on Patient Experience
(October 1, 2019, through September 30, 2020)**

Questions	Scoring	VHA Average	Medical Center Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	69.5	71.3
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	82.5	88.6
Survey of Healthcare Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	84.8	88.3

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2020).

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans by 2048.[21] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

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

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

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

be actively engaged with male and female patients (for example, by assigning female providers and staffing a separate clinic to provide services for women veterans).

Table 7. Inpatient Survey Results on Experiences by Gender (October 1, 2019, through September 30, 2020)

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average‡
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.5	71.3	–
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	84.8	83.8	–
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	85.1	83.3	91.2	–

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 20, 2020).

*The VHA averages are based on 48,907–49,521 male and 2,395–2,423 female respondents, depending on the question.

†The medical center averages are based on 387–397 male respondents, depending on the question.

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

Table 8. Patient-Centered Medical Home Survey Results on Patient Experiences by Gender (October 1, 2019, through September 30, 2020)

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.3	44.0	57.1	70.9

Questions	Scoring	VHA*		Medical Center	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.5	53.0	61.1	63.2
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.0	68.9	77.5	80.6

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 20, 2020).

*The VHA averages are based on 74,278–223,617 male and 6,158–13,836 female respondents, depending on the question.

†The medical center averages are based on 318–1,120 male and 16–56 female respondents, depending on the question.

Table 9. Specialty Care Survey Results on Patient Experiences by Gender (October 1, 2019, through September 30, 2020)

Questions	Scoring	VHA*		Medical Center†	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.5	47.3	60.9	47.7
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.4	54.3	61.4	66.7

Questions	Scoring	VHA*		Medical Center	
		Male Average	Female Average	Male Average	Female Average
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.2	77.1	67.6

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 20, 2020).

**The VHA averages are based on 63,661–187,441 male and 3,777–10,616 female respondents, depending on the question.*

†*The medical center averages are based on 469–1,314 male and 19–54 female respondents, depending on the question.*

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders responded to identified problems.[22] Table 10 summarizes the relevant medical center inspections most recently performed by the OIG and The Joint Commission (TJC).[23] At the time of the OIG review, the medical center had closed all recommendations for improvement issued since the previous CHIP site visit conducted in August 2017.

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

[23] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. TJC provides an "internationally accepted external validation that an organization has systems and processes in place to provide safe and quality-oriented health care." TJC "has been accrediting VA medical facilities for over 35 years." Compliance with TJC standards "facilitates risk reduction and performance improvement."

The OIG team also noted the medical center's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[24]

Table 10. Office of Inspector General Inspection/The Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection Program Review of the Providence VA Medical Center, Providence, Rhode Island*, Report No. 17-01761-129, March 21, 2018)	August 2017	12	0
TJC Hospital Accreditation	March 2018	28	0
TJC Behavioral Health Care Accreditation		5	0
TJC Home Care Accreditation		18	0

Source: OIG and TJC (inspection/survey results received from the Chief of Quality Management and Accreditation Coordinator on February 1, 2021).

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

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms.

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

Table 11 lists the reported patient safety events from August 19, 2017 (the prior OIG CHIP site visit), through February 1, 2021.[25]

**Table 11. Summary of Selected
Organizational Risk Factors
(August 19, 2017, through February 1, 2021)**

Factor	Number of Occurrences
Sentinel Events	2
Institutional Disclosures	2
Large-Scale Disclosures	0

*Source: Providence VA Medical Center's Chief of Staff and
Patient Safety Officer (received February 2 and 5, 2021).*

## Veterans Health Administration Performance Data for the Medical Center

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency." Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[26]

Figure 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2020. Figure 5 shows the Providence VA Medical Center's performance in the first through fifth quintiles. Those in the

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[25] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (The Providence VA Medical Center is a mid-high complexity (1c) affiliated system as described in appendix B.) VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life." Additionally, as stated in VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") as "a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse." Lastly, in VHA Directive 1004.08, VHA defines large-scale disclosures of adverse events (sometimes referred to as "notifications") as "a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue."

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

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first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, in the areas of care transition, rating (of) primary care (PC) provider, and rating (of) hospital). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, health care (HC) associated (assoc) infections, adjusted length of stay (LOS), and acute care 30-day standardized mortality ratio (SMR30)).[27]
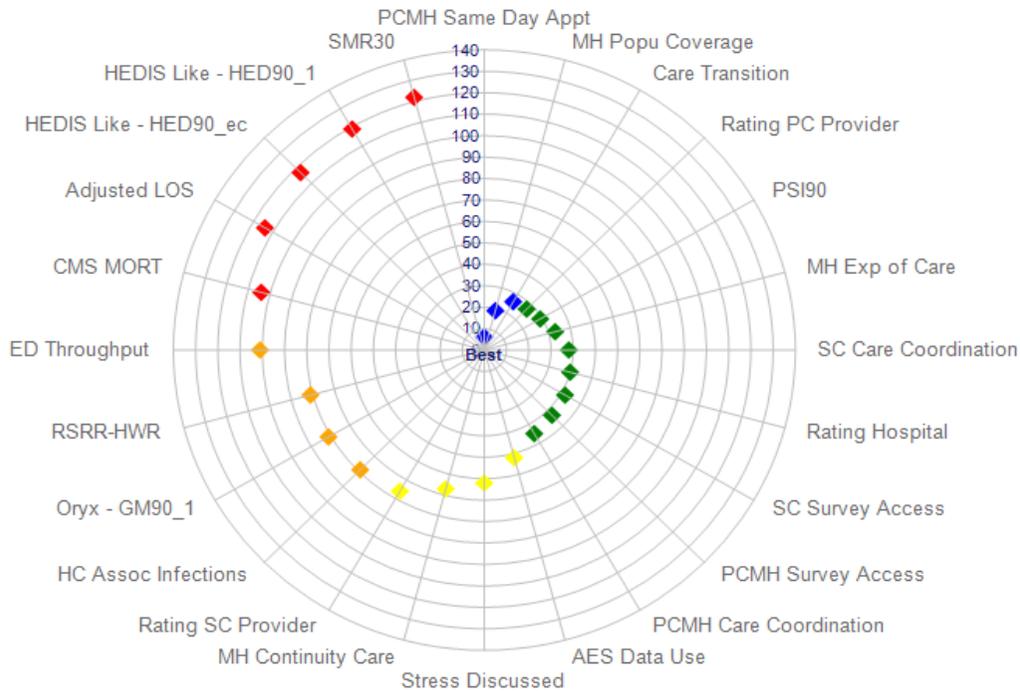
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

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

Source: VHA Support Service Center.

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

Leadership and Organizational Risks Findings and Recommendations

The medical center's executive leadership positions were filled at the time of OIG's review, and the team had worked together for over seven months. The Director had served in the role since June 2020, and the other team members had been in their positions for more than two years.

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

The Director was able to speak about the effect of the FY 2020 annual budget increase, and the Chief of Staff was able to discuss interim strategies taken to address historical occupational shortages.

Employee satisfaction survey responses demonstrated satisfaction with leaders and maintenance of an environment where staff felt respected and discrimination was not tolerated, but responses also pointed to opportunities for the Chief of Staff and Director to improve feelings of servant leadership and reduce moral distress at work, respectively. Patient experience survey data indicated satisfaction with the care provided. Further, the OIG found that selected survey results for male and female respondents were generally more favorable than VHA patients nationally.

The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors.

In addition, the executive leaders were knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL model and were able to speak about actions taken during the previous 12 months to maintain or improve organizational performance.

The OIG made no recommendations.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic.[28] VHA subsequently issued its *COVID-19 Response Plan* on March 23, 2020, which presents strategic guidance on prevention of viral transmission among veterans and staff and appropriate care for sick patients.[29]

During this time, VA continued providing care to veterans and engaged its fourth mission, the "provision of hospital care and medical services during certain disasters and emergencies" to persons "who otherwise do not have VA eligibility for such care and services."[30] "In effect, VHA facilities provide a safety net for the nation's hospitals should they become overwhelmed—for veterans (whether previously eligible or not) and non-veterans."[31]

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

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

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

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

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

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

[30] 38 U.S.C. § 1785. VA's missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA's fourth mission, the provision of hospital care and medical services during certain disasters and emergencies "During and immediately following a disaster or emergency…VA under 38 U.S.C. § 1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency."

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

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high quality, safe, reliable, and veteran-centered care.[32] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[33] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."[34]

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

- Review of aggregated QSV data

- Recommendation and implementation of improvement actions

- Monitoring of fully implemented improvement actions

The OIG reviewers also assessed the medical center's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization." Systems redesign and improvement processes drive organizational change toward the goal of "zero harm" and can create strong cultures of safety. VHA implemented systems redesign and improvement programs to "optimize Veterans' experience by providing services to develop self-sustaining improvement capability."[35] The OIG team examined various requirements related to systems redesign and improvement:

- Designation of a systems redesign and improvement coordinator

- Tracking of facility-level performance improvement capability and projects

- Participation on the facility quality management committee and VISN Systems Redesign Review Advisory Group

- Staff education on performance improvement principles and techniques

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[32] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

[33] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.

[34] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.

[35] VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

Next, the OIG assessed the medical center's processes for conducting protected peer reviews of clinical care.[36] Protected peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[37] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[38] The OIG team examined the completion of the following elements:

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)

- Peer review of all applicable deaths within 24 hours of admission to the hospital

- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[39]

- Completion of final reviews within 120 calendar days

- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[40]

- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

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

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

[37] VHA Directive 1190.

[38] VHA Directive 1190.

[39] VHA Directive 1190.

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

(2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select specialty programs."[41] The medical center's performance was assessed on several dimensions:

- Assignment and duties of a chief of surgery

- Assignment and duties of a surgical quality nurse (registered nurse)

- Establishment of a surgical work group with required members who meet at least monthly

- Surgical work group tracking and review of quality and efficiency metrics

- Investigation of adverse events[42]

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, National Surgery Office reports, and other relevant information.[43]

Quality, Safety, and Value Findings and Recommendations

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

VHA requires the Systems Redesign and Improvement Coordinator to track "facility level improvement capabilities and projects."[44] The OIG reviewed Quality, Safety, and Value Committee minutes for meetings held from January 22 through December 24, 2020, and found no evidence that the coordinator tracked improvement capabilities and projects for three of four quarters. This may have resulted in missed opportunities to identify resources needed to implement improvement activities. The Assistant Director for Operations (former Chief of Quality Management) reported that improvement capabilities and projects were not tracked due to time constraints imposed by the COVID-19 pandemic.

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

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

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

[44] VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

Recommendation 1

1. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that the Systems Redesign and Improvement Coordinator tracks facility-level improvement capabilities and projects.

Medical Center concurred.

Target date for completion: 02/01/2022

Medical Center response: The reasons for noncompliance were considered when developing the action plan.

The Chief of Quality Management and Systems Redesign Coordinator reviewed the process of capturing and documenting facility-level capabilities and projects. To comply with VHA Directive 1026.01; a decision was made to utilize the VHA's National Quality Improvement Tracking Tool (QuITT) to track project progress and outcomes more effectively while contributing to nation-wide VHA knowledge and sharing. In addition, the Systems Redesign Coordinator is developing a collaborative process with all Providence VA Healthcare System (PVAHS) service points-of-contact to utilize the National project tracker database. An initial system-wide PVAHS project list will be input into this tracker and reported out at the September 23, 2021 Quality, Safety and Value (QSV) Committee meeting.

Furthermore, VISN 1 has decided as of October 1, 2021, to retire their VISN 1 Culture of Improvement (CoI) project tracker and utilize QuITT as a mode to standardize project tracking. All Systems Redesign Coordinators within VISN 1 will input all Lean Yellow Belt projects and any other local projects. Lean Six Sigma Green Belt and Black Belt projects will be input by a VISN 1 Performance Improvement Specialist. Locally, the Systems Redesign Coordinator will continue to work with all PVAHS services to further capture and log all system-wide improvement projects into the database as well as perform periodic updates to the database as needed.

To ensure facility-level improvement capabilities and projects are being captured appropriately, the Systems Redesign Coordinator or Designee will provide an updated report from the VHA National QuITT application quarterly to the QSV Committee. Compliance will be tracked by Quality Management.

Failure to report or failure to include essential data in quarterly reporting will trigger specific and measurable action plans and interventions to bring performance to 100 percent compliance. Continued monitoring will be performed and documented by Quality Management until 100 percent compliance is maintained for 6 consecutive months with an expected completion date by February 1, 2022.

VHA requires medical facilities that have surgery programs to have a surgical work group responsible for the "monthly review of surgical deaths, an analysis of efficiency and utilization metrics, an identification of gaps within current surgical care, a review of NSO [National Surgery Office] surgical quality reports, and evaluation of critical surgical events."[45] The OIG reviewed the Surgical Work Group meeting minutes from January 15, 2020, through January 20, 2021, and found that the group did not meet for 4 of 12 months. Failure to consistently review and analyze surgical program data could result in missed opportunities to identify issues in the practice of one or more providers. The Chief of Surgery stated that Surgical Work Group meetings were cancelled due to the COVID-19 pandemic.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that the Surgical Work Group meets monthly.

Medical Center concurred.

Target date for completion: 02/01/2022

Medical Center response: The reasons for noncompliance were considered when developing the action plan.

The Acting Chief of Staff and Acting Chief of Surgery reviewed the VHA Directive 1102.01(1), National Surgery Office, April 24, 2019, amended May 22, 2019. To comply with the directive, the Acting Chief of Surgery will ensure the Surgical Work Group meets monthly to consistently review and analyze surgical program data to identify issues in the practice of one or more providers.

The Surgical Work Group Chair or designated recorder will provide Surgical Work Group minutes to the Quality Management SharePoint site on a monthly basis for compliance tracking. Compliance will be reported to the Quality, Safety and Value (QSV) Committee as part of the quarterly accreditation report.

Failure to conduct monthly meetings, upload monthly meeting minutes or include essential data to Quality Management will trigger specific and measurable action plans and interventions to bring performance to 100 percent compliance. Continued monitoring will be performed and documented by Quality Management until 100 percent compliance is maintained for 6 consecutive months with an expected completion date by February 1, 2022.

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

Registered Nurse Credentialing

VHA has defined procedures for the credentialing of registered nurses (RNs) that include verification of "professional education, training, licensure, certification, registration, previous experience, including documentation of any gaps (greater than 30 days) in training and employment, professional references, adverse actions, or criminal violations, as appropriate."[46] Licensure is defined by VHA as "the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State in the form of a license and/or registration."[47]

VA requires all RNs to hold at least one active, unencumbered license.[48] Individuals who hold a license in more than one state are not eligible for RN appointment if a state has terminated the license for cause or if the RN voluntarily relinquished the license after written notification from the state of potential termination for cause.[49] When an action has been "taken against [an] applicant's sole license or against any of the applicant's licenses, a review by the Chief, Human Resources Management Service, or the Regional Counsel, must be completed to determine whether the applicant satisfies VA's licensure requirements," and documented as required.[50] Additionally, all current and previously held licenses must be verified from the primary or original source and documented in VetPro, VHA's electronic credentialing system, prior to appointment to a VA medical facility.[51]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 39 RNs hired from January 1, 2020, through January 3, 2021. The OIG determined whether

- the RNs were free from potentially disqualifying licensure actions, or

- the Chief, Human Resources Management Service or Regional Counsel determined that the RNs met VA licensure requirements.

The OIG also reviewed credentialing files for 30 of the 39 RNs to determine whether medical center staff completed primary source verification prior to the appointment.

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

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

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

[49] 38 U.S.C. § 7402.

[50] VHA Directive 2012-030.

[51] VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

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

Medication Management: Remdesivir Use in VHA

On May 1, 2020, the Food and Drug Administration (FDA) authorized the emergency use of remdesivir. At that time, remdesivir was an unapproved, investigational antiviral medication for the treatment of adults and children hospitalized with severe COVID-19.[52] The FDA provided information on specific laboratory tests to be ordered prior to and during the administration of remdesivir. Additionally, the FDA required providers to report potentially related adverse events.[53]

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.[54] Due to the limited supply and specific storage requirements of remdesivir, VA needed someone to be available 24 hours a day, 7 days a week to accept overnight, cold-chain shipments of the drug and report any unused medication to the Emergency Pharmacy Services group.[55]

On August 28, 2020, the FDA amended the Emergency Use Authorization criteria for remdesivir to include "suspected or laboratory-confirmed COVID-19 in all hospitalized adult and pediatric patients."[56] The FDA subsequently approved remdesivir October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.[57]

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

- Staff availability to receive medication shipments

- Medication orders used proper name

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

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

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

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

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

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

- Staff determined patients met criteria for receiving medication prior to administration

- Required testing completed prior to medication administration for

  o Potential pregnancy

  o Kidney assessment (estimated glomerular filtration rate)[58]

  o Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)[59]

- Patient/caregiver education provided

- Staff reported any adverse events to the FDA

Medication Management: Findings and Recommendations

The OIG team observed general compliance with many elements of expected performance, including the availability of staff to receive remdesivir shipments, proper naming of medication orders, completion of required testing prior to remdesivir administration, and reporting of adverse events. However, the OIG identified deficiencies with patient/caregiver education.

Under the Emergency Use Authorization, VA Pharmacy Benefits Management Services required healthcare providers to provide the "Fact Sheet for Patients and Parents/Caregivers," inform patients or caregivers that remdesivir was not an FDA-approved medication, provide the option to refuse the medication, and advise patients or caregivers of known risks, benefits, and alternatives to remdesivir prior to administration.[60]

Of the eight patients who received remdesivir, the OIG found that clinical staff did not

- provide any of the patients or caregivers the "Fact Sheet for Patients and Parents/Caregivers,"

- inform 25 percent of patients or caregivers that remdesivir was not an FDA-approved drug,

- inform 63 percent of patients or caregivers of the option to refuse the medication,

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

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

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

- inform 75 percent of patients or caregivers of the known risks or benefits, and

- advise 88 percent of patients or caregivers of alternatives to receiving remdesivir prior to administration.

This could have resulted in patients or caregivers lacking the information needed to make a fully informed decision to receive the medication. The Chief of Pharmacy reported believing that the facility was meeting requirements.

Given the FDA's approval of remdesivir for use in adult patients requiring hospitalization for the treatment of COVID-19, the OIG made no recommendations related to Emergency Use Authorization requirements.[61]

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

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

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.[62] The suicide rate for veterans was 1.5 times greater than for nonveteran adults and estimated to represent approximately 13.8 percent of all suicide deaths in the United States during 2018.[63] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[64]

VHA has implemented various evidence-based approaches to reduce veteran suicides. In addition to expanded mental health services and community outreach, VHA has adopted a three-phase process to screen and assess for suicide risk in most clinical settings. The phases include primary and secondary screens and a comprehensive assessment. However, screening for patients seen in emergency departments or urgent care centers begins with the secondary screen, the Columbia-Suicide Severity Rating Scale, and subsequent completion of the Comprehensive Suicide Risk Assessment when screening is positive.[65] The OIG examined whether staff initiated the Columbia-Suicide Severity Rating Scale and completed all required elements.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from the emergency department or urgent care center.[66] The medical center was assessed for its adherence to the following requirements for suicide safety plans:

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

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

- relevant documents;

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

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

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

[65] Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum, *Suicide Risk Screening and Assessment Requirements*, May 23, 2018.

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

- the electronic health records of 46 randomly selected patients who were seen in the emergency department/urgent care center from December 1, 2019, through August 31, 2020; and

- staff training records.

Mental Health Findings and Recommendations

The medical center met the requirements listed above; therefore, the OIG made no recommendations.

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.[67]

VHA medical facility directors are "responsible for ensuring that a written policy is in effect that ensures the safe, appropriate, orderly, and timely transfer of patients." Further, VHA staff are required to use the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record to monitor and evaluate all transfers.[68]

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

- Existence of a facility policy for inter-facility transfers

- Monitoring and evaluation of inter-facility transfers

- Completion of all required elements of the *Inter-Facility Transfer Form* or facility-defined equivalent by the appropriate provider(s) prior to patient transfer

- Transmission of patient's active medication list and advance directive to the receiving facility

- Communication between nurses at sending and receiving facilities

To determine whether the medical center complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 39 patients who were transferred from the medical center due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

The medical center complied with many of the requirements for inter-facility patient transfers. However, the OIG identified deficiencies with staff sending patients' advance directives to receiving facilities and nurse-to-nurse communication between facilities.

VHA requires that the Chief of Staff and ADPC ensure that patients' advance directives are sent to the receiving facility.[69] The OIG determined that for all 15 patients with advance directives,

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

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

[69] VHA Directive 1094.

the electronic health records lacked evidence that staff sent a copy to the receiving facility during the transfer. As a result, there was no assurance that receiving facility staff could determine patient preferences regarding future health care decisions at transfer. The Administrative Officer, Department of Medicine reported documentation errors were due to frequent rotations of resident trainees, inpatient attending physicians, and part-time physicians. Due to the small number of patients identified for the advance directive requirement, the OIG made no recommendation.

VHA states that nurse-to-nurse communication during the inter-facility transfer process is essential and allows for questions and answers at both sending and receiving facilities.[70] The OIG did not find evidence that nurse-to-nurse communication occurred in an estimated 49 percent of inter-facility transfers.[71] This could have resulted in receiving staff lacking information needed to care for patients. The Administrative Officer, Department of Medicine and Associate Director for Patient Care reported that physicians accompanied patients to the receiving facilities during emergent transfers, and therefore, nurse-to-nurse communication did not occur.

Recommendation 3

3. The Associate Director for Patient Care evaluates and determines any additional reasons for noncompliance and ensures nurse-to-nurse communication occurs between sending and receiving facilities.

Medical Center concurred.

Target date for completion: 03/01/2022

Medical Center response: The reasons for noncompliance were considered when developing the action plan.

The Associate Director for Patient Care (ADPC), Chief of Quality Management and Emergency Department Leadership reviewed the process and identified gaps in nurse-to-nurse communication for Providence VA Health System (PVAHS) interfacility transfers to both VA and non-VA facilities. In addition, the VISN 1 Flow Coordinator was consulted as there is a current VISN 1 task force initiative to standardize the interfacility transfer process.

The VISN 1 interfacility task force was convened in Spring 2021 with the goal to develop a VISN-level standardized process to ensure all VISN 1 facilities uniformly meet VHA Directive 1094 requirements, incorporate content of VA Forms 10-2649A and 10-2649B, and reflect overall best practices for interfacility transfer communications.

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[70] VHA Directive 1094.

[71] The OIG estimated that 95 percent of the time, the true compliance rate is between 35.7 and 66.7 percent, which is statistically significantly below the 90 percent benchmark.

The VISN 1 initiative will be presented to VISN 1 leadership for approval with a plan for implementation set for Fall 2021. Once fully in use, any previously used templates will be removed from use to prevent confusion and the VISN will be responsible for providing oversight and maintaining ongoing compliance.

Though a VISN-level initiative is set in place for Fall 2021, a collaborative decision was made by PVAHS leadership to develop an immediate facility-level plan to address the identified deficiencies as set forth in this recommendation with the intent to move to the new VISN process when implemented. For interfacility transfers initiated from the PVAMC [Providence VA Medical Center] Emergency Department, the plan specifically addresses some facilities that currently request a single handoff report process via a physician handoff. The new process now includes a concomitant physician-nurse communication with the receiving facility triage Registered Nurse. This communication will allow both physician and nurse communication that allows for questions and answers at both sending and receiving facilities. For other PVAHS interfacility transfers, the expectation for a nurse-to-nurse communication will be reinforced with PVAHS nursing staff as part of the new template training in August 2021. Any barriers identified in relation to communications with receiving facilities will be addressed through PVAHS ADPC collaborative intervention and facilitation with those particular facilities, as needed.

Compliance with documentation requirements for nurse-to-nurse communication were achieved through the addition of a templated interfacility nurse-to-nurse communication section in the nursing discharge note that includes: 1) the date/time nurse-to-nurse communication was performed, 2) the sending/receiving facility Registered Nurses who participated in the handoff communication, and 3) attestation that questions were addressed, along with any pertinent information stemming from that conversation, as needed. This template was approved by the Medical Records Committee for implementation by September 1, 2021. The Nursing Education Service is responsible for training and education on the new template to be completed during August 2021.

To ensure compliance with Directive 1094 and this recommendation, both PVAHS and VISN 1 monitoring systems have been put in place. A VISN-based monitoring tool was initiated in June 2021 and is currently in use at PVAHS. The Emergency Department Nurse Manager is responsible for performing daily record audits for each interfacility transfer with the intent to immediately respond to any deficiencies, including documentation of nurse-to-nurse communication. Monitor results will be reported to the Nursing Administration Council and submitted to the VISN 1 CMO [Chief Medical Officer] on a monthly basis for review and action, as needed. In addition, these reports will be reported quarterly to the Quality, Safety and Value Committee as part of the quarterly accreditation report. The VISN 1 will additionally aggregate all facility reports for further quality improvement and monitoring.

Failure to report or failure to meet a benchmark of at least 90 percent compliance with nurse-to-nurse communication documentation will trigger specific and measurable action plans and

interventions to bring performance up to benchmark. Continued monitoring will be performed and documented by the Nursing Administration Council and Quality Management until 90 percent compliance is maintained for 6 consecutive months with an expected completion date by March 1, 2022.

High-Risk Processes: Management of Disruptive and Violent Behavior

VHA defines disruptive behavior as "behavior by any individual that is intimidating, threatening, dangerous, or that has, or could, jeopardize the health or safety of patients, Department of Veterans Affairs (VA) employees, or individuals at the facility."[72] Balancing the rights and healthcare needs of violent and disruptive patients with the health and safety of other patients, visitors, and staff poses a significant challenge for VHA facilities. VHA has "committed to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety."[73] The OIG examined various requirements for the management of disruptive and violent behavior:

- Development of a policy for reporting and tracking disruptive behavior

- Implementation of an employee threat assessment team[74]

- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[75]

- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[76]

- Patient notification of an Order of Behavioral Restriction

- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[77]

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

[73] VHA Directive 2012-026.

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

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

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

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

VHA also requires that all staff complete part 1 of the prevention and management of disruptive behavior training within 90 days of hire. The Workplace Behavioral Risk Assessment results are used to assign additional levels of training. When the assessment results deem a facility location as low or moderate risk, staff working in the area are also required to complete part 2 of the training. When results indicate high risk, staff are required to complete parts 1, 2, and 3 of the training.[78] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[79] The OIG assessed staff compliance with the completion of required training.

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

High-Risk Processes Findings and Recommendations

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

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

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

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines three OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Director, Chief of Staff, and ADPC. The intent is for these leaders to use the recommendations to guide improvements in operations and clinical care. The recommendations address findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

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

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

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination: Inter-facility Transfers	• Inter-facility transfer policy • Inter-facility transfer monitoring and evaluation • Inter-facility transfer form/facility-defined equivalent with all required elements completed by the appropriate provider(s) prior to patient transfer • Patient's active medication list and advance directive sent to receiving facility • Communication between nurses at sending and receiving facilities	• Nurse-to-nurse communication occurs between sending and receiving facilities.	• None
High-Risk Processes: Management of Disruptive and Violent Behavior	• Policy for reporting and tracking of disruptive behavior • Employee threat assessment team implementation • Disruptive behavior committee or board establishment • Disruptive Behavior Reporting System use • Patient notification of an Order of Behavioral Restriction • Annual Workplace Behavioral Risk Assessment with involvement from required participants • Mandatory staff training	• None	• None

Appendix B: Medical Center Profile

The table below provides general background information for this mid-high complexity (1c) affiliated medical center reporting to VISN 1.[1]

Table B.1. Profile for Providence VA Medical Center (650)
(October 1, 2017, through September 30, 2020)

Profile Element	Medical Center Data FY 2018*	Medical Center Data FY 2019†	Medical Center Data FY 2020‡
Total medical care budget	$287,956,236	$293,932,825	$351,790,821
Number of:			
• Unique patients	35,458	36,765	34,367
• Outpatient visits	478,228	487,101	455,906
• Unique employees§	1,257	1,287	1,277
Type and number of operating beds:			
• Medicine	44	44	44
• Mental health	17	17	17
• Surgery	12	12	12
Average daily census:			
• Medicine	29	28	28
• Mental health	13	13	11
• Surgery	6	5	4

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

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

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

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[1] "Facility Complexity Model," VHA Office of Productivity, Efficiency & Staffing (OPES), accessed August 20, 2021, http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx. (This is an internal website not publicly accessible.) An affiliated medical center is associated with a medical residency program. VHA medical centers are classified according to a facility complexity model; a designation of "1c" indicates a facility with "medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs."

Appendix C: VA Outpatient Clinic Profiles

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

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

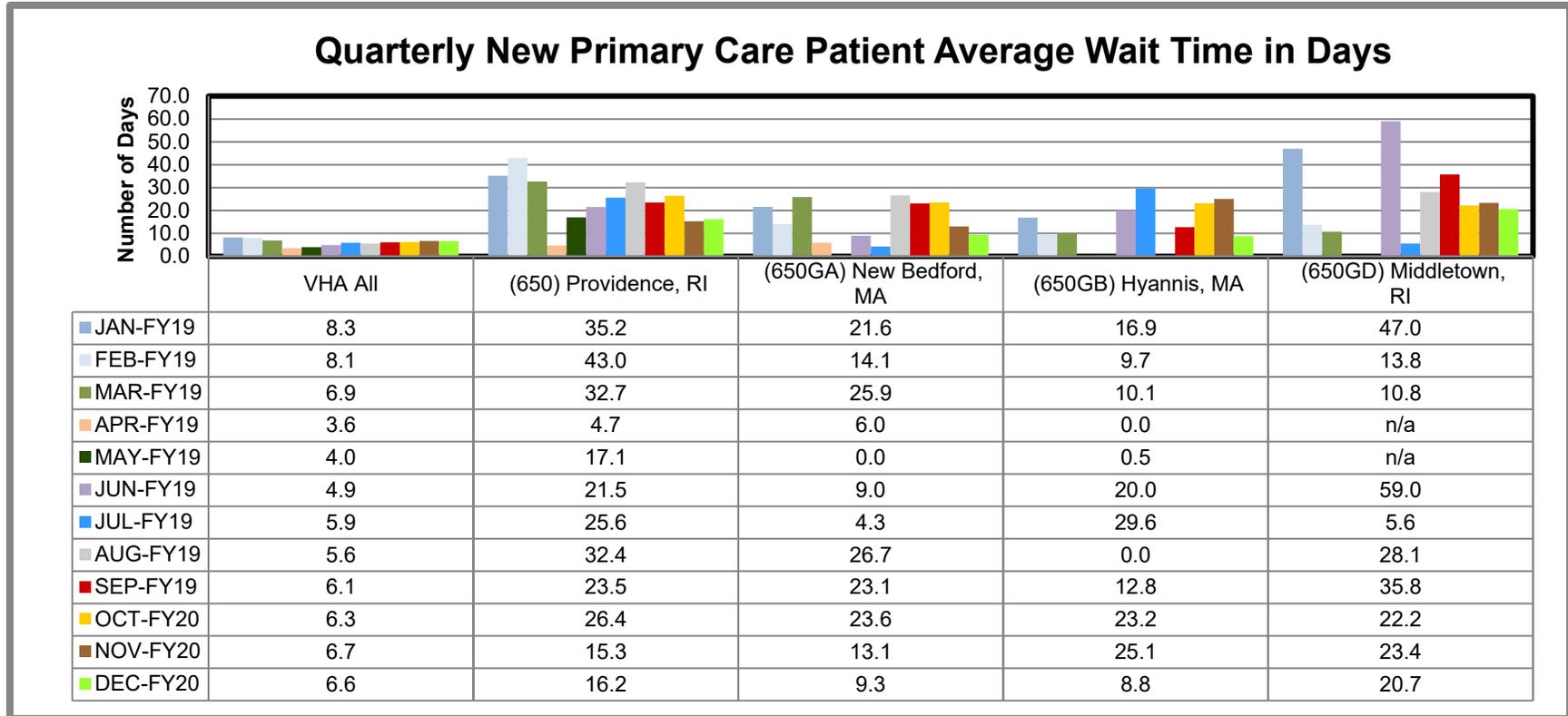| Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
New Bedford, MA	650GA	8,027	3,067	Cardiology Dermatology Gastroenterology Neurology Poly-Trauma	EKG Radiology Vascular lab	Nutrition Pharmacy

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[1] VHA Directive 1230(4), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended June 17, 2021. An encounter is a "professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient's condition." Specialty care services refer to non-primary care and non-mental health services provided by a physician.

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Hyannis, MA	650GB	6,112	2,640	Allergy Anesthesia Cardiology Dermatology Endocrinology Gastroenterology General Surgery Neurology Orthopedics Otolaryngology Podiatry Pulmonary/ Respiratory disease Urology Vascular	EKG Vascular lab	Nutrition Pharmacy Weight management
Middletown, RI	650GD	4,845	1,866	Cardiology Dermatology Hematology/ Oncology	EKG	Nutrition Pharmacy
Providence, RI	650QA	–	486	Eye	–	Prosthetics

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

Note: The OIG did not assess VA's data for accuracy or completeness.
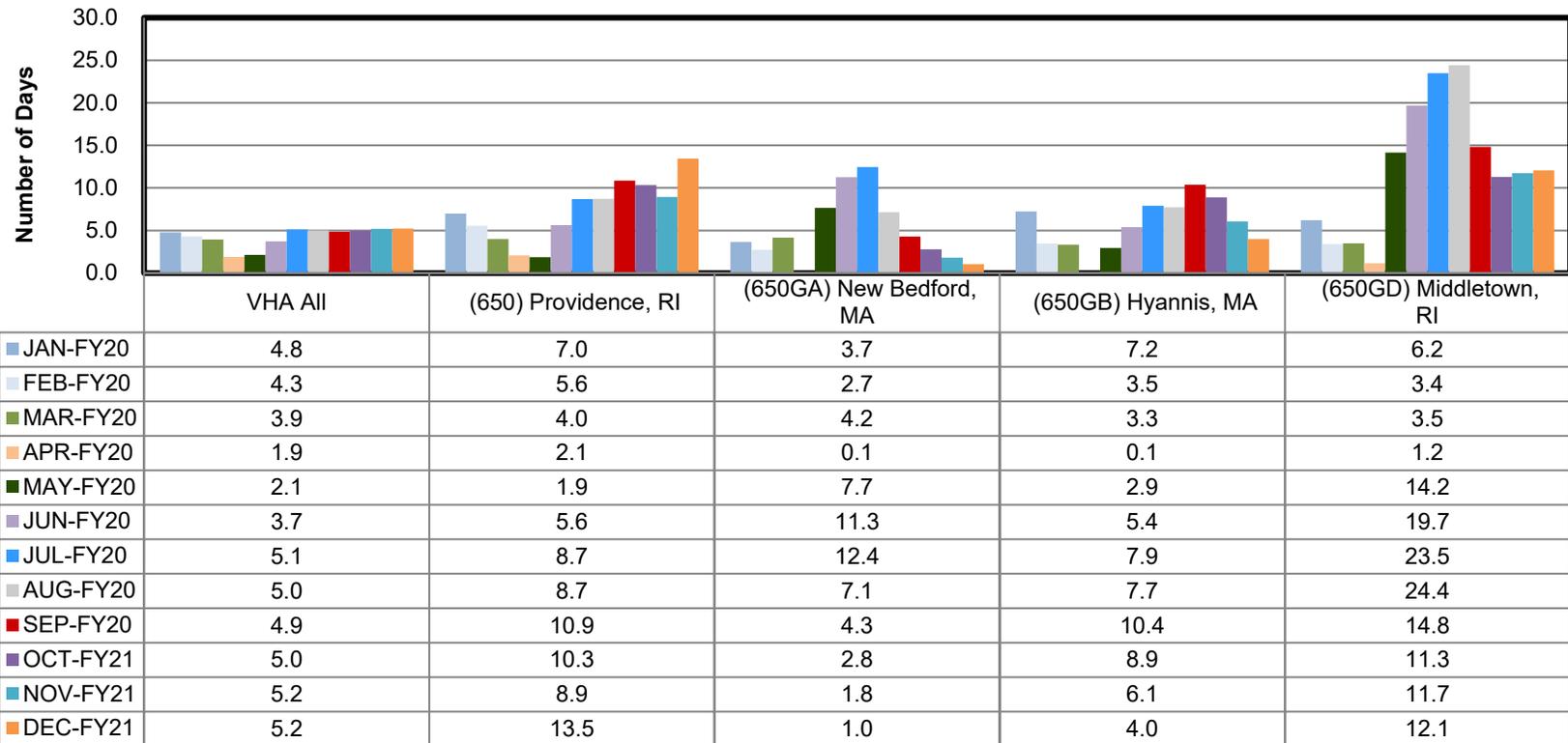
Appendix D: Patient Aligned Care Team Compass Metrics

Quarterly New Primary Care Patient Average Wait Time in Days

	VHA All	(650) Providence, RI	(650GA) New Bedford, MA	(650GB) Hyannis, MA	(650GD) Middletown, RI
JAN-FY19	8.3	35.2	21.6	16.9	47.0
FEB-FY19	8.1	43.0	14.1	9.7	13.8
MAR-FY19	6.9	32.7	25.9	10.1	10.8
APR-FY19	3.6	4.7	6.0	0.0	n/a
MAY-FY19	4.0	17.1	0.0	0.5	n/a
JUN-FY19	4.9	21.5	9.0	20.0	59.0
JUL-FY19	5.9	25.6	4.3	29.6	5.6
AUG-FY19	5.6	32.4	26.7	0.0	28.1
SEP-FY19	6.1	23.5	23.1	12.8	35.8
OCT-FY20	6.3	26.4	23.6	23.2	22.2
NOV-FY20	6.7	15.3	13.1	25.1	23.4
DEC-FY20	6.6	16.2	9.3	8.8	20.7

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

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the medical center's explanation for the increased wait times for the outpatient clinics in Providence and Middletown, RI. The OIG omitted (650QA) Eagle Square, RI and (650QB) Eagle Street, RI as no data were reported.

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

Quarterly Established Primary Care Patient Average Wait Time in Days

	VHA All	(650) Providence, RI	(650GA) New Bedford, MA	(650GB) Hyannis, MA	(650GD) Middletown, RI
JAN-FY20	4.8	7.0	3.7	7.2	6.2
FEB-FY20	4.3	5.6	2.7	3.5	3.4
MAR-FY20	3.9	4.0	4.2	3.3	3.5
APR-FY20	1.9	2.1	0.1	0.1	1.2
MAY-FY20	2.1	1.9	7.7	2.9	14.2
JUN-FY20	3.7	5.6	11.3	5.4	19.7
JUL-FY20	5.1	8.7	12.4	7.9	23.5
AUG-FY20	5.0	8.7	7.1	7.7	24.4
SEP-FY20	4.9	10.9	4.3	10.4	14.8
OCT-FY21	5.0	10.3	2.8	8.9	11.3
NOV-FY21	5.2	8.9	1.8	6.1	11.7
DEC-FY21	5.2	13.5	1.0	4.0	12.1

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

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (650QA) Eagle Square, RI and (650QB) Eagle Street, RI as no data were reported.

Data Definition: "The average number of calendar days between an Established Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date."

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

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

Measure	Definition	Desired Direction
PCMH care coordination	Care coordination (PCMH)	A higher value is better than a lower value
PCMH same day appt	Days waited for an appointment for urgent care (PCMH survey)	A higher value is better than a lower value
PCMH survey access	Timeliness in getting appointments, care and information (PCMH survey access composite)	A higher value is better than a lower value
PSI90	Patient Safety and Adverse Events Composite (PSI90) focused on potentially avoidable complications and events	A lower value is better than a higher value
Rating hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC provider	Rating of primary care providers (PCMH survey)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care survey)	A higher value is better than a lower value
RSRR-HWR	All cause hospital-wide readmission rate	A lower value is better than a higher value
SC care coordination	Care coordination (specialty care)	A higher value is better than a lower value
SC survey access	Timeliness in getting specialty care urgent care and routine care appointments (specialty care survey access composite)	A higher value is better than a lower value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Stress discussed	Stress discussed (PCMH survey)	A higher value is better than a lower value

Source: VHA Support Service Center.

Appendix F: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: August 9, 2021

From: Director, VA New England Healthcare System (10N1)

Subj: Comprehensive Healthcare Inspection of the Providence VA Medical Center in Rhode Island

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

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

1. Thank you for the opportunity to provide a status report to the findings from the Comprehensive Healthcare Inspection of the Providence VA Medical Center in Providence, Rhode Island.

2. I concur with your findings and recommendations, as well as the submitted action plans.

(Original signed by:)

Ryan S. Lilly

Appendix G: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: August 9, 2021

From: Director, Providence VA Medical Center (650/00)

Subj: Comprehensive Healthcare Inspection of the Providence VA Medical Center in Rhode Island

To: Director, VA New England Healthcare System (10N1)

1. Thank you for the opportunity to provide a response to the findings from the Comprehensive Healthcare Inspection of the Providence VA Medical Center in Providence, Rhode Island.

2. I concur with the findings and recommendations and will ensure that actions to correct these findings are completed as described in the responses.

(Original signed by:)

Lawrence B. Connell

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