Department of Veterans Affairs
Office of Inspector General

Comprehensive Healthcare Inspection Program Review of the Providence VA Medical Center Providence, Rhode Island

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Glossary

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CNH	community nursing home
EHR	electronic health record
EOC	environment of care
facility	Providence VA Medical Center
FY	fiscal year
LIP	licensed independent practitioner
MH	mental health
Nurse Executive	Associate Director for Patient Care Services
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
PSM	Patient Safety Manager
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Report Overview

This Comprehensive Healthcare Inspection Program (CHIP) review provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Providence VA Medical Center (facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

CHIP reviews are one element of the Office of Inspector General's (OIG) overall efforts to ensure that our nation's veterans receive high-quality and timely VA health care services. The reviews are performed approximately every 3 years for each facility. OIG selects and evaluates specific areas of focus on a rotating basis each year. OIG's current areas of focus are:

1. Leadership and Organizational Risks
2. Quality, Safety, and Value
3. Medication Management
4. Coordination of Care
5. Environment of Care
6. High-Risk Processes
7. Long-Term Care

This review was conducted during an unannounced visit made during the week of August 14, 2017. OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although OIG reviewed a spectrum of clinical and administrative processes, the sheer complexity of VA medical centers limits the ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of facility performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help facilities identify areas of vulnerability or conditions that, if properly addressed, will potentially improve patient safety and health care quality.

Results and Review Impact

Leadership and Organizational Risks. At the Providence VA Medical Center, the leadership team consists of the Facility Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), and Associate Director for Operations. Organizational communication and accountability are carried out through a committee reporting structure with the Executive Governing Board having oversight for working groups such as the Clinical Leadership, Administrative Leadership, and Quality Management Committees. The leaders are members of the Executive Governing Board through which they track, trend, and monitor quality of care and patient outcomes.

The Facility Director, Chief of Staff, Nurse Executive, and Associate Director were all permanently assigned. However, the Associate Director served as Acting Facility Director due to the Facility Director's temporary appointment to another facility in

VISN 1, and a Health System Specialist within the Director's office served as the Acting Associate Director. The Nurse Executive was the most recent addition to the leadership team in October 2016. The Facility Director, Chief of Staff, and Associate Director have been in their respective positions for greater than two years. In the review of selected employee and patient survey results regarding facility senior leadership, OIG noted high satisfaction scores that reflected active engagement with patients. OIG also noted that facility leaders implemented processes and plans to maintain a committed workforce and positive patient experiences.

Additionally, OIG reviewed accreditation agency findings, sentinel events, disclosures of adverse patient events, Patient Safety Indicator data, and Strategic Analytics for Improvement and Learning (SAIL) data and did not identify any substantial organizational risk factors. OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within the Veterans Health Administration (VHA).[1]

Although the senior leadership team was knowledgeable about Patient Safety Indicator data and selected SAIL metrics, the leaders should continue to take actions to address acute care nursing staff training, clinician assessments and hand-offs, and coding procedures and improve performance of the Quality of Care and Efficiency metrics likely contributing to the current 4-star SAIL rating. In the review of key care processes, OIG issued 12 recommendations that are attributable to the Facility Director, Chief of Staff, and Associate Director. Of the six areas of clinical operations reviewed, OIG noted findings in four. These are briefly described below.

Quality, Safety, and Value. OIG found that senior managers were engaged with quality, safety, and value activities. When opportunities for improvement were identified, they supported clinical leaders' implementation of corrective actions and monitoring of effectiveness. Additionally, OIG noted general compliance with requirements for protected peer review and utilization management.[2] However, OIG noted deficiencies with credentialing and privileging data reviews and patient safety processes.

Coordination of Care. OIG noted safe inter-facility patient transfer practices. The facility developed and implemented a patient transfer policy, completed the VA form and/or transfer/progress notes prior to or within a few hours after the transfer, and

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[1] VHA Support Service Center (VSSC). The Strategic Analytics for Improvement and Learning (SAIL) Value Model Documentation Manual. Accessed on April 16, 2017:
http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146.
VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a "star" ranking system to designate a facility's performance in individual measures, domains, and overall quality.
[2] According to VHA Directive 1117 (July 9, 2014), utilization management involves the forward-looking evaluation of the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.

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communicated required information to the accepting facility. However, OIG identified deficiencies with transfer documentation and the collection of transfer data.

Environment of Care. OIG noted a safe and clean environment of care. The parent facility and representative community based outpatient clinic had general safety, infection prevention, and privacy measures in place. Radiology Service and the locked mental health unit met many of the performance indicators evaluated. However, OIG identified deficiencies with the frequency of emergency cart and defibrillator checks in Radiology Service and with panic alarm testing and Interdisciplinary Safety Inspection Team training for the locked mental health unit.

Long Term Care: Community Nursing Home Oversight. OIG noted a lack of compliance with overall requirements for community nursing home oversight. OIG identified deficiencies with oversight committee membership and meeting frequency, integration of the community nursing home program into the facility's quality improvement program, and the performance of annual reviews and cyclical clinical visits.

Summary

In the review of key care processes, OIG issued 12 recommendations that are attributable to the Facility Director, Chief of Staff, and Associate Director. The number of recommendations should not be used as a gauge for the overall quality provided at this facility. The intent is for facility leadership to use these recommendations as a "road map" to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Acting Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 44–45, and the responses within the body of the report for the full text of the Directors' comments.) OIG considers recommendations 2 and 3 closed. OIG will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
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Purpose and Scope

Purpose

This Comprehensive Healthcare Inspection Program (CHIP) review was conducted to provide a focused evaluation of the quality of care delivered in the Providence VA Medical Center's (facility) inpatient and outpatient settings through a broad overview of key clinical and administrative processes that are associated with quality care and positive patient outcomes. The purpose of the review was to provide oversight of health care services to veterans and to share findings with facility leaders so that informed decisions can be made to improve care.

Scope

The current seven areas of focus for facility reviews are: (1) Leadership and Organizational Risks; (2) Quality, Safety, and Value (QSV); (3) Medication Management; (4) Coordination of Care; (5) Environment of Care (EOC); (6) High-Risk Processes; and (7) Long-Term Care. These were selected because of risks to patients and the organization when care is not performed well. Within four of the fiscal year (FY) 2017 focus areas, the Office of Inspector General (OIG) selected processes for special consideration—Anticoagulation Therapy Management, Inter-Facility Transfers, Moderate Sedation, and Community Nursing Home Oversight (see Figure 1).

Figure 1. Fiscal Year 2017 Comprehensive Healthcare Inspection Program Review of Health Care Operations and Services
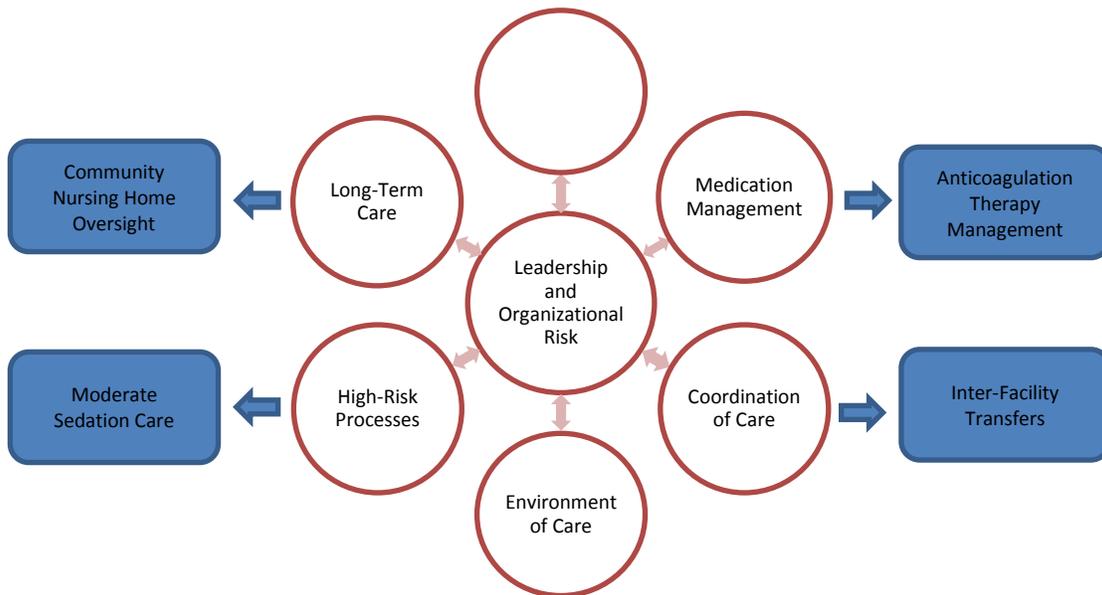
Source: VA OIG.

Additionally, OIG staff provide crime awareness briefings to increase facility employees' understanding of the potential for VA program fraud and the requirement to report suspected criminal activity to OIG.

Methodology

To determine compliance with Veterans Health Administration (VHA) requirements[3] related to patient care quality, clinical functions, and the EOC, OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;[4] and discussed processes and validated findings with managers and employees. OIG interviewed applicable managers and members of the executive leadership team.

The review covered operations for June 1, 2014[5] through August 14, 2017, the date when an unannounced week-long site visit commenced. OIG also presented crime awareness briefings on August 24, 2017, to 24 of the facility's 1,373 employees. These briefings covered procedures for reporting suspected criminal activity to OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Recommendations for improvement in this report target problems that can impact the quality of patient care significantly enough to warrant OIG follow-up until the facility completes corrective actions. The Facility Director's comments submitted in response to the recommendations in this report appear within each topic area.

While onsite, OIG did not receive any concerns beyond the scope of the CHIP Review. OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reviews and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

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[3] Appendix C lists policies that had expired recertification dates but were considered in effect as they had not been superseded by more recent policy or guidance.

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

[5] This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Primary Care Clinic reviews.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risk issues can impact the facility's ability to provide care in all of the selected clinical areas of focus. The factors OIG considered in assessing the facility's risks and strengths were:

1. Executive leadership stability and engagement

2. Employee satisfaction and patient experience

3. Accreditation/for-cause surveys and oversight inspections

4. Indicators for possible lapses in care

5. VHA performance data

Executive Leadership Stability and Engagement. Because each VA facility organizes its leadership to address the needs and expectations of the local veteran population that it serves, organizational charts may differ between facilities. Figure 2 illustrates this facility's reported organizational structure. The facility has a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), and Associate Director for Operations. The Chief of Staff and Nurse Executive are responsible for overseeing patient care.

It is important to note that the Facility Director, Chief of Staff, Nurse Executive, and Associate Director were all permanently assigned. However, at the time of our visit and since July 2017, the Associate Director served as Acting Facility Director due to the Facility Director's temporary appointment to another facility in VISN 1, and a Health System Specialist within the Director's office served as the Acting Associate Director. The Nurse Executive was the most recent addition to the leadership team in October 2016. The Facility Director, Chief of Staff, and Associate Director have been in their respective positions for greater than two years.

Figure 2. Facility Organizational Chart

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                          │ Facility Director │
                          └─────────────────┘
        ┌──────────────┬──────────────┬──────────────┬──────────────┐
┌──────────────┐ ┌──────────────┐ ┌──────────────┐ ┌──────────────────┐
│ Chief of Staff│ │Nurse Executive│ │  Associate   │ │ Chaplain Service │
│              │ │              │ │ Director for │ │Quality Management│
│              │ │              │ │  Operations  │ │   Social Work    │
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Chief of Staff	Nurse Executive	Associate Director for Operations
Dental	Case Management	Business Office
Diagnostic Imaging	Infection Control	Canteen
Group Practice Manager		Chief Information Officer
Medical Service		Clinical Engineering
Mental Health		Contracting
Pathology and Laboratory		Environmental Management Service
Pharmacy		Environmental Safety
Primary Care		Facilities Management
Research		Facility Planner
Sensory Rehabilitation		Fiscal
Surgical Service		Human Resources
		Logistics
		Nutrition
		Police
		Prosthetics
		Public Affairs
		Voluntary Service

Source: Providence VA Medical Center (received August 22, 2017).

To help assess engagement of facility executive leadership, OIG interviewed the Acting Facility Director, Chief of Staff, Nurse Executive, and Acting Associate Director regarding their knowledge of various metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leaders generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, employee and patient survey results, and selected Strategic Analytics for Improvement and Learning (SAIL) metrics within the scope of their positions and responsibilities. These are discussed more fully below.

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the facility's Executive Governing Board, which tracks, trends, and monitors quality of care and patient outcomes. The Facility Director serves as the Chairperson with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Governing Board also oversees various working committees,

such as the Clinical Leadership, Administrative Leadership, and Quality Management Committees. See Figure 3.

Figure 3. Facility Committee Reporting Structure

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                        ┌─────────────────────────┐
                        │  Executive Governing    │
                        │         Board           │
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Clinical Leadership Committee

- Anesthesia Committee
- Behavior or Behaviors That Undermine a Culture of Safety Committee
- Blood Usage Committee
- Cancer Committee
- Case Management/Care Coordination Telehealth Committee
- Clinical Bar Code Multidisciplinary Committee
- Contract Nursing Home Oversight Committee
- End Stage Renal Disease Committee
- Infection Control Committee
- Lab Utilization Review Committee
- Medical Executive Committee
- Medical Records Committee
- Nutrition Committee
- Operative/Invasive Procedures Committee
- Pain Committee
- Patient/Family Education Committee
- Peer Review Committee
- Pharmacy & Therapeutics Committee
- Physical Standards Board
- Research and Development Committee
- Sterilization Processing Service & Reusable Medical Equipment
- Skin Integrity Committee
- Special Care Committee

Administrative Leadership Committee

- Clinical Applications Committee
- Clinical Product Review Committee
- Construction Safety Committee
- Data Validation Committee
- Education Committee
- Education Leadership Committee
- Environment of Care Committee
- HISA (Home Improvement & Structural Alterations) Committee
- Information Management Committee
- Major Prosthetics Medical Equipment Committee
- Radiation Safety Committee
- VAVS (Veterans' Volunteer Service) Committee

- Compliance Committee
- Dean's Committee
- Equal Employment Opportunity Advisory Board
- Executive Resource Management Committee
- Health Promotion & Disease Prevention Committee
- Information Protection Council
- Institutional Review Board
- Integrated Ethics Committee
- Mini Management Advisory Council
- Nursing Practice Council
- Partnership Council
- Patient Centered Care Committee
- Quality Management Committee
- Strategic Planning Committee
- Systems Redesign Council
- VERA (Veterans Equitable Resource Allocation) Committee

Source: Providence VA Medical Center (received August 22, 2017).

Employee Satisfaction and Patient Experience. To assess employee and patient attitudes toward facility senior leadership, OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2015 through September 30, 2016. Although OIG recognizes that employee satisfaction and patient experience survey data are subjective, they can be a starting point for discussions and indicate areas for further inquiry, which can be considered along with other information on facility leadership. Table 1 provides relevant survey results for VHA and the facility for the 12-month period. The facility leaders' results (Director's office average) were rated similarly to the facility and VHA averages.[6] All four of the patient survey results reflected higher care ratings compared to the VHA average. In all, both employees and patients appear generally satisfied with the leadership and care provided.

Table 1. Survey Results on Employee and Patient Attitudes toward Facility Leadership
(October 1, 2015 through September 30, 2016)

Questions	Scoring	VHA Average	Facility Average	Director's Office Average[7]
All Employee Survey[8] Q59. How satisfied are you with the job being done by the executive leadership where you work?	1 (Very Dissatisfied) – 5 (Very Satisfied)	3.31	3.45	3.22
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.68	71.11	69.47
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.	65.8	72.13	
Survey of Healthcare Experiences of Patients (inpatient): I felt like a valued customer.	The response average is the percent of "Agree" and "Strongly Agree" responses.	82.75	88.74	
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.		73.2	84.69	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.8	86.12	

Accreditation/For-Cause[9] Surveys and Oversight Inspections. To further assess Leadership and Organizational Risks, OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to

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[6] 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.

[7] Rating is based on responses by employees who report to the Director.

[8] The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. The instrument has been refined at several points since 2001 in response to operational inquiries by VA leadership on organizational health relationships and VA culture.

[9] TJC conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or reported complaints. The outcomes of these types of activities may affect the current accreditation status of an organization.

identified problems. Table 2 summarizes the relevant facility inspections most recently performed by the VA OIG and The Joint Commission (TJC). Indicative of effective leadership, the facility had closed[10] all but one recommendation for improvement as listed in Table 2. Since the onsite inspection, the remaining recommendation was closed.

OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[11] and College of American Pathologists,[12] which demonstrates the facility leaders' commitment to quality care and services.

Table 2. Office of Inspector General Inspections/Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
VA OIG (*Healthcare Inspection – Alleged Misdiagnosis and Delay in Treatment, Providence VA Medical Center, Providence, Rhode Island, June 15, 2017*)	December 2015	2	1
VA OIG (*Combined Assessment Program Review of the Providence VA Medical Center, Providence, Rhode Island, September 2, 2014*)	June 2014	15	0
VA OIG (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at Providence VA Medical Center, Providence, Rhode Island, August 13, 2014.*)	June 2014	3	0
TJC[13] • Hospital Accreditation • Behavioral Health Care Accreditation • Home Care Accreditation	April–May 2015	26 4 2	0

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[10] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by accreditation organization or inspecting agency.

[11] 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 the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.

[12] For 70 years, the College of American Pathologists has fostered excellence in laboratories and advanced the practice of pathology and laboratory science. In accordance with VHA Handbook 1106.01, VHA laboratories must meet the requirements of the College of American Pathologists.

[13] TJC is 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 VHA facilities for over 30 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

Indicators for Possible Lapses in Care. Within the health care field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 3 summarizes key indicators of risk since OIG's previous June 2014 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Primary Care (PC) review inspections through the week of August 14, 2017.

Table 3. Summary of Selected Organizational Risk Factors[14]
(June 2014 to August 14, 2017)

Factor	Number of Occurrences
Sentinel Events[15]	0
Institutional Disclosures[16]	2
Large-Scale Disclosures[17]	1

OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[18] The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. Table 4 summarizes Patient Safety Indicator data from October 1, 2015 through September 30, 2016.

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[14] It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events 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. (Note that the Providence VA Medical Center is a medium complexity (2) affiliated facility as described in Appendix B.)

[15] A sentinel event is a patient safety event that involves a patient and results in death, permanent harm, or severe temporary harm and intervention required to sustain life.

[16] Institutional disclosure of adverse events (sometimes referred to as "administrative disclosure") is a formal process by which facility leaders together with clinicians and others, as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse.

[17] Large-scale disclosure of adverse events (sometimes referred to as "notification") is a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.

[18] Agency for Healthcare Research and Quality website, https://www.qualityindicators.ahrq.gov/, accessed March 8, 2017.

Table 4. October 1, 2015 through September 30, 2016, Patient Safety Indicator Data

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 1	Facility
Pressure Ulcers	0.55	0.58	0.71
Death among surgical inpatients with serious treatable conditions	103.31	148.51	111.11
Iatrogenic Pneumothorax	0.20	0.36	0.37
Central Venous Catheter-Related Bloodstream Infection	0.12	0.19	0
In Hospital Fall with Hip Fracture	0.08	0	0
Perioperative Hemorrhage or Hematoma	2.59	1.98	10.55
Postoperative Acute Kidney Injury Requiring Dialysis	1.20	0.38	0
Postoperative Respiratory Failure	6.31	20.60	0
Perioperative Pulmonary Embolism or Deep Vein Thrombosis	3.29	2.40	2.55
Postoperative Sepsis	4.45	2.39	4.39
Postoperative Wound Dehiscence	0.65	0	0
Unrecognized Abdominopelvic Accidental Puncture/Laceration	0.67	1.64	0

Source: VHA Support Service Center.

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

Six of the 12 Patient Safety Indicators (pressure ulcers, death among surgical inpatients with serious treatable conditions, iatrogenic pneumothorax, perioperative hemorrhage or hematoma, perioperative pulmonary embolism or DVT, and postoperative sepsis) showed an observed rate per 1,000 hospital discharges in excess of the observed rates for VISN 1 and/or VHA. The facility leadership reported the reasons for these observations were multifactorial and involved patients with multiple pre-existing comorbidities and pre-operative risks for complications. Facility leadership also offered the following reasons for the observed rates:

- Lack of training for acute care nursing staff

- Low acute care bed census

- Lack of clinician assessment and hand-off documentation

- Incorrect coding for acute care and surgical admissions

Veterans Health Administration Performance Data. The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA.[19] This model includes measures on health care quality, employee satisfaction, access to care, and efficiency, but the model has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to

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[19] The model is derived from the Thomson Reuters Top Health Systems Study.

understand the similarities and differences between the top and bottom performers" within VHA.[20]

VA also uses a star-rating system that is designed to make model results more accessible for the average user. Facilities with a 5-star rating are performing within the top 10 percent of facilities, whereas 1-star facilities are performing within the bottom 10 percent of facilities. Figure 4 describes the distribution of facilities by star rating. As of September 30, 2016, the Providence VA Medical Center received an interim rating of 5 stars for overall quality. This means the facility is in the 1st quintile (top 10 percent range). Updated data as of June 30, 2017, indicates that the facility has declined to 4 stars for overall quality.

Figure 4. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of September 30, 2016)
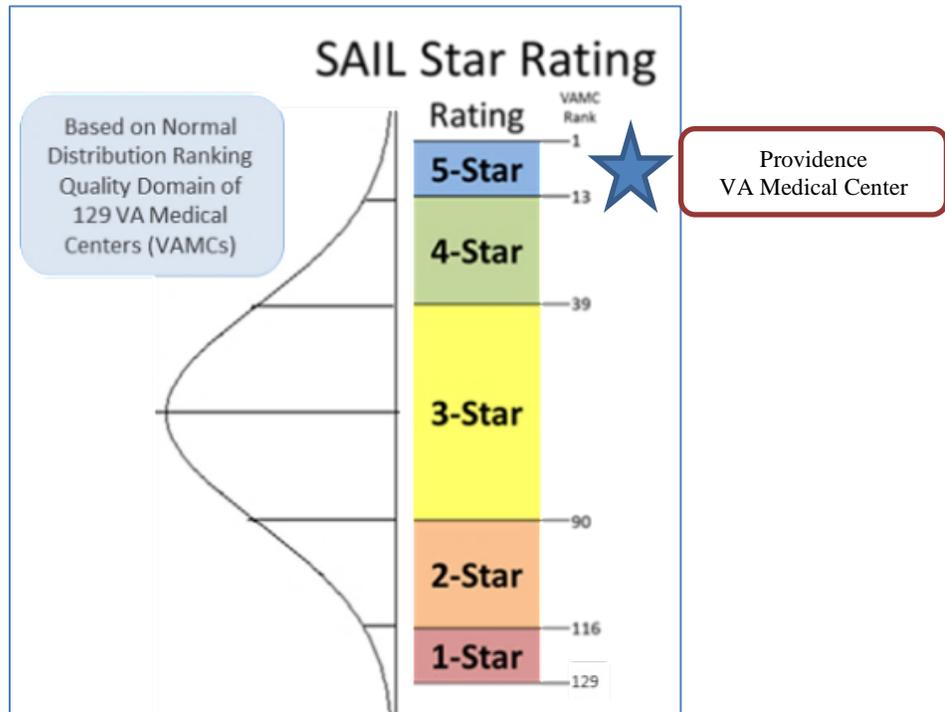
Source: VA Office of Informatics and Analytics' Office of Operational Analytics and Reporting.

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[20] VHA Support Service Center (VSSC). The Strategic Analytics for Improvement and Learning (SAIL) Value Model Documentation Manual. Accessed on April 16, 2017: http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146

Figure 5 illustrates the facility's Quality of Care and Efficiency metric rankings and performance compared to other VA facilities as of March 31, 2017. Of note, Figure 5 shows blue and green data points in the top quintiles that show high performance (for example, Capacity, acute care in-hospital standardized mortality ratio [SMR], and Mental Health Continuity of Care). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, risk standardized readmission rate [for] hospital wide readmission [RSRR-HWR], outpatient performance measures [HEDIS Like], and Complications).

Figure 5. Facility Quality of Care and Efficiency Metric Rankings
(as of March 31, 2017)
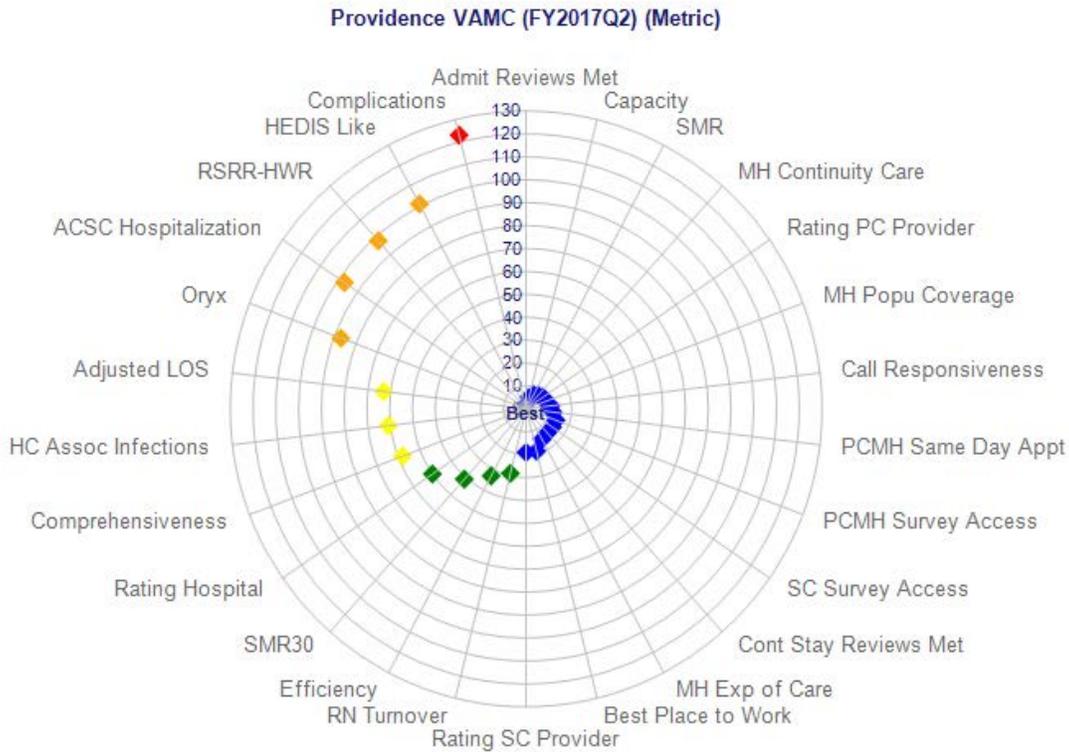
Source: VHA Support Service Center.

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

Conclusions. The facility has generally stable executive leadership and active engagement with patients as evidenced by high satisfaction scores. Organizational leaders support patient safety, quality care, and other positive outcomes (such as initiating processes and plans to maintain positive perceptions of the facility through active stakeholder engagement). OIG's review of accreditation organization findings, sentinel events, disclosures, and SAIL results did not identify any substantial organizational risk factors.[21] The senior leadership team was knowledgeable about Patient Safety Indicator data and selected SAIL metrics but should continue to take actions to address acute care nursing staff training, clinician assessments and hand-offs, and coding procedures to improve performance of selected SAIL metrics, particularly Quality of Care and Efficiency metrics likely contributing to the current 4-star rating.

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[21] OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk. OIG is using it as "a way to understand the similarities and differences between the top and bottom performers" within the VHA system.

Quality, Safety, and Value

One of VA's strategies is to deliver high-quality, veteran-centered care that compares favorably to the best of the private sector in measured outcomes, value, and efficiency.[22] VHA requires that its facilities operate a QSV program to monitor patient care quality and performance improvement activities.

The purpose of this review was to determine whether the facility complied with key QSV program requirements.[a] To assess this area of focus, OIG evaluated the following:

1. Senior-level involvement in QSV/performance improvement committee

2. Protected peer review[23] of clinical care

3. Credentialing and privileging

4. Utilization management (UM) reviews[24]

5. Patient safety incident reporting and root cause analyses

OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, licensed independent practitioners' profiles, protected peer reviews, root cause analyses, and other relevant documents. The list below shows the performance indicators for each of the following QSV program activities.

- Senior-level committee responsible for key QSV functions
  - Met at least quarterly
  - Chaired or co-chaired by the Facility Director
  - Reviewed aggregated data routinely
- Protected peer reviews
  - Examined important aspects of care (appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation)
  - Resulted in implementation of Peer Review Committee recommended improvement actions
- Credentialing and privileging processes
  - Considered frequency for Ongoing Professional Practice Evaluation (OPPE)[25] data review
  - Indicated a Focused Professional Practice Evaluation[26]

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

[23] According to VHA Directive 2010-025 (June 3, 2010), this is a peer evaluation of the care provided by individual providers within a selected episode of care. This also involves a determination of the necessity of specific actions, and confidential communication is given to the providers who were peer reviewed regarding the results and any recommended actions to improve performance. The process may also result in identification of systems and process issues that require special consideration, investigation, and possibly administrative action by facility staff.

[24] According to VHA Directive 1117 (July 9, 2014), UM reviews evaluate the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.

[25] OPPE is the ongoing monitoring of privileged practitioners to identify professional practice trends that impact the quality of care and patient safety.

- UM personnel
  - Completed at least 75 percent of all required inpatient reviews
  - Documented Physician UM Advisors' decisions in the National UM Integration database
  - Reviewed UM data using an interdisciplinary group
- Patient safety personnel
  - Entered all reported patient incidents into the WEBSPOT database
  - Completed the required minimum of eight root cause analyses
  - Reported root cause analysis findings to reporting employees
  - Submitted an annual patient safety report

Conclusions. Generally, OIG found that senior managers were engaged with QSV activities. When opportunities for improvement were identified they supported clinical leaders' implementation of corrective actions and monitoring for effectiveness. OIG also found general compliance with requirements for protected peer review and utilization management. However, OIG identified the following deficiencies in the remaining areas that warranted recommendations for improvement.

Credentialing and Privileging. VHA provides guidance and policy for the OPPE process whereby licensed independent practitioners (LIPs) receive periodic peer and supervisory reviews addressing specific aspects of their privileges according to specialty. Although VHA only requires OPPEs to be performed every 6 months, the facility required clinical managers to review OPPE data on a quarterly basis. The ongoing monitoring of privileged practitioners is essential to confirm the quality of care delivered and allows the facility to identify professional practice trends that impact patient safety. For the 12 months prior to this review, 9 of 29 practitioner profiles did not contain evidence that service chiefs reviewed OPPE data quarterly. Generally, service chiefs cited a lack of attention to detail and oversight as reasons for noncompliance.

Recommendation

1. The Chief of Staff ensures clinical managers consistently review Ongoing Professional Practice Evaluation data quarterly and monitors the managers' compliance.

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[26] Focused Professional Practice Evaluation is a process whereby the facility evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privileges of the facility. It typically occurs at the time of initial appointment to the medical staff or the granting of new, additional privileges. The Focused Professional Practice Evaluation may be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high-quality patient care.

Facility concurred.

Target date for completion: July 31, 2018

Facility response: The COS reviewed policy and expectations with all Clinical Service Chiefs immediately after CHIP survey completion. All service chiefs submit a quarterly report to the medical staff/credentialing coordinator as attestation that OPPE reviews have been completed. This is reported to the COS by the Credentialing Coordinator and then reported to the Medical Executive Committee (MEC). During monthly MEC meetings, OPPEs for medical staff members being presented, will be reviewed for completion with a focus on details, i.e., signatures. The results of these reviews will be reported in the committee minutes. Any non-compliance issues will be addressed by the COS and documented in the MEC minutes. This will be monitored for two quarters with a goal of 90 percent compliance.

Patient Safety. VHA requires facilities to complete four individual root cause analyses every fiscal year. The process of root cause analysis is integral to promoting patient safety and a just culture, where errors are explored in order to make systematic adjustments to processes or procedures that improve safety and health care quality. VHA also requires submission of an annual patient safety report to facility leadership. This report is integral to determination of patient safety issues for the entire facility and an important tool for use in the preparation of action plans. During FY 2016, the Patient Safety Manager (PSM) conducted only three of the required four individual root cause analyses and did not prepare the annual patient safety report for FY 2016. The PSM reported not completing all required root cause analyses because of other priorities and was unaware of the requirement to prepare an annual report.

Recommendation

2. The Facility Director ensures the Patient Safety Manager conducts the minimum of four individual root cause analyses each year and monitors compliance.

Facility concurred.

Target date for completion: December 30, 2017

Facility response: The PSM was new in their role in FY 2016. Since then, they have completed 10 root cause analyses (RCAs) for FY 2017 and completed the patient safety annual report for FY 2017. This was reviewed and signed by the Acting Medical Center Director.

Recommendation

3. The Facility Director ensures the Patient Safety Manager prepares and submits annual patient safety reports and monitors the Patient Safety Manager's compliance.

Facility concurred.

Target date for completion: December 30, 2017

Facility response: The Acting Medical Center Director has reviewed requirements and has ensured compliance. The annual report for FY 2017 is completed and signed.

Medication Management: Anticoagulation Therapy

Comprehensive medication management is defined as the standard of care that ensures clinicians individually assess each patient's medications to determine that each is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications prescribed, and able to be taken by the patient as intended. From October 1, 2015 through September 30, 2016, more than 482,000 veterans received an anticoagulant,[27] or a blood thinner, which is a drug that works to prevent the coagulation or clotting of blood. TJC's National Patient Safety Goal (3.05.01) focuses on improving anticoagulation safety to reduce patient harm and states, "…anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance."

Within medication management, OIG selected a special focus on anticoagulation therapy given its risk and common usage among veterans. The purpose of this review was to determine whether facility clinicians appropriately managed and provided education to patients with new orders for anticoagulant medication.[b]

OIG reviewed relevant documents and the competency assessment records of three employees actively involved in the anticoagulant program and interviewed key employees. Additionally, OIG reviewed the electronic health records (EHRs) of 36 randomly selected patients who were prescribed new anticoagulant medications from July 1, 2015 through June 30, 2016. The list below shows the performance indicators examined.

- Development and implementation of anticoagulation management policies
- Algorithms, protocols, or standardized care processes
    - Initiation and maintenance of warfarin
    - Management of anticoagulants before, during, and after procedures
    - Use of weight-based, unfractionated heparin
- Provision of a direct telephone number for patient anticoagulation-related calls
- Designation of a physician anticoagulation program champion
- Risk minimization of dosing errors
- Routine review of quality assurance data
- Provision of transition follow-up and education for patients with newly prescribed anticoagulant medications
- Laboratory testing
    - Prior to initiating anticoagulant medications
    - During anticoagulation treatment
- Documentation of justification/rationale for prescribing the anticoagulant when laboratory values did not meet selected criteria
- Competency assessments for employees actively involved in the anticoagulant program

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[27] Managerial Cost Accounting Pharmacy Cube, Corporate Data Warehouse data pull on March 23, 2017.

Conclusions. Generally, the facility met requirements with the above performance indicators. OIG made no recommendations.

Coordination of Care: Inter-Facility Transfers

Coordination of care is the process of ensuring continuity of care, treatment, or services provided by a facility, which includes referring individuals to appropriate community resources to meet ongoing identified needs. Effective coordination of care also involves implementing a plan of care and avoiding unnecessary duplication of services. OIG selected a special focus on inter-facility transfers because they are frequently necessary to provide patients with access to specific providers or services. VHA has the responsibility to ensure that transfers into and out of its medical facilities are carried out appropriately under circumstances that provide maximum safety for patients and comply with applicable standards.

The purpose of this review was to evaluate selected aspects of the facility's patient transfer process, specifically transfers out of the facility.[c]

OIG reviewed relevant policies and facility data and interviewed key employees. Additionally, OIG reviewed the EHRs of 48 randomly selected patients who were transferred acutely out of facility inpatient beds or the Emergency Department/urgent care center to another VHA facility or non-VA facility from July 1, 2015 through June 30, 2016. The list below shows the performance indicators OIG examined.

- Development and implementation of patient transfer policy
- Collection and reporting of data about transfers out of the facility
- Completion of VA Form 10-2649A and/or transfer/progress notes prior to or within a few hours after the transfer
  - Date of transfer
  - Patient or surrogate informed consent
  - Medical and/or behavioral stability
  - Identification of transferring and receiving provider or designee
  - Details of the reason for transfer or proposed level of care needed
- Documentation by acceptable designees in the absence of staff/attending physicians
  - Staff/attending physician approval
  - Staff/attending physician countersignature on the transfer note
- Nurse documentation of transfer assessments/notes
- Provider documentation for emergent transfers
  - Patient stability for transfer
  - Provision of all medical care within the facility's capacity
- Communication with the accepting facility
  - Available history
  - Observations, signs, symptoms, and preliminary diagnoses
  - Results of diagnostic studies and tests

Conclusions. OIG noted that the facility developed and implemented a patient transfer policy. However, OIG identified the following deficiencies for data collection and transfer documentation that warranted recommendations for improvement.

Data Collection. VHA requires facilities to collect and report data for patient inter-facility transfers, such as date of transfer, documentation of informed consent, medical or behavioral stability, and identification of transferring and receiving provider as part of VHA's quality management program. The collection and reporting of data allows the facility to analyze and improve the inter-facility transfer process to maximize patient safety. There was no evidence that the facility collected this data. The inter-facility transfer team told OIG that no data had been collected for a year after the previous transfer coordinator left the position. There was a realignment of personnel, and in June 2017 the facility began the process of reinitiating data collection.

Recommendation

4. The Chief of Staff ensures inter-facility patient transfer data are collected and analyzed as part of the facility's quality management program and monitors compliance.

Facility concurred.

Target date for completion: April 30, 2018

Facility Response: Data is collected and analyzed each month for all transfers. It is reported to the COS and Quality Management (QM) Committee as well as the clinical service chiefs. This will be monitored until three sequential months demonstrates 90 percent compliance.

Transfer Documentation. VHA requires that transfer-related documentation signed by a non-physician designee must subsequently be countersigned by the staff/attending physician. This ensures that the decision to transfer patients out of VHA facilities was made by a credentialed provider. Sixteen of the 22 transfer notes written by designees did not contain a staff/attending physician countersignature. Managers were unaware. Lack of attention to detail by staff/attending physicians, who were contract providers, resulted in noncompliance.

Recommendation

5. The Chief of Staff ensures that staff/attending physicians countersign transfer notes written by acceptable designees for patients transferring to another facility and monitors physicians' compliance.

Facility concurred.

Target date for completion: April 30, 2018

Facility Response: This is one of the mandatory elements on VA Form 10-2649A that physicians must complete for a patient transfer to another facility.   All VA Form 10-2649A are reviewed to ensure proper completion, data is tracked on a monthly basis, reported to the COS and to the QM Committee. Any noncompliance will be addressed by the COS.   This will be monitored until three sequential months demonstrates 90 percent compliance.

Provider Documentation for Emergent Transfers. VHA requires facilities to provide all medical treatment to unstable patients prior to transferring the patients to another facility to minimize risks. The EHRs of 3 of the 15 patients requiring emergent transfer did not contain evidence that all medical care was provided. The Chief Hospitalist told OIG that, at times, contract physicians or residents failed to fully complete the transfer form and cited lack of oversight and/or effective controls as the primary reasons for noncompliance with VHA documentation requirements.

Recommendation

6. The Chief of Staff ensures that facility staff consistently document provision of necessary medical care within the facility's capacity for all patients prior to transfer to another facility and monitors staff compliance.

Facility concurred.

Target date for completion: April 30, 2018

Facility Response: This is one of the mandatory elements on VA Form 10-2649A that physicians must complete for a patient transfer to another facility.   All forms are reviewed to ensure proper completion and the data is tracked on a monthly basis, reported to COS and to QM committee. Any noncompliance will be addressed by the COS. This will be monitored until three sequential months demonstrates 90 percent compliance.

Environment of Care

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. OIG also determined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, in this case, with a special emphasis on Radiology Service and the locked MH unit.[d]

Fluoroscopic imaging equipment produces x-rays for the diagnosis, localization, and guidance of interventional procedures.[28] Although an integral part of health care, fluoroscopic imaging can deliver large doses of radiation to patients and employees. Large doses of radiation are known to increase the incidence of cancer and can cause fetal abnormalities.

VHA provides various MH services to patients with acute and severe emotional and/or behavioral symptoms. These services are often provided in an inpatient setting.[29] The inpatient locked MH unit must provide a healing, recovery-oriented environment as well as be a safe place for patients and employees. VHA developed the MH EOC Checklist to reduce environmental factors that contribute to inpatient suicides, suicide attempts, and other self-injurious behaviors and factors that reduce employee safety on MH units.

In all, OIG inspected six inpatient units (medical/surgical/telemetry, intensive care, step-down, post-anesthesia care, ambulatory-day treatment, and locked MH), the Emergency Department, Radiology Service, and the women's clinic. OIG also inspected the Middleton CBOC. Additionally, OIG reviewed relevant documents and 19 employee training records and interviewed key employees and managers. The list below shows the location-specific performance indicators selected to examine the risk areas specific to particular settings.

Parent Facility
- EOC deficiency tracking
- EOC rounds
- General safety
- Infection prevention
- Environmental cleanliness
- Exam room privacy
- Availability of feminine hygiene products
- Availability of medical equipment and supplies

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[28] VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
[29] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

Community Based Outpatient Clinic
- General safety
- Infection prevention
- Environmental cleanliness
- Medication safety and security
- Exam room privacy
- General privacy
- Availability of feminine hygiene products
- IT network room security
- Availability of medical equipment and supplies

Radiology
- Safe use of fluoroscopy equipment
- Environmental safety
- Infection prevention
- Medication safety and security
- Radiology equipment inspection
- Availability of medical equipment and supplies
- Maintenance of radiological equipment

Locked Mental Health Unit
- MH EOC inspections
- Environmental suicide hazard identification and abatement
- Environmental safety
- Infection prevention
- Employee training on MH environmental hazards
- Availability of medical equipment and supplies

Conclusions. General safety, infection prevention, and privacy measures were in place at the parent facility and representative CBOC. OIG did not note any issues with the availability of medical equipment and supplies. Although the Radiology Service met many of the above performance indicators, there was a lack of inspection and documentation of the emergency crash cart and defibrillator. The locked MH unit had MH EOC inspection and environmental suicide hazard identification and abatement processes in place; however, OIG identified the following deficiencies for the locked unit that warranted recommendations for improvement.

Radiology Service: General Safety. Facility policy requires that emergency carts and defibrillators located in non-acute care areas be checked on a daily basis during business hours. This ensures that emergency equipment and supplies are available and in working order when needed. OIG reviewed records of Radiology Service emergency cart and defibrillator checks for July 1–August 15, 2017 and noted five missing emergency cart and defibrillator checks. Radiology Service staff and managers were aware of the requirements, but managers' lack of oversight for staff performance of the emergency cart and defibrillator checks resulted in noncompliance.

Recommendation

7. The Chief of Staff ensures Radiology Service employees check the emergency cart and defibrillator according to facility policy and monitors compliance.

Facility concurred.

Target date for completion. April 30, 2018

Facility Response: Radiology Service employees will perform daily checks of crash carts and defibrillators Monday through Friday when the service is operational per policy. The Radiology Service leadership will report compliance to the COS on a monthly basis. This report will be sent to the COS the first week of the month for the previous month with a copy to Quality Management. Any non-compliance issues will be addressed by the COS with the Radiology Service leadership. This will be monitored until three sequential months demonstrates 90 percent compliance.

Locked Mental Health Unit: Panic Alarm Testing. VHA requires that facilities ensure rapid response by VA Police to panic alarm activation within locked inpatient MH units to preserve both patient and staff safety. Panic alarm testing for locked inpatient MH units is to be documented in a log that includes VA Police response time. Although OIG found panic alarm testing for the months of February through July 2017 VA Police response time was not documented because they were unaware of the requirement for documentation of response time for panic alarm testing for locked inpatient MH units.

Recommendation

8. The Associate Director ensures locked mental health unit panic alarm testing documentation includes VA Police response time and monitors compliance.

Facility concurred.

Target date for completion. April 30, 2018

Facility Response: The outcome of the drills, which include police response times, are documented and maintained within the police Record Control System (RCS). Additionally, in accordance with VA Regulation 0730 re-occurring functional test of duress systems are conducted. We will report monthly and ensure all requirements have been met, which includes police response time. This will be reported to the Facility Director and quality management on a monthly basis. This will be monitored until three sequential months demonstrates 90 percent compliance.

Locked Mental Health Unit: Employee Training. VHA requires that locked MH unit staff and MH Interdisciplinary Safety Inspection Team members receive training on the identification and correction of environmental hazards, including the proper use of the MH EOC Checklist. This ensures they possess the necessary knowledge and skills to perform locked MH unit inspections to ensure staff, patient, and visitor safety. Two of seven MH Interdisciplinary Safety Inspection Team members did not complete the

training within the past 12 months (August 2016 through July 2017). MH leadership and MH Interdisciplinary Safety Inspection Team members were aware of the requirements for training, but staff availability and collateral duties resulted in noncompliance.

Recommendation

9. The Associate Director ensures all members of the Interdisciplinary Safety Inspection Team complete the required training on how to identify and correct environmental hazards, including the proper use of the Mental Health Environment of Care Checklist, and monitors members' compliance.

Facility concurred.

Target date for completion. April 30, 2018

Facility Response: The Patient Safety Manager (PSM) leads the MH EOC activity and was one of two identified for not meeting Talent Management System (TMS) completion. The PSM's understanding was that when they attended VHA PSM boot camp, which included MH EOC training, that they had completed the requirement. The PSM completed the TMS training at the time of survey when this was discussed and going forward has developed a regular reporting thru TMS of all MH EOC personnel to ensure all have completed the requirement. The PSM will report on a monthly basis, compliance to quality management and the Medical Center Director. This will be monitored until three sequential months demonstrates 90 percent compliance.

High Risk Processes: Moderate Sedation

OIG's special focus within high-risk processes for the facility was moderate sedation, which is a drug-induced depression of consciousness during which patients can still respond purposefully to verbal comments.[30] Non-anesthesiologists administer sedatives and analgesics to relieve anxiety and increase patient comfort during invasive procedures and usually do not have to provide interventions to maintain a patient's airway, spontaneous ventilations, or cardiovascular function. The administration of moderate sedation could lead to a range of serious adverse events, including cardiac and respiratory depression, brain damage due to low oxygen levels, cardiac arrest, or death.[31]

Properly credentialed providers and trained clinical staff must provide safe care while sedating patients for invasive procedures. Additionally, facility leaders must monitor moderate sedation adverse events, report and trend the use of reversal agents, and systematically aggregate and analyze the data to enhance patient safety and employee performance.[32] During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures, of which more than half were gastroenterology-related endoscopies.[33] To minimize risks, VHA and TJC have issued requirements and standards for moderate sedation care.

The purpose of this review was to evaluate selected aspects of care to determine whether the facility complied with applicable policies in the provision of moderate sedation.[e]

OIG reviewed relevant documents, interviewed key employees, and inspected the intensive care, ambulatory-day treatment, and post-anesthesia care units; Emergency Department; and endoscopy and bronchoscopy procedure areas to assess whether required equipment and sedation medications were available. Additionally, OIG reviewed the EHRs of 42 randomly selected patients who underwent an invasive procedure involving moderate sedation from July 1, 2015 through June 30, 2016, and the training records of 19 clinical employees who performed or assisted during these procedures. The list below shows the performance indicators OIG reviewed.

- Reporting and trending the use of reversal agents in moderate sedation cases
- Performance of history and physical examinations and pre-sedation assessment within 30 calendar days prior to the moderate sedation procedure
- Re-evaluation of patients immediately before administration of moderate sedation
- Documentation of informed consent prior to the moderate sedation procedure

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[30] American Society of Anesthesiologists (ASA), Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, 2002. Anesthesiology 2002; 96:1004-17.

[31] VA National Center for Patient Safety. March 2015. Moderate Sedation Toolkit for Non-Anesthesiologists: Facilitator's Guide, Retrieved March 20, 2017 from:
https://www.patientsafety.va.gov/docs/modSedationtoolkit/FacilitatorGuide.pdf.

[32] VHA Directive 1073, *Moderate Sedation by Non-Anesthesiology Providers*, December 30, 2014.

[33] Per VA Corporate Data Warehouse data pull on February 22, 2017.

- Performance of timeout[34] prior to the moderate sedation procedure
- Post-procedure documentation
- Discharge practices
- Clinician training for moderate sedation
- Availability of equipment and medications in moderate sedation procedure areas

Conclusions. Generally, the facility met requirements with the above performance indicators. OIG made no recommendations.

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[34] A time out is the process of verifying correct patient, procedure, and procedure site/side. The procedure team (physician, nurses, and other support staff) also verifies that the patient has given consent for the procedure and that any specialty equipment needed is available. This is performed prior to the start of the procedure.

Long-Term Care: Community Nursing Home Oversight

Since 1965, VHA has provided nursing home care under contracts. VHA facilities must integrate the CNH program into their Quality Improvement Programs. The Facility Director establishes the CNH Oversight Committee, which reports to the chief clinical officer (Chief of Staff, Nurse Executive, or the equivalent) and includes multidisciplinary management-level representatives from social work, nursing, quality management, acquisition, and the medical staff. The CNH Oversight Committee must meet at least quarterly.[35] Local oversight of CNHs is achieved through annual reviews and monthly visits.

The purpose of this review was to assess whether the facility complied with applicable requirements regarding the monitoring of veterans in contracted CNHs.[f]

OIG interviewed key employees and reviewed relevant documents and the results from CNH annual reviews completed July 5, 2015 through June 30, 2016. Additionally, OIG reviewed the EHRs of 31 randomly selected patients who received CNH care for more than 3 months during the timeframe July 1, 2015 through June 30, 2016. The list below shows the performance indicators OIG reviewed.

- Implementation of a CNH Oversight Committee with representation by required disciplines and meetings at least quarterly
- Integration of CNH program into quality improvement program
- Completion of CNH annual reviews by CNH Review Team
- Completion of exclusion review documentation when CNH annual reviews noted four or more exclusionary criteria
- Documentation of social worker and registered nurse cyclical clinical visits

The performance indicator that did not apply to this facility is listed below.

- Documentation of hand-off for patients placed in CNHs outside catchment area

Conclusions. OIG noted a lack of compliance with overall requirements for the CNH Oversight Committee. OIG identified the following deficiencies that warranted recommendations for improvement.

Oversight Committee. VHA requires the CNH Oversight Committee to meet at least quarterly and to include representation from social work, nursing, quality management, acquisitions, and the medical staff. This multidisciplinary approach helps to ensure that VHA's contracted nursing homes provide high quality care in a safe environment. VHA also requires that leaders integrate the CNH program into the facility's quality improvement program so that organizational goals are aligned to improve patient outcomes and optimize function and quality of life. The facility's CNH Oversight Committee did not meet quarterly nor did their membership include a representative

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[35] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures,* June 4, 2004.

from quality management. OIG also reviewed Clinical Leadership Committee meeting minutes and found no evidence that the facility had integrated the CNH program into the its quality improvement program. The CNH Oversight Committee chairperson lacked attention to detail when scheduling the meetings, and senior managers failed to ensure program compliance.

Recommendation

10. The Chief of Staff ensures the Community Nursing Home Oversight Committee meets at least quarterly, includes representatives from all required disciplines, and integrates the CNH program into the facility's quality improvement program, and the Chief of Staff monitors the committee's compliance.

Facility concurred.

Target date for completion: July 31, 2018

Facility Response: The facility has established meeting dates and key membership for the Community Nursing Home Oversight Committee per VHA directive as well as a process for integrating the CNH program activities into the Quality Management Committee. The first meeting was scheduled for January 17, 2018, ongoing as follows: April 18, 2018; July 18, 2018; and October 17, 2018. Meeting minutes will be generated for all meetings. Membership includes: a representative from the Veterans Home, social worker, nursing, quality management representative, acquisition, medical staff, and CNH staff. This will be monitored until a goal of 100 percent attendance for two quarters is met.

Annual Reviews. VHA requires CNH Review Teams to complete annual reviews of all CNHs under VHA contract. These reviews must include an analysis of the most recent CNH state survey to ensure CNHs meet all state licensing requirements and are safe for veteran patients. The facility's CNH Review Team did not complete annual reviews on six of the nine CNHs during the review period of July 5, 2015 to June 30, 2016. Although the CNH coordinator responsible for the reviews reported awareness of the requirement to perform annual reviews, these were not completed, and senior managers did not provide adequate oversight to ensure compliance.

Recommendation

11. The Chief of Staff ensures the Community Nursing Home Review Team completes annual reviews within the required timeframe and monitors the team's compliance.

Facility concurred.

Target date for completion: July 31, 2018

Facility Response: Executive leadership has retooled the staffing matrix which represents an increase in staffing levels. Requests for social worker(s) to be detailed to the CNH program have been advertised and we have received two candidates. These persons will assume monthly visit workload to ensure compliance. This process will take up to 4 months to catch up on backlog, based on veteran volume we currently have. This will be monitored until three sequential months demonstrates 90 percent compliance.

Clinical Visits. VHA requires that every patient under contract in a nursing home must be visited by a social worker or registered nurse at least every 30 days (unless specific criteria allow an exception). Social workers and registered nurses must alternate monthly visits unless otherwise indicated by the patient's individualized visitation plan. This interdisciplinary monitoring ensures vulnerable nursing home patients consistently receive quality care and necessary follow-up services. None of the 28 EHRs contained documentation of social worker and/or registered nurse cyclical clinical visits with the frequency required by VHA policy. The CNH social worker and registered nurse expressed a lack of knowledge of the national and facility requirements. The CNH Review Team and supervisors also stated that inadequate staffing and lack of CNH program oversight caused noncompliance with requirements.

Recommendation

12. The Chief of Staff ensures social workers and registered nurses conduct cyclical clinical visits with the required frequency and monitors social workers' and registered nurses' compliance.

Facility concurred.

Target date for completion: July 31, 2018

Facility Response: The CNH coordinator will report compliance rates for nursing and social worker monthly visits to the COS and the Facility Director. This report will also be reviewed at the QM Committee monthly meetings. This will be monitored until three sequential months demonstrates 90 percent compliance.

Summary Table of Comprehensive Healthcare Inspection Program Review Findings

Healthcare Processes	Performance Indicators	Conclusion	
Leadership and Organizational Risks	• Executive leadership stability and engagement • Employee satisfaction and patient experience • Accreditation/for-cause surveys and oversight inspections • Indicators for possible lapses in care • VHA performance data	Twelve OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Facility Director, Chief of Staff, and Associate Director. See details below.	
Healthcare Processes	**Performance Indicators**	**Critical Recommendations[36] for Improvement**	**Recommendations for Improvement**
Quality, Safety, and Value	• Senior-level involvement in QSV/performance improvement committee • Protected peer review of clinical care • Credentialing and privileging • UM reviews • Patient safety incident reporting and root cause analyses	• Clinical managers consistently review OPPE data quarterly.	• The PSM conducts the minimum of four individual root cause analyses each year. • The PSM prepares and submits annual patient safety reports.

Medication Management	• Anticoagulation management policies and procedures
	• Management of patients receiving new orders for anticoagulants
	  o Prior to treatment
	  o During treatment
	• Ongoing evaluation of the anticoagulation program
	• Competency assessment
		None	None

[36] OIG defines "critical recommendations" as those that rise above others and address vulnerabilities and risks that could cause exceptionally grave health care outcomes and/or significant impact to quality of care.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Coordination of Care	• Transfer policies and procedures
	• Oversight of transfer process
	• EHR documentation
	  o Non-emergent transfers
	  o Emergent transfers
		• Staff/attending physicians countersign transfer notes written by acceptable designees for patients transferring to another facility.
		• Facility staff consistently provide necessary medical care within the facility's capacity for all patients prior to transfer to another facility.
			• Inter-facility patient transfer data are collected and analyzed as part of the facility's quality management program.

Environment of Care	• Parent facility
	  o EOC deficiency tracking and rounds
	  o General Safety
	  o Infection prevention
	  o Environmental cleanliness
	  o Exam room privacy
	  o Availability of feminine hygiene products and medical equipment and supplies
	• CBOC
	  o General safety
	  o Infection prevention
	  o Environmental cleanliness
	  o Medication safety and security
	  o Privacy
	  o Availability of feminine hygiene products and medical equipment and supplies
	  o IT network room security
	• Radiology
	  o Safe use of fluoroscopy equipment
	  o Environmental safety
	  o Infection prevention
	  o Medication safety and security
	  o Radiology equipment inspection
	  o Availability of medical equipment and supplies
	  o Maintenance of radiological equipment
		• Radiology Service employees check the emergency cart and defibrillator according to facility policy.	• Locked MH unit panic alarm testing documentation includes VA Police response time.
			• All members of the Interdisciplinary Safety Inspection Team complete the required training on how to identify and correct environmental hazards, including the proper use of the MH EOC Checklist.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care (continued)	• Inpatient MH
	   o MH EOC inspections
	   o Environmental suicide hazard identification
	   o Employee training
	   o Environmental safety
	   o Infection prevention
	   o Availability of medical equipment and supplies
		(See previous page.)	(See previous page.)

High-Risk Processes: Moderate Sedation	• Outcomes reporting
	 • Patient safety and documentation
	   o Prior to procedure
	   o After procedure
	 • Staff training and competency
	 • Monitoring equipment and emergency management
		None	None

Long-Term Care: Community Nursing Home Oversight	• CNH Oversight Committee and CNH program integration
	 • EHR documentation
	   o Patient hand-off
	   o Clinical visits
	 • CNH annual reviews
		• The CNH Review Team completes annual reviews within the required timeframe.
		 • Social workers and registered nurses conduct cyclical clinical visits with the required frequency.
			• The CNH Oversight Committee meets at least quarterly, includes representatives from all required disciplines, and integrates the CNH program into the facility's quality improvement program.

Facility Profile

The table below provides general background information for this medium-complexity (2)[37] affiliated[38] facility reporting to VISN 1.

Table 5. Facility Profile for Providence (650) for October 1, 2013 through September 30, 2016

Profile Element	Facility Data FY 2014[39]	Facility Data FY 2015[40]	Facility Data FY 2016[41]
Total Medical Care Budget in Millions	$235.1	$258.7	$271.8
Number of:			
• **Unique Patients**	34,608	35,592	36,663
• **Outpatient Visits**	420,530	438,940	466,490
• **Unique Employees**[42]	1,123	1,181	1,233
Type and Number of Operating Beds:			
• **Acute**	56	56	56
• **Mental Health**	17	17	17
• **Community Living Center**	NA	NA	NA
• **Domiciliary**	NA	NA	NA
Average Daily Census:			
• **Acute**	34	37	35
• **Mental Health**	14	10	13
• **Community Living Center**	NA	NA	NA
• **Domiciliary**	NA	NA	NA

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

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

NA = Not applicable

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[37] VHA medical centers are classified according to a facility complexity model; 2 designation indicates a facility with medium volume, low-risk patients, few complex clinical programs, and small or no research and teaching programs. Retrieved November 8, 2017, http://opes.vssc.med.va.gov/FacilityComplexityLevels/Pages/default.aspx

[38] Associated with a medical residency program.

[39] October 1, 2013 through September 30, 2014.

[40] October 1, 2014 through September 30, 2015.

[41] October 1, 2015 through September 30, 2016.

[42] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[43]

The VA outpatient clinics in communities within the catchment area of the facility provide PC integrated with women's health, MH, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table 6 provides information relative to each of the clinics.

Table 6. VA Outpatient Clinic Workload/Encounters[44] and Specialty Care, Diagnostic, and Ancillary Services Provided for October 1, 2015 through September 30, 2016

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[45] Provided	Diagnostic Services[46] Provided	Ancillary Services[47] Provided
New Bedford, MA	650GA	8,391	4,222	Cardiology Dermatology Neurology Poly-Trauma Eye Podiatry	EKG	Nutrition Pharmacy Weight Management
Hyannis, MA	650GB	8,840	3,479	Cardiology Dermatology Neurology Blind Rehab Eye Anesthesia ENT	Vascular Lab	Nutrition Pharmacy Weight Management
Middletown, RI	650GD	5,930	3,271	Cardiology Dermatology Anesthesia Podiatry	EKG	Nutrition Pharmacy

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

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

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[43] Includes all outpatient clinics in the community that were in operation as of February 15, 2017. We have omitted Providence, RI (650QA), as no workload/encounters or services were reported.

[44] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.

[45] Specialty care services refer to non-primary care and non-MH services provided by a physician.

[46] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

[47] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

VHA Policies Beyond Recertification Dates

In this report, OIG cited three policies that were beyond the recertification date:

1. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (recertification due date June 30, 2015).

2. VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012 (recertification due date July 31, 2017).

3. VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004 (recertification due date January 31, 2009).

OIG considered these policies to be in effect, as they had not been superseded by more recent policy or guidance. In a June 29, 2016, memorandum to supplement policy provided by VHA Directive 6330(1),[48] the VA Under Secretary for Health mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[49] The Under Secretary for Health also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[50]

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[48] VHA Directive 6330(1), *Controlled National Policy/Directives Management System,* June 24, 2016, amended January 11, 2017.
[49] VA Under Secretary for Health. "Validity of VHA Policy Document." Memorandum. June 29, 2016.
[50] Ibid.

Patient Aligned Care Team Compass Metrics
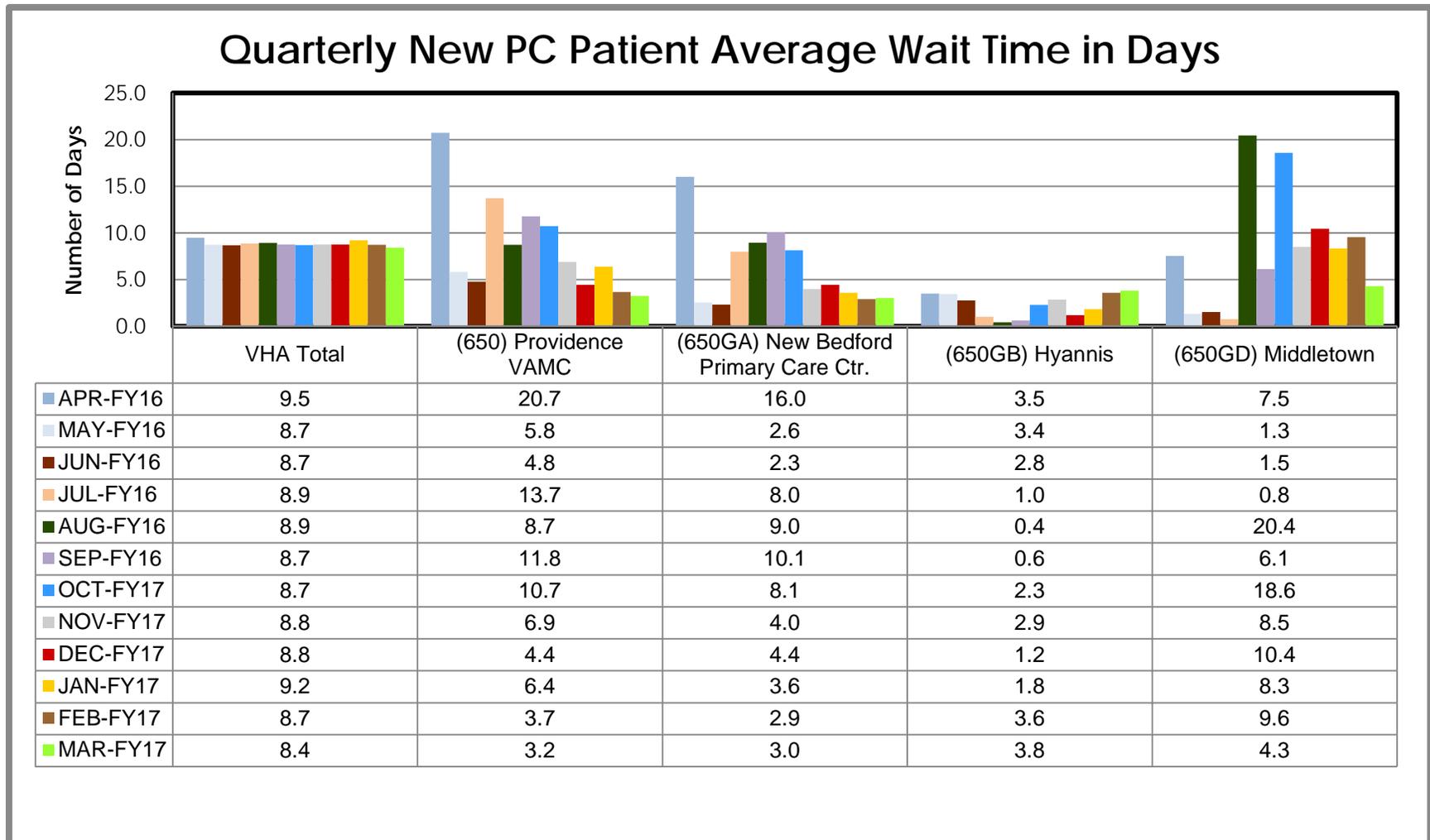
Quarterly New PC Patient Average Wait Time in Days

	VHA Total	(650) Providence VAMC	(650GA) New Bedford Primary Care Ctr.	(650GB) Hyannis	(650GD) Middletown
APR-FY16	9.5	20.7	16.0	3.5	7.5
MAY-FY16	8.7	5.8	2.6	3.4	1.3
JUN-FY16	8.7	4.8	2.3	2.8	1.5
JUL-FY16	8.9	13.7	8.0	1.0	0.8
AUG-FY16	8.9	8.7	9.0	0.4	20.4
SEP-FY16	8.7	11.8	10.1	0.6	6.1
OCT-FY17	8.7	10.7	8.1	2.3	18.6
NOV-FY17	8.8	6.9	4.0	2.9	8.5
DEC-FY17	8.8	4.4	4.4	1.2	10.4
JAN-FY17	9.2	6.4	3.6	1.8	8.3
FEB-FY17	8.7	3.7	2.9	3.6	9.6
MAR-FY17	8.4	3.2	3.0	3.8	4.3

Source: VHA Support Service Center.

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

Data Definition[g]: The average number of calendar days between a new patient's PC 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. *Note that prior to FY 2015, this metric was calculated using the earliest possible create date.*

Quarterly Established PC Patient Average Wait Time in Days
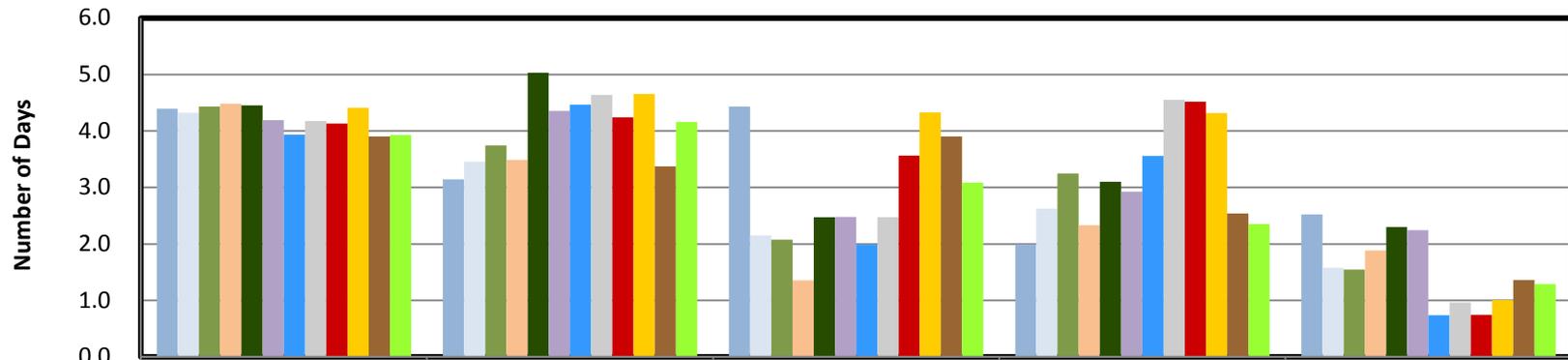
	VHA Total	(650) Providence VAMC	(650GA) New Bedford Primary Care Ctr.	(650GB) Hyannis	(650GD) Middletown
APR-FY16	4.4	3.1	4.4	2.0	2.5
MAY-FY16	4.3	3.5	2.1	2.6	1.6
JUN-FY16	4.4	3.7	2.1	3.3	1.5
JUL-FY16	4.5	3.5	1.4	2.3	1.9
AUG-FY16	4.5	5.0	2.5	3.1	2.3
SEP-FY16	4.2	4.4	2.5	2.9	2.2
OCT-FY17	3.9	4.5	2.0	3.6	0.7
NOV-FY17	4.2	4.6	2.5	4.6	1.0
DEC-FY17	4.1	4.2	3.6	4.5	0.7
JAN-FY17	4.4	4.7	4.3	4.3	1.0
FEB-FY17	3.9	3.4	3.9	2.5	1.4
MAR-FY17	3.9	4.2	3.1	2.4	1.3

Source: VHA Support Service Center.

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

Data Definition: The average number of calendar days between an established patient's PC 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.

Quarterly Team 2-Day Post Discharge Contact Ratio
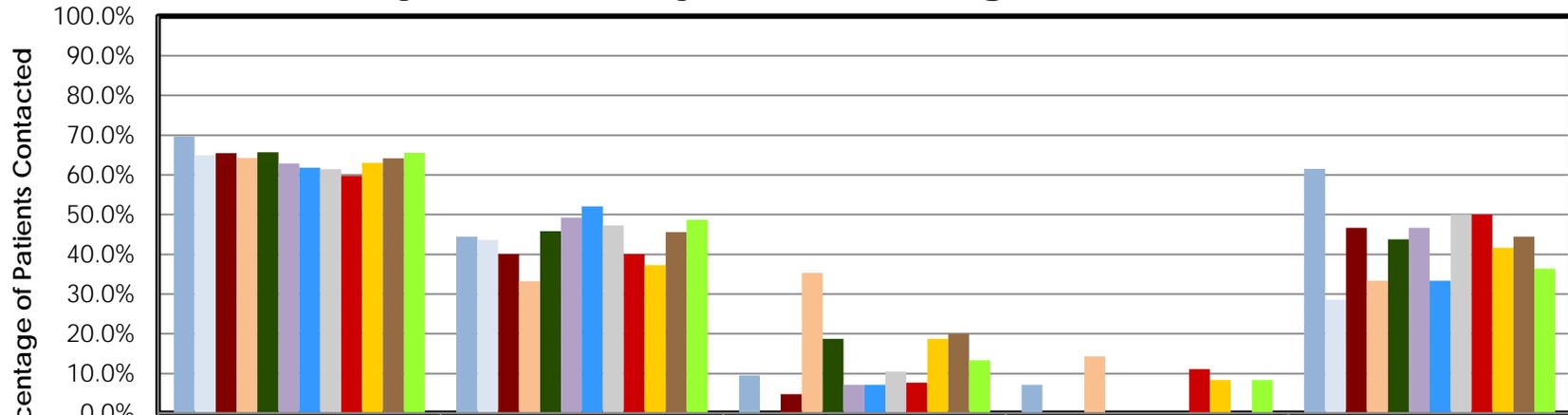
Percentage of Patients Contacted

	VHA Total	(650) Providence VAMC	(650GA) New Bedford Primary Care Ctr.	(650GB) Hyannis	(650GD) Middletown
APR-FY16	69.7%	44.4%	9.5%	7.1%	61.5%
MAY-FY16	65.0%	43.6%	0.0%	0.0%	28.6%
JUN-FY16	65.5%	40.1%	4.8%	0.0%	46.7%
JUL-FY16	64.3%	33.2%	35.3%	14.3%	33.3%
AUG-FY16	65.7%	45.8%	18.8%	0.0%	43.8%
SEP-FY16	62.9%	49.2%	7.1%	0.0%	46.7%
OCT-FY17	61.8%	52.1%	7.1%	0.0%	33.3%
NOV-FY17	61.4%	47.3%	10.5%	0.0%	50.0%
DEC-FY17	59.8%	40.1%	7.7%	11.1%	50.0%
JAN-FY17	63.0%	37.3%	18.8%	8.3%	41.7%
FEB-FY17	64.2%	45.6%	20.0%	0.0%	44.4%
MAR-FY17	65.6%	48.7%	13.3%	8.3%	36.4%

_Source: VHA Support Service Center._

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

Data Definition: The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 2 business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within 2 business days to any VA facility. Team members must have been assigned to the patient's team at the time of the patient's discharge. Team member identification is based on the primary provider on the encounter. Performance measure mnemonic "PACT17."

Quarterly Ratio of ER/Urgent Care Encounters While on Panel to PC Encounters While on Panel (FEE ER Excluded)
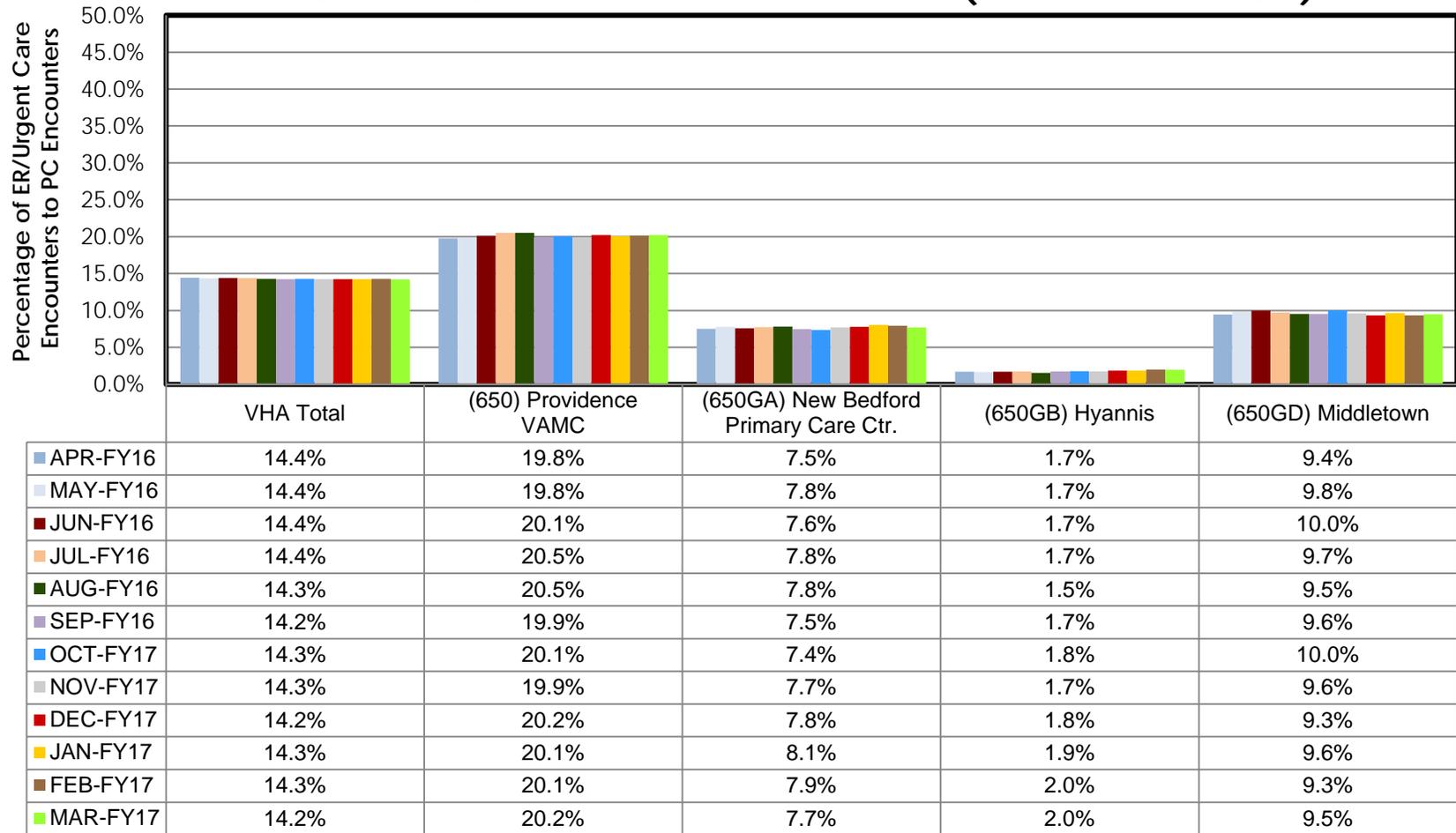
	VHA Total	(650) Providence VAMC	(650GA) New Bedford Primary Care Ctr.	(650GB) Hyannis	(650GD) Middletown
APR-FY16	14.4%	19.8%	7.5%	1.7%	9.4%
MAY-FY16	14.4%	19.8%	7.8%	1.7%	9.8%
JUN-FY16	14.4%	20.1%	7.6%	1.7%	10.0%
JUL-FY16	14.4%	20.5%	7.8%	1.7%	9.7%
AUG-FY16	14.3%	20.5%	7.8%	1.5%	9.5%
SEP-FY16	14.2%	19.9%	7.5%	1.7%	9.6%
OCT-FY17	14.3%	20.1%	7.4%	1.8%	10.0%
NOV-FY17	14.3%	19.9%	7.7%	1.7%	9.6%
DEC-FY17	14.2%	20.2%	7.8%	1.8%	9.3%
JAN-FY17	14.3%	20.1%	8.1%	1.9%	9.6%
FEB-FY17	14.3%	20.1%	7.9%	2.0%	9.3%
MAR-FY17	14.2%	20.2%	7.7%	2.0%	9.5%

Source: VHA Support Service Center.

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

Data Definition: This is a measure of where the patient receives his PC and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care Encounters While on Team (WOT) with a Licensed Independent Practitioner (LIP) *divided by* the number of PC Team Encounters WOT with an LIP **plus** the total number of VHA ER/Urgent Care Encounters WOT with an LIP.

Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[h]

Measure	Definition	Desired Direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit Reviews Met	% Acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Cont Stay Reviews Met	% Acute Continued Stay reviews that meet InterQual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
PC Routine Care Appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC Urgent Care Appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PC Wait Time	PC wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC Provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC Provider	Rating of specialty care providers (specialty care module)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value

Measure	Definition	Desired Direction
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value
SC Urgent Care Appt	Timeliness in getting a SC urgent care appointment (Specialty Care)	A higher value is better than a lower value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value

Source: VHA Support Service Center.

Relevant OIG Reports

June 1, 2014 through March 1, 2018[51]

Healthcare Inspection – Alleged Misdiagnosis and Delay in Treatment, Providence VA Medical Center, Providence, Rhode Island
6/15/2017 | 15-05123-254 | Summary | Report

Combined Assessment Program Review of the Providence VA Medical Center, Providence, Rhode Island
9/2/2014 | 14-02066-266 | Summary | Report

Audit of VBA's Efforts to Effectively Obtain Veterans' Service Treatment Records
8/28/2014 | 14-00657-261 | Summary | Report

Community Based Outpatient Clinic and Primary Care Clinic Reviews at Providence VA Medical Center, Providence, Rhode Island
8/13/2014 | 14-00922-240 | Summary | Report

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[51] These are relevant reports that focused on the facility as well as national-level evaluations of which the facility was a component of the review.

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: January 24, 2018

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

Subject: **CHIP Review of the Providence VA Medical Center, Providence, RI**

To: Associate Director, Bay Pines Office of Healthcare Inspections (54SP)

Director, Management Review Service (VHA 10E1D MRS Action)

I have reviewed and concur with the findings, recommendations, and action plans submitted by Providence VAMC in regards to the CHIP review of the Providence VA Medical Center.

Sincerely,
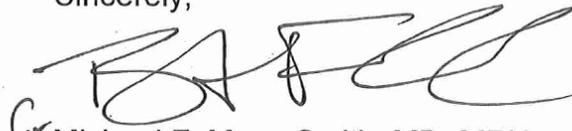
Michael F. Mayo-Smith, MD, MPH
Network Director, VISN 1

Acting Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: January 12, 2018

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

Subject: **CHIP Review of the Providence VA Medical Center, Providence, RI**

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

Providence VAMC concurs with the OIG's Report.

Erin Clare Sears 149435
Digitally signed by Erin Clare Sears 149435
Date: 2018.01.12 13:37:12 -05'00'

Erin Clare Sears, MBA, MSW
Medical Center Director, Acting

OIG Contact and Staff Acknowledgments

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Other Contributors	Elizabeth Bullock Limin Clegg, PhD LaFonda Henry, RN-BC, MSN Larry Ross, Jr., MS Marilyn Stones, BS April Terenzi, BS, BA Carol Torczon, MSN, ACNP Mary Toy, RN, MSN

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    Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Ed Markey, Jack Reed, Elizabeth Warren, Sheldon Whitehouse
U.S. House of Representatives: Michael E. Capuano, David L. Cicilline, Katherine Clark,
    Bill Keating, Joe Kennedy III, Jim Langevin, Stephen F. Lynch, Jim McGovern,
    Seth Moulton, Richard E. Neal, Niki Tsongas

This report is available at www.va.gov/oig.

Endnotes

[a] The references used for QSV were:

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

[b] The references used for Medication Management: Anticoagulation Therapy included:

- VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*; August 2, 2013.
- VHA Directive 1033, *Anticoagulation Therapy Management,* July 29, 2015.
- VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

[c] The references used for Coordination of Care: Inter-Facility Transfers included:

- VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007. This directive was in effect during the timeframe of OIG's review but has been rescinded and replaced with VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.

[d] The references used for EOC included:

- VHA Directive 1014, *Safe Medication Injection Practices*, July 1, 2015.
- VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
- VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.
- VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs*, November 7, 2017.
- VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.
- VHA Directive 1229, *Planning and Operating Outpatient Sites of Care*, July 7, 2017.
- VHA Directive 1330.01(1), *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017).
- VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.
- VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- VHA Radiology Online Guide, http://vaww.infoshare.va.gov/sites/diagnosticservices/NRP/Mammography/Radiology%20Shared%20Files/Radiology_Service_Online_Guide_2016.docx, November 3, 2016.
- MH EOC Checklist, VA National Center for Patient Safety, http://vaww.ncps.med.va.gov/guidelines.html#mhc, accessed December 8, 2016.
- Various requirements of TJC, Association for the Advancement of Medical Instrumentation/Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration, International Association of Healthcare Central Service Materiel Management, National Fire Protection Association.

[e] The references used for Moderate Sedation included:

- VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009.
- VHA Directive1039, *Ensuring Correct Surgery and Invasive Procedures*, July 26, 2013.
- VHA Directive 1073, *Moderate Sedation by Non-Anesthesia Providers*, December 30, 2014.
- VHA Directive 1177; *Cardiopulmonary Resuscitation, Basic Life Support, and Advanced Cardiac Life Support Training for Staff*; November 6, 2014.
- VA National Center for Patient Safety. *Facilitator's Guide for Moderate Sedation Toolkit for Non-Anesthesiologists*. March 29, 2011.
- American Society of Anesthesiologists. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology*. 2002; 96:1004–17.

- TJC. Hospital Standards. January 2016. PC.03.01.01, EP1 and MS.06.01.03 EP6.

[f] The references used for CNH Oversight included:

- VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.
- VA OIG report, *Healthcare Inspection – Evaluation of the Veterans Health Administration's Contact Community Nursing Home Program,* (Report No. 05-00266-39, December 13, 2007).

[g] The reference used for PACT Compass data graphs was:

- Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed: April 28, 2017.

[h] The reference used for the Strategic Analytics for Improvement and Learning (SAIL) metric definitions was:

- VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: October 3, 2016.