



US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Providence Healthcare System in Rhode Island

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Figure 1. Providence VA Medical Center of the VA Providence Healthcare System in Rhode Island.

Source: <https://www.va.gov/providence-health-care/locations> (accessed March 3, 2023).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Report Overview

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

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following five areas of clinical and administrative operations:

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

The OIG initiated an unannounced inspection of the VA Providence Healthcare System during the week of December 12, 2022. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted opportunities for improvement and issued two recommendations to the Chief of Staff in the Medical Staff Privileging and Mental Health areas of review. The number of recommendations should not be used as a gauge for the overall quality of care provided at this healthcare system. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the delivery of quality health care. The results

are detailed throughout the report, and the recommendations are summarized in appendix A on page 20.

VA Comments

The Veterans Integrated Service Network Director and the System Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 22-23, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.



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Purpose and Scope

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

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.² Effective leadership has been cited as “among the most critical components that lead an organization to effective and successful outcomes.”³

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

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

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

² Anam Parand et al., “The Role of Hospital Managers in Quality and Patient Safety: A Systematic Review,” *British Medical Journal* 4, no. 9 (September 5, 2014): 13, <https://doi.org/10.1136/bmjopen-2014-005055>.

³ Danae F. Sfantou et al., “Importance of Leadership Style towards Quality of Care Measures in Healthcare Settings: A Systematic Review,” *Healthcare (Basel)* 5, no. 4 (October 14, 2017): 73, <https://doi.org/10.3390/healthcare5040073>.

⁴ CHIP site visits addressed these processes during fiscal year (FY) 2023 (October 1, 2022, through September 30, 2023); they may differ from prior years’ focus areas.

Methodology

The VA Providence Healthcare System includes the Providence VA Medical Center and multiple outpatient clinics in Massachusetts and Rhode Island. General information about the healthcare system can be found in appendix B.

The OIG inspected the VA Providence Healthcare System beginning the week of December 12, 2022.⁵ During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.⁶ The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

⁵ The OIG's last comprehensive healthcare inspection of the VA Providence Healthcare System occurred in February 2021. The Joint Commission performed hospital, behavioral health care, and home care accreditation reviews in July 2021 and a laboratory review in March 2022.

⁶ Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Results and Recommendations

Leadership and Organizational Risks

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

To assess this healthcare system’s leadership and risks, the OIG considered the following indicators:

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

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The healthcare system had a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Associate Director, and Assistant Director. The Chief of Staff and ADPCS oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the executive leaders had worked together for almost 11 months since the Chief of Staff joined in January 2022. The Associate Director, appointed in April 2013, was the most tenured leader.

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

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

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

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

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2022 annual medical care budget of \$405,540,321 had increased by almost 7 percent compared to the previous year's budget of \$380,435,002.¹⁰ The Director and Chief of Staff stated that salary caps made it difficult for the healthcare system to compete against community facilities for specialty providers.¹¹ The Chief of Staff described a staffing crisis with anesthesiology providers (anesthesiologists and certified registered nurse anesthetists), orthopedists, laboratory technicians, and diagnostic radiology technologists. To recruit additional staff, the Chief of Staff discussed strategies such as providing salary adjustments; tuition reimbursement; and retention, recruitment, and relocation incentives. The Associate Director explained that staff from other facilities temporarily assisted in the anesthesiology department. Additionally, the Associate Director stated leaders used the increased funds to upgrade the security camera system and hire program managers and complementary care practitioners such as chiropractors and acupuncturists to support the Whole Health initiative.¹²

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."¹³ Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical facility leaders.

To assess employee viewpoints, the OIG reviewed results from VA's All Employee Survey from FYs 2020 through 2022 regarding their perceived ability to disclose a suspected violation

¹⁰ Veterans Health Administration (VHA) Support Service Center.

¹¹ Under VHA pay authority 38 U.S.C. §§ 7410, the total salary for federal employees including healthcare providers cannot exceed the annual pay of the President of the United States. On August 10, 2022, the *Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics* (PACT) Act was signed into law, which amended 38 U.S.C. §§ 7410 to exclude recruitment, retention, and relocation bonuses from the total salary.

¹² VA's Whole Health initiative focuses on developing personalized health plans based on patients' "values, needs, and goals." "Whole Health," Department of Veterans Affairs, accessed February 21, 2023, <https://www.va.gov/wholehealth/>.

¹³ "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center.

without fear of reprisal.¹⁴ Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the healthcare system over time.

The OIG found that the healthcare system’s averages were comparable to VHA averages. The Director attributed the scores to the organization’s culture and employees’ sense of psychological safety and dedication, adding that they loved working in the family-like environment. The Director also stated that *Forbes* magazine ranked the facility as the third-best employer in the state. The ADPCS discussed several factors that may have affected scores, including leaders modeling high reliability organization principles and endorsing mutual accountability and transparency with staff.¹⁵

The ADPCS shared a story highlighting an impressive effort from a nurse who found a cross left by a veteran who had been recently discharged. The nurse recognized the significance of the item and was able to track down the family and return it. The family appreciated the effort and conveyed that the veteran, who had recently died, had wished to be buried with the cross.

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

All Employee Survey Group	FY 2020	FY 2021	FY 2022
VHA	3.8	3.9	3.9
VA Providence Healthcare System	3.8	3.9	3.9

Source: VA All Employee Survey (accessed October 18, 2022).

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

Patient Experience

VHA uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to assess patients’ healthcare experiences and compare them to the private sector. VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.¹⁶ The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from

¹⁴ The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only.

¹⁵ A high-reliability organization “is an organization with a goal of achieving ‘zero harm’ in an environment where accidents are expected due to complexity or risk factors.” VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

¹⁶ “Patient Experiences Survey Results,” VHA Support Service Center.

October 2019 (FY 2020) to July 2022 (FY 2022). Table 2 provides survey results for VHA and the healthcare system over time.

The inpatient satisfaction survey scores were higher than VHA averages in FY 2020 and 2021 but declined significantly in FY 2022. The Chief of Staff attributed the decline to COVID-19 pandemic protocols, explaining the facility often reached maximum capacity, staff frequently had to move beds to accommodate patient care needs, and patients did not like being asked to wear masks in their rooms.

Survey scores for primary and specialty care satisfaction were consistently higher than VHA averages, indicating patients were more satisfied with their care compared to VHA patients nationally. The Director, ADPCS, and Associate Director attributed the higher scores to the dedicated staff, family-like atmosphere, and welcoming culture. The Director stated patients loved the care they received at the facility as evidenced by above-average VSignals scores.¹⁷ Also, the Director indicated that patients chose to receive care at the facility despite having other options, characterizing the staff as exceptional, focused, and willing to go the extra mile. The ADPCS reiterated the Director's statements and explained that patients nominated deserving staff, who received special contribution and DAISY awards for their caring service.¹⁸ The Associate Director described placing greeters at the doors to help veterans get to their clinics and highlighted the robust patient advocacy team composed of social workers familiar with individual patients due to their close working relationships.

¹⁷ "In April 2016, the Veterans Experience Office (VEO) launched Veterans Signals (VSignals), the survey platform used to measure trust in VA." "Veteran Trust in VA," Department of Veterans Affairs, accessed January 23, 2023, <https://www.va.gov/initiatives/veteran-trust-in-va/>.

¹⁸ The DAISY Award is an international program that rewards and celebrates the extraordinary clinical skill and compassionate care given by nurses every day. "What is The DAISY Award?," The DAISY Foundation, accessed January 23, 2023, <https://www.daisyfoundation.org/daisy-award>.

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Healthcare System	VHA	Healthcare System	VHA	Healthcare System
Inpatient: <i>Would you recommend this hospital to your friends and family?*</i>	69.5	71.3	69.7	72.7	68.5	67.4
Patient-Centered Medical Home: <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?</i>	82.5	88.6	81.9	88.7	81.0	83.9
Specialty Care: <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?</i>	84.8	88.3	83.3	87.6	82.0	90.2

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 7, 2022).

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

The response average is the percent of “Very satisfied” and “Satisfied” responses.

Identified Factors Related to Possible Lapses in Care and Healthcare System Leaders’ Responses

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.¹⁹ According to The Joint Commission’s standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.²⁰ A VA medical facility’s culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

¹⁹ Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; “Quality and Patient Safety (QPS),” Department of Veterans Affairs, accessed October 13, 2021, <https://www.va.gov/QUALITYANDPATIENTSAFETY/>.

²⁰ The Joint Commission, *Standards Manual*, E-dition, July 1, 2022. A culture of safety is “the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization’s health and safety management.” “Hospital Survey on Patient Safety Culture Version 2.0 User’s Guide,” Agency for Healthcare Research and Quality, June 2021, <https://www.ahrq.gov/sites/default/files/wysiwyg/sops/surveys/hospital/AHRO-Hospital-Survey-2.0-Users-Guide-5.26.2021.pdf>.

when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.²¹

“A sentinel event is a patient safety event (not primarily related to the natural course of a patient’s illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm).”²²

Additionally, an institutional disclosure is “a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient’s personal representative that an adverse event has occurred during the patient’s care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient’s rights and recourse.”²³ Lastly, a large-scale disclosure is “a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue.”²⁴ To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.²⁵

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred during FY 2022 and reviewed the information staff provided. When asked about patient safety processes at the facility, the Director expressed a belief that through their high reliability organization journey, employees’ sense of psychological safety had increased and more employees were comfortable reporting patient safety events, adding that the number of reported events had recently increased from approximately 5 per month to over 100.

The Director said the Patient Safety Manager updated leaders during morning huddles and monitored patient safety event trends through predictive analyses. The ADPCS stated the Patient Safety Manager assessed the risk level of each event, coordinated clinical reviews, and tracked reported cases. The Director described discussing events with the Chief of Staff and Patient Safety Manager to determine the type of disclosure needed. The Director also reported being responsible for the final decision, although the Chief of Staff recommended the type of disclosure then coordinated with the Patient Safety Manager to schedule it.

²¹ Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events (2nd ed.)*, Institute for Healthcare Improvement White Paper, 2011.

²² The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, Sentinel Event Policy (SE), July 2023. VHA incorporates The Joint Commission’s definition of a sentinel event in VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

²³ VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

²⁴ VHA Directive 1004.08.

²⁵ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. The new directive contains similar language regarding patient safety as the rescinded handbook.)

The OIG discussed the results of the prior comprehensive healthcare inspection with the Chief, Quality Management; Patient Safety Manager; and Risk Manager. The Chief, Quality Management acknowledged that one recommendation related to nurse-to-nurse communication for intra-facility transfers remained open, saying staff had recently submitted documentation to the VISN supporting compliance and requesting closure.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.²⁶ To achieve this goal, VHA requires that its medical facility leaders implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.²⁷ Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.²⁸

VHA implemented the National Center for Patient Safety program to develop a range of patient safety methodologies and practices. VHA's Patient Safety program includes staff assessing system vulnerabilities that may result in patient harm, reporting adverse patient safety events, and focusing on prevention.²⁹ According to The Joint Commission's standards for performance improvement, staff must analyze data to monitor performance and identify trends and improvement opportunities, then implement actions to enhance patient safety.³⁰

The OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.³¹ Peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."³² Peer reviews are "intended to promote confidential and non-punitive assessments of care" that consistently contribute to quality management efforts at the individual provider level.³³

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

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

²⁶ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

²⁷ VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.

²⁸ VHA Directive 1100.16.

²⁹ VHA Handbook 1050.01; VHA Directive 1050.01.

³⁰ The Joint Commission, *Standards Manual*, E-dition, PI.03.01.01, PI.04.01.01, January 1, 2022.

³¹ A peer review is a "critical review of care performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190.

³² VHA Directive 1190.

³³ VHA Directive 1190.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of “all health care professionals who are permitted by law and the facility to practice independently.”³⁴ These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care “without supervision or direction, within the scope of the individual’s license, and in accordance with individually-granted clinical privileges.”³⁵

Privileges need to be specific and based on the individual practitioner’s clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP’s credentials and service chief’s recommendation to determine whether “clinical competence is adequately demonstrated to support the granting of the requested privileges,” and submits the final recommendation to the facility director.³⁶ LIPs are granted clinical privileges for a limited time and must be repriviledged prior to their expiration.³⁷

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs’ professional performance. The Focused Professional Practice Evaluation process occurs when a practitioner is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP’s performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.³⁸

VHA’s credentialing process involves the assessment and verification of healthcare practitioners’ qualifications to provide care and is the first step in ensuring patient safety.³⁹ Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office under the chief of staff. VHA also requires facilities to have credentialing and

³⁴ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded this handbook and replaced it with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

³⁵ VHA Handbook 1100.19.

³⁶ VHA Handbook 1100.19.

³⁷ VHA Handbook 1100.19.

³⁸ VHA Handbook 1100.19.

³⁹ VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.⁴⁰

The OIG interviewed key managers and selected and reviewed the privileging folders of 28 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

VHA requires providers with equivalent specialized training and similar privileges to complete Focused Professional Practice Evaluations.⁴¹ The OIG found that a similarly trained and privileged provider did not complete one Focused Professional Practice Evaluation for a solo LIP.⁴² This could result in the LIP providing care without a thorough evaluation, which could adversely affect quality of care and jeopardize patient safety. The Chief of Staff acknowledged the deficiency but did not provide a reason for noncompliance.

Recommendation 1

1. The Chief of Staff ensures providers with equivalent specialized training and similar privileges complete Focused Professional Practice Evaluations for licensed independent practitioners.

⁴⁰ Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo, “Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020,” December 16, 2020.

⁴¹ Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer’s Revision memo, “Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators,” May 18, 2021. VHA Directive 1100.21(1).

⁴² VHA refers to a solo LIP as being one provider in the facility who is privileged in a particular specialty. Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer’s Revision memo, “Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators.”

Healthcare system concurred.

Target date for completion: December 31, 2023

Healthcare system response: All service chiefs have been re-educated to the expectation of a completed Focused Professional Practice Evaluation review, including the fact that similarly privileged providers must perform the peer review for Focused Professional Practice Evaluations. All personnel files are reviewed by service chiefs for completion, ensuring all Focused Professional Practice Evaluation reviews have been completed by similarly privileged providers. All personnel files presented to Executive Committee of the Medical Staff are also reviewed by the accreditation coordinator and/or credentialing manager for completion prior to approval. Any record missing a Focused Professional Practice Evaluation document is deferred until completed, and the Focused Professional Practice Evaluation extensions are noted in Executive Committee of the Medical Staff minutes.

VAPHS [VA Providence Healthcare System] will continue to track and monitor all completed Focused Professional Practice Evaluation reviews monthly for review by similarly privileged providers. Monthly reviews by the accreditation coordinator and/or credentialing manager of all personnel files will continue until we have achieved 90% adherence for 6 consecutive months. The numerator will be number of completed Focused Professional Practice Evaluations by similarly privileged providers and the denominator will be the total number of Focused Professional Practice Evaluations.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of VHA's environment of care program is to ensure "a safe, clean health care environment that provides the highest standards in the health care setting."⁴³ The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.⁴⁴

The purpose of this inspection was to determine whether staff at VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG inspected selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.⁴⁵

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected 10 patient care areas:

- Emergency Department
- Intensive care unit (medical/surgical)
- Medical/surgical inpatient units (5-B, 6-B, and 6-E)
- Mental health inpatient unit (4-A)
- Mental health outpatient clinic
- Primary care clinic
- Specialty clinic (rotated by day of the week: dermatology, neurology, orthopedic, surgical, urology)
- Women's health clinic

⁴³ VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. (This directive was in effect at the time of the inspection. VHA amended it September 7, 2023.)

⁴⁴ VHA Directive 1608. The supply chain management system must meet the needs of its customers, which involves ensuring availability of the right product in the right place and at the right time. VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

⁴⁵ VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (VHA rescinded and replaced this handbook with VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023.) VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142, *Standards for Community Living Centers*, October 5, 2023.)

Environment of Care Findings and Recommendations

The OIG made no recommendations.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.⁴⁶ Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.⁴⁷ The suicide rate for veterans was higher than for nonveteran adults during 2020.⁴⁸ “Congress, VA, and stakeholders continue to express concern over seemingly limited progress made...to reduce veteran suicide.”⁴⁹

Due to the prevalence of suicide among at-risk veterans, VHA implemented a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.⁵⁰ VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.⁵¹

VHA requires each medical center and very large community-based outpatient clinic to have a full-time suicide prevention coordinator to track and follow up with high-risk veterans, conduct community outreach activities, and inform leaders of suicide-related events.⁵²

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and reviewed relevant documents and the electronic health records of 23 patients who had a positive suicide screen in FY 2022 and received primary care services.

⁴⁶ VA Secretary memo, “Agency-Wide Required Suicide Prevention Training,” October 15, 2020.

⁴⁷ “Suicide Prevention: Facts about Suicide,” Centers for Disease Control and Prevention, accessed March 14, 2022, https://www.cdc.gov/suicide/facts/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Fsuicide%2Ffastfact.html.

⁴⁸ VA Office of Mental Health and Suicide Prevention, *2022 National Veteran Suicide Prevention Annual Report*, September 2022.

⁴⁹ Congressional Research Service, “Veteran Suicide Prevention,” IF11886 version 2, July 29, 2021.

⁵⁰ Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy),” November 13, 2020. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy),” November 23, 2022.)

⁵¹ Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy);” Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Suicide Behavior and Overdose Reporting,” July 20, 2021. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Update to Suicide Behavior and Overdose Reporting,” May 9, 2023.)

⁵² VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021. “Very large CBOCs [community-based outpatient clinics] are those that serve more than 10,000 unique veterans each year.” VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. (VHA rescinded and replaced this handbook with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.)

Mental Health Findings and Recommendations

VHA requires providers to complete the Comprehensive Suicide Risk Evaluation following a positive suicide risk screen. VHA also states that providers should complete the evaluation on the same calendar day unless it is not clinically appropriate, such as when urgent or emergent care is needed.⁵³ The OIG found that providers did not complete the evaluation following a positive screen for 13 percent of patients. The OIG also determined that, of those evaluations completed, providers did not complete 25 percent of them on the same calendar day when clinically appropriate. When providers do not assess patients for suicidal thoughts and behaviors or evaluate them promptly, they may miss signs of imminent risk. The Associate Chief of Staff, Mental Health Behavioral Sciences Service discussed the need to re-educate and re-train providers about completing evaluations on the same day.

Recommendation 2

2. The Chief of Staff ensures providers complete the Comprehensive Suicide Risk Evaluation on the same calendar day, when it is clinically appropriate, following a positive suicide risk screen.

⁵³ Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy);” Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy).”

Healthcare system concurred.

Target date for completion: December 31, 2023

Healthcare system response: All Licensed Independent Practitioners have been re-educated to suicide risk screening and completion of [the] Comprehensive Suicide Risk Evaluation on the same calendar day, following a positive suicide risk screen. The VAPHS suicide prevention team receives and reviews a report twice a day for positive Columbia-Suicide Severity Rating Scale Screener assessments. Our suicide prevention coordinator/designee reviews records of patients with positive Columbia-Suicide Severity Rating Scale Screener and follows up with the treating provider to ensure [the] Comprehensive Suicide Risk Evaluation was completed. If [the] Comprehensive Suicide Risk Evaluation was not documented at time of review, [the] suicide prevention coordinator will work with [the] provider to coordinate arrangements for outreach and completion of the Comprehensive Suicide Risk Evaluation. Real-time education is provided to providers requiring suicide prevention coordinator follow-up. If [the] Comprehensive Suicide Risk Evaluation was not documented on the same day as a positive screen, a safety report is also filed to identify any further opportunities for improvement and systemic challenges.

VAPHS will continue to track and monitor all completed Comprehensive Suicide Risk Evaluation assessments for patients screened positive for [the] Columbia-Suicide Severity Rating Scale Screener. As numbers of patients with positive Columbia-Suicide Severity Rating Scale Screener are generally fewer than 10 per month, assessment of compliance will be measured on a quarterly basis. We will demonstrate 90% adherence for two consecutive quarters.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	<ul style="list-style-type: none"> • None
Quality, Safety, and Value	<ul style="list-style-type: none"> • None
Medical Staff Privileging	<ul style="list-style-type: none"> • Providers with equivalent specialized training and similar privileges complete Focused Professional Practice Evaluations for licensed independent practitioners.
Environment of Care	<ul style="list-style-type: none"> • None
Mental Health: Suicide Prevention Initiatives	<ul style="list-style-type: none"> • Providers complete the Comprehensive Suicide Risk Evaluation on the same calendar day, when it is clinically appropriate, following a positive suicide risk screen.

Appendix B: Healthcare System Profile

The table below provides general background information for this mid-high complexity (1c) affiliated healthcare system reporting to VISN 1.¹

**Table B.1. Profile for VA Providence Healthcare System (650)
(October 1, 2019, through September 30, 2022)**

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021	Healthcare System Data FY 2022‡
Total medical care budget	\$351,790,821	\$380,435,002	\$405,540,321
Number of:			
• Unique patients	34,368	37,571	34,341
• Outpatient visits	455,906	498,978	478,616
• Unique employees§	1,277	1,311	1,324
Type and number of operating beds:			
• Medicine	44	44	44
• Mental health	17	17	17
• Surgery	12	12	12
Average daily census:			
• Medicine	29	40	40
• Mental health	11	12	13
• Surgery	4	4	4

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

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

*October 1, 2019, through September 30, 2020.

October 1, 2020, through September 30, 2021.

‡October 1, 2021, through September 30, 2022.

§Unique employees involved in direct medical care (cost center 8200).

¹ VHA medical facilities are classified according to a complexity model; a designation of “1c” indicates a facility with “medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs.” VHA Office of Productivity, Efficiency & Staffing (OPES), “VHA Facility Complexity Model Fact Sheet,” October 1, 2020. An affiliated healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: November 9, 2023

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

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

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

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

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the VA Providence Healthcare System, Providence, Rhode Island.
2. I have reviewed and concur with the recommendations, findings and action plans set forth in this report.

(Original signed by:)

Ryan Lilly

Network Director, VISN 1 • VHA

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: November 9, 2023

From: Director, VA Providence Healthcare System (650)

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

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

1. Thank you for the opportunity to review and provide a response to the findings from the draft report of the Comprehensive Healthcare Inspection of the VA Providence Healthcare System, Providence, Rhode Island.
2. I have reviewed and concur with the findings and recommendations. I have provided detailed actions completed after our Comprehensive Healthcare Inspection to correct these findings.
3. I appreciate the Office of Inspector General's partnership in our continuous improvement efforts.

(Original signed by:)

Lawrence Connell
Director-VAPHS

OIG Contact and Staff Acknowledgments

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