Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-00708-171

Combined Assessment Program Review of the Providence VA Medical Center Providence, Rhode Island

April 27, 2012

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Glossary

CAP	Combined Assessment Program
COC	coordination of care
CPR	cardiopulmonary resuscitation
CRC	colorectal cancer
EOC	environment of care
facility	Providence VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
GI	gastroenterology
HF	heart failure
MH	mental health
OIG	Office of Inspector General
PRRC	Psychosocial Rehabilitation and Recovery Center
PUMA	Physician Utilization Management Advisor
QM	quality management
TBI	traumatic brain injury
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Providence VA Medical Center, Providence, RI

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of March 5, 2012.

Review Results: The review covered eight activities. We made no recommendations in the following five activities:

- Colorectal Cancer Screening
- Environment of Care
- Medication Management
- Polytrauma
- Psychosocial Rehabilitation and Recovery Centers

The facility's reported accomplishments were strengthening the colorectal cancer management program and establishing a highly effective system for assessing and caring for veterans with polytrauma and/or traumatic brain injury.

Recommendations: We made recommendations in the following three activities:

Quality Management: Ensure that results from Focused Professional Practice Evaluations are consistently documented in practitioners' profiles and that for all cases referred by utilization management reviewers, Physician Utilization Management Advisors respond, collaborate, and make medical recommendations.

Moderate Sedation: Ensure that pre-sedation assessment documentation includes all required elements and that patients are discharged from the recovery area in the company of a responsible, designated adult or to facility lodging or are admitted to an inpatient unit.

Coordination of Care: Ensure that follow-up appointments are consistently scheduled within the timeframes requested by providers.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- COC
- CRC Screening
- EOC
- Medication Management
- Moderate Sedation
- Polytrauma
- PRRCs
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2011 and FY 2012 through February 29, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from

our prior CAP review of the facility (*Combined Assessment Program Review of the Providence VA Medical Center, Providence, Rhode Island,* Report No. 10-01158-190, July 13, 2010.) The facility had corrected all findings from our previous review. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 35 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 365 responded. Survey results were shared with the facility Director.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishments

CRC Collaborative

The facility participated in the national pilot CRC Care Collaborative and now serves as a VISN resource to assist other facilities. The GI section embraced VHA policy and offers colonoscopy as the primary screening method for CRC. Since this resulted in an increased demand for colonoscopies, system redesign principles were used to improve efficiency. Patient-negotiated scheduling is the core of this successful program, and GI staff make every effort to select the patient's preferred date for the procedure. In addition, patients can self-refer to the GI clinic to schedule screening colonoscopies if they otherwise meet criteria.

Prior to the procedure, GI clinic staff meet with patients to discuss the preparation needed for colonoscopy and to review what will happen during the procedure. Staff also review any special needs patients may have, such as an escort the day of the procedure. This process has reduced the number of potentially unused appointment slots, and these improvement efforts have resulted in a no-show rate of less than 3 percent.

Facility interdisciplinary efforts have further strengthened the CRC management program. A Post-CRC Treatment Surveillance Clinic was implemented to ensure compliance with National Comprehensive Cancer Network CRC surveillance guidelines for 5 years following treatment. GI nurse practitioners review positive fecal occult blood tests each week to ensure prompt patient notification and to initiate a follow-up plan. A nurse clinical specialist tracks patients and assures that they get the appropriate follow-up visits and testing.

Polytrauma/TBI Team

The Polytrauma/TBI Team established a system for assessing and caring for patients with polytrauma/TBI. A board-certified neurologist with specialty training in TBI rehabilitation leads the core team of two neuropsychologists and one full-time masters-level social worker case manager.

The team collaboratively completes a comprehensive TBI evaluation and treatment plan in which the core providers see the patient in succession. (One provider directly introduces the patient to the next provider in one appointment.) This process ensures efficient and comprehensive care for the patient and allows for immediate discussion of diagnostic impressions and treatment planning. Team members then meet weekly to review and update Individualized Rehabilitation and Community Reintegration Care Plans. This system promotes efficient, high quality ongoing care to Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn veterans with Polytrauma/TBI.

Team members have also made educational presentations about Polytrauma/TBI to facility providers and to the community in military and academic settings.

Results

Review Activities With Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether VHA facilities complied with selected requirements within their QM programs.

We interviewed senior managers and QM personnel, and we evaluated meeting minutes, medical records, and other relevant documents. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
X	FPPEs for newly hired licensed independent practitioners complied with selected requirements.
	Staff who performed UM reviews met requirements and participated in daily interdisciplinary discussions.
X	If cases were referred to a PUMA for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
	There was a medical record quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.

Noncompliant	Areas Reviewed
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.
	The facility complied with any additional elements required by local policy.

FPPEs. VHA requires that the results from FPPEs be documented in practitioners' profiles.[1] We reviewed the profiles of 10 newly hired licensed independent practitioners and found that for 2 of the practitioners, results were not documented in their profiles.

UM. VHA requires facility PUMAs to collaborate with facility UM and medical staff to provide medical recommendations on UM case referrals that did not meet acute inpatient care criteria.[2] We reviewed 10 cases that did not meet the required criteria, which were referred to the PUMA by UM reviewers. We found no evidence that the PUMA responded, collaborated, or made any medical recommendations regarding nine of these cases.

Recommendations

1. We recommended that processes be strengthened to ensure that results from FPPEs are consistently documented in practitioners' profiles.

2. We recommended that processes be strengthened to ensure that for all cases referred by UM reviewers, PUMAs respond, collaborate, and make medical recommendations.

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[2] VHA Directive 2010-021, *Utilization Management Program,* May 14, 2010.

Moderate Sedation

The purpose of this review was to determine whether the facility developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, 9 medical records, and 95 training/competency records, and we interviewed key individuals. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
X	Pre-sedation documentation was complete.
	Informed consent was completed appropriately and performed prior to administration of sedation.
	Timeouts were appropriately conducted.
	Monitoring during and after the procedure was appropriate.
X	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.
	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.
	The facility complied with any additional elements required by local policy.

Pre-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a procedure where moderate sedation will be used.[3] Five patients' medical records did not include all required elements of the history and physical examination, such as assessment of substance abuse.

Appropriate Discharge. VHA requires that patients be discharged from the recovery area in the company of a responsible, designated adult or to lodging within the facility or that they be admitted to a facility inpatient unit.[4] Two patients' medical records did not include evidence that the patients were discharged from the recovery area in the company of a responsible, designated adult or to facility lodging or were admitted to an inpatient unit.

[3] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[4] VHA Directive 2006-023.

Recommendations

3. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

4. We recommended that processes be strengthened to ensure that patients are discharged from the recovery area in the company of a responsible, designated adult or to facility lodging or are admitted to an inpatient unit.

COC

The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 30 HF patients' medical records and relevant facility policies, and we interviewed employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Medications in discharge instructions matched those ordered at discharge.
	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
X	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
	The facility complied with any additional elements required by local policy.

Follow-Up Appointments. VHA requires that discharge instructions include recommendations regarding initial follow-up appointments.[5] Although provider discharge instructions requested specific follow-up appointment timeframes in 22 of the records reviewed, 3 appointments were not scheduled within the timeframes requested.

Recommendation

5. We recommended that processes be strengthened to ensure that follow-up appointments are consistently scheduled within the timeframes requested by providers.

[5] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Review Activities Without Recommendations

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of VHA's CRC screening.

We reviewed the medical records of 20 patients who had positive CRC screening tests, and we interviewed key employees involved in CRC management. The table below details the areas reviewed. The facility met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Patients were notified of positive screening test results within the required timeframe.
	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
	Patients received a diagnostic test within the required timeframe.
	Patients were notified of the diagnostic test results within the required timeframe.
	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

We inspected the intensive care, acute psychiatric, telemetry, and medical-surgical inpatient units. We also inspected the dental, physical therapy, polytrauma, and outpatient surgical clinics; the emergency department; and the operating room suite. Additionally, we reviewed facility policies, meeting minutes, training records, and other relevant documents, and we interviewed employees and managers. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed for EOC
	Patient care areas were clean.
	Fire safety requirements were properly addressed.
	Environmental safety requirements were met.
	Infection prevention requirements were met.
	Medications are secured and properly stored, and medication safety practices are in place.
	Sensitive patient information was protected.
	If the community living center had a resident animal program, facility policy addressed VHA requirements.
	Laser safety requirements in the operating room were properly addressed, and users received medical laser safety training.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH Residential Rehabilitation Treatment Program
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	MH Residential Rehabilitation Treatment Program inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Medication Management

The purpose of this review was to determine whether the facility had properly provided selected vaccinations according to Centers for Disease Control and Prevention guidelines and VHA recommendations.

We reviewed a total of 20 medical records for evidence of screening and administration of tetanus and shingles vaccines to primary care patients. We also reviewed documentation of selected vaccine administration requirements and interviewed key personnel. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Staff screened patients for pneumococcal and tetanus vaccinations.
	Staff properly administered pneumococcal and tetanus vaccinations.
	Staff properly documented vaccine administration.
	Vaccines were available for use.
	If applicable, staff provided vaccines as expected by the VISN.
	The facility complied with any additional elements required by local policy.

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and COC for patients affected by polytrauma.

We reviewed relevant documents, 10 medical records of patients with positive TBI results, and training records, and we interviewed key staff. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Providers communicated the results of the TBI screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
	Adequate services and staffing were available for the polytrauma care program.
	Employees involved in polytrauma care were properly trained.
	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-TBI System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

PRRCs

The purpose of this review was to determine whether the facility had implemented a PRRC and whether VHA required programmatic and clinical elements were in place. VHA directed facilities to fully implement PRRCs by September 30, 2009, or to have a Deputy Under Secretary for Health for Operations and Management approved modification or exception. Facilities with missing PRRC programmatic or clinical elements must have an Office of MH Services' approved action plan or Deputy Under Secretary for Health for Operations and Management approved modification.

We reviewed facility policies and relevant documents, inspected the PRRC, and interviewed employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	A PRRC was implemented and was considered fully designated by the Office of MH Services, or the facility had an approved modification or exception.
	There was an established method for soliciting patient feedback, or the facility had an approved action plan or modification.
	The PRRC met space and therapeutic resource requirements, or the facility had an approved action plan or modification.
	PRRC staff provided required clinical services, or the facility had an approved action plan or modification.
	The facility complied with any additional elements required by local policy.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 21–24, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[6]		
Type of Organization	Primary	
Complexity Level	2	
VISN	1	
Community Based Outpatient Clinics	Middletown, RI Hyannis, MA New Bedford, MA	
Veteran Population in Catchment Area	84,295	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	73	
• **Community Living Center/Nursing Home Care Unit**	N/A	
• **Other**	N/A	
Medical School Affiliation(s)	Brown Alpert Medical School Harvard School of Dental Medicine University of Rhode Island College of Pharmacy	
• **Number of Residents**	294	
	FY 2012 (through December 2011)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$211.1	$225.6
• **Medical Care Expenditures**	$55.9	$225.2
Total Medical Care Full-Time Employee Equivalents	1,155	1,122
Workload:		
• **Number of Station Level Unique Patients**	22,252	33,083
• **Inpatient Days of Care:**		
o **Acute Care**	5,123	20,558
o **Community Living Center/Nursing Home Care Unit**	N/A	N/A
Hospital Discharges	869	3,386
Total Average Daily Census (including all bed types)	55.7	56.3
Cumulative Occupancy Rate (in percent)	76.3	77.1
Outpatient Visits	86,880	368,975

[6] All data provided by facility management.

Follow-Up on Previous Recommendations		
Recommendations	**Current Status of Corrective Actions Taken**	**Repeat Recommendation? Y/N**
QM		
1. Require that QM action plans address identified issues, establish target dates, are tracked to completion, and have post-implementation evaluation.	QM Committee minutes reflect action plans that identify issues, establish target dates, track actions to completion, and monitor implementation of those actions.	N
2. Ensure compliance with VHA policy pertaining to adverse event disclosure.	Local policy reflects VHA policy process, templates for disclosures are in place, and clinical disclosures are reviewed and tracked by the Chief of Staff. There were no institutional disclosures in 2011.	N
3. Complete root cause analysis action plans timely, and consistently evaluate the effectiveness of action items.	Root cause analysis plans are current and are tracked and monitored by the Patient Safety Manager.	N
4. Require that the Peer Review Committee track actions through to completion.	The peer review process reflects that committee minutes track actions through to completion.	N
5. Fully implement the local policy for monitoring the copy and paste functions in the electronic medical record.	There is ongoing reporting and monitoring of the copy and paste functions as reflected in Medical Record Review Committee minutes.	N
6. Document and implement a plan to address delivery of care to patients in temporary bed locations.	Local policy and the temporary bed plan address delivery of care to patients who needed to be located in a temporary bed.	N
7. Ensure that CPR certification is maintained and tracked and that the local policy reflects actions to be taken when CPR certification expires.	Local policy reflects the CPR certification process. CPR certifications are tracked by the Education Department and are up to date.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
Reusable Medical Equipment		
8. Ensure that supply, processing, and distribution; operating room; and endoscopy suite personnel comply with VHA policy regarding the use of personal protective equipment.	Personnel receive ongoing training. Infection control staff monitor the use of personal protective equipment and hand hygiene. The results are tracked and trended.	N
9. Implement interim measures to ensure appropriate airflow in the supply, processing, and distribution area until corrective measures are completed.	A new decontamination room was constructed and is now being used.	N
EOC		
10. Require that staff conduct and document dialysate testing.	Dialysate testing has been implemented and is documented.	N
11. Ensure that staff identified as being at risk receive annual training and respirator fit testing.	Respirator fit testing and training records are completed and maintained for staff at risk.	N
12. Ensure that appropriate staff complete bloodborne pathogens training.	Annual bloodborne pathogens training is accomplished and documented in the Talent Management System.	N
13. Require that designated Multidisciplinary Safety Inspection Team members consistently participate in MH EOC inspections.	Appropriate team members attend consistently, and attendance records are maintained.	N
14. Ensure that all locked MH unit staff and Multidisciplinary Safety Inspection Team members receive annual environmental hazards training.	Team members are compliant with annual training requirements according to training records.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
COC		
15. Require that staff complete inter-facility transfer documentation and implement processes to monitor and evaluate transfers.	Staff completed appropriate inter-facility documentation, and compliance is greater than 90 percent.	N
16. Require that staff provide patients with appropriate written discharge instructions, educate patients regarding discharge instructions, and consistently document these actions.	Patients are provided discharge education and written instructions, and compliance is greater than 90 percent.	N
Suicide Prevention Safety Plans		
17. Ensure that all required elements in suicide prevention safety plans are consistently documented and that patients and/or their families are given copies of the safety plans.	Providers document all required elements of suicide prevention safety plans and provide a copy to patients and/or their families. Compliance is greater than 90 percent.	N
Pressure Ulcer Prevention and Management		
18. Ensure that skin care assessments and interventions are consistently documented.	Skin care assessments and interventions are monitored for compliance. Nursing staff complete skin care assessments and document interventions.	N

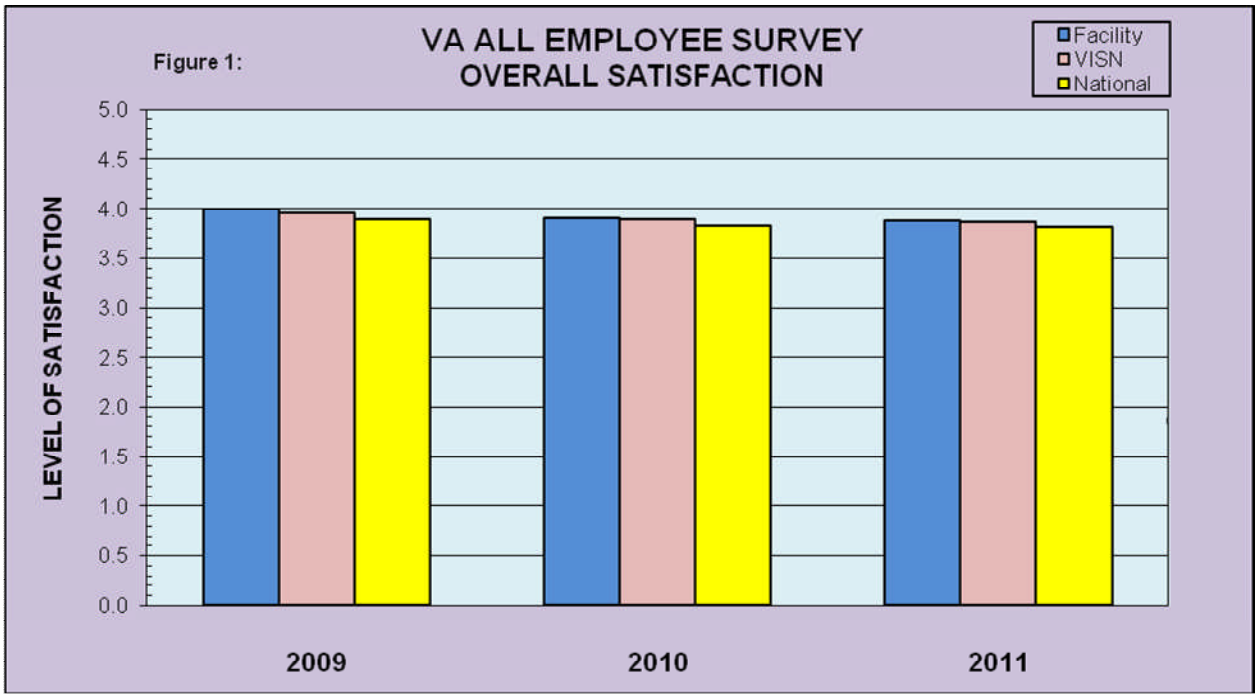
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2011.

Table 1

	FY 2011 Inpatient Scores		FY 2011 Outpatient Scores			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	67.5	65.7	61.6	60.5	68.7	61.1
VISN	65.2	67.4	62.3	60.6	62.8	60.5
VHA	63.9	64.1	55.9	55.3	54.2	54.5

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[7] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[8]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	15.3	10.4	14.5	20.4	30.6	19.5
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

[7] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Congestive HF is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[8] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 19, 2012

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

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

To: Director, Bedford Office of Healthcare Inspections (54BN)

Director, Management Review Service (VHA 10A4A4 Management Review)

I have reviewed and concur with the findings, recommendations and action plans in the attached memorandum from Providence VA Medical Center.

(original signed by:)
Michael Mayo-Smith, MD, MPH
Network Director

Appendix E

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 12, 2012

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

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

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

I concur with this OIG CAP review of the Providence VA Medical Center.

(original signed by:)
Vincent Ng
Medical Center Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that results from FPPEs are consistently documented in practitioners' profiles.

Concur

Target date for completion: 04/02/12

The FPPE process is tracked by the COS [Chief of Staff] and Medical Affairs Officer to assure completion of FPPE documentation at the MEC [Medical Executive Committee] meeting when individual FPPEs are presented, reviewed, and approved by the COS. Monitoring of documentation to assure completeness was initiated, tracked by Medical Affairs Officer and reported on a monthly basis to QM Dept. This will occur for 3 months to assure 90% or greater compliance.

Recommendation 2. We recommended that processes be strengthened to ensure that for all cases referred by UM reviewers, PUMAs respond, collaborate, and make medical recommendations.

Concur

Target date for completion: 3/30/12

The QM UM RNs [registered nurse] created a tool which is sent to the PUMAs identifying a case needing review and requesting action within 24 hours; the PUMAs return this form to the UM RNs indicating action to be followed and UM RNs track all cases referred to PUMAs. This is tracked and then trended on a monthly basis and reported to COS and QM Dept. This will be monitored for three months to assure 90% or greater compliance.

Recommendation 3. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: 3/30/12

H&P [History & Physical] requirements for moderate sedation patients specifically screening for alcohol, drug abuse, and smoking were reviewed with all LIPs [licensed independent practitioners] performing moderate sedation. The compliance tracking was initiated 4/1/12. The data is tracked, trended and reported on a monthly basis to QM

Dept and the Chiefs of Medicine and Anesthesia. This will be monitored for three months to assure 90% or greater compliance.

Recommendation 4. We recommended that processes be strengthened to ensure that patients are discharged from the recovery area in the company of a responsible, designated adult or to facility lodging or are admitted to an inpatient unit.

Concur

Target date for completion: 3/30/12

Per hospital protocol, patients discharged after recovery from moderate sedation must be discharged home with a responsible adult and the name of the individual taking the person home must be written in the patient's EMR [electronic medical record]. All responsible RN staff was reeducated by 3/30/12. Monitoring of compliance was initiative 4/1/12 by the Nurse Manager. The data is tracked, trended, and results reported to Manager ADTU [Ambulatory Diagnostics and Treatment Unit] and to QM Dept.

Recommendation 5. We recommended that processes be strengthened to ensure that follow-up appointments are consistently scheduled within the timeframes requested by providers.

Concur

Target date for completion: 3/30/12

All disciplines involved with this aspect of care reviewed findings then the current process was reviewed and all team members were reeducated regarding pertinent clinical reminders and processes to assure timely follow up appointments. This patient population will be monitored for post discharge follow up appointments to assure timeliness per initiative. This will be tracked, trended and reported on a monthly basis to assure 90% compliance or greater. This will be reported to QM department and COS. This will be completed for three months.

OIG Contact and Staff Acknowledgments

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