DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Program Review of the VA St. Louis Health Care System

Missouri

CHIP REPORT | REPORT #18-00612-260 | AUGUST 23, 2018

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Figure 1. *VA St. Louis Health Care System, St. Louis, Missouri*
(Source: https://vaww.va.gov/directory/, accessed on May 10, 2018.)

Abbreviations

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CLABSI	central line-associated bloodstream infection
CS	controlled substances
CSC	controlled substances coordinator
CSI	controlled substances inspector
EHR	electronic health record
EOC	environment of care
FPPE	Focused Professional Practice Evaluation
GE	geriatric evaluation
LIP	licensed independent practitioner
MH	mental health
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
PTSD	post-traumatic stress disorder
QSV	quality, safety, and value
RCA	root cause analysis
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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 VA St. Louis Health Care System (Facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

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

The OIG's current areas of focus are

1. Leadership and Organizational Risks;
2. Quality, Safety, and Value;
3. Credentialing and Privileging;
4. Environment of Care;
5. Medication Management;
6. Mental Health Care;
7. Long-Term Care;
8. Women's Health; and
9. High-Risk Processes.

This review was conducted during an unannounced visit made during the week of February 12, 2018. The OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the 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, could improve patient safety and healthcare quality.

Results and Review Impact

Leadership and Organizational Risks

At the Facility, the leadership team consists of the Director, Deputy Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director. Organizational communication and accountability are carried out through a committee reporting structure, with the Executive Board having oversight for leadership groups such as the Clinical Executive, Quality Executive, Medical Executive, and Administrative Executive Boards. The leaders are members of the Executive Board through which they track, trend, and monitor quality of care and patient outcomes.

It is important to note that the Deputy Director entered on duty on October 1, 2017. With that one exception, the executive leaders had been working together as a team since June 2017. In the review of selected employee and patient survey results regarding Facility leaders, the OIG noted that employees appear generally satisfied with leadership, while multiple opportunities appear to exist to improve patient satisfaction with care provided.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (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 VHA.[1] Although the leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve performance of the Quality of Care and Efficiency metrics likely contributing to the current "2-Star" rating.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[2] disclosures of adverse patient events, and Patient Safety Indicator data, and did not identify any substantial organizational risk factors.

The OIG noted findings in four of the eight areas reviewed and issued seven recommendations that are attributable to the Director, Chief of Staff, and Associate Director. These are briefly described below.

[1] 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" rating system to designate a facility's performance in individual measures, domains, and overall quality. http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146. (Website accessed on April 16, 2017.)

[2] A sentinel event is an incident or condition that results in patient death, permanent harm, severe temporary harm, or intervention required to sustain life.

Credentialing and Privileging

The OIG found general compliance with requirements for credentialing, processes for approving clinical privileges, and establishing criteria for professional practice evaluations. However, the OIG identified a deficiency with designating timeframes for focused professional practice evaluations and periodic review of ongoing professional practice evaluations.

Environment of Care

The OIG noted a generally safe environment of care. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG noted that several required disciplines were not consistently attending environment of care rounds.

Medication Management

The OIG found general compliance with requirements for controlled substance reports, annual physical security surveys, ordering procedures, and completion of required training. Pharmacy inspections were generally completed as required. However, the OIG identified deficiencies with the Alternate Controlled Substance Coordinator's position description, controlled substance inspectors' appointment letters, and completion of monthly inspections of controlled substance storage areas.

Women's Health

The OIG noted general compliance with the electronic linking of mammography results to the radiology order, inclusion of required elements in reports, communication of results and recommended courses of action to patients, and provision of follow-up care, if indicated. However, the OIG identified a deficiency with the communication of mammography results to the ordering provider.

Summary

In the review of key care processes, the OIG issued seven recommendations that are attributable to the 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 leaders 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 Facility Director agreed with the Comprehensive Healthcare Inspection Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 56–57, for the full text of the Directors' comments.) The OIG considers recommendation 4 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Assistant Inspector General
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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 inpatient and outpatient settings of the VA St. Louis Health Care System (Facility) 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 healthcare services to veterans and to share findings with Facility leaders so that informed decisions can be made to improve care.

Scope

Good leadership makes a difference in managing organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a quality improvement culture to sustain positive change.[3,4] Investment in a culture of safety and quality improvement with robust communication and leadership is more likely to result in positive patient outcomes in healthcare organizations.[5] Figure 2 shows the direct relationship leadership and organizational risks have with the processes used to deliver health care to veterans.

To examine risks to patients and the organization when these processes are not performed well, the OIG focused on the following nine areas of clinical care and administrative operations that support quality care—Leadership and Organizational Risks; Quality, Safety, and Value (QSV); Credentialing and Privileging; Environment of Care (EOC); Medication Management: Controlled Substances (CS) Inspection Program; Mental Health: Post-Traumatic Stress Disorder (PTSD) Care; Long-Term Care: Geriatric Evaluations; Women's Health: Mammography Results and Follow-up; and High-Risk Processes: Central Line-Associated Bloodstream Infections (CLABSI) (see Figure 2).[6]

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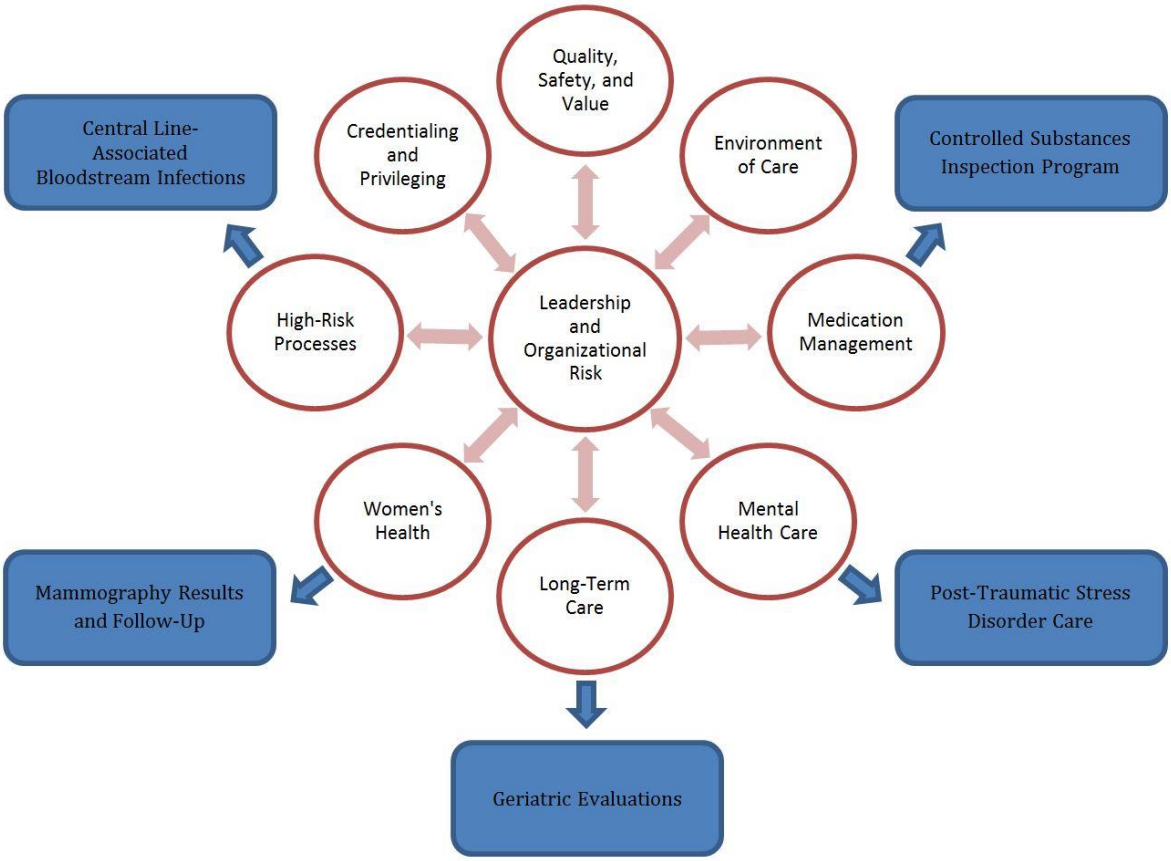
[3] Carol Stephenson, "The role of leadership in managing risk," *Ivey Business Journal*, November/December 2010. https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/. (Website accessed on March 1, 2018.)

[4] Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/. (Website accessed on March 1, 2018.)

[5] Institute for Healthcare Improvement, "How risk management and patient safety intersect: Strategies to help make it happen", March 24, 2015. http://www.npsf.org/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen. (Website accessed March 1, 2018.)

[6] CHIP reviews address these processes during fiscal year (FY) 2018 (October 1, 2017, through September 30, 2018).

Figure 2. FY 2018 Comprehensive Healthcare Inspection Program Review of Healthcare Operations and Services



Source: VA OIG

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

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the EOC, the OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;[7] and discussed processes and validated findings with managers and employees. The OIG interviewed applicable managers and members of the executive leadership team.

The review covered operations for March 2, 2015,[8] through February 12, 2018, the date when an unannounced week-long site visit commenced. On April 4, 2018, the OIG presented crime awareness briefings to 58 of the Facility's 3,499 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.

This report's recommendations for improvement 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 on site, the OIG did not receive any complaints beyond the scope of the CHIP review. The OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reviews and Q*uality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

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

[8] This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Other Outpatient 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 risks can impact the Facility's ability to provide care in all of the selected clinical areas of focus.[9] To assess the Facility's risks, the OIG considered the following organizational elements

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, and
5. VHA performance data.

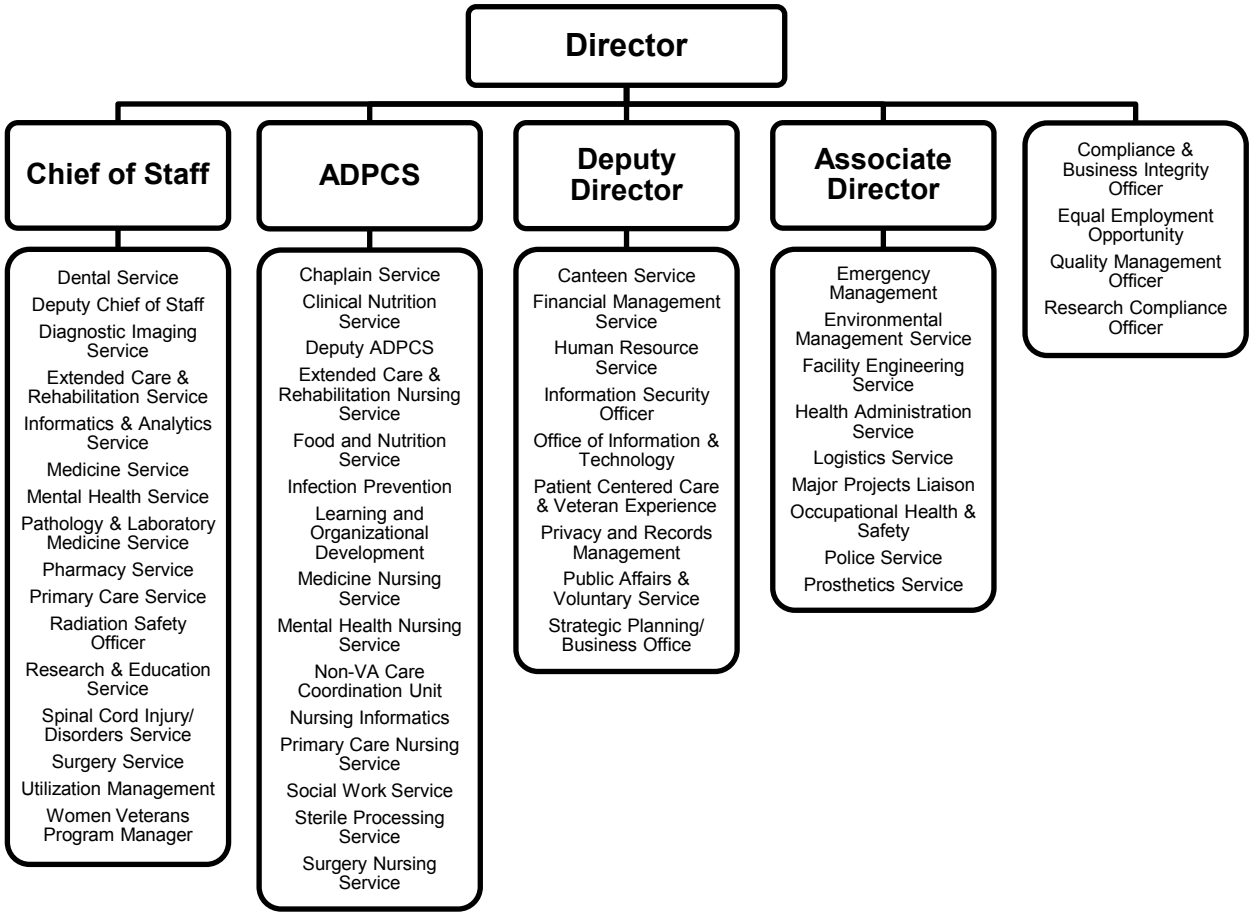
Executive Leadership Stability and Engagement

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 among facilities. Figure 3 illustrates the Facility's reported organizational structure. The Facility has a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Deputy Director, and Associate Director. The Chief of Staff and ADPCS are responsible for overseeing patient care and service directors, as well as program and practice chiefs.

It is important to note that the Deputy Director entered on duty on October 1, 2017. With that one exception, the executive leaders had been working together as a team since June 2017.

[9] L. Botwinick, M. Bisognano, and C. Haraden. "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006. http://www.ihi.org/resources/Pages/IHIWhitePapers/LeadershipGuidetoPatientSafetyWhitePaper.aspx. (Website accessed on February 2, 2017.)

Figure 3. Facility Organizational Chart



Source: VA St. Louis Health Care System (received February 14, 2018)

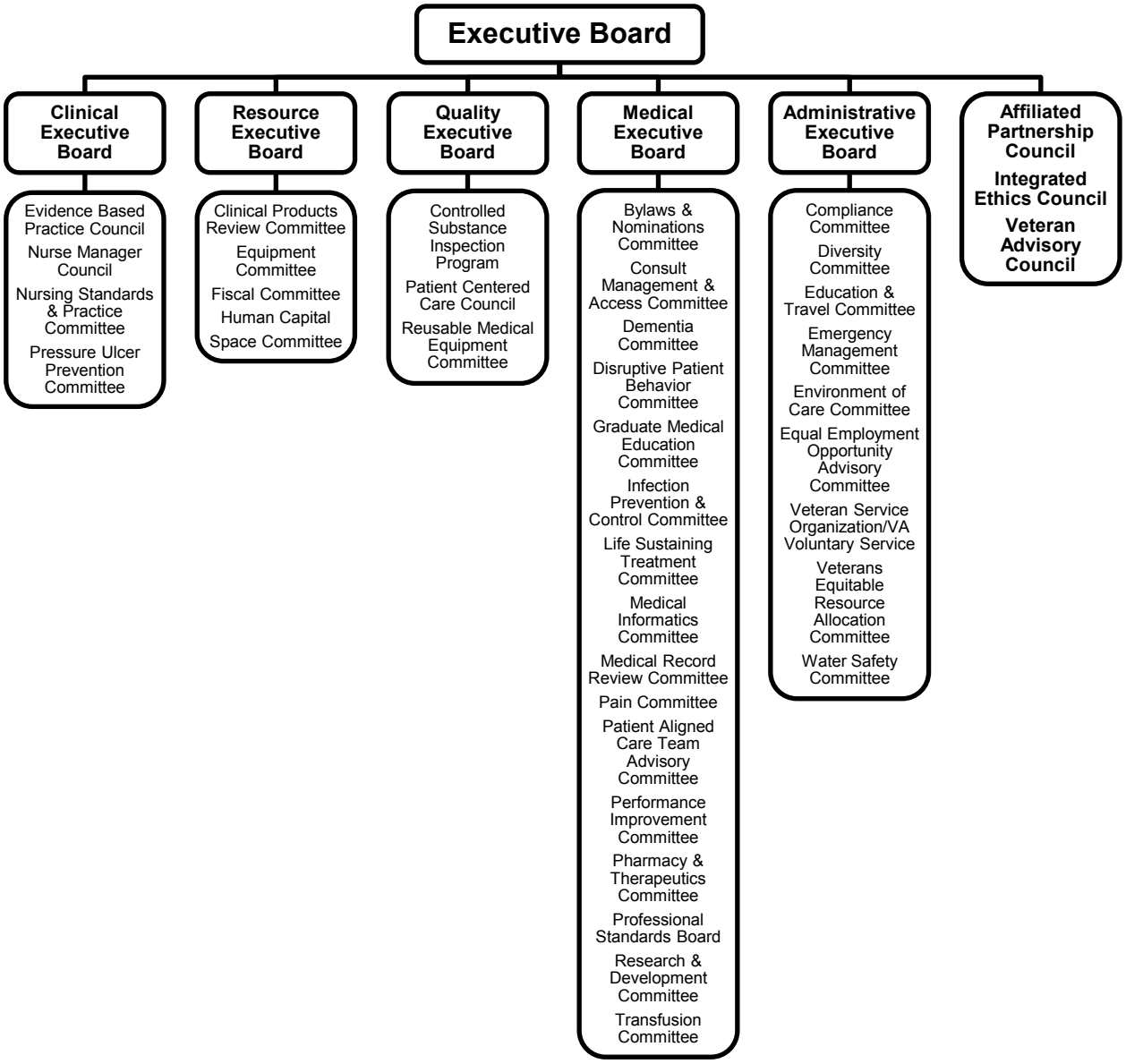
To help assess engagement of Facility executive leadership, the OIG interviewed the Director, Deputy Director, Chief of Staff, ADPCS, and Associate Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leadership team members were generally 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, given their individual responsibilities and tenure. 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 Board, which tracks, trends, and monitors quality of care and patient outcomes. The 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 Board also oversees various working groups, such as the Clinical Executive Board, Quality Executive Board, and the Medical Executive Board. See Figure 4.

Figure 4. Facility Committee Reporting Structure



Source: VA St. Louis Health Care System (received February 13, 2018)

Employee Satisfaction and Patient Experience

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

points in response to VA leadership inquiries on VA culture and organizational health. 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 Facility leadership.

To assess employee and patient attitudes toward Facility leadership, the OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2016, through September 30, 2017. Tables 1 and 2 provide relevant survey results for VHA and the Facility. As Table 1 indicates, the Facility leaders' results (Director's office average) were rated above the VHA and overall Facility average, while the Facility averages were similar to the VHA average.[10] In all, employees appear generally satisfied with leadership.

Table 1. Survey Results on Employee Attitudes toward Facility Leadership (October 1, 2016, through September 30, 2017)

Questions/Survey Items	Scoring	VHA Average	Facility Average	Director's Office Average[11]
All Employee Survey Q59. *How satisfied are you with the job being done by the executive leadership where you work?*	1 (Very Dissatisfied)–5 (Very Satisfied)	3.3	3.3	4.0
All Employee Survey: *Servant Leader Index Composite*	0–100 where HIGHER scores are more favorable	67.7	66.7	79.0

Source: VA All Employee Survey (accessed January 12, 2018)

VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA utilizes industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences of their health care and to support the goal of benchmarking its performance against the private sector.

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. From these, the OIG selected four survey items that reflect patient attitudes towards Facility leaders. As Table 2 indicates, for this Facility, all four patient survey results reflected lower care ratings than the VHA average. Multiple opportunities appear to exist to improve patient satisfaction with care provided.

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

[11] Rating is based on responses by employees who report to or are aligned under the Director.

Table 2. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2016, through September 30, 2017)

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	66.7	48.8
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.	83.4	76.4
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	74.9	72.2
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	75.2	73.0

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed January 12, 2018)

Accreditation/For-Cause Surveys[12] and Oversight Inspections

To further assess Leadership and Organizational Risks, the OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 3 summarizes the relevant Facility inspections most

[12] The Joint Commission (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.

recently performed by the OIG and The Joint Commission (TJC).[13] Indicative of effective leadership, the Facility has closed all recommendations for improvement as listed in Table 3.[14]

The OIG also noted the Facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[15] and College of American Pathologists,[16] which demonstrates the Facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute conducted inspections of the Facility's Community Living Center,[17] and the Paralyzed Veterans of America conducted inspections of the Facility's spinal cord injury/disease unit and related services.[18]

Table 3. Office of Inspector General Inspections/Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
OIG (*Combined Assessment Program Review of the VA St. Louis Health Care, St. Louis, Missouri, May 18, 2015*)	March 2015	45	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of the VA St. Louis Health Care System, St. Louis, Missouri, April 23, 2015*)	March 2015	4	0
OIG (*Combined Assessment Program Follow-Up Review of the VA St. Louis Health Care System, St. Louis, Missouri, January 20, 2016*)	November 2015	10	0
OIG (*Combined Assessment Program Follow-Up Review of Environment of Care at*	June 2016	1	0

[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 more than 30 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

[14] 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 the accreditation organization or inspecting agency.

[15] 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.

[16] 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.

[17] Since 1999, the Long Term Care Institute has been to over 3,500 healthcare facilities conducting quality reviews and external regulatory surveys. The Long Term Care Institute is a leading organization focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings.

[18] The Paralyzed Veterans of America inspections took place October 6–7, 2016, and October 11–12, 2017. This Veteran Service Organization review does not result in accreditation status.

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
the VA St. Louis Health Care System, St. Louis, Missouri, January 18, 2017)			
OIG (*Healthcare Inspection – Review of Complaints Regarding Mental Health Services Clinical and Administrative Processes, VA St. Louis Health Care System, St. Louis, Missouri, December 13, 2016*)	July 2014	9	0
TJC			
• Regular	August 2016		
○ Hospital Accreditation		31	0
○ Nursing Care Center Accreditation		0	0
○ Behavioral Health Care Accreditation		2	0
○ Home Care Accreditation		4	0
• Special Unannounced Event (Opioid Treatment Program)	July 2015	2	0
• Special Unannounced Event[19]	July 2015	1	0

Sources: OIG and TJC (verified by the ADPCS on April 9, 2018)

Indicators for Possible Lapses in Care

Within the healthcare 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 4 summarizes key indicators of risk since the OIG's previous March 2015 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of February 12, 2018.[20]

[19] TJC conducted special focused surveys of VHA organizations and selected CBOCs from October 2014 to September 2015 at VHA's request in response to whistleblower accounts of improprieties and delays in patient care at the Phoenix VA Health Care System. The VA St. Louis Health Care System was surveyed as part of this VHA review.

[20] 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 VA St. Louis Health Care System is a highest complexity (1a) affiliated Facility as described in Appendix B.)

Table 4. Summary of Selected Organizational Risk Factors (March 2015 to February 12, 2018)

Factor	Number of Occurrences
Sentinel Events[21]	1
Institutional Disclosures[22]	5
Large-Scale Disclosures[23]	0

Source: VA St. Louis Health Care System's Patient Safety Manager (received February 13, 2018)

The 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.[24] The rates presented are specifically applicable for this Facility, and lower rates indicate lower risks. Table 5 summarizes Patient Safety Indicator data from October 1, 2015, through September 30, 2017.

Table 5. Patient Safety Indicator Data (October 1, 2015, through September 30, 2017)

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 15	Facility
Pressure ulcers	0.60	0.48	0.37
Death among surgical inpatients with serious treatable conditions	100.97	106.60	69.44
Iatrogenic pneumothorax	0.19	0.05	0.18
Central venous catheter-related bloodstream infection	0.15	0.04	0.17
In-hospital fall with hip fracture	0.08	0.18	0.11
Perioperative hemorrhage or hematoma	1.94	0.58	0.47

[21] A sentinel event is an incident or condition that results in patient death, permanent harm, severe temporary harm, or intervention required to sustain life.

[22] 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 his or her personal representative that an adverse event has occurred during 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] 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.

[24] Agency for Healthcare Research and Quality website. https://www.qualityindicators.ahrq.gov/. (Website accessed on March 8, 2017.)

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 15	Facility
Postoperative acute kidney injury requiring dialysis	0.88	1.50	2.65
Postoperative respiratory failure	5.55	7.46	2.70
Perioperative pulmonary embolism or deep vein thrombosis	3.29	1.76	1.33
Postoperative sepsis	4.00	5.64	8.27
Postoperative wound dehiscence	0.52	0.00	0.00
Unrecognized abdominopelvic accidental puncture/laceration	0.53	0.49	0.70

Source: VHA Support Service Center

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

The Patient Safety Indicator data show an observed rate in excess of the Veterans Integrated Service Network (VISN) 15 and/or VHA observed rates for

- Iatrogenic pneumothorax,
- Central Venous Catheter-Related Bloodstream Infection,
- In Hospital Fall with Hip Fracture,
- Postoperative Acute Kidney Injury Requiring Dialysis,
- Postoperative Sepsis, and
- Unrecognized Abdominopelvic Accidental Puncture/Laceration.

One patient was transferred from a local facility with multiple medical complications. Shortly after admission, the patient suffered cardiac arrest, was intubated, and received cardiopulmonary resuscitation. The patient underwent an emergent procedure following the code. Later, a chest/abdominal computed tomography scan showed an iatrogenic pneumothorax that was resolved with a chest tube. During the hospitalization course, the patient received replacement therapies and intravenous medications and had abdominal surgeries, but remained critical. The patient died approximately three weeks after being transferred to the Facility. The Surgical Service's Quality Improvement Conference reviewed the case and determined that the care provided by the surgical team was appropriate.

One patient developed a central venous catheter-related bloodstream infection and improved when treated with antibiotic medication. Facility managers reported re-educating staff on the use of peripherally inserted central catheters for fluid and medication administration and updating the protocol for central line dressing changes.

One patient had an in-hospital fall with a hip fracture. Facility managers attributed this to the patient tripping over a piece of equipment while walking in the hallways. The Facility has falls

prevention processes in place, and all falls are presented to the Falls Committee and reviewed by the Patient Safety Officer.

Three patients had postoperative acute kidney injury requiring dialysis. Facility leaders reported that all three cases were reviewed, and there were no identified issues with the care provided. The first case was the result of a rare surgical complication. In the second case, the patient was immunocompromised prior to the operative procedure. In the last case, the patient's treatment course was complicated by a diagnosis of alcohol withdrawal. Based on this occurrence and subsequent cases of alcohol withdrawal, the Facility developed a nurse-driven alcohol withdrawal protocol for the acute and critical care units.

Nine patients developed postoperative sepsis while hospitalized. Facility leaders reported that all cases were reviewed, all nine patients had comorbid and complex health conditions, and there were no identified issues with the care provided.

Facility leaders reviewed the case of unrecognized abdominopelvic accidental puncture/laceration and believe that this complication was reported incorrectly, as the patient never had an open or endoscopic abdominopelvic procedure. They believe that some of the reported data was incorrect due to incomplete clinical documentation and faulty coding or training. Executive leaders have taken actions to support optimal coding accuracy and authorized the hiring of a clinical documentation specialist and filling coding of staff vacancies.

Veterans Health Administration Performance Data

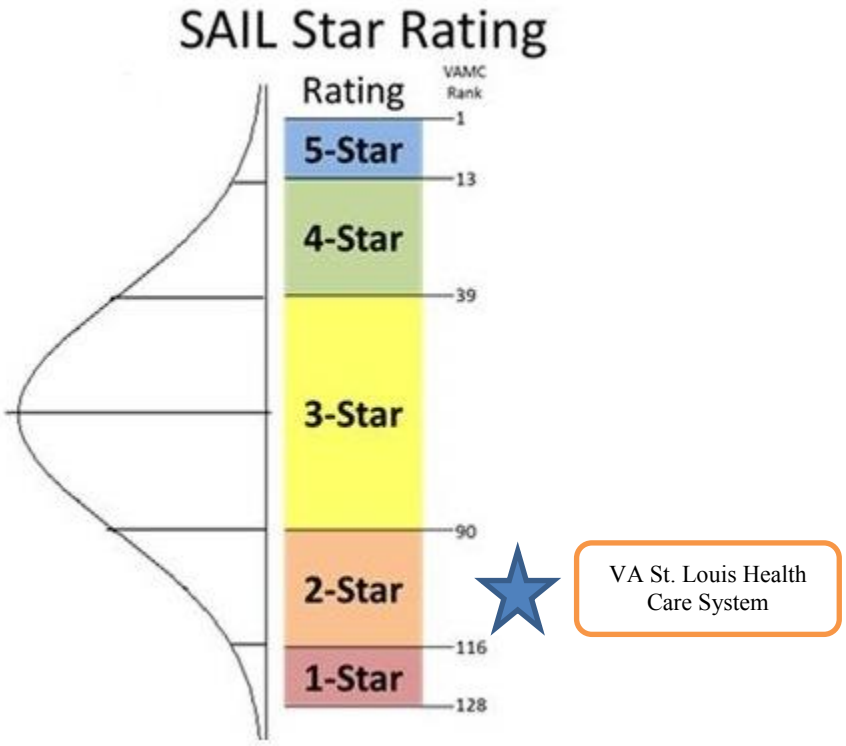
The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes measures on healthcare quality, employee satisfaction, access to care, and efficiency, but has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to understand the similarities and differences between the top and bottom performers" within VHA.[25]

VA also uses a star-rating system where facilities with a "5-Star" rating are performing within the top 10 percent of facilities and "1-Star" facilities are performing within the bottom 10 percent of facilities. Figure 5 describes the distribution of facilities by star rating.[26] As of June 30, 2017, the Facility was rated at "2 Stars" for overall quality.

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

[26] Based on normal distribution ranking quality domain of 128 VA Medical Centers.

Figure 5. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2017)

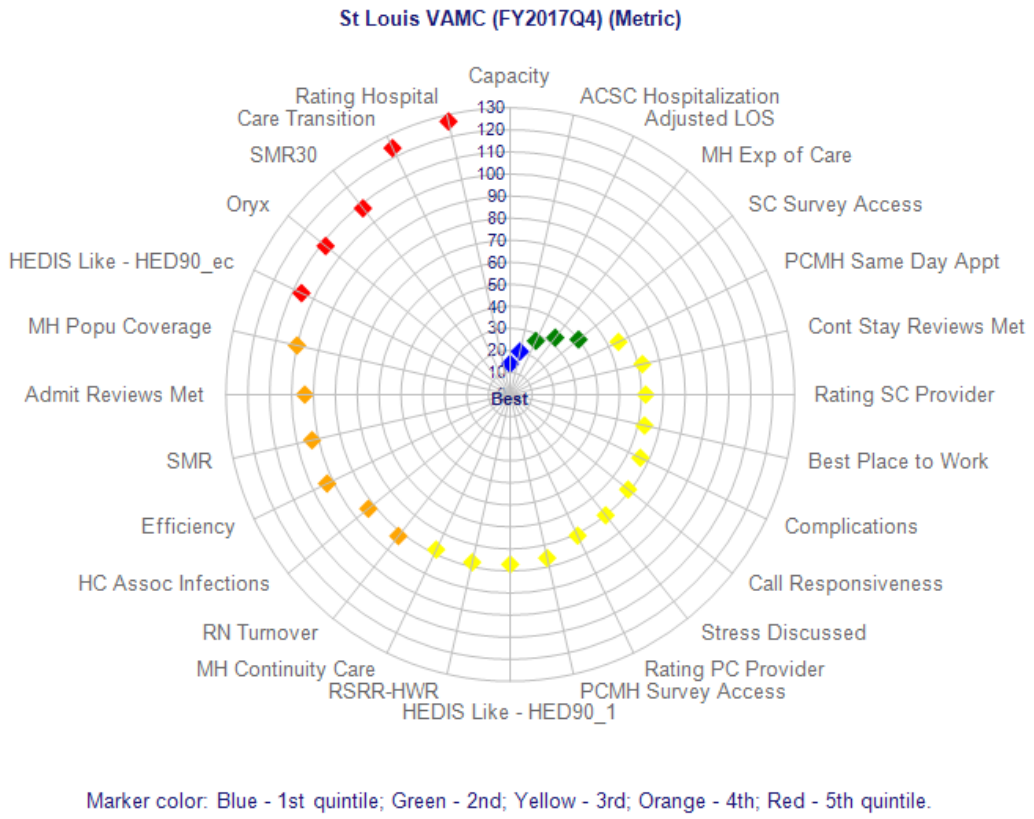


Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed January 12, 2018)

Figure 6 illustrates the Facility's Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of September 30, 2017. Of note, Figure 6 uses blue and green data points to indicate high performance (for example in the areas of Capacity, Adjusted Length of Stay (LOS), and Specialty Care (SC) Survey Access).[27] Metrics that need improvement are denoted in orange and red (for example, Registered Nurse (RN) Turnover, Standardized Mortality Ratio (SMR), and Rating (of) Hospital).

[27] For data definitions of acronyms in the SAIL metrics, please see Appendix D.

Figure 6. Facility Quality of Care and Efficiency Metric Rankings (as of September 30, 2017)



Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). For data definitions, see Appendix D.

Conclusion

The Facility has generally stable executive leadership and active engagement with employees as evidenced by satisfaction scores; however, multiple opportunities appear to exist to improve patient satisfaction with care provided. Organizational leaders support patient safety, quality care, and other positive outcomes (such as initiating processes and plans to improve the patient experience and positive perceptions of the Facility through active stakeholder engagement). The OIG's review of accreditation organization findings, sentinel events, disclosures, Patient Safety Indicator data, and SAIL results did not identify any substantial organizational risk factors. The senior leadership team appeared knowledgeable about selected SAIL metrics but should continue to take actions to improve care and performance of Quality of Care and Efficiency metrics likely contributing to the current "2-Star" rating.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care using a coordinated care continuum. To meet this goal, VHA must foster a culture of integrity and accountability that is vigilant and mindful, proactively risk aware, and predictable, while seeking continuous improvement.[28] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[29]

VHA requires that its facilities operate a Quality, Safety, and Value (QSV) program to monitor the quality of patient care and performance improvement activities. The purpose of the OIG review was to determine whether the Facility implemented and incorporated selected key functions of VHA's Enterprise Framework for QSV into local activities. To assess this area of focus, the OIG evaluated the following: protected peer reviews of clinical care,[30] utilization management (UM) reviews,[31] and patient safety incident reporting with related root cause analyses (RCAs).[32]

VHA has implemented approaches to improving patient safety, including the reporting of patient safety incidents to its National Center of Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required RCAs help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the organization.[33]

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[28] VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.

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

[30] 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. (Due for recertification June 30, 2015, but has not been updated.)

[31] According to VHA Directive 1117, UM reviews evaluate the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria.

[32] According to VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011, VHA has implemented approaches to improve patient safety, including the reporting of patient safety incidents to the VHA National Center for Patient Safety, in order for VHA to learn about system vulnerabilities and how to address them as well as the requirement to implement RCA (a widely-used methodology for dealing with safety-related issues) to allow for more accurate and rapid communication throughout an organization of potential and actual causes of harm to patients.

[33] VHA Handbook 1050.01.

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, RCAs, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:[34]

- Protected peer reviews
  - Examination of important aspects of care (for example, appropriate and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
  - Implementation of improvement actions recommended by the Peer Review Committee
- UM
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of Physician UM Advisors' decisions in National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Entry of all reported patient incidents into WebSPOT[35]
  - Annual completion of a minimum of eight RCAs[36]
  - Provision of feedback about root cause analysis actions to reporting employees
  - Submission of annual patient safety report

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

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

[35] WebSPOT is the software application used for reporting and documenting adverse events in the VHA (National Center for Patient Safety) Patient Safety Information System database.

[36] According to VHA Handbook 1050.01, March 4, 2011, the requirement for a total of eight RCAs and aggregated reviews is a minimum number, as the total number of RCAs is driven by the events that occur and the Safety Assessment Code (SAC) score assigned to them. At least four analyses per fiscal year must be individual RCAs, with the balance being aggregated reviews or additional individual RCAs.

Credentialing and Privileging

VHA has defined procedures for the credentialing and privileging of all healthcare professionals who are permitted by law and the facility to practice independently—without supervision or direction, within the scope of the individual's license, and in accordance with individually granted clinical privileges. These healthcare professionals are also referred to as licensed independent practitioners (LIP).[37]

Credentialing refers to the systematic process of screening and evaluating qualifications. Credentialing involves ensuring an applicant has the required education, training, experience, and mental and physical health. This systematic process also ensures that the applicant has the skill to fulfill the requirements of the position and to support the requested clinical privileges.[38]

Clinical privileging is the process by which an LIP is permitted by law and the facility to provide medical care services within the scope of the individual's license. Clinical privileges need to be specific, based on the individual's clinical competence, recommended by service chiefs and the Medical Staff Executive Committee, and approved by the Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to the expiration of the held privileges.[39]

The purpose of the OIG review was to determine whether the Facility complied with selected requirements for credentialing and privileging of selected members of the medical staff. The OIG team interviewed key managers and reviewed the credentialing and privileging folders of 12 LIPs who were hired within 18 months prior to the on-site visit,[40] and 18 LIPs who were re-privileged within 12 months prior to the visit.[41] The OIG evaluated the following performance indicators:

- Credentialing
  - Current licensure
  - Primary source verification
- Privileging
  - Verification of clinical privileges
  - Requested privileges

[37] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (Due for recertification October 31, 2017, but has not been updated.)

[38] VHA Handbook 1100.19.

[39] VHA Handbook 1100.19.

[40] The 18-month period was from July 12, 2016, through January 12, 2018.

[41] The 12-month review period was from January 12, 2017, through January 12, 2018.

        - Facility-specific
        - Service-specific
        - Provider-specific
    - Service chief recommendation of approval for requested privileges
    - Medical Staff Executive Committee decision to recommend requested privileges
    - Approval of privileges for a period of less than, or equal to, two years
- Focused Professional Practice Evaluation (FPPE)
    - Evaluation initiated
        - Timeframe clearly documented
        - Criteria developed
        - Evaluation by another provider with similar training and privileges
        - Medical Staff Executive Committee decision to recommend continuing initially granted privileges
- Ongoing Professional Practice Evaluation (OPPE)
    - Determination to continue privileges
        - Criteria specific to the service or section
        - Evaluation by another provider with similar training and privileges
        - Medical Staff Executive Committee decision to recommend continuing privileges

Conclusion

The OIG found general compliance with requirements for credentialing, processes for approving clinical privileges, and establishing criteria for professional practice evaluations. However, the OIG identified the following deficiencies in documentation of the timeframes for FPPEs and periodic review of OPPEs.

Focused Professional Practice Evaluations

VHA requires that all clinical supervisors complete FPPEs for newly hired licensed independent practitioners, maintain this documentation in the practitioner's provider profile, and report the results to an appropriate committee of the Medical Staff. FPPEs involve the evaluation of privilege-specific competence of the practitioner who has not had documented evidence of competently performing the requested privileges using objective criteria. This process may include periodic chart review, direct observation, monitoring of diagnostic and treatment

techniques, or discussion with other individuals involved in the care of patients.[42] VHA also requires that FPPEs are time limited. Time limitations help to ensure an efficient process by preventing undefined or indefinite evaluation of practitioners.

For 5 of 12 practitioners, clinical managers granted privileges without clearly documenting the timeframe for the FPPE. Facility leaders cited two reasons for noncompliance: service chiefs failed to ensure that the timeframe was specified prior to signing off on the FPPEs, and the Medical Staff Office had an extended vacancy while the facility prioritized the recruitment of direct care staff.

Recommendation 1

1. The Chief of Staff ensures that clinical managers initiate Focused Professional Practice Evaluations that include clearly delineated timeframes and monitors compliance.

Facility concurred.

Target date for completion: April 2019

Facility response: The Chief of Staff and Chair of the Professional Standards Board (PSB) provided education to Associate Chief of Staff for Mental Health, Primary Care, Medicine, Surgery, Extended Care and Rehabilitation Services, Spinal Cord Injury and Service Chiefs for Diagnostic Imaging, Pathology and Laboratory, and Dental on the findings from this review and the need to have timeframes identified on each FPPE in March 2018. The Chair of PSB will review and return the FPPE if it does not meet the requirements. Monthly audit of a random sample of FPPEs will be completed to ensure the timeframe for the FPPE is clearly documented. The results will be reported to the Quality Executive Board. Will monitor for compliance of 90% for 6 months.

Ongoing Professional Practice Evaluations

VHA requires that the determination to continue LIP privileges be based in part on the results of OPPE activities, such as results of EHR reviews, outcome data, and direct observation.[43] These activities allow the Facility to identify professional practice trends that impact patient care, safety, and quality of care. The data from OPPEs must be provider specific, reliable, and timely. In 9 of 18 re-privileging actions, there was no evidence that the determination to continue current privileges was based on the results of OPPE activities. As a result, providers continued delivering care without a thorough evaluation of their practice. Facility leaders cited multiple reasons for noncompliance, including failure of the service chief to keep service-level processes

[42] VHA Handbook 1100.19.

[43] VHA Handbook 1100.19.

updated with established procedures, the shifting of work from service staff to others unfamiliar with established procedures, and turnover in key positions.

Recommendation 2

2. The Chief of Staff ensures that clinical managers consistently review Ongoing Professional Practice Evaluation data every six months and monitors compliance.

Facility concurred.

Target date for completion: April 2019

Facility response: The Chief of Staff and Chair of the Professional Standards Board (PSB) provided education to Associate Chief of Staff for Mental Health, Primary Care, Medicine, Surgery, Extended Care and Rehabilitation Services, Spinal Cord Injury and Service Chiefs for Diagnostic Imaging, Pathology and Laboratory, and Dental on the findings from this review and the need to have Ongoing Professional Practice Evaluations (OPPE) completed every 6 months in March 2018. The OPPE formats were standardized to have the timeframes to be October thru March and April thru September. Audit of a random sample of OPPEs will be completed to ensure the OPPE data is consistently reviewed every 6 months and is clearly documented. The results will be reported to the Quality Executive Board. Compliance of 90% will be demonstrated for 6 months.

Environment of Care

Any medical center, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct EOC inspection rounds and resolve issues in a timely manner. The goal of the EOC program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.[44]

The purpose of the OIG review was to determine whether the Facility maintained a clean and safe healthcare environment in accordance with applicable requirements.[45] The 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 construction safety[46] and Nutrition and Food Services processes.[47]

VHA requires a safe and healthy worksite for staff, patients, and the general public during construction and renovation-related activities. The implementation of a proactive and comprehensive construction safety program reduces the potential for injury, illness, accidents, or exposures.[48]

The Nutrition and Food Services Program must provide quality meals that meet the regulatory requirements for food safety in accordance with the U.S. Food and Drug Administration's Food Code and VHA's food safety program. Facilities must have a hazard analysis critical control point food safety plan, food services inspections, a food service emergency operations plan, and safe food transportation and storage practices.[49]

At the John Cochran campus, the OIG team inspected seven inpatient units (7-north and south, 6-north and south, surgical and medical intensive care, and the progressive care units), two outpatient clinics (gastroenterology and primary care), and the cardiac catheterization lab. At the Jefferson Barracks campus, the OIG team inspected five inpatient units (domiciliary, mental health, spinal cord injury, and two community living center units), the optometry clinic, and Nutrition and Food Services. The team also inspected the St. Louis CBOC. The OIG reviewed the most recent Infection Prevention Risk Assessment, Infection Control Committee minutes for

[44] VHA Directive 1608, *Comprehensive Environment of Care*, February 1, 2016.

[45] Applicable requirements include various VHA Directives, Joint Commission hospital accreditation standards, Occupational Safety and Health Administration, American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), and National Fire Protection Association (NFPA).

[46] VHA Directive 7715, *Safety and Health during Construction*, April 6, 2017.

[47] VHA Handbook 1109.04, *Food Service Management Program*, October 11, 2013.

[48] VHA Directive 7715.

[49] VHA Handbook 1109.04.

the past six months, and other relevant documents, and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent Facility
  - EOC rounds
  - EOC deficiency tracking
  - Infection prevention
  - General safety
  - Environmental cleanliness
  - General privacy
  - Women veterans' exam room privacy
  - Availability of medical equipment and supplies
- Community Based Outpatient Clinic
  - General safety
  - Medication safety and security
  - Infection prevention
  - Environmental cleanliness
  - General privacy
  - Exam room privacy
  - Availability of medical equipment and supplies
- Construction Safety
  - Completion of infection control risk assessment for all sites
  - Infection Prevention/Infection Control Committee discussions on construction activities
  - Dust control
  - Safety and security

  - Selected requirements based on project type and class[50]
- Nutrition and Food Services
  - Hazard Analysis Critical Control Point Food Safety System plan
  - Food Services inspections
  - Emergency operations plan for food service
  - Safe transportation of prepared food
  - Environmental safety
  - Infection prevention
  - Storage areas

Conclusion

General safety, infection prevention, and privacy measures were in place at the John Cochran and Jefferson Barracks campuses, and at the St Louis CBOC. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified the following deficiency that warranted a recommendation for improvement.

Parent Facility's Environment of Care Rounds Attendance

VHA requires facilities to perform comprehensive EOC rounds with a designated team that includes specific membership to ensure a safe, clean, and high-quality care environment.[51] From October 1, 2016, through September 30, 2017, 11 of 13 required members did not consistently participate in EOC rounds. Facility managers told the OIG that they were aware of VHA requirements but were unaware of the EOC members' level of participation. The managers stated that attendance data was not correctly entered into the Comprehensive EOC Assessment and Compliance Tool; however, no other attendance documentation could be produced.[52]

[50] VA Master Construction Specifications, Section 01-35-26, Sub-Section 1.12. The Type assigned to construction work ranges from Type A (non-invasive activities) to Type D (major demolition and construction). Type C construction involves work that generates a moderate to high level of dust or requires demolition or removal of any fixed building components or assemblies. The Class assigned to construction work ranges from Class I (low-risk groups affected) to Class IV (highest risk groups affected). Class III construction projects affect patients in high-risk areas such as the Emergency Department, inpatient medical and surgical units, and the pharmacy.

[51] According to VHA, core membership is composed of representatives from programmatic areas such as nursing, infection control, patient safety, and medical equipment management to ensure adherence to various program requirements.

[52] Attendance is tracked and trended with the Comprehensive EOC Assessment and Compliance Tool.

Recommendation 3

3. The Associate Director ensures required team members consistently participate on environment of care rounds and monitors compliance.

Facility concurred.

Target date for completion: September 2018

Facility response: The Safety Office implemented a revised tracking process in March 2018. The revised process specifies the required EOC team members for each area reviewed. The revised process removed not applicable team members from the attendance requirements. Monthly audit of a EOC round attendance will be completed to ensure team members are consistently participating. The results will be reported to the Quality Executive Board. Compliance of 90% will be demonstrated for 6 months.

Medication Management: Controlled Substances Inspection Program

The Controlled Substances (CS) Act divides controlled drugs into five categories based on whether they have a currently accepted medical treatment use in the United States, their relative abuse potential, and likelihood of causing dependence when abused.[53] Diversion by healthcare workers—the transfer of a legally-prescribed CS from the prescribed individual to another person for illicit use—remains a serious problem that can increase serious patient safety issues, causes harm to the diverter, and elevates the liability risk to healthcare organizations.[54]

VHA requires that facility managers implement and maintain a CS inspection program to minimize the risk for loss and diversion and to enhance patient safety.[55] Requirements include the appointment of CS Coordinator(s) (CSC) and CS inspectors (CSI), procedures for inventory control, and the inspection of the pharmacy and clinical areas with CS.

The OIG review of these issues was conducted to determine whether the Facility complied with requirements related to CS security and inspections and to follow up on recommendations from the 2014 report.[56] The OIG team interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;[57] monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months;[58] CS inspection quarterly trend reports for the prior four quarters;[59] and other relevant documents. The OIG evaluated the following performance indicators:

- CSC reports
  - Monthly summary of findings to the Director
  - Quarterly trend report to the Director
  - Actions taken to resolve identified problems
- Pharmacy operations
  - Annual physical security survey of the pharmacy/pharmacies by VA Police

[53] Drug Enforcement Agency Controlled Substance Schedules. https://www.deadiversion.usdoj.gov/schedules/. (Website accessed on August 21, 2017.)

[54] American Society of Health-System Pharmacists, "ASHP Guidelines on Preventing Diversion of Controlled Substances," *American Journal of Health-System Pharmacists* 74, no. 5 (March 1, 2017): 325-348.

[55] VHA Directive 1108.02(1), *Inspection of Controlled Substances*, November 28, 2016 (amended March 6, 2017).

[56] VA Office of Inspector General, *Combined Assessment Program Summary Report – Evaluation of the Controlled Substances Inspection Program at Veterans Health Administration Facilities*, Report No. 14-01785-184, June 10, 2014.

[57] The review period was July 1, 2017, through December 31, 2017.

[58] The review period was January 1, 2017, through December 31, 2017.

[59] The four quarters were from January 1, 2017, through December 31, 2017.

  - CS ordering processes
  - Inventory completion during Chief of Pharmacy transition
  - Staff restrictions for monthly review of balance adjustments
- Requirements for CSCs
  - Free from conflicts of interest
  - CSC duties included in position description or functional statement
  - Completion of required CSC orientation training course
- Requirements for CSIs
  - Free from conflicts of interest
  - Appointed in writing by the Director for a term not to exceed three years
  - Hiatus of one year between any reappointment
  - Completion of required CSI certification course
  - Completion of required annual updates and/or refresher training
- CS area inspections
  - Monthly inspections
  - Rotations of CSIs
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of CS orders
  - CS inspections performed by CSIs
- Pharmacy inspections
  - Monthly physical counts of the CS in the pharmacy by CSIs
  - Completion of inspections on day initiated
  - Security and documentation of drugs held for destruction[60]
  - Accountability for all prescription pads in pharmacy

[60] The "Destructions File Holding Report" lists all drugs awaiting local destruction or turn-over to a reverse distributor. CSIs must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report.

- Verification of hard copy outpatient pharmacy CS prescriptions
- Verification of 72-hour inventories of the main vault
- Quarterly inspections of emergency drugs
- Monthly CSI checks of locks and verification of lock numbers

Conclusion

The OIG found general compliance with requirements for most of the performance indicators evaluated, including CSC reports, pharmacy operations, and completion of CSC and CSI training. Inspections of pharmacy areas were completed as required. However, the OIG identified deficiencies with inclusion of the alternate CSC duties in the employee's position description, appointment letters for the CSIs, and completion of monthly inspections that warranted recommendations for improvement.

CSC Duties in the Position Description or Functional Statement

VHA requires that CSC and alternate CSC duties be included in the employee's position description or functional statement.[61] These duties may be added as an addendum to the position description or functional statement. This ensures that CSC tasks are assigned and clearly communicated as part of the employee's duties. The OIG found that the Alternate CSC's position description did not include duties related to the CSC program as required. Facility managers informed the OIG that a miscommunication and lack of follow-up were the reasons for noncompliance.

Recommendation 4

4. The Facility Director ensures that the duties of the Alternate Controlled Substances Coordinator are included in the employee position description or functional statement and monitors compliance.

Facility concurred.

Target date for completion: June 2018

Facility response: The Acting Director of Quality Value and Safety developed a position description addendum for the Alternate Control Substance Coordinator. The addendum was made to the Alternate Control Substance Coordinator position description and issued to the employee in June 2018.

[61] VHA Directive 1108.02(1).

Requirements for Controlled Substance Inspectors

VHA requires that the Director appoint, by email or memo, an adequate number of CSIs to a term not to exceed 3 years.[62] This ensures that the term of appointment is clear and trackable and that the collateral duties can be periodically rotated among staff. The OIG found that 5 of 10 CSI appointment memos were not signed by the Director. All appointment memos were also dated after the effective date of appointment, which indicates that CSIs performed inspections before they had been appointed. Although the CSC said that this was due to a miscommunication between the CSC and Quality Management, the Facility Director has ultimate responsibility for CSI appointments.

Recommendation 5

5. The Facility Director ensures that Controlled Substances Inspectors are appointed in writing prior to performing inspector duties and monitors compliance.

Facility concurred.

Target date for completion: September 2018

Facility response: The Facility Director appointed, in writing, all Controlled Substance Inspectors prior to performing inspector duties. A monthly audit of a random sample of completed inspections will be performed to validate that the inspector was appointed prior to performing the inspections. The results will be reported to the Quality Executive Board. Compliance of 100% will be demonstrated for 6 months.

Controlled Substance Area Inspections

VHA requires that inspections are completed monthly where controlled substances are stored.[63] Three clinical units were not inspected during the six-month review period. Missed inspections could increase the possibility of diversion and expose the Facility to unnecessary risk. The Facility stated that one unit was not inspected in July 2017 because the CSI reportedly did not inform the CSC of unavailability to perform duties until the month had passed. Two other clinical areas were not inspected in September 2017. The CSC failed to maintain required oversight of CS inspections.

Recommendation 6

6. The Facility Director ensures that controlled substances inspections are completed monthly in all clinical areas and monitors compliance.

[62] VHA Directive 1108.02(1).

[63] VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: September 2018

Facility response: The Controlled Substance Coordinator revised scheduling and monitoring processes to ensure that all clinical areas are inspected monthly. The revision allowed for 5 business days at the end of the month to identify and assign an alternate inspector if the assigned inspector was unable to complete. Monthly audits of clinical areas inventory will be completed. The results will be reported to the Quality Executive Board. Compliance of 100% will be demonstrated for 6 months.

Mental Health Care: Post-Traumatic Stress Disorder Care

Post-Traumatic Stress Disorder (PTSD) may occur "following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; other threat to one's physical integrity; witnessing an event that involves death, injury, or threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, threat of death or injury experienced by a family member or other close associate."[64] For veterans, the most common traumatic stressor contributing to a PTSD diagnosis is war-zone related stress. Non-war zone military experiences, such as the crash of a military aircraft, may also contribute to the development of PTSD.[65]

The PTSD screen is performed through a required national clinical reminder and is triggered for completion when the patient has his or her first visit at a VHA medical facility. The reminder typically remains active until it is completed.[66] VHA requires that

1. PTSD screening is performed for every new patient and then is repeated every year for the first five years post-separation and every five years thereafter, unless there is a clinical need to re-screen earlier;
2. If the patient's PTSD screen is positive, an acceptable provider must evaluate treatment needs and assess for suicide risk; and
3. If the provider determines a need for treatment, there is evidence of referral and coordination of care.[67]

To assess whether the Facility complied with the requirements related to PTSD screening, diagnostic evaluation, and referral to specialty care, the OIG team reviewed relevant documents and interviewed key employees and managers. Additionally, the OIG reviewed the electronic health records (EHR) of 42 randomly selected outpatients who had a positive PTSD screen from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Completion of suicide risk assessment by acceptable provider within required timeframe
- Offer to patient of further diagnostic evaluation

[64] VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010. (rescinded November 16, 2017).

[65] VHA Handbook 1160.03.

[66] A PTSD screen is not required if the patient received a PTSD diagnosis in outpatient setting in the past year; has a life expectancy of 6 months or less; has severe cognitive impairment, including dementia; is enrolled in a VHA or community-based hospice program; or has a diagnosis of cancer of the liver, pancreas, or esophagus.

[67] Department of Veterans Affairs, Information Bulletin, *Clarification of Posttraumatic Stress Disorder Screening Requirements*, August 6, 2015.

- Referral for diagnostic evaluation
- Completion of diagnostic evaluation within required timeframe

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

Long-term Care: Geriatric Evaluations

More than nine million veterans of all ages are enrolled with VA, and 46 percent of these veterans are age 65 and over.[68] As a group, veterans experience more chronic disease and disability than their non-veteran peers. VA must plan for the growing health demands by aging veterans and to have mechanisms in place for delivering those services in an appropriate and cost-effective manner.[69] Participants in geriatric evaluation (GE) programs have been shown to be significantly less likely to lose functional ability, experience health-related restrictions in their daily activities, or use home healthcare services.[70]

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.[71] This includes a comprehensive, multidimensional assessment and the development of an interdisciplinary plan of care. The healthcare team would then manage the patient with treatment, rehabilitation, health promotion, and social service interventions necessary for fulfillment of the plan of care by key personnel.[72] Facility leaders must also evaluate the GE program through a review of program objectives, procedures for monitoring care processes and outcomes, and analyses of findings.[73]

In determining whether the Facility provided an effective geriatric evaluation, OIG staff reviewed relevant documents and interviewed key employees and managers. Additionally, the team reviewed the EHRs of 48 randomly selected patients who received a GE from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Provision of or access to GE
- Program oversight and evaluation
  - Evidence of GE program evaluation
  - Evidence of performance improvement activities through leadership board
- Provision of clinical care
  - Medical evaluation by GE provider
  - Assessment by GE nurse

[68] VHA Directive 1140.04, *Geriatric Evaluation*, November 28, 2017.

[69] VHA Directive 1140.04.

[70] Chad Boult, Lisa B. Boult, Lynne Morishita, Bryan Dowd, Robert L. Kane, and Cristina F. Urdangarin, "A randomized clinical trial of outpatient geriatric evaluation and management," *Journal of the American Geriatrics Society* 49, no. 4 (April 2001): 351–359.

[71] Public Law 106-117.

[72] VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016.

[73] VHA Directive 1140.04.

  - Comprehensive psychosocial assessment by GE social worker
  - Patient or family education
  - Plan of care based on GE
- Geriatric management
  - Implementation of interventions noted in plan of care

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

Women's Health: Mammography Results and Follow-Up

In 2017, an estimated 252,710 new cases of invasive breast cancer and 40,610 breast cancer deaths were expected to occur among US women.[74] Timely screening, diagnosis, notification, and treatment are essential to early detection and optimal patient outcomes.

The Veterans Health Care Amendments of 1983 mandated VA provide veterans with preventive care, including breast cancer screening.[75] The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services, including mammography services to eligible women veterans.[76]

VHA has established timeframes for clinicians to notify ordering providers and patients of mammography results. "Incomplete" and "probably benign" results must be communicated to the ordering provider within 30 days of the procedure and to the patient within 14 calendar days from the date the results are available to the ordering provider. "Suspicious" and "highly suggestive of malignancy" results must be communicated to the ordering provider within three business days of the procedure, and the recommended course of action should be communicated to the patient as soon as possible, with seven calendar days representing the outer acceptable limit. Verbal communication with patients must be documented.[77]

The OIG team examined whether the Facility complied with selected VHA requirements for the reporting of mammography results by reviewing relevant documents and interviewing selected employees and managers. The team also reviewed the EHRs of 49 randomly selected women veteran patients who received a mammogram from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Electronic linking of mammogram results to radiology order
- Scanning of hard copy mammography reports, if outsourced
- Inclusion of required components in mammography reports
- Communication of results and any recommended course of action to ordering provider
- Communication of results and any recommended course of action to patient

[74] U.S. Breast Cancer Statistics. http://www.BreastCancer.org. (Website accessed on May 18, 2017.)

[75] Veterans Health Care Amendments of 1983, Pub. L. 98-160 (1983).

[76] Veterans Health Care Act of 1992, Title I, Pub. L. 102-585 (1992).

[77] VHA Directive 1330.01(2), *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017, and further amended July 24, 2018); VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011, which was rescinded and replaced by VHA Directive 1105.03, *Mammography Program Procedures and Standards*, May 21, 2018.

- Performance of follow-up mammogram if indicated
- Performance of follow-up study

Conclusion

The OIG found general compliance with electronically linking mammogram results to the radiology order, including required components in mammography reports; communicating results and any recommended course of action to the patient; and performing follow-up mammogram or other studies, if indicated. However, the OIG identified the following deficiency with communicating results to the ordering provider.

Communication of Results to the Ordering Provider

VHA requires the signed written mammography report be provided to the ordering provider and that an effective communication system exist. This ensures the ordering provider is able to communicate the findings to the patient, as well as alternatives for further study, treatment, or referral if needed.[78] The OIG estimated that the Facility communicated results to the ordering provider in 20 percent of the EHRs reviewed. The OIG is 95 percent confident that the true compliance rate is somewhere between 10.4 and 32.8 percent, which is statistically significantly below the 90 percent benchmark. This resulted in ordering providers not being aware that mammogram reports had been completed. The Chief of Diagnostic Imaging Services was unaware that the ordering provider had to be notified of normal mammogram results, and facility leaders approved turning off the EHR notifications for normal mammography results to reduce alert fatigue.[79]

Recommendation 7

7. The Chief of Staff ensures that ordering providers are notified of all mammography results and monitors compliance.

Facility concurred.

Target date for completion: September 2018

Facility Response: The Diagnostic Imaging Service Chief revised the reporting process to ensure that the ordering providers are notified of all mammography results. The ordering provider is added as a cosigner to the CPRS note documenting the mammography results patient letter. A copy of the patient letter is contained in this note. The Diagnostic Imaging Service will complete

[78] VHA Directive 1330.01(2).

[79] Notifications are messages that relay information or prompt providers to act on clinical information. Notifications are triggered by test results, including mammography. "Alert fatigue" refers to providers receiving so many notifications that they become desensitized to these alerts and may not respond appropriately.

a monthly random sample audit of completed mammography reports. The results will be reported to the Quality Executive Board. Compliance of 90% will be demonstrated for 6 months.

High-Risk Processes: Central Line-Associated Bloodstream Infections

TJC requires facilities to establish systematic infection prevention and control programs to reduce the risk of acquiring and transmitting infections.[80] Central lines "refer to a broad category of intravascular (within blood vessels) devices used to administer fluids, medications, blood and blood products, and parenteral nutrition. Unlike the short, temporary catheters inserted into the peripheral vasculature,"[81] central lines are threaded through a vein in the arm, chest, neck, or groin and advanced so that the furthest tip terminates at or close to the heart or in one of the great vessels.[82]

The use of central lines has greatly facilitated the care provided to patients; however, they are not without their risks. The Centers for Disease Control and Prevention defines a central line-associated bloodstream infection (CLABSI) as a "primary bloodstream infection that develops in a patient with a central line in place. This type of infection occurs within the 48 hours of insertion and is not related to infection at another site."[83]

Infections occurring on or after the third calendar day following admission to an inpatient location are considered "healthcare-associated."[84] The patient's age, underlying conditions, and gender are basic risk factors, but external risk factors such as prolonged hospitalization, multi-lumen central lines, and central line duration far outnumber the basic ones. External factors are associated with a 2.27-fold increased risk for mortality and increased healthcare costs.[85]

The OIG's review of these issues examined whether the Facility established and maintained programs to reduce the incidence of healthcare-associated bloodstream infections in intensive care unit patients with indwelling central lines. In addition to conducting manager and staff interviews, the OIG team reviewed committee minutes, the Infection Prevention/Control Risk Assessment, and other relevant documents. The team also reviewed the training records of 15 clinical employees involved in inserting and/or managing central lines. The OIG evaluated the following performance indicators:

- Presence of Facility policy on the use and care of central lines

[80] TJC. Infection Control and National Patient Safety Goals: IC.01.03.01, EP 4, 5, July 2017.

[81] Association for Professionals in Infection Control and Epidemiology, *Guide to Preventing Central Line-Associated Bloodstream Infections*, 2015.

[82] These are vessels that enter and leave the heart—superior and inferior vena cava, pulmonary artery, pulmonary vein, aorta.

[83] The Centers for Disease Control and Prevention, *Guidelines for the Prevention of Intravascular Catheter-Related Infections*, 2011.

[84] The Centers for Disease Control and Prevention National Healthcare Safety Network, *Bloodstream Infection Event: Central Line-Associated Bloodstream Infection and non-central line-associated Bloodstream Infection*, January 2017.

[85] Association for Professionals in Infection Control and Epidemiology, 2015.

- Performance of annual infection prevention risk assessment
- Evidence of routine discussion of CLABSI data and prevention outcome measures in committee minutes
- Provision of infection incidence data on CLABSI
- Education on reducing the risk of CLABSI for staff involved in inserting and/or managing central lines
- Educational materials about CLABSI prevention for patients and families
- Use of a checklist for central line insertion and maintenance

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

Appendix A: 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	Seven OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Director, Chief of Staff, and Associate Director. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer review of clinical care • UM reviews • Patient safety incident reporting and RCAs	• None	• None
Credentialing and Privileging	• Medical licenses • Privileges • FPPEs • OPPEs	• Clinical managers initiate FPPEs that include clearly delineated timeframes. • Clinical managers consistently review OPPE data as required.	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Parent Facility
	  ○ EOC rounds and deficiency tracking
	  ○ Infection prevention
	  ○ General safety
	  ○ Environmental cleanliness
	  ○ General and exam room privacy
	  ○ Availability of medical equipment and supplies
	• CBOC
	  ○ General safety
	  ○ Medication safety and security
	  ○ Infection prevention
	  ○ Environmental cleanliness
	  ○ General and exam room privacy
	  ○ Availability of medical equipment and supplies
	• Construction Safety
	  ○ Infection control risk assessment
	  ○ Infection Prevention/ Infection Control Committee discussions
	  ○ Dust control
	  ○ Safety/security
	  ○ Selected requirements based on project type and class
	• Nutrition and Food Services
	  ○ Hazard Analysis Critical Control Point Food Safety System plan
	  ○ Food Services inspections
	  ○ Safe transportation of prepared food
	  ○ Environmental safety
	  ○ Infection prevention
	  ○ Storage areas
		• None	• Required team members consistently participate on EOC rounds.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management	• CSC reports • Pharmacy operations • Annual physical security survey • CS ordering processes • Inventory completion during Chief of Pharmacy transition • Review of balance adjustments • CSC requirements • CSI requirements • CS area inspections • Pharmacy inspections	• Duties of the Alternate CSC are included in the employee position description or functional statement. • Controlled Substance Inspectors are appointed in writing prior to performing inspector duties. • CS inspections are completed monthly in all clinical areas.	• None
Mental Health Care: Post-Traumatic Stress Disorder Care	• Suicide risk assessment • Offer of further diagnostic evaluation • Referral for diagnostic evaluation • Completion of diagnostic evaluation	• None	• None
Long-Term Care: Geriatric Evaluations	• Provision of or access to GE • Program oversight and evaluation • Provision of clinical care • Geriatric management	• None	• None
Women's Health: Mammography Results and Follow-Up	• Result linking • Report scanning and content • Communication of results and recommended actions • Follow-up mammograms and studies	• Ordering providers are notified of all mammography results.	• None
High-Risk Processes: Central Line-Associated Bloodstream Infections	• Policy and infection prevention risk assessment • Committee discussion • Infection incidence data • Education and educational materials	• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	• Policy, procedure, and checklist for insertion and maintenance of central venous catheters		

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this high-complexity (1a)[86] affiliated[87] Facility reporting to VISN 15.

Table 6. Facility Profile for St. Louis (657)
(October 1, 2014, through September 30, 2017)

Profile Element	Facility Data FY 2015[88]	Facility Data FY 2016[89]	Facility Data FY 2017[90]
Total Medical Care Budget in Millions[91]	$989.7	$2,390.6	$3,008.7
Number of:			
• Unique Patients	59,886	76,924	62,038
• Outpatient Visits	706,261	702,215	697,879
• Unique Employees[92]	2,384	2,470	2,651
Type and Number of Operating Beds:			
• Community Living Center	71	71	71
• Domiciliary	75	75	75
• Medicine	66	66	66
• Mental Health	46	46	46
• Spinal Cord	38	38	38
• Surgery	50	50	50

[86] The VHA medical centers are classified according to a Facility complexity model; 1a designation indicates a Facility with high volume, high-risk patients, most complex clinical programs, and large research and teaching programs.

[87] Associated with a medical residency program.

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

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

[90] October 1, 2016, through September 30, 2017.

[91] Values include expenditures for CHOICE (0172), Medical Care (0152, 0160, 0162), and Community Care (0140) funds. Fiscal years 2015, 2016, and 2017 include CHOICE expenditures of $425.5, $1,799.5, and $2,387.4 million, respectively.

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

Profile Element	Facility Data FY 2015[93]	Facility Data FY 2016[94]	Facility Data FY 2017[95]
Average daily Census:			
• Community Living Center	50	52	53
• Domiciliary	48	39	51
• Medicine	57	55	54
• Mental Health	29	25	25
• Neurology	4	4	3
• Spinal Cord	19	21	23
• Surgery	17	18	19

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

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

[93] October 1, 2014, through September 30, 2015.
[94] October 1, 2015, through September 30, 2016.
[95] October 1, 2016, through September 30, 2017.

VA Outpatient Clinic Profiles[96]

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 7 provides information relative to each of the clinics.

Table 7. VA Outpatient Clinic Workload/Encounters[97] and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2016, through September 30, 2017)

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[98] Provided	Diagnostic Services[99] Provided	Ancillary Services[100] Provided
Belleville, IL	657GA	7,150	980	Endocrinology	n/a	Alternative Pharmacy Weight Management Nutrition
Florissant, MO	657GB	8,635	1,310	Endocrinology	n/a	Alternative Pharmacy Weight Management Nutrition

[96] Includes all outpatient clinics in the community that were in operation as of August 15, 2017.

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

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

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

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

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[98] Provided	Diagnostic Services[99] Provided	Ancillary Services[100] Provided
O'Fallon, MO	657GD	7,798	797	Endocrinology	n/a	Alternative Pharmacy Weight Management Nutrition
Washington, MO	657GS	3,763	678	Cardiology Endocrinology	n/a	Alternative Pharmacy Weight Management Nutrition
St. Louis, MO	657GX	119	8	n/a	n/a	Pharmacy Nutrition
St. Louis, MO	657GY	6,656	429	n/a	n/a	Pharmacy Nutrition
St. Louis, MO	657QA	2,891	430	Dermatology GYN	n/a	n/a
St. Louis, MO	657QB	7,482	450	Endocrinology	n/a	Pharmacy Nutrition
Scott Air Force Base, IL	657QE	n/a	384	n/a	n/a	n/a

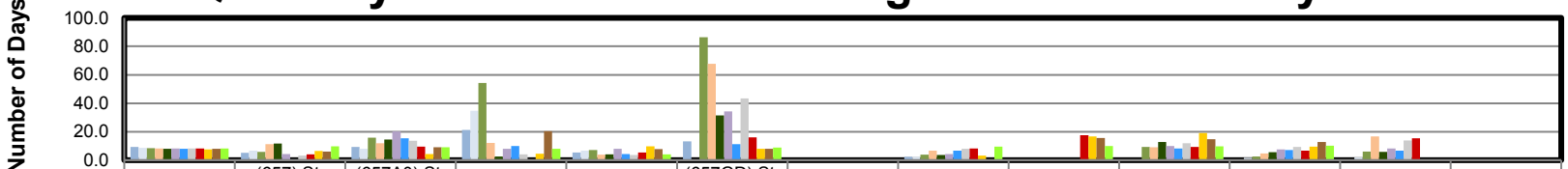
Source: VHA Support Service Center and VA Corporate Data Warehouse

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

n/a = not applicable

Appendix C: Patient Aligned Care Team Compass Metrics[101]

Quarterly New PC Patient Average Wait Time in Days



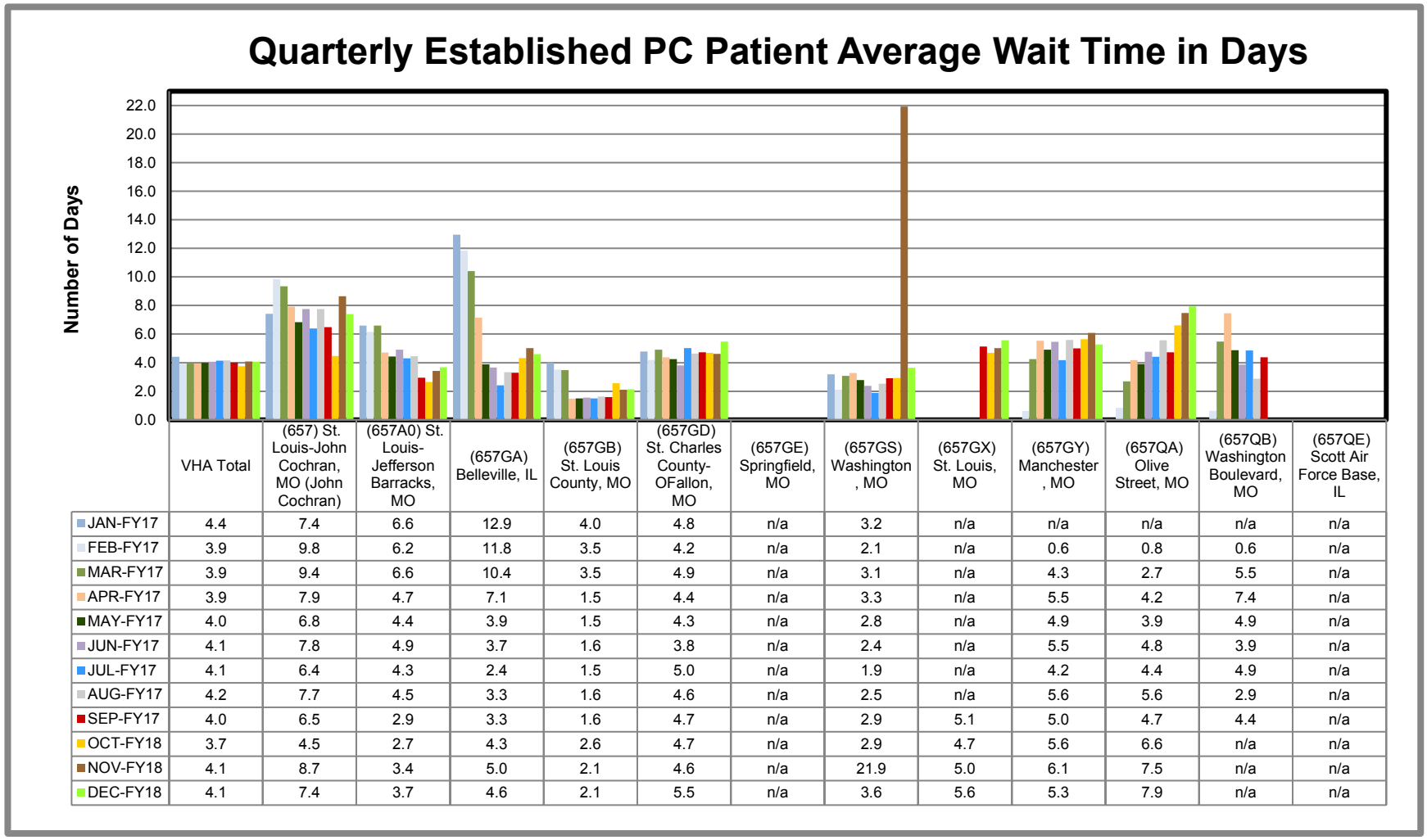
	VHA Total	(657) St. Louis-John Cochran, MO (John Cochran)	(657A0) St. Louis-Jefferson Barracks, MO	(657GA) Belleville, IL	(657GB) St. Louis County, MO	(657GD) St. Charles County-OFallon, MO	(657GE) Springfield	(657GS) Washington, MO	(657GX) St. Louis, MO	(657GY) Manchester, MO	(657QA) Olive Street, MO	(657QB) Washington Boulevard, MO	(657QE) Scott Air Force Base, IL
JAN-FY17	9.2	5.1	9.2	21.1	5.3	13.1	n/a	2.2	n/a	n/a	n/a	n/a	n/a
FEB-FY17	8.7	6.6	7.9	34.6	6.6	0.2	n/a	2.3	n/a	0.3	1.6	2.0	n/a
MAR-FY17	8.4	5.8	15.8	54.3	7.0	86.5	n/a	3.9	n/a	9.3	2.6	6.0	n/a
APR-FY17	8.2	11.2	12.0	12.0	3.8	67.7	n/a	6.8	n/a	9.0	4.7	16.7	n/a
MAY-FY17	7.9	11.7	14.5	2.5	4.1	31.5	n/a	3.6	n/a	12.8	5.5	5.9	n/a
JUN-FY17	8.2	4.3	20.2	7.9	7.9	34.2	n/a	4.3	n/a	9.9	7.5	8.1	n/a
JUL-FY17	8.0	0.5	15.5	10.0	4.3	11.2	n/a	6.8	n/a	8.2	7.1	6.7	n/a
AUG-FY17	8.1	3.1	13.6	4.0	3.7	43.3	n/a	8.0	n/a	11.9	9.3	13.8	n/a
SEP-FY17	8.2	4.2	9.4	0.0	5.3	16.0	n/a	8.2	17.6	9.3	6.7	15.4	n/a
OCT-FY18	7.5	6.5	4.3	4.4	9.8	8.1	n/a	3.2	16.6	19.0	9.5	n/a	n/a
NOV-FY18	8.0	6.1	9.0	20.4	7.8	7.9	n/a	n/a	15.5	14.6	12.8	n/a	n/a
DEC-FY18	8.1	9.7	9.2	8.0	4.0	8.9	n/a	9.4	9.9	9.8	10.1	n/a	n/a

Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the Facility's explanation for the increased wait times for the Belleville, IL, and O'Fallon, MO, CBOCs.

Data Definition: 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. The absence of reported data is indicated by "n/a."

[101] Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 11, 2017.

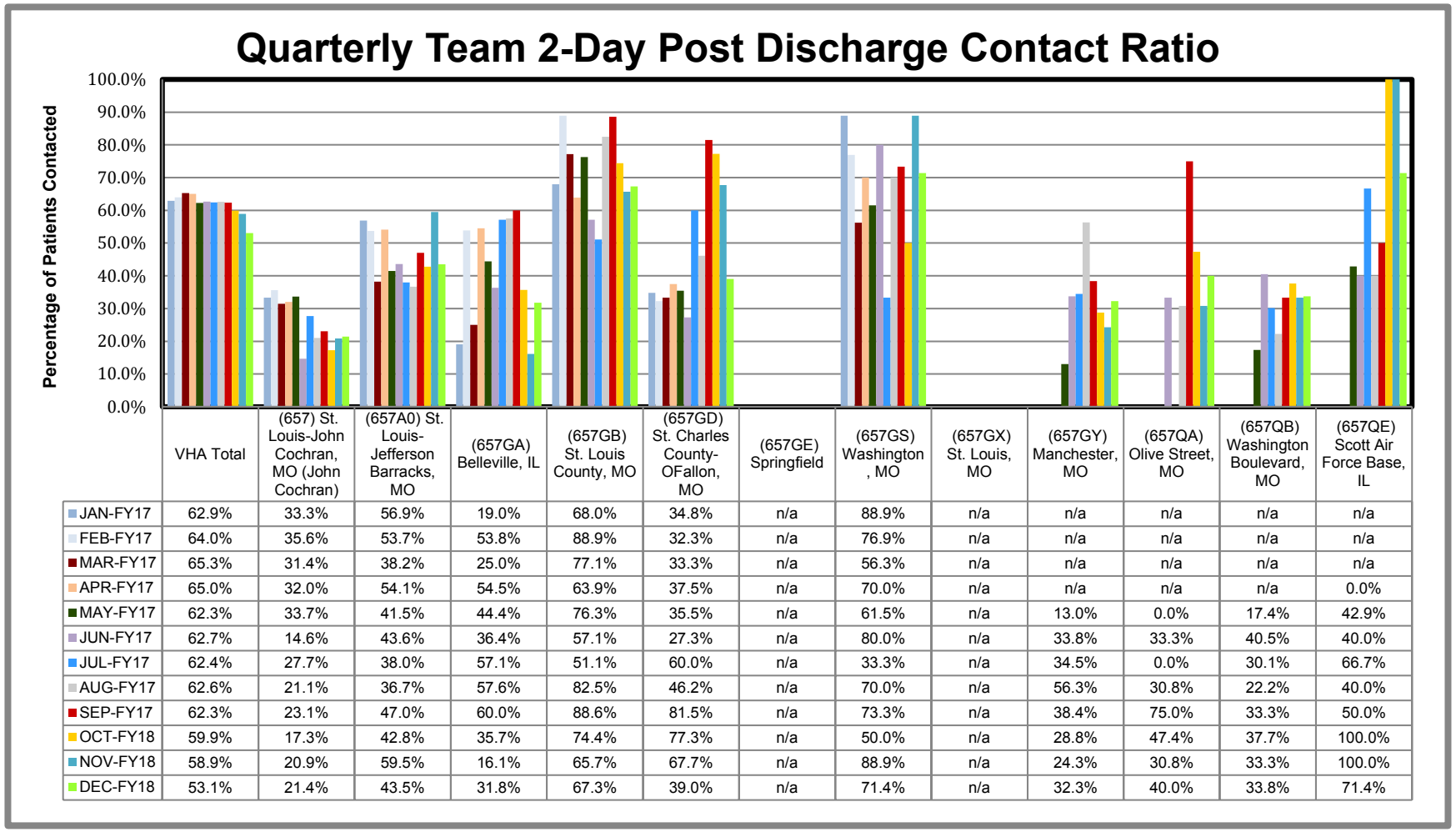


	VHA Total	(657) St. Louis-John Cochran, MO (John Cochran)	(657A0) St. Louis-Jefferson Barracks, MO	(657GA) Belleville, IL	(657GB) St. Louis County, MO	(657GD) St. Charles County-OFallon, MO	(657GE) Springfield, MO	(657GS) Washington, MO	(657GX) St. Louis, MO	(657GY) Manchester, MO	(657QA) Olive Street, MO	(657QB) Washington Boulevard, MO	(657QE) Scott Air Force Base, IL
JAN-FY17	4.4	7.4	6.6	12.9	4.0	4.8	n/a	3.2	n/a	n/a	n/a	n/a	n/a
FEB-FY17	3.9	9.8	6.2	11.8	3.5	4.2	n/a	2.1	n/a	0.6	0.8	0.6	n/a
MAR-FY17	3.9	9.4	6.6	10.4	3.5	4.9	n/a	3.1	n/a	4.3	2.7	5.5	n/a
APR-FY17	3.9	7.9	4.7	7.1	1.5	4.4	n/a	3.3	n/a	5.5	4.2	7.4	n/a
MAY-FY17	4.0	6.8	4.4	3.9	1.5	4.3	n/a	2.8	n/a	4.9	3.9	4.9	n/a
JUN-FY17	4.1	7.8	4.9	3.7	1.6	3.8	n/a	2.4	n/a	5.5	4.8	3.9	n/a
JUL-FY17	4.1	6.4	4.3	2.4	1.5	5.0	n/a	1.9	n/a	4.2	4.4	4.9	n/a
AUG-FY17	4.2	7.7	4.5	3.3	1.6	4.6	n/a	2.5	n/a	5.6	5.6	2.9	n/a
SEP-FY17	4.0	6.5	2.9	3.3	1.6	4.7	n/a	2.9	5.1	5.0	4.7	4.4	n/a
OCT-FY18	3.7	4.5	2.7	4.3	2.6	4.7	n/a	2.9	4.7	5.6	6.6	n/a	n/a
NOV-FY18	4.1	8.7	3.4	5.0	2.1	4.6	n/a	21.9	5.0	6.1	7.5	n/a	n/a
DEC-FY18	4.1	7.4	3.7	4.6	2.1	5.5	n/a	3.6	5.6	5.3	7.9	n/a	n/a

Source: VHA Support Service Center

Note: The 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. The absence of reported data is indicated by "n/a."

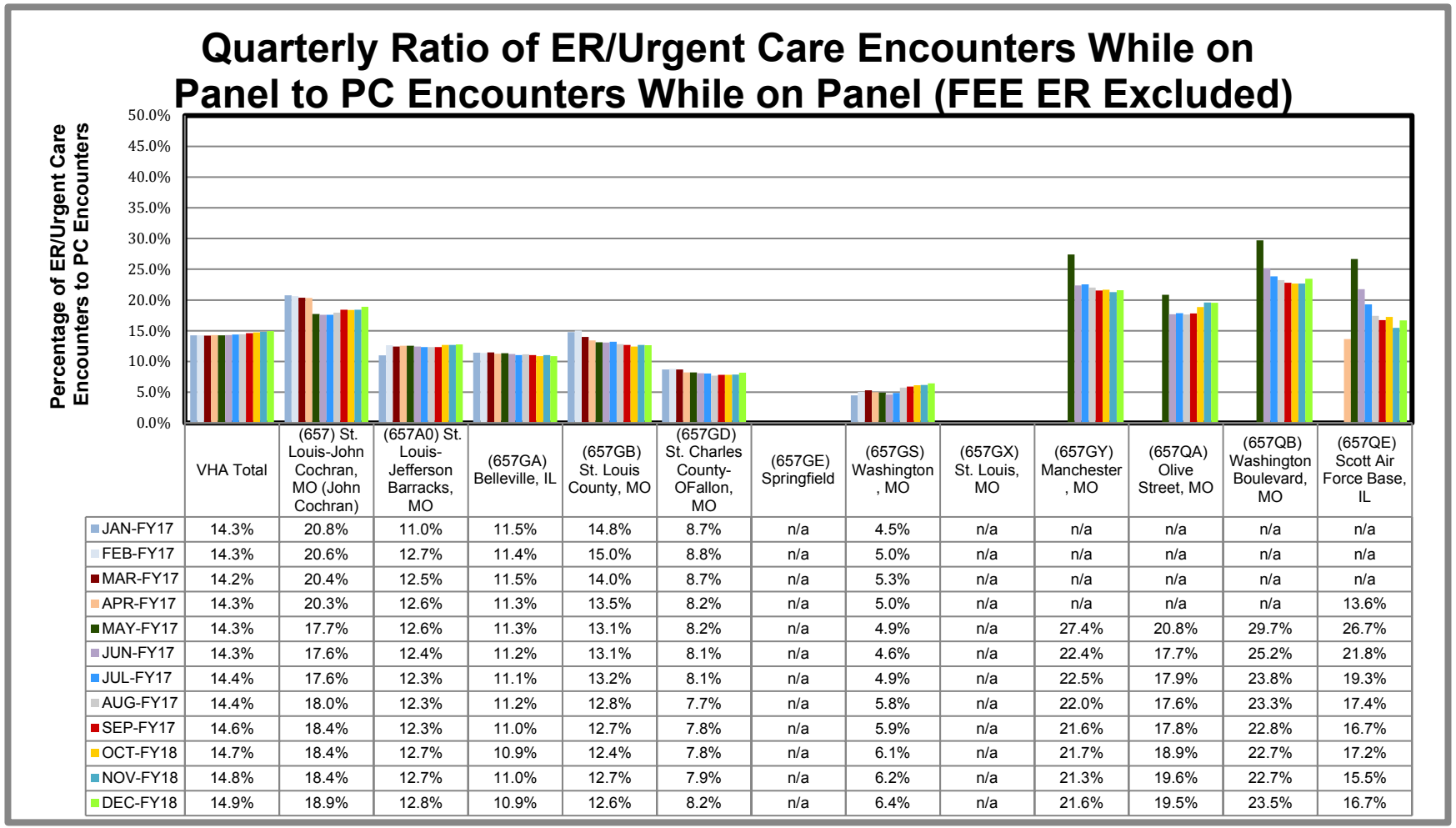


	VHA Total	(657) St. Louis-John Cochran, MO (John Cochran)	(657A0) St. Louis-Jefferson Barracks, MO	(657GA) Belleville, IL	(657GB) St. Louis County, MO	(657GD) St. Charles County-OFallon, MO	(657GE) Springfield	(657GS) Washington, MO	(657GX) St. Louis, MO	(657GY) Manchester, MO	(657QA) Olive Street, MO	(657QB) Washington Boulevard, MO	(657QE) Scott Air Force Base, IL
JAN-FY17	62.9%	33.3%	56.9%	19.0%	68.0%	34.8%	n/a	88.9%	n/a	n/a	n/a	n/a	n/a
FEB-FY17	64.0%	35.6%	53.7%	53.8%	88.9%	32.3%	n/a	76.9%	n/a	n/a	n/a	n/a	n/a
MAR-FY17	65.3%	31.4%	38.2%	25.0%	77.1%	33.3%	n/a	56.3%	n/a	n/a	n/a	n/a	n/a
APR-FY17	65.0%	32.0%	54.1%	54.5%	63.9%	37.5%	n/a	70.0%	n/a	n/a	n/a	n/a	0.0%
MAY-FY17	62.3%	33.7%	41.5%	44.4%	76.3%	35.5%	n/a	61.5%	n/a	13.0%	0.0%	17.4%	42.9%
JUN-FY17	62.7%	14.6%	43.6%	36.4%	57.1%	27.3%	n/a	80.0%	n/a	33.8%	33.3%	40.5%	40.0%
JUL-FY17	62.4%	27.7%	38.0%	57.1%	51.1%	60.0%	n/a	33.3%	n/a	34.5%	0.0%	30.1%	66.7%
AUG-FY17	62.6%	21.1%	36.7%	57.6%	82.5%	46.2%	n/a	70.0%	n/a	56.3%	30.8%	22.2%	40.0%
SEP-FY17	62.3%	23.1%	47.0%	60.0%	88.6%	81.5%	n/a	73.3%	n/a	38.4%	75.0%	33.3%	50.0%
OCT-FY18	59.9%	17.3%	42.8%	35.7%	74.4%	77.3%	n/a	50.0%	n/a	28.8%	47.4%	37.7%	100.0%
NOV-FY18	58.9%	20.9%	59.5%	16.1%	65.7%	67.7%	n/a	88.9%	n/a	24.3%	30.8%	33.3%	100.0%
DEC-FY18	53.1%	21.4%	43.5%	31.8%	67.3%	39.0%	n/a	71.4%	n/a	32.3%	40.0%	33.8%	71.4%

Source: VHA Support Service Center

Note: The 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." The absence of reported data is indicated by "n/a."



	VHA Total	(657) St. Louis-John Cochran, MO (John Cochran)	(657A0) St. Louis-Jefferson Barracks, MO	(657GA) Belleville, IL	(657GB) St. Louis County, MO	(657GD) St. Charles County-OFallon, MO	(657GE) Springfield	(657GS) Washington, MO	(657GX) St. Louis, MO	(657GY) Manchester, MO	(657QA) Olive Street, MO	(657QB) Washington Boulevard, MO	(657QE) Scott Air Force Base, IL
JAN-FY17	14.3%	20.8%	11.0%	11.5%	14.8%	8.7%	n/a	4.5%	n/a	n/a	n/a	n/a	n/a
FEB-FY17	14.3%	20.6%	12.7%	11.4%	15.0%	8.8%	n/a	5.0%	n/a	n/a	n/a	n/a	n/a
MAR-FY17	14.2%	20.4%	12.5%	11.5%	14.0%	8.7%	n/a	5.3%	n/a	n/a	n/a	n/a	n/a
APR-FY17	14.3%	20.3%	12.6%	11.3%	13.5%	8.2%	n/a	5.0%	n/a	n/a	n/a	n/a	13.6%
MAY-FY17	14.3%	17.7%	12.6%	11.3%	13.1%	8.2%	n/a	4.9%	n/a	27.4%	20.8%	29.7%	26.7%
JUN-FY17	14.3%	17.6%	12.4%	11.2%	13.1%	8.1%	n/a	4.6%	n/a	22.4%	17.7%	25.2%	21.8%
JUL-FY17	14.4%	17.6%	12.3%	11.1%	13.2%	8.1%	n/a	4.9%	n/a	22.5%	17.9%	23.8%	19.3%
AUG-FY17	14.4%	18.0%	12.3%	11.2%	12.8%	7.7%	n/a	5.8%	n/a	22.0%	17.6%	23.3%	17.4%
SEP-FY17	14.6%	18.4%	12.3%	11.0%	12.7%	7.8%	n/a	5.9%	n/a	21.6%	17.8%	22.8%	16.7%
OCT-FY18	14.7%	18.4%	12.7%	10.9%	12.4%	7.8%	n/a	6.1%	n/a	21.7%	18.9%	22.7%	17.2%
NOV-FY18	14.8%	18.4%	12.7%	11.0%	12.7%	7.9%	n/a	6.2%	n/a	21.3%	19.6%	22.7%	15.5%
DEC-FY18	14.9%	18.9%	12.8%	10.9%	12.6%	8.2%	n/a	6.4%	n/a	21.6%	19.5%	23.5%	16.7%

Source: VHA Support Service Center

Note: The 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 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. The absence of reported data is indicated by "n/a."

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[102]

Measure	Definition	Desired Direction
ACSC Hospitalization	Ambulatory Care Sensitive Conditions hospitalizations	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	All Employee Survey Best Places to Work score	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
Capacity	Physician Capacity	A lower value is better than a higher value
Care Transition	Care Transition (Inpatient)	A higher value is better than a lower value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Comprehensiveness	Comprehensiveness (PCMH)	A higher value is better than a lower 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
Efficiency/Capacity	Efficiency and Physician Capacity	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value

[102] VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: February 14, 2018.

Measure	Definition	Desired Direction
HC Assoc Infections	Healthcare 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
HEDIS Like – HED90_1	HEDIS-EPRP Based PRV TOB BHS	A higher value is better than a lower value
HEDIS Like – HED90_ec	HEDIS-eOM Based DM IHD	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
PCMH Same Day Appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH Survey Access	Timely Appointment, care and information (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
Rating Hospital	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

Measure	Definition	Desired Direction
Rating SC Provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
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-COPD	30-day risk standardized mortality rate for COPD	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-COPD	30-day risk standardized readmission rate for COPD	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 Survey Access	Timely Appointment, care and information (Specialty Care)	A higher value is better than a lower value

Measure	Definition	Desired Direction
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
Stress Discussed	Stress Discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center

Appendix E: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 25, 2018

From: Director, VA Heartland Network (10N15)

Subj: CHIP Review of the VA St. Louis Health Care System, MO

To: Director, Atlanta Office of Healthcare Inspections (54AT)

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

1. In response to the findings of OIG CHIP Review of the VA St Louis Health Care System conducted February 12 to February 16, 2018, the facility has taken actions to address the seven (7) recommendations.

2. I have reviewed and concur with the report, findings, recommendations and actions submitted by the facility. Monitoring of completion and sustainment of the actions will be done.

(Original signed by:)

William P. Patterson, MD, MSS
Network Director, VA Heartland Network
VISN 15

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Americans with Disabilities Act.

Appendix F: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 23, 2018

From: Director, VA St. Louis Health Care System (657/00)

Subj: CHIP Review of the VA St. Louis Health Care System, MO

To: Director, VA Heartland Network (10N15)

1. In response to the findings of OIG CHIP Review of the VA St Louis Health Care System conducted February 12 to February 16, 2018, the facility has taken actions to address the seven (7) recommendations.

2. I have reviewed and concur with the findings, recommendations and actions as submitted. The action plans will be followed through to completion and sustainment.

(Original signed by:)

Keith Repko
Medical Center Director
VA St Louis Health Care System

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Americans with Disabilities Act.

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