Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the St. Louis VA Medical Center St. Louis, Missouri

Report No. 06-02818-100

March 14, 2007

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

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

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

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

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Contents

Executive Summary

Introduction

The Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the St. Louis VA Medical Center (the medical center), St. Louis, MO, during the week of October 2–6, 2006. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we provided fraud and integrity awareness training to 292 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 15.

Results of Review

The CAP review focused on eight areas. The medical center complied with selected standards in the following four areas:

- Breast Cancer Management.
- Community Based Outpatient Clinics.
- Contract Community Nursing Homes.
- Diabetes and Atypical Antipsychotic Medications.

We identified four areas that needed additional management attention. To improve operations, we made the following recommendations:

- Strengthen cardiac catheterization laboratory processes.
- Correct environment of care deficiencies.
- Improve QM structure and processes.
- Develop Survey of Health Experiences of Patients corrective action plans.

In addition, we followed up on previous healthcare CAP recommendations from the OIG report *Combined Assessment Program Review of the VA Medical Center, St. Louis, Missouri* (Report No. 04-01893-148, June 2, 2005) and made a recommendation for a repeat finding for Moderate Sedation regarding the cardiopulmonary resuscitation training policy.

This report was prepared under the direction of Ms. Virginia Solana, Director, and Ms. Dorothy Duncan, Associate Director, Kansas City Regional Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and provided acceptable improvement plans (see Appendixes A and B, pages 15–21, for the full text of the Directors' comments). We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Medical Center Profile

Organization. The St. Louis VA Medical Center (the medical center) is a two-division, tertiary care facility. The John Cochran division is located in downtown St. Louis, and the Jefferson Barracks division is located in south St. Louis County. The medical center also has community based outpatient clinics (CBOCs) located in St. Charles, MO; Belleville, IL; and at the Missouri State Veterans Home in north St. Louis County. Additional CBOCs are jointly operated with other VA medical facilities in Effingham and Springfield, Illinois.

Programs. With 116 acute care beds, the John Cochran division provides acute medical and surgical programs with a wide range of specialty care. The Jefferson Barracks division provides primary care and has 102 acute care beds (70 psychiatry and 32 spinal cord injury), a 50-bed domiciliary, and a 71-bed nursing home.

Affiliations and Research. The medical center has affiliations with St. Louis University School of Medicine and Washington University School of Medicine. The residency program supports 122 positions. In addition, the medical center has affiliations with schools of nursing, pharmacy, psychology, physician assistants, and social work in the St. Louis area.

In fiscal year (FY) 2006, the medical center's Research Service reported expenditures of approximately $13.3 million in support of basic biomedical, clinical, and health services research. As of August 2006, the medical center had nine VA-funded basic biomedical research programs and three VA cooperative studies. In total, 85 investigators directed 174 active programs.

Resources. The medical center's budget expenditures for FYs 2005 and 2006 were approximately $244 million and $250 million, respectively. Staffing for FY 2005 was 1,907 full-time equivalent employees (FTE). Staffing for FY 2006 was 1,911 cumulative FTE, including 127 physician and 353 nurse FTE.

Workload. The medical center treated 83,345 patients in FY 2005. The inpatient care workload totaled 9,053 discharges, and the average daily census, including nursing home patients, was 214.8. Outpatient workload totaled 467,954 visits for FY 2006.

Objectives and Scope of the Combined Assessment Program Review

Objectives. Combined Assessment Program (CAP) reviews are one element of the Office of Inspector General's (OIG's) efforts to ensure that our Nation's veterans receive high quality VA health care and benefits services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations focusing on patient care administration and quality management (QM).
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

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

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

Breast Cancer Management	Diabetes and Atypical Antipsychotic Medications
Cardiac Catheterization Laboratory Standards	Environment of Care (EOC)
CBOCs	QM
Contract Community Nursing Homes (CNHs)	Survey of Healthcare Experiences of Patients (SHEP)

The review covered facility operations for FYs 2005 and 2006 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on the healthcare recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the VA Medical Center, St. Louis, Missouri,* Report No. 04-01893-148, June 2, 2005).

During this review, we also presented fraud and integrity awareness briefings for 292 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.

In this report, we summarize selected focused inspections and make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the Other Review Topics section have no reportable conditions.

Results of Review

Opportunities for Improvement

Cardiac Catheterization Laboratory Standards – Informed Consents, Physician Training, and the Quality Improvement Review Process Needed To Be Strengthened

Conditions Needing Improvement. Informed consents needed to consistently include the name of the procedure performed, potential risks of the procedure, the names of clinicians performing the procedure, and signatures of witnesses. Physicians who performed cardiac catheterization procedures needed to complete cardiopulmonary resuscitation training. The cardiac catheterization laboratory needed to report quality improvement information to the designated oversight committee.

The purpose of this review was to evaluate if cardiac catheterization laboratory processes were consistent with American College of Cardiology/Society for Cardiac Angiography and Interventions (ACC) standards. Cardiac catheterization is a specialty procedure used to diagnose defects in the heart chambers, valves, and blood vessels. If physicians identify a blockage, they may perform a procedure to open the blockage in the cardiac catheterization laboratory or send the patient for a surgical procedure. The ACC has reported a direct correlation between complications and volume of procedures performed. Medical center physicians performed an acceptable volume of procedures and had low complication rates. Cardiac surgery was readily available for patients who required it.

We reviewed the medical records of 10 randomly selected patients to determine the quality of the informed consent process, outcomes of the cardiac catheterization procedures, and if applicable, availability of surgery. None of the 10 patients had complications or required surgery. However, improvements were needed in the informed consent process.

Informed Consents. Veterans Health Administration (VHA) requires that all practitioners who participate in cardiac catheterization procedures must be identified on the informed consent. We reviewed procedure notes and informed consents to determine if the practitioners who performed the procedures were the same as those noted on the consents. Only one (10 percent) of the 10 consents was correctly completed in all required areas. Two (20 percent) of the 10 consents had a different practitioner listed than the person who actually performed the procedure. Other documentation that was incomplete or missing included names of the procedures, descriptions of the procedures in layman's terms and without abbreviations, details of the procedures, risks, and witnessed signatures.

Cardiopulmonary Resuscitation Training. As part of the review to determine if physicians who performed cardiac catheterization procedures had appropriate credentialing and training, we noted that neither attending physician had current cardiopulmonary resuscitation (CPR) training in the Credentialing and Privileging (C&P) records. VHA requires that all clinically active staff have CPR training.

Quality Improvement Review. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and ACC standards require that cardiac catheterization laboratories collect performance data in order to trend and analyze results and, if necessary, make recommendations for improvement. Cardiac catheterization laboratory managers had raw data on complication rates but had not reported to the medical center committee responsible for operative and invasive procedures oversight. Cardiology was in the process of expanding services and increasing workload and agreed that tracking data quarterly and reporting to the committee would be beneficial.

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) clinicians meet all requirements for completing informed consents, (b) cardiac catheterization laboratory physicians receive CPR training or document CPR proficiency, and (c) the cardiac catheterization laboratory develop a quality improvement review process and report findings to the designated oversight committee on at least a quarterly basis.

The VISN and Medical Center Directors agreed with the findings and recommendations. An electronic template has been developed which will ensure that all informed consent requirements are met. Documentation of CPR training for each of the cardiac catheterization laboratory physicians was obtained, and review of the documentation shows both physicians are current in their certification. The cardiac catheterization laboratory will develop a quality improvement process, and the results will be reported to the Medical Staff Performance Improvement (PI) Committee on at least a quarterly basis. The improvement actions are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Environment of Care – General Conditions Needed To Be Improved

Conditions Needing Improvement. We observed general environmental concerns related to cleanliness and infection control, including ceiling air vents, window air conditioning units, window sills, linen storage, and refrigerator thermometers.

VHA policy requires that patient care areas be clean, sanitary, and maintained to optimize patient safety and infection control. We conducted EOC inspections on inpatient units and outpatient areas at the John Cochran and Jefferson Barracks divisions. We randomly selected and inspected eight pieces of clinical equipment at the John Cochran division and six pieces at the Jefferson Barracks division. All equipment was clean with properly functioning alarms, and preventive maintenance checks were current. The medical

center was generally clean and safe. Managers corrected most conditions identified during our inspection.

General Environmental Conditions. We inspected occupied and unoccupied patient rooms; bathrooms; medication and utility rooms; Supply, Processing, and Distribution (SPD); and outpatient clinic areas at both divisions. We observed environmental concerns related to cleanliness and infection control, including:

- *Ceiling air vents.* We observed thick dust covering air vent openings in several patient rooms at the John Cochran division. During our visit, it appeared that ceiling air vents had not been cleaned for some time. The July 27, 2006, EOC rounds identified the problem, but there was no corrective action noted. Ceiling air vents must be cleaned regularly to prevent infection control issues.
- *Portable window air conditioning units.* We found dirty filters in portable window air conditioning units in several patient rooms at the John Cochran division. The filters had not been changed and were covered with dust. Filters in portable window air conditioning units must be clean to reduce the chance of respiratory infection. Management agreed to replace the filters immediately.
- *Window sills.* We found large amounts of dust on window sills in multiple patient rooms at the John Cochran division. The staff told us that the window sills are not routinely dusted during regular room cleaning. Window sills must be included in regular room cleaning to maintain a clean and safe patient care environment.
- *Linen storage.* We found bags with clean isolation gowns stored on the floor at both divisions. Staff reported that the bags constantly slip off the linen carts and fall on the floor. VHA and JCAHO require that clean linen must be stored off the floor. Linen found or stored on the floor is considered contaminated and should not be used for patient care activities. Use of contaminated linen may be a potential source for the spread of infectious organisms.
- *Refrigerator thermometers.* We found patient nourishment and staff refrigerators with missing thermometers, although temperature logs were present and current. Nurses reported that refrigerator thermometers were visible on the previous day but could not locate the thermometers during our visit. Patient nourishment and staff refrigerator temperatures must be monitored and recorded daily to prevent spoilage of food and nourishments. Management agreed to provide thermometers during our visit.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that (a) ceiling air vents are routinely checked and cleaned; (b) filters in window air conditioning units are inspected quarterly during EOC rounds and changed as needed; (c) window sills are regularly cleaned; (d) all clean linen, including cloth bags used for isolation gowns, be secured and not stored on the floor; and

(e) all refrigerators are checked daily for the presence of thermometers and recorded temperatures.

The VISN and Medical Center Directors agreed with the findings and recommendations. Ceiling air vents will be checked and cleaned on a daily basis. A quarterly maintenance schedule has been established to inspect window air conditioners. This process will be monitored during EOC rounds. Environmental Management Service (EMS) will dust window sills on a daily basis. Cloth bags containing isolation gowns are now hung on a hook on the wall of the linen closet. The log sheets for refrigerators have been revised to record the presence of thermometers and recorded temperatures on a daily basis. EOC will monitor the log sheets. The improvement actions are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Quality Management – Improve Structure, Analysis, Documentation, Implementation, and Reporting Processes

Conditions Needing Improvement. Program managers needed to collect and analyze pertinent data in all areas required by VHA policy and JCAHO. JCAHO requires hospitals to analyze data for trends and make recommendations to improve care. The medical center needed to improve their processes in key program areas.

QM Program Structure. The medical center had three committees designated for QM oversight: (1) the Executive Committee of the Medical Staff, (2) the PI Committee of the Medical Staff, and (3) the Quality and Performance Management Council (QPMC). Membership in the first two groups, the Executive Committee and PI Committee, was limited to physicians; and only physicians reviewed physician QM. According to the Quality and Performance Management Plan, the medical staff committees (the first two committees) were responsible for monitoring and approval of medical records, pharmacy and therapeutics, peer review, infection control, surgical case review, special care, blood transfusion, utilization management (UM), risk management, and patient safety. The QPMC was responsible for setting PI priorities, identifying potential risks, reviewing service level PI plans, and for oversight of Education and Safety and EOC Committees. Because QM responsibilities were split between the three groups, fragmentation of processes occurred, and the committees did not consistently monitor all required areas. PI findings need to be evaluated and discussed in interdisciplinary groups that can address integrated system issues.

Managers had appointed PI teams to address discharge issues and clinic access. While these teams were effective and their recommendations had resulted in corrective actions, there was no documentation of those actions at the local level. Those teams reported results to the VISN. The medical center managers agreed that results should be reported at the local level in order to facilitate communication to employees. Services had developed individual QM plans based on a recommendation from the previous CAP report. However, the services had not consistently reported results to the QPMC per local

policy. QM managers reported that they planned to initiate a reporting schedule starting in 2007.

Peer Review. Although the Peer Review Committee met monthly, clinicians had not submitted quarterly reports of trended peer review results to the designated oversight committee since 1st quarter FY 2006. As a result, there were no recommendations for improving patient care. In addition, not all peer reviews were completed within the VHA required timeframe of 120 days. Program managers stated that the person responsible for the peer review reports left the position, and no one had taken over the responsibility. Documentation of peer review follow-up actions was a cited deficiency in the previous CAP report.

Adverse Event Disclosure. When serious adverse events occur as a result of patient care, VHA and local policies require staff to discuss the events with patients and, with input from Regional Counsel, inform them of their right to file tort or benefit claims. Those discussions must be documented. The medical center reported they had discussed events with patients, but there was no documentation of those discussions.

Reprivileging. JCAHO requires that provider-specific PI results be reviewed as part of the reprivileging process. Services are to consider the results to determine if there may be a need for education and training. While some limited information was available, it needed to be expanded to include meaningful areas, such as medication usage and medical records documentation.

Patient Complaint Analysis. Patient advocates did not trend, analyze, or report patient complaints to an oversight committee. VHA policy requires that patient advocates aggregate complaints, analyze the data, and present trended reports to senior managers and patient care providers. The patient advocates needed to expand data analyses in the patient complaint program to include comparisons with SHEP scores and identification of meaningful trends. Results needed to be reported to an oversight group to make recommendations for corrective action.

UM. UM review staff collected data in all VHA-required areas but did not consistently report results to any oversight group for recommendations and actions to improve clinical operations.

National Patient Safety Goals. JCAHO has developed safety goals that each healthcare organization must evaluate and, if not meeting, formulate an action plan to meet those goals. The medical center had not established a plan for hand-off communication, medication reconciliation at time of admission, or for patients who are placed in temporary locations until beds are available for admission.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) the QM committee structure and reporting process be

revised; (b) clinicians complete results of peer reviews within the required time frame and trend, analyze, and report quarterly results to the Medical Executive Committee; (c) clinicians document adverse event disclosure; (d) service chiefs review provider-specific PI data prior to reprivileging; (e) patient advocates trend and analyze patient complaints, compare with SHEP scores, and report results; (f) UM staff report results to a designated oversight committee for recommendations and corrective actions; and (g) action plans be developed for patient safety goals that are not met.

The VISN and Medical Center Directors agreed with the findings and recommendations. The QM committee structure and reporting process has been reviewed and will be revised to ensure there is consistent monitoring and no fragmentation of QM responsibilities. The Risk Manager will provide summaries of peer review activities to the Executive Committee of the Medical Staff on a quarterly basis. The Risk Manager will review patients' medical records for evidence of documentation of adverse event disclosures. Service chiefs will use provider-specific data for reprivileging. Patient advocates will compare trended patient complaints with SHEP scores and provide quarterly reports to QPMC. A charter team has been established to develop a process to ensure that UM and other relevant data is reported to the appropriate oversight committee. Action plans are being developed for patient safety goals that are not met. The improvement actions are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Survey of Healthcare Experiences of Patients – An Action Plan Needed To Be Developed for Areas Below Target Scores and Results Needed To Be Disseminated to All Medical Center Employees

Conditions Needing Improvement. The medical center had not met VHA performance standards for patient satisfaction, had not disseminated results to employees, and had not developed action plans for improvement. Inpatient scores were below the target in Access, Coordination of Care, Education and Information, and Emotional Support and Transition. Outpatient scores were lower than target in Access, Education and Information, Overall Coordination, and Pharmacy Pick-up. If scores are lower than the targets, VHA requires medical centers to develop performance improvement action plans.

The purpose of this review was to assess the extent to which the medical center used the results of VHA's patient satisfaction survey to improve care, treatment, and services. In 1995, VHA began surveying its patients using a standardized instrument modeled from the Picker Institute, a non-profit health care surveying group. VHA set 76 percent of inpatients and 77 percent of outpatients rating care as very good or excellent as the FY 2006 targets for the results of its SHEP.

The medical center senior leadership was aware of SHEP results. However, they did not widely disseminate the information to other employees or formulate plans to address the areas that did not meet the VHA expected scores.

The table below shows national, VISN 15, and the medical center's survey results.

St. Louis VA Medical Center

Inpatient SHEP Results 1st and 2nd Quarter FY 2006

Facility Name	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
VA National	81.31	78.63	89.95	68.02	65.80	75.85	83.41	74.49	70.03
VISN 15	83+	80.3+	90.10	67.80	65.40	75.40	83.50	74.30	68.2-
St. Louis VA Medical Center	**70.6-**	**71-**	**83.8-**	**62.9-**	**58.2-**	**78.3+**	**79.4-**	**68.3-**	**62.1-**

St. Louis VA Medical Center

Outpatient SHEP Results 2nd Quarter 2006

	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	80.7	78.1	94.8	72.6	83.3	75.8	81.5	65.5	81.7	80.8	84.7
VISN	82	76.9	95	73.9	86.7 +	76.9	84.8	71.9	82.8	79.1	87.6 +
St. Louis Outpatient Clinics - Overall	**73.7 -**	**80.9**	**90**	**65.8**	**79.8**	**71.5**	**78.1**	**50.8**	**79**	**76.3**	**83.3**
St. Louis Outpatient Clinic	71.1 -	82.7	88.5	67.5	78	72.2	79.7	48.3	80.4	77.9	83.2
Jefferson Barracks Outpatient Clinic	77.3	79.2	92	61	81.2	69.3	76.9	*	75.9	72	82.7
Belleville Outpatient Clinic	80	77	96.1	73.5	90.4	78.2	77.1	*	84.5	87.6	85.5
St. Louis Veterans Home	74.3	76	89.9	77.3	88.1	75.1	72.4	*	82.6	69.1	87
St. Charles, MO Outpatient Clinic	77.8	71.6	90.1	63.3	76.2	74.4	80	*	73.1 -	80.8	86.6
Springfield CBOC	94 +	*	96.3 +	*	89.7 +	*	*	*	86.4 +	*	*

Legend: * Less than 30 respondents

+ Significantly better than national average

- Significantly worse than national average

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that (a) SHEP results be shared with medical center employees and (b) an action plan be developed and implemented to address satisfaction areas that are below the target.

The VISN and Medical Center Directors agreed with the findings and recommendations. A communication plan has been developed to share the SHEP results across the medical center. An in-depth review of the medical center's SHEP results has been completed, and a plan of action to address the major areas of improvement has been developed. The improvement actions are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Moderate Sedation – Follow-Up of Previously Identified Deficiencies Was Insufficient

Condition Needing Improvement. We determined that managers had not followed up on some corrective actions taken in response to moderate sedation deficiencies identified in our 2005 CAP report. As a result, some conditions had not been adequately resolved.

In our 2005 report, we noted that the medical center did not have a policy addressing CPR requirements for patient care employees. The medical center's corrective action was to expand the requirement for CPR education to include all medical and dental staff and to monitor compliance.

However, we found that the revised CPR policy still did not require CPR training for all employees who provide patient care. We sampled the C&P files of six clinicians who provided moderate sedation to determine if they had CPR training. Two (33 percent) of the six clinicians did not have current CPR training.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director takes action to (a) revise the CPR policy to include the requirement that all patient care employees have CPR training and (b) monitor CPR training compliance.

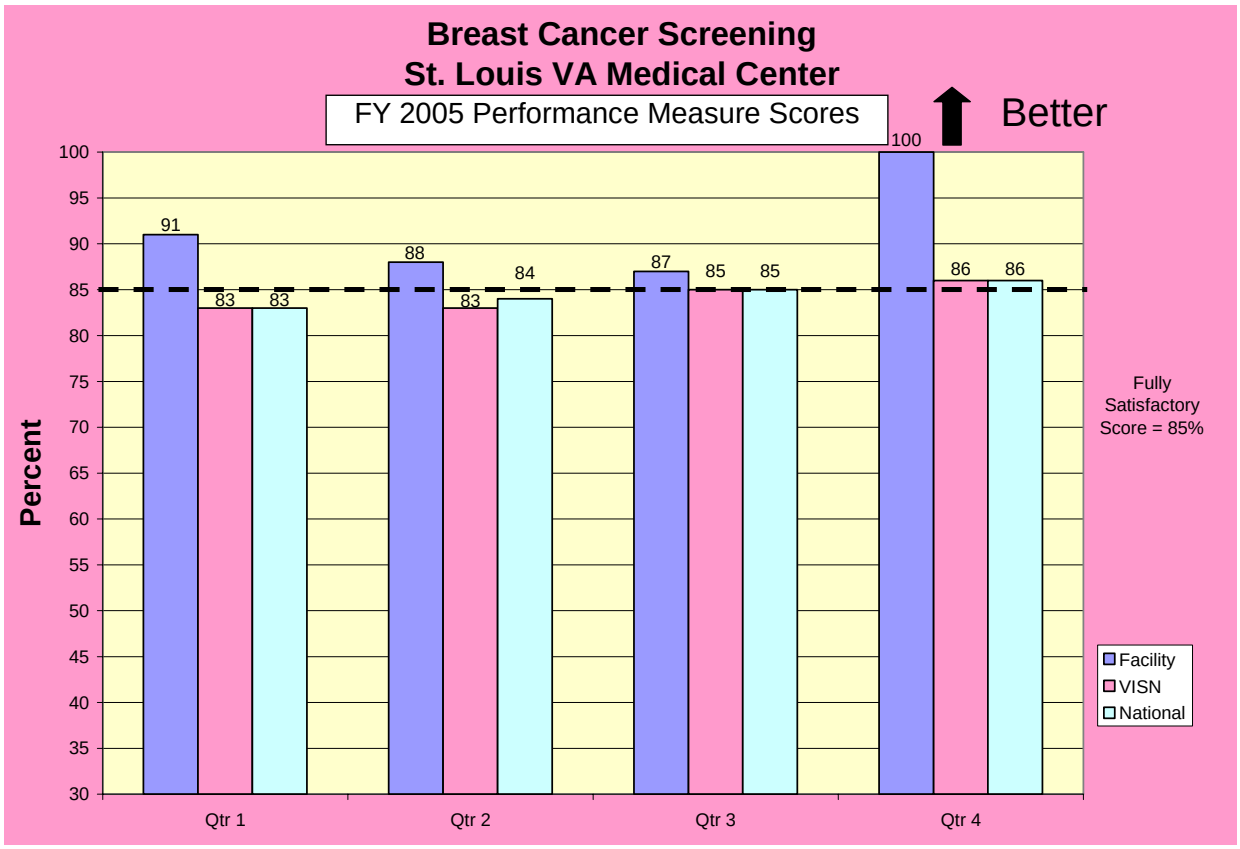
The VISN and Medical Center Directors agreed with the findings and recommendations. The CPR policy will be revised to ensure that all clinically active employees have CPR training. Compliance with CPR training will be tracked by administrative officers or business managers for each service or program. The improvement actions are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Other Review Topics

Breast Cancer Management

The medical center provided timely breast cancer screening and follow up, utilizing on-site mammography and biopsy services. Reports were timely, and patients were promptly notified of results of diagnostic testing and biopsies. Surgery and oncology consultative and treatment services were promptly provided.

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. The medical center achieved the fully satisfactory level for all quarters in FY 2005.



Patients appropriately screened	Mammography results reported to patient within 30 days	Patients appropriately notified of their diagnoses	Patients received timely consultations	Patients received timely biopsy procedure
10/10	10/10	10/10	10/10	10/10

Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. We reviewed these items in a random sample of 10 patients who had abnormal mammography findings during FY 2005. Because the medical center provided appropriate screening and timely services for all 10 patients, we did not make any recommendations.

Community Based Outpatient Clinics

The purpose of this review was to assess the effectiveness of CBOC operations and to determine whether CBOCs are in compliance with selected standards of operation.

We selected one CBOC for review. We interviewed key staff at the medical center and the CBOC; reviewed documentation and self-assessment tools; and reviewed credentialing, education, and background checks for five selected clinicians. Three

physicians' files and two nurses' files were randomly selected for review. All files contained documentation of licensure, credentialing, mandatory education, and background checks.

We interviewed eight patients who were being treated at the CBOC the day of our inspection. All patients reported a high level of satisfaction with their providers and the care they receive at the CBOC. We reviewed the CBOC warfarin[1] clinic and found evidence that the same standards of care provided to patients at the medical center are in effect at the CBOC. A clinical pharmacist manages the warfarin patients at both facilities. Mental health patients are treated at the CBOC via telemedicine by a psychologist located at the medical center.

We also inspected the CBOC environment of care. The facility was clean and safe with current emergency preparedness plans and training. The Automated External Defibrillator was inspected, and documentation was current.

We found that the CBOC was in compliance with all expected regulations and standards; therefore, we made no recommendations.

Contract Community Nursing Homes

CNH Program staff provided appropriate and comprehensive oversight of the community nursing homes caring for veterans. We reviewed the CNH Program to assess compliance with local and national policies regarding the selection of contract homes, the review process for contract renewal, and the monitoring of patients in contract CNHs. We evaluated whether patients received rehabilitation services (speech, physical, or occupational therapy) when ordered and whether there were effective processes in place to more closely monitor the contract CNHs if deficiencies had been identified.

The medical center had 54 veterans under contract in 12 CNHs. We selected five homes for review and conducted a site visit at one. We interviewed the administrators at this site, inspected the facility, and interviewed patients. We also conducted 10 patient record reviews.

The CNH review team utilized the exclusion review reports, including quality indicators, in order to conduct their annual review of each facility. The CNH Program staff collected and reviewed PI data from the contract CNHs contained on the Medicare internet site. Contract renewal recommendations were based on these reviews, as well as information gained from site inspections done by the team. The CNH Program staff was aware of their options to utilize increased monitoring, suspension of placements, and contract termination, when warranted. No contracts had been terminated as a result of non-compliance.

[1] Warfarin is a medication used to prevent blood clots.

Social work and nursing staff conducted monthly patient visits and documented patient assessments and discussions of concerns regarding care in the medical records. The administrators, nursing directors, and patients reported that the CNH staff was accessible and responsive to their needs and concerns. We confirmed that patients received services as ordered, and the program provided appropriate oversight. Therefore, we did not make any recommendations.

Diabetes and Atypical Antipsychotic Medications

Clinicians appropriately screened and managed mental health patients receiving atypical antipsychotic medications. The purpose of this review was to determine the effectiveness of diabetes screening, monitoring, and treatment of mental health patients receiving atypical antipsychotic medications (medications that cause fewer neurological side effects but increase the patient's risk for the development of diabetes).

VHA clinical practice guidelines for the management of diabetes suggest that: a diabetic patient's hemoglobin A1c (HbA1c)[2] should be less than 9 percent; blood pressure should be 140/90 millimeters of mercury (mmHg) or less; and low density lipoprotein cholesterol (LDL-C) should be less than 120 milligrams per deciliter (mg/dl). To receive fully satisfactory ratings for the diabetes performance measures, the medical center must achieve the following scores:

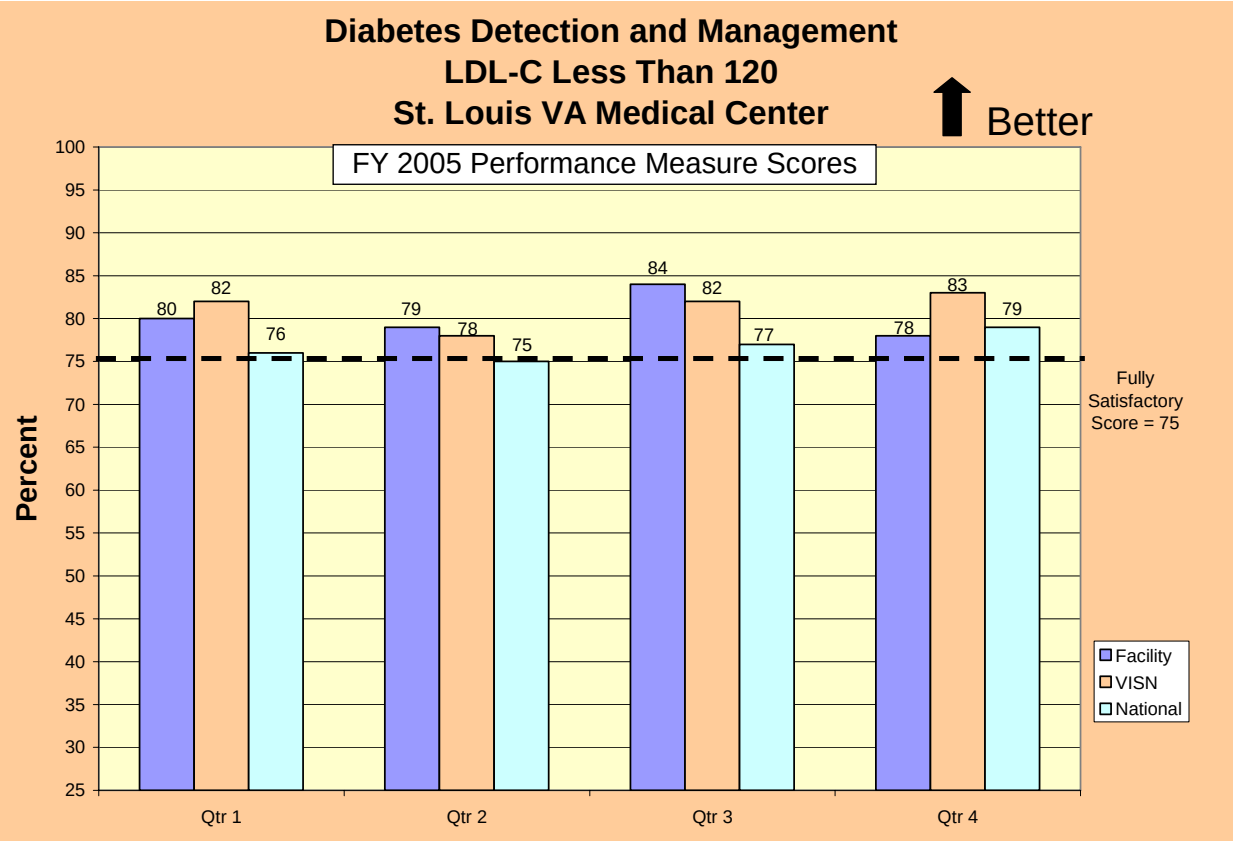
- HbA1c greater than 9 percent – 15 percent or lower
- Blood pressure less than or equal to 140/90mmHg – 72 percent or higher
- LDL-C less than 120mg/dl – 75 percent or higher

We reviewed the medical records of 13 randomly selected patients who were on one or more atypical antipsychotic medications for at least 90 days. Three of the 13 patients had diabetes. All patients were screened for diabetes and counseled about prevention. Providers utilize an electronic clinical reminder to notify clinicians about patients' health maintenance requirement schedules.

Diabetic patients with HbA1c greater than 9 percent	Diabetic patients with blood pressure less than 140/90 mm/Hg	Diabetic patients with LDL-C less than 120mg/dl	Non-diabetic patients appropriately screened	Non-diabetic patients who received diabetes prevention counseling
0/3	3/3	3/3	10/10	10/10

[2] HbA1c reflects the average blood glucose level over a period of time and should remain in control to prevent complications.

The review showed that the medical center met or exceeded VHA performance measures for LDL-C control for FY 2005. Clinical staff had identified areas for improvement and implemented appropriate action plans. Because senior managers had analyzed performance measure results and supported the corrective actions for meeting these measures, we made no recommendations.



Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 11, 2006

From: Director, Veterans Integrated Service Network (10N15)

Subject: **St. Louis VA Medical Center, St. Louis, Missouri**

To: Kansas City Regional Office of Healthcare Inspections

I have reviewed and concur with the responses to the recommendations and action plans as outlined by the St. Louis VAMC.

(original signed by:)

PETER L. ALMENOFF, M.D., FCCP

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 7, 2006

From: Director, St. Louis VA Medical Center (657/00)

Subject: **St. Louis VA Medical Center St. Louis, Missouri**

To: Director, VISN 15

Attached is the St. Louis VA Medical Center response and actions plan to the OIG report from the Combined Assessment Program that was conducted on October 2–6, 2006.

(original signed by:)

GLEN E. STRUCHTEMEYER

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General Report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) clinicians meet all requirements for completing informed consents, (b) cardiac catheterization laboratory physicians receive CPR training or document CPR proficiency, and (c) the cardiac catheterization laboratory develop a quality improvement review process and report findings to the designated oversight committee on at least a quarterly basis.

Concur **Target Completion Date:** February 28, 2007

(a) The sample of records reviewed as part of the OIG CAP review included patients seen in FY05. At that time, documentation of informed consent was on a paper form with multiple fields to be completed by the clinician. In FY06, the electronic informed consent process (iMED) was implemented. The iMED process forced all fields to be completed and has plain language descriptions for all procedures. A random sample of 20 patients that underwent cardiac catheterization in the 4th quarter of FY06 was reviewed for compliance; 20 of 20 records were compliant for the required elements. (Completed November 21, 2006)

(b) Documentation of CPR training for each of the Cardiac Cath Lab physician was obtained after the OIG CAP review exit. Review of the documentation showed that each physician was and remains current in their certification. (Completed December 1, 2006)

(c) The Cardiac Catheterization Laboratory will develop a quality improvement process reflective of the qualitative, quantitative, and process outcomes of the Cardiac Catheterization Laboratory procedures. The results will be reported to the Medical Staff Performance Improvement Committee no less than quarterly.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) ceiling air vents are routinely checked and cleaned; (b) filters in window air conditioning units are inspected quarterly during EOC rounds and changed as needed; (c) window sills are regularly cleaned; (d) all clean linen, including cloth bags used for isolation gowns, be secured and not stored on the floor; and (e) all refrigerators are checked daily for the presence of thermometers and recorded temperatures.

Concur **Target Completion Date:** January 31, 2007

(a) EMS supervisors have re-instructed staff on the checking and cleaning of the vents as part of daily work assignments. Supervisors will include checking vents as part of daily inspections. (Completed December 1, 2006) The Engineering Service handymen will perform a through cleaning of the inside of the vent and grill on a semiannual basis. (Began October 2006)

(b) A quarterly preventative maintenance (PM) schedule for window air conditioners was established to include replacement of filters. This will be monitored as part of Environment of Care rounds. (Began October 2006)

(c) Environmental Management Service (EMS) supervisors have re-instructed staff on dusting horizontal and flat surfaces as part of daily work assignments. Supervisors will include checking flat surfaces as part of daily inspections. (Completed December 1, 2006).

(d) The storage of cloth bags containing isolation gowns has been changed from the placement on the linen cart to being hung on a hook on the wall of the linen closet. This will allow easy access to the gowns and keep them off the floor. Work orders have been submitted for all closets as of December 4, 2006. This will be monitored as part of Environment of Care rounds. (Began October 2006)

(e) The refrigerators temperature log will be changed from a 6 month log sheet to a monthly log sheet to allow for the recording of the presence of a thermometer and temperature. Action will be taken when a thermometer is not present or the temperature is out of range. This will be monitored as part of the Environment of Care Rounds.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) the QM committee structure and reporting process be revised; (b) clinicians complete results of peer reviews within the required time frame and trend, analyze, and report quarterly results to Medical Executive Committee; (c) clinicians document adverse event disclosure; (d) service chiefs review provider-specific PI data prior to reprivileging; (e) patient advocates trend and analyze patient complaints, compare with SHEP scores, and report results; (f) UM staff report results to a designated oversight committee for recommendations and corrective actions; and (g) action plans be developed for patient safety goals that are not met.

Concur **Target Completion Date:** February 28, 2007

(a) The Executive Management team reviewed the QM committee structure and reporting process (Completed October 2006). The VISN 15 Quality Management Officer provided consultation on structure within other VISN 15 facilities for local review (Completed November 2006). The Quality Manager and Chief of Staff will review structures at other similarly complex VA facilities. The Executive Management team will finalize a revised QM committee structure and reporting process that ensures there is consistent monitoring and no fragmentation of QM responsibilities.

(b) The Risk Manager provided an annual report of FY06 Peer Review activities to the Executive Committee of the Medical Staff in October 2006. This report included quarterly summaries of activities that had not been reported on and a cumulative summary. Quarterly reports are provided to the ECMS. (Beginning October 2006).

(c) Adverse events are routinely reviewed at the weekly Patient Safety Council meetings. Subsequent to this review, the Risk Manager reviews the patient's electronic medical record as evidence of documentation of clinical disclosures. For events that rise to the level of institutional disclosure, the Risk Manager will complete an entry in the patient medical record using a template note. Disclosure status is included in the final Root Cause Analysis (RCA) reports to the Director/Chief of Staff. (Completed November 2006)

(d) The Medical and Dental staff will identify data elements to be used in ongoing professional practice evaluation. Elements will be specific to the privileges. IRM will complete programming to generate reports. Once completed the reports will be routinely produced and sent to the provider and supervisor and included as part of the reprivileging process.

(e) A Patient Advocate representative is a member of the Quality and Performance Management Council. They will provide a quarterly report of trends and analysis of data collected through the patient advocate database. A comparison of the medical center SHEP scores will be included.

(f) A charter team has been established to develop a process to ensure appropriate review and dissemination of relevant data. The team recommendations will be reviewed by Quality and Performance Management Council. Subsequently the council will make a recommendation action to the Executive Leadership Council. Once approved, the Utilization Management Plan and reporting will be implemented.

(g) Action plans are being developed to address the National Patient Safety Goals that are not met. The plans will be reviewed and approved by the Patient Safety Committee. Once approved, implementation and monitoring will occur.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that (a) SHEP results be shared with medical center employees and (b) an action plan be developed and implemented to address satisfaction areas that are below the target.

Concur **Target Completion Date:** January 31, 2007

(a) A communication plan has been developed to share the SHEP results across the medical center. This includes quarterly reports to Executive Leadership Council, Executive Committee of the Medical Staff, Performance Improvement Committee, Quality and Performance Management Council, Programs, Services, Managers and Supervisors. A quarterly update will be provided to employees via the medical center's Employee Newsletter. Access to the NCR+Picker website will be expanded and training provided on how to use the site. (Began December 1, 2006)

(b) An in-depth review of the Medical Center's SHEP results has been completed. A plan of action to address the major areas of improvement has been developed. Implementation has begun. (December 1, 2006)

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director takes action to (a) revise the CPR policy to include the requirement that all patient care employees have CPR training and (b) monitor CPR training compliance.

Concur **Target Completion Date:** February 28, 2007

(a) The CPR policy will be revised to include that all clinically active employees have CPR training

(b) Compliance with CPR training will be tracked by Administrative Officers or Business Managers for each service or program. A report of compliance will be submitted to the Chief of Staff Office for review.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia L. Solana, Director Kansas City Regional Office of Healthcare Inspections 816/426-2023
Acknowledgments	Dorothy Duncan Jennifer Kubiak Reba Ransom Marilyn Stones Jim Werner

Appendix D

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