US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA St. Louis Healthcare System in Missouri

Healthcare Facility Inspection	24-00600-136	June 10, 2025

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Executive Summary

The Office of Inspector General's (OIG's) mission is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs (VA). Furthering that mission, and building on prior evaluation methods, the OIG established the Healthcare Facility Inspection cyclical review program. Healthcare Facility Inspection teams review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle to measure and assess the quality of care provided using five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net. The inspections incorporate VHA's high reliability organization principles to provide context for facility leaders' commitment to a culture of safety and reliability, as well as the well-being of patients and staff.

What the OIG Found

The OIG physically inspected the VA St. Louis Healthcare System (facility) from June 3 through 6, 2024.[1] The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed.

Culture

The OIG examined several aspects of the facility's culture, including unique circumstances and system shocks (events that disrupt healthcare operations), leadership communication, and both employees' and veterans' experiences. Staff identified turnover in key leadership positions as a system shock. The OIG noted a complete turnover in the executive leadership team beginning in January 2021.

The Director identified another system shock with the mid-fiscal year 2024 VHA budget decrease and hiring pause. Leaders reported using the decrease as an opportunity to realign staff positions, but the Director expressed concern about increased staff workload and potential burnout. Additionally, leaders shared that they use available resources, such as telework and flexible schedules, to aid in staff satisfaction and promote a psychologically safe environment by

[1] See appendix A for a description of the OIG's inspection methodology. Additional information about the facility can be found in the Facility in Context graphic below, with a detailed description of data displayed in appendix B.

encouraging staff to report concerns.[2] Leaders also highlighted assistance with resumes and new supervisor training as professional growth opportunities for staff.

Lastly, veterans service organizations and patient advocates provided insight regarding veterans' experiences, which included their concerns with provider communication, treatment plans, and care coordination. Leaders said staff review veterans' concerns and route them to the appropriate staff for resolution. Leaders described a success story involving a local veterans service organization that helped transport veterans to their appointments.

Environment of Care

The OIG examined the general entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also physically inspected patient care areas and compared findings from prior inspections to determine if there were recurring issues.

Although the facility offered valet parking at the John J. Cochran Veterans Hospital, the OIG noted challenges with external directional signs and parking, which staff attributed to ongoing construction. The OIG found dust on patients' bedframes, which staff immediately cleaned, and mobile medical equipment that was overdue for preventive maintenance. In addition, the OIG found expired supplies in clinical areas, which was similar to a fiscal year 2022 Joint Commission finding, as well as expired supplies for video laryngoscopes.[3] The OIG recommends leaders ensure staff keep areas clean, complete preventive maintenance for biomedical equipment, and remove expired supplies from storage locations.

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight recommendations; and implementation of continuous learning processes to identify opportunities for improvement.

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[2] The site visit occurred in June 2024, which pre-dated the "Return To In-Person Work" Presidential Order, dated January 20, 2025. Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025); "Return to In-Person Work," The White House, January 20, 2025, https://www.whitehouse.gov/presidential-actions/2025/01/return-to-in-person-work. The OIG cannot comment on VA's plan of action to comply with the Presidential Order. "Psychological safety is an organizational factor that is defined as a shared belief that it is safe to take interpersonal risks in the organization." Jiahui Li et al., "Psychological Safety and Affective Commitment Among Chinese Hospital Staff: The Mediating Roles of Job Satisfaction and Job Burnout," *Psychology Research and Behavior Management* 15 (June 2022): 1573–1585, https://doi.org/10.2147/PRBM.S365311.

[3] The video laryngoscope provides a clear view of structures in the trachea, making it easier for medical professionals to place a tube to support patient breathing. Matthew E. Prekker et al., "Video Versus Direct Laryngoscopy for Tracheal Intubation of Critically Ill Adults," *The New England Journal of Medicine* 389, no. 5 (June 16, 2023): 418-429, https://www.nejm.org/doi/full/10.1056/NEJMoa2301601.

The OIG found facility leaders developed a communication of test result policy in June 2024, but did not develop service-level workflows to designate which staff communicate results to patients.[4] The OIG also determined that diagnostic imaging and pathology and laboratory service staff have processes to monitor the timely communication of critical test results to ordering providers; however, facility staff lacked a consistent process to monitor how ordering providers communicate urgent, noncritical results to patients. The OIG recommends leaders address these vulnerabilities.

Primary Care

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act implementation affected the primary care delivery structure and examined facility enrollment data related to the PACT Act and new patient appointment wait times.[5]

The facility had 97 primary care teams that averaged 93 percent of the expected patient capacity, despite multiple teams above 100 percent. Primary care leaders explained space constraints limited the creation of new primary care teams, but they were working on alternative solutions to decrease panel size (number of patients assigned to a team). Staff described challenges with the community care appointment process, stating it could be time-consuming. Primary care staff stated PACT Act implementation had not affected primary care work.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The facility homeless programs had mixed results for performance measures. For the areas where the facility did not meet targets, staff identified barriers including lack of available, affordable, and safe housing, exacerbated by the area's aging infrastructure; staffing challenges; and limited veteran transportation. Staff had concerns about the recent strategic pause in hiring, but the OIG noted VHA issued guidance in May 2024 that exempted homeless program positions and allowed leaders to continue recruitment. Program staff reported collaborating with a variety of community partners to help enroll veterans and meet their needs.

[4] VHA defines service-level workflows as "a written document that describes the processes for communicating test results for each clinic, service, department, unit or other point of service where tests are ordered." VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

[5] PACT Act, Pub. L. No. 117-168, 136 Stat. 1759 (2022).

What the OIG Recommended

The OIG made five recommendations for improvement.

1. Facility leaders determine appropriate supply storage locations, and for any supplies stored outside these defined locations, implement a process to ensure staff identify and remove expired supplies.
2. Facility leaders ensure video laryngoscope supplies are readily available and not expired.
3. The Director ensures staff keep patient care areas clean and safe.
4. The Director ensures staff complete required preventive maintenance for biomedical equipment.
5. Facility leaders develop service-level workflows and processes to monitor communication of test results to patients.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director agreed with the inspection findings and recommendations and provided acceptable improvement plans (see appendixes D and E and the responses within the report body for the full text of the directors' comments). The OIG will follow up on the planned actions until they are completed.

JULIE KROVIAK, MD
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

Abbreviations

ADPCS	Associate Director for Patient Care Services
FY	fiscal year
HCHV	Health Care for Homeless Veterans
HRO	high reliability organization
OIG	Office of Inspector General
PACT	Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics
VHA	Veterans Health Administration
VSO	veterans service organization

FACILITY IN CONTEXT

VA St. Louis Healthcare System
St. Louis, Missouri
Level 1b-High Complexity
St. Louis County
Hospital Referral Region: St. Louis

Description of Community

POPULATION

Female **2,008,363**	Male **1,943,221**
Veteran Female **27,402**	Veteran Male **240,655**

Homeless - State **5,992**
Homeless Veteran -State **476**

MEDIAN INCOME

$51,348

EDUCATION

87% Completed High School
58% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **244**

SUBSTANCE USE

26.3% Driving Deaths Involving Alcohol
19.8% Excessive Drinking
1,421 Drug Overdose Deaths

UNEMPLOYMENT RATE

5% Unemployed Rate 16+
4% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	1,512,895
Carpool	144,434
Work at Home	122,921
Walk to Work	36,566
Public Transportation	28,717
Other Means	20,609

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**31 Minutes, 27 Miles**
Specialty Care	**58 Minutes, 55 Miles**
Tertiary Care	**84 Minutes, 85 Miles**

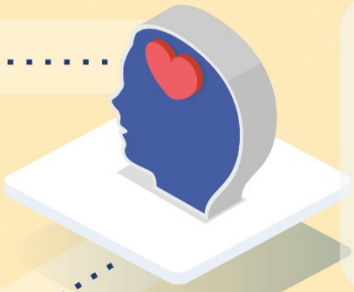
Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **20,856**

Veterans Receiving Telehealth (VHA)	41%
Veterans Receiving Telehealth (Facility)	39%
<65 without Health Insurance	14%

Health of the Veteran Population



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

15,445

78 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

4.60 Days

30-DAY READMISSION RATE

12%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veterans Suicide Rate (state level)
24	45

Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	64K
Unique Patients VA Care	60K
Unique Patients Non-VA Care	20K

- John J. Cochran Veterans Hospital
- St. Louis VA Medical Center-Jefferson Barracks

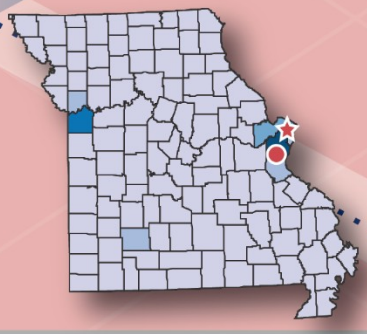
The VA St. Louis Healthcare System includes the John J. Cochran Veterans Hospital and St. Louis VA Medical Center - Jefferson Barracks in St. Louis, MO.

COMMUNITY CARE COSTS

Unique Patient $19,428	Outpatient Visit $347
Line Item $866	Bed Day of Care $245

STAFF RETENTION

Onboard Employees Stay <1 Yr	11.29%
Facility Total Loss Rate	10.93%
Facility Retire Rate	2.38%
Facility Quit Rate	7.44%
Facility Termination Rate	0.98%



VETERAN POPULATION

0.03% 2.71% 5.38% 8.05% 10.72% 13.38%

See Appendix B: Facility in Context Data Definitions for a detailed description of data displayed.

Contents

Background and Vision

The Office of Inspector General's (OIG's) mission is to conduct meaningful independent oversight of the Department of Veterans Affairs (VA). The OIG's Office of Healthcare Inspections focuses on the Veterans Health Administration (VHA), which provides care to over nine million veterans through 1,321 healthcare facilities.[1] VHA's vast care delivery structure, with its inherent variations, necessitates sustained and thorough oversight to ensure the nation's veterans receive optimal care.

The OIG established the Healthcare Facility Inspection (HFI) cyclical review program to help accomplish its mission. HFI teams routinely evaluate VHA medical facilities on an approximately three-year cycle. Each cyclic review is organized around a set of content domains (culture, environment of care, patient safety, primary care, and veteran-centered safety net) that collectively measure the internal health of the organization and the resulting quality of care, set against the backdrop of the facility's distinct social and physical environment. Underlying these domains are VHA's high reliability organization (HRO) principles, which provide context for how facility leaders prioritize the well-being of staff and patients.

Figure 1. *VHA's high reliability organization framework. Source: Department of Veterans Affairs, "VHA's Journey to High Reliability."*

HFI reports illuminate each facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. These reports are intended to provide insight into the experience of working and receiving care at VHA facilities; inform veterans, the public, and Congress about the quality of care received; and increase engagement for facility leaders and staff by noting specific actions they can take to improve patient safety and care.

[1] "About VHA," Department of Veterans Affairs, accessed May 29, 2024, https://www.va.gov/health/aboutvha.

High Reliability Organization Framework

HROs focus on minimizing errors "despite highly hazardous and unpredictable conditions," such as those found in healthcare delivery settings.[2] The aviation and nuclear science industries used these principles before the healthcare sector adopted them to reduce the pervasiveness of medical errors.[3] The concept of high reliability can be equated to "persistent mindfulness" that requires an organization to continuously prioritize patient safety.[4]

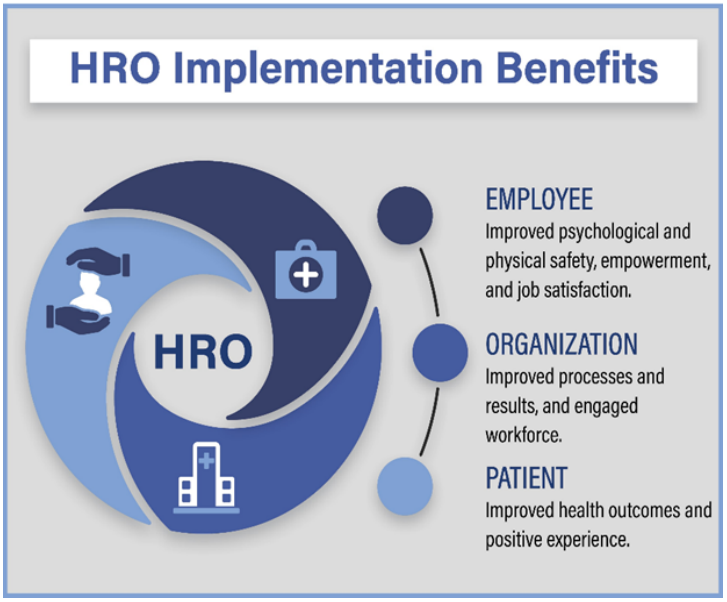


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

In 2018, VHA officially began the journey to become an HRO with the goals of improving accountability and reliability and reducing patient harm. The HRO framework provides the blueprint for VHA-wide practices to stimulate and sustain ongoing culture change.[5] As of 2020, VHA implemented HRO principles at 18 care sites and between 2020 and 2022, expanded to all VHA facilities.[6]

Implementing HRO principles requires sustained commitment from leaders and employees at all levels of an organization.[7] Over time, however, facility leaders who prioritize HRO principles increase employee engagement and improve patient outcomes.[8] The OIG's inspectors observed how facility leaders incorporated high reliability principles into their operations. Although not all facilities have formally piloted VHA's HRO

[2] Stephanie Veazie, Kim Peterson, and Donald Bourne, "Evidence Brief: Implementation of High Reliability Organization Principles," *Evidence Synthesis Program*, May 2019.

[3] Veazie, Peterson, and Bourne, "Evidence Brief: Implementation of High Reliability Organization Principles."

[4] "PSNet Patient Safety Network, High Reliability," Agency for Healthcare Research and Quality, September 7, 2019, https://psnet.ahrq.gov/primer/high-reliability.

[5] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*, March 2020, revised in April 2023.

[6] "VHA Journey to High Reliability, Frequently Asked Questions," Department of Veterans Affairs, https://dvagov.sharepoint.com/sites/vhahrojourney/SitePages/FAQ_Home.aspx. (This web page is not publicly accessible.)

[7] "PSNet Patient Safety Network, High Reliability," Agency for Healthcare Research and Quality.

[8] Stephanie Veazie et al., "Implementing High-Reliability Principles Into Practice: A Rapid Evidence Review," *Journal of Patient Safety 18*, no. 1 (January 2022): e320–e328, https://doi.org/10.1097/pts.0000000000000768.

framework, it is vital that facility leaders emphasize patient safety in their operational and governance decisions.

PACT Act

In August 2022, the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act became law, which expanded VA health care and benefits to veterans exposed to toxic substances.[9] The PACT Act is "perhaps the largest health care and benefit expansion in VA history."[10] As such, it necessitates broad and sustained efforts to help new veteran patients navigate the system and receive the care they need. Following the enactment, VHA leaders distributed operational instructions to medical facilities on how to address this veteran population's needs.[11] As of April 2023, VA had logged over three million toxic exposure screenings; almost 42 percent of those screenings revealed at least one potential exposure.[12] The OIG reviewed how PACT Act implementation may affect facility operations and care delivery.

[9] PACT Act, Pub. L. No. 117-168, 136 Stat. 1759 (2022).

[10] "The PACT Act and Your VA Benefits," Department of Veterans Affairs, accessed April 21, 2023, https://www.va.gov/resources/the-pact-act-and-your-va-benefits/.

[11] Assistant Secretary for Management and Chief Financial Officer; Assistant Secretary for Human Resources and Administration/Operations, Security and Preparedness; Assistant Secretary for the Office of Enterprise Integration, "Guidance on Executing Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act Toxic Exposure Fund Initial Funding," October 21, 2022. Assistant Under Secretary for Health for Operations, "Toxic Exposure Screening Installation and Identification of Facility Navigators," October 31, 2022. Director VA Center for Development & Civic Engagement and Executive Director, Office of Patient Advocacy, "PACT Act Claims Assistance," November 22, 2022.

[12] "VA PACT Act Performance Dashboard," VA. On May 1, 2023, VA's website contained this information (it has since been removed from their website).

Content Domains

Figure 3. *HFI's five content domains.*
**Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11.*
Sources: Boris Groysberg et al., "The Leader's Guide to Corporate Culture: How to Manage the Eight Critical Elements of Organizational Life," Harvard Business Review 96, no. 1 (January-February 2018): 44-52; Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review"; VHA Directive 1608(1), Comprehensive Environment of Care Program, June 21, 2021, amended September 7, 2023; VHA Directive 1050.01(1), VHA Quality and Patient Safety Programs, March 24, 2023, amended March 5, 2024; VHA Directive 1406(1), Patient Centered Management Module (PCMM) for Primary Care, June 20, 2017, amended April 17, 2024; VHA Homeless Programs Office, Fiscal Year 2022 Annual Report.

The OIG evaluates each VHA facility across five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net. The evaluations capture facilities' successes and challenges with providing quality care to veterans. The OIG also considered how facility processes in each of these domains incorporated HRO pillars and principles.

Leaders reported the St. Louis VA Medical Center-Jefferson Barracks and John J. Cochran Veterans Hospital, both part of the VA St. Louis Healthcare System (facility), opened in the 1920s and 1950s, respectively. The Chief of Quality, Safety, and Value reported renovations included parking, lighting, and security improvements at the Jefferson Barracks site in 2023. Further renovations in spring 2024 provided a Whole Health Clinic, in addition to space for chiropractic care, acupuncture, and other specialty services; rooms for group therapy classes; and space for nutrition and cooking classes to promote health and prevent disease. During the OIG's site visit, the John. J. Cochran Veterans Hospital location was undergoing renovations to improve parking and add patient care space.[13]

Executive leaders described infrastructure changes that were expansions to support the increase in new enrollees. The leaders said they worked with Veterans Benefits Administration staff to stay abreast of the veteran population in areas served by the facility, which increased by 8 percent in fiscal year (FY) 2023. The Deputy Director detailed the completed FY 2023 multimillion-dollar upgrade at Jefferson Barracks, as well as the expansion of the John J. Cochran Veterans Hospital site, which included road and utility work, such as for water and electric services, and acquisitions of surrounding land. The Deputy Director said both projects supported patient safety and enhanced privacy by upgrading shared rooms to single occupancy.

At the time of the inspection, leaders reported the facility's executive leaders consisted of the Medical Center Director (Director), Chief of Staff, Acting Associate Director for Patient Care Services (Acting ADPCS), Deputy Director, Associate Director, and Assistant Director. In FY 2023, leaders said the facility's budget was approximately $1 billion. The quality, safety, and value staff reported the facility had 337 total operating beds, with 122 at the John J. Cochran site (116 hospital and 6 spinal cord injury beds) and 215 at the Jefferson Barracks site (71 community living center, 32 spinal cord injury, 66 domiciliary, and 46 inpatient mental health beds).[14] Additionally, due to proximity, the facility provided care to veterans in southwestern Illinois.

[13] "Whole Health is an approach to health care that empowers and equips people to take charge of their health and well-being and to live their lives to the fullest." VHA Directive 1445, *Whole Health System*, October 13, 2023.

[14] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed November 19, 2024, https://www.va.gov/Geriatrics/VA_CLC.asp. A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed November 19, 2024, https://www.va.gov/homeless/dchv.asp.

A 2019 study of struggling healthcare systems identified poor organizational culture as a defining feature of all included systems; leadership was one of the primary cultural deficits. "Unsupportive, underdeveloped, or non-transparent" leaders contributed to organizations with "below-average performance in patient outcomes or quality of care metrics."[15] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[16] The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, and both employees' and veterans' experiences. The OIG administered a facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[17]

System Shocks

A system shock is the result of an event that disrupts an organization's usual daily operations. Shocks may result from planned or unplanned events and have lasting effects on organizational focus and culture.[18] An example of a planned system shock is the implementation of a new electronic health record system. An example of an unplanned system shock is a patient suicide on a VHA medical facility campus. By directly addressing system shocks in a transparent manner, leaders can turn both planned and unplanned events into opportunities for continuous process improvement, one of VHA's three HRO pillars.[19] The OIG reviewed whether facility staff experienced recent system shocks that affected the organizational culture

> The Deputy Director reported recognizing staff for over 30 years of service during quarterly award ceremonies, expressing the belief that long-standing tenure demonstrated staff engagement and commitment to the mission. The Deputy Director also described the work environment as more than just a job and more like a family.

Figure 4. *Facility leader example of staff recognition.*
Source: OIG interview.

[15] Valerie M. Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies," *BMJ Quality and Safety* 28 (2019): 74–84, https://doi.org/10.1136/bmjqs-2017-007573.

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

[17] For more information on the OIG's data collection methods, see appendix A. For additional information about the facility, see the Facility in Context graphic above and associated data definitions in appendix B.

[18] Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies."

[19] Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies"; Department of Veterans Affairs, *VHA HRO Framework*.

and whether leaders directly addressed the events that caused those shocks.

Most staff responses to the facility-wide questionnaire indicated turnover in key leadership positions was the top system shock over the past three years.[20] Facility leaders provided information to the OIG showing the executive leadership team had a complete turnover beginning in January 2021, including a new Director, who started in January 2023. The ADPCS position was vacant and filled by acting staff beginning October 2023, when the permanent leader was assigned to cover a position with Veterans Integrated Service Network 15.[21]

The Director described the mid-FY 2024 VHA budget decrease and resulting strategic hiring pause as another system shock. Leaders reported the changes allowed them to continue evaluating current staffing and realign positions to ensure effective use of staff. For example, leaders moved staff from one area to another to support staffing productivity and worked with human resources to close positions that had been vacant for an extended time. Leaders said they communicated the staffing changes through town halls, newsletters, and face-to-face interactions with frontline staff and labor union representatives, adding that these efforts increased staff's engagement and sharing of ideas. The Director expressed concern the changes may cause staff burnout in some areas due to increased workloads, and retirement among those with long tenures may be the next system shock.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[22] Facility leaders can demonstrate dedication to this strategy through "clear and open communication," which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright culture.[23] Additionally, The Joint Commission identifies communication between administrators and staff as one of the "five key systems that influence the

EXECUTIVE LEADER COMMUNICATION
Executive leaders described communicating with staff about All Employee Survey results.

EXECUTIVE LEADER INFORMATION SHARING
Executive leaders shared information with staff during town halls, small workgroups, and visits to various work areas.

Figure 5. *Executive leader communication with staff. Source: OIG interviews with facility leaders.*

[20] There were 455 respondents to the OIG facility-wide questionnaire, from a reported FY 2023 total workforce of 3,462.

[21] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, accessed February 3, 2025, https://department.va.gov/integrated-service-networks/.

[22] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*, September 2022.

[23] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*; Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

effective performance of a hospital."[24] The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[25]

Leaders said they were proud that participation in the FY 2023 All Employee Survey had increased to 80 percent. The Acting ADPCS described leaders' efforts to improve the response rates; they provided staff with electronic tablets to complete the survey, educated them about the data, and discussed the results during new supervisor training to ensure awareness and understanding. The OIG also found that survey scores for senior leader goals for communication, information sharing, and transparency increased from FY 2022 to FY 2023.

[24] The five key systems support hospital wide practices and include using data, planning, communicating, changing performance, and staffing. The Joint Commission, *Standards Manual*, E-dition, LD.03.04.01, January 14, 2024.

[25] The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." "AES Survey History, Understanding Workplace Experiences in VA," VHA National Center for Organization Development.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[26] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[27]

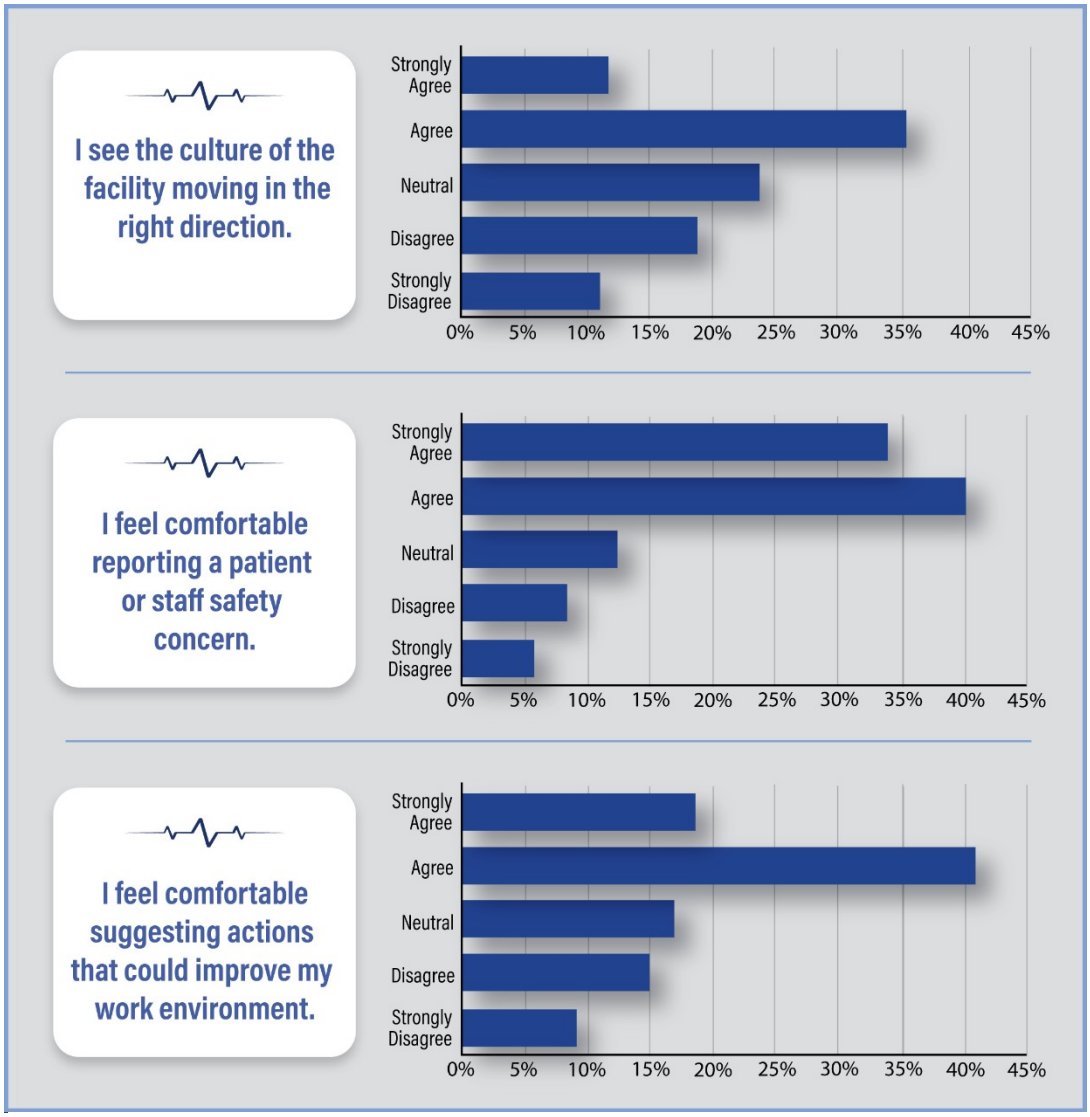


Figure 6. *Employee and leaders' perceptions of facility culture.*
Source: OIG questionnaire responses.

[26] "Psychological safety is an organizational factor that is defined as a shared belief that it is safe to take interpersonal risks in the organization." Jiahui Li et al., "Psychological Safety and Affective Commitment Among Chinese Hospital Staff: The Mediating Roles of Job Satisfaction and Job Burnout," *Psychology Research and Behavior Management* 15 (June 2022): 1573–1585, https://doi.org/10.2147/PRBM.S365311.

[27] Ravinder Kang et al., "Association of Hospital Employee Satisfaction with Patient Safety and Satisfaction within Veterans Affairs Medical Centers," *The American Journal of Medicine* 132, no. 4 (April 2019): 530–534, https://doi.org/10.1016/j.amjmed.2018.11.031.

The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.

Leaders described their efforts to enhance employees' experiences by offering training opportunities on psychological safety, encouraging employees to report concerns, and accepting that everyone makes mistakes. The leaders shared a web-based application in which employees could report safety and environmental concerns in real time (see appendix C, figures C.1 and C.2).

The Director further described schedule flexibilities, telework, recognition awards, and open communication as efforts taken to improve employees' satisfaction, which resulted in better overall care for veterans.[28] Additionally, leaders emphasized the importance of leading by example and added that employees had other professional growth opportunities that involved resume building, supervisor training, and a facility-funded program to assist employees with college tuition. The Associate Director spoke about future endeavors, such as possibly implementing artificial intelligence software to support staff with activities, including dictation and medical coding.

Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates and VSOs. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[29] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[30] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

VSO and patient advocate questionnaire respondents indicated they were satisfied with how leaders addressed veterans' concerns. Some respondents identified that veterans had concerns with provider communication delays, lack of trust or confidence in providers, treatment plan concerns, and problems with timely coordination of care. Additionally, the OIG found patient advocate reports from the past three years involving complaints about communication, care coordination, dignity, referrals, documentation, abuse, neglect, and retaliation. The reports

[28] The site visit occurred in June 2024, which pre-dated the "Return To In-Person Work" Presidential Order, dated January 20, 2025. Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025); "Return to In-Person Work," The White House, January 20, 2025, https://www.whitehouse.gov/presidential-actions/2025/01/return-to-in-person-work. The OIG cannot comment on VA's plan of action to comply with the Presidential Order.

[29] "Veterans Health Administration, Patient Advocate," Department of Veterans Affairs, accessed May 9, 2023, https://www.va.gov/HEALTH/patientadvocate/.

[30] Edward R. Reese Jr., "Understanding Veterans Service Organizations Roles" (PowerPoint presentation, November 19, 2008), https://www.va.gov/gulfwaradvisorycommittee/docs/VSO.pdf.

documented all items as either resolved or routed to appropriate staff for review. The Director reported reviewing all concerns staff routed to executive leaders and discussing them with the veterans to reach a resolution.

The Associate Director highlighted a positive, collaborative relationship with local VSO representatives and shared an example of their support. The Assistant Director described transportation difficulties for veterans living in rural areas and how volunteers from the Disabled Veterans of America drove them to appointments in vans that had been donated to the facility. The Deputy Director added that communication with VSOs occurred through monthly town halls, which rotated through various community settings and online methods.

ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[31] To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also interviewed staff and physically inspected patient care areas, focusing on safety, hygiene, infection prevention, and privacy. The OIG compared findings from prior inspections with data and observations from this inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

Figure 7. *John J. Cochran Veterans Hospital.*
Source: "VA St. Louis Health Care," Department of Veterans Affairs, accessed May 1, 2024, https://www.va.gov/st-louis-health-care/locations.

Figure 8. *St. Louis VA Medical Center-Jefferson Barracks.*
Source: "VA St. Louis Health Care," Department of Veterans Affairs, accessed July 15, 2024, https://www.va.gov/st-louis-health-care/locations.

[31] VHA Directive 1608(1).

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[32] The OIG assessed how a facility's physical features and entry touchpoints may shape the veteran's perception and experience of health care they receive. The OIG applied selected VA and VHA guidelines and standards, and Architectural Barriers Act and Joint Commission standards when evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.[33]

Transit and Parking

The ease with which a veteran can reach the facility's location is part of the healthcare experience. The OIG expects the facility to have sufficient transit and parking options to meet veterans' individual needs.

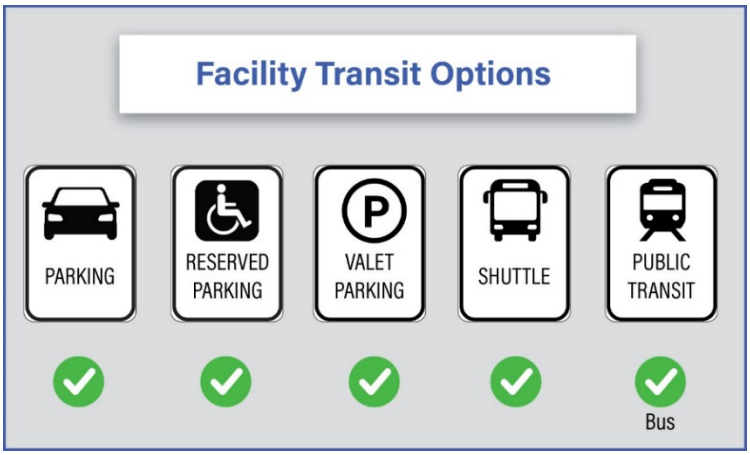


Figure 9. *Transit options for arriving at John J. Cochran Veterans Hospital.*
Source: OIG analysis of documents and observations.

The OIG used a commercial navigation application to travel to the John J. Cochran Veterans Hospital and found the instructions easy to follow. However, upon arrival, the OIG did not find clear signage directing veterans to available parking. The OIG's review of patient advocate reports also revealed veterans' concerns regarding parking. During interviews, facility leaders explained the multi-phase construction project included updating and installing directional signage and increasing parking areas. At the time of the site visit, the OIG noted parking meters had already been removed from side roads, and spaces that were previously available to everyone were designated as patient-only parking. Since the construction project addresses signage and parking concerns, the OIG did not make a recommendation.

[32] Roger S. Ulrich et al., "A Review of the Research Literature on Evidence-Based Healthcare Design," *HERD: Health Environments Research & Design Journal* 1, no. 3 (Spring 2008): 61-125, https://doi.org/10.1177/193758670800100306.

[33] Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*, December 2012; Department of Veterans Affairs, *VA Signage Design Guide*, December 2012; Department of Veterans Affairs, *VA Barrier Free Design Standard*, January 1, 2017, revised November 1, 2022; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook,* January 2024. Access Board, *Architectural Barriers Act (ABA) Standards,* 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2023.

Main Entrance

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[34]

The OIG noted the main entrance of the John J. Cochran Veterans Hospital had valet services and a passenger loading zone with a canopy, power-assisted doors, and wheelchair accessibility. In the main lobby, the OIG observed a well-lit open space with a coffee shop, seating area, and information desk staffed with employees and volunteers.

Navigation

Navigational cues can help people find their destinations. The OIG would expect a first-time visitor to easily navigate the facility and campus using existing cues. The OIG determined whether VA followed interior design guidelines and evaluated the effectiveness of the facility's navigational cues.[35]

In addition to the staff at the information desk to assist veterans with navigation, the OIG found there were maps with large print on the walls, and kiosks at the main entrance and near the emergency department entrance. The kiosks were generally up-to-date and provided both auditory and visual turn-by-turn directions. However, the OIG followed the navigational tools to various locations and found opportunities for improvement. For example, using the available maps and directional signs, the OIG was unable to find the emergency department. The OIG suggests facility leaders review and consider enhancing internal navigational signage, especially those with directions to the emergency department.

[34] VHA Directive 1850.05, *Interior Design Program*, January 11, 2023; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage Design Guide*.

[35] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage Design Guide*.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[36] The OIG observed multiple features, including map kiosks, where users could increase the map size on the screen for ease of reading, and raised symbols on signs (braille). Additionally, information desk staff said they help people with visual impairments get to their locations.

Although the information desk staff reported being unable to communicate using sign language, they communicated through writing with hearing-impaired individuals. They added that, although the facility offered interpreter services such as American Sign Language, they did not know how to access it.

Figure 10. *Accessibility tools available at the John J. Cochran Veterans Hospital.*
Source: OIG analysis of documents and observations.

The OIG also observed closed captioning on televisions in patient rooms but not on those in common areas. The OIG suggests facility leaders consider using closed captioning on common area televisions.

Toxic Exposure Screening Navigators

VA recommends that each facility identify two toxic exposure screening navigators. The OIG reviewed the accessibility of the navigators, including wait times for screenings, at the facility based on VA's guidelines.[37]

The OIG determined the facility had two toxic exposure screening navigators, and both had other primary job duties in addition to this role. The OIG learned from a questionnaire response that staff conducted toxic exposure screening outreach activities at the facility and in the community. During these events, staff provide information about the PACT Act and veterans can register for screening.

[36] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; "Best Practices Guide for Hospitals Interacting with People Who Are Blind or Visually Impaired," American Foundation for the Blind, accessed May 26, 2023, https://www.afb.org/research-and-initiatives/serving-needs-individuals-visual-impairments-healthcare-setting; Anjali Joseph and Roger Ulrich, *Sound Control for Improved Outcomes in Healthcare Settings*, The Center for Health Design Issue Paper, January 2007.

[37] Assistant Under Secretary for Health for Operations, "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum to Veterans Integrated Service Network Directors (VISN), October 31, 2022; VA, *Toxic Exposure Screening Navigator: Roles, Responsibilities, and Resources*, updated April 2023.

Repeat Findings

Continuous process improvement is one of the pillars of the HRO framework. The OIG expects facility leaders to address environment of care-related recommendations from oversight and accreditation bodies and enact processes to prevent repeat findings.[38] The OIG analyzed facility data such as multiple work orders reporting the same issue, environment of care inspection findings, and reported patient advocate concerns. The OIG also examined recommendations from prior OIG inspections to identify areas with recurring issues and barriers to addressing these issues.

The OIG reviewed The Joint Commission's 2022 survey report, which included a finding about expired supplies in the surgical intensive care unit.[39] The OIG also found expired supplies in the surgical intensive care unit and emergency department. Staff in the areas were not able to provide a reason for the expired supplies or explain the facility's process for maintaining supplies. The OIG determined that although staff stored supplies on equipment carts and other locations outside the standard supply rooms, there was no process for monitoring those supplies. The OIG would expect facility staff to maintain and inventory all supplies in the same manner as those kept in standard supply rooms.[40]

Additionally, the OIG observed inconsistencies in the type or number of supplies stocked for video laryngoscopes, and some of the supplies were expired.[41] This could result in staff lacking the necessary supplies to care for patients in an emergency. A staff member explained that staff were drafting a policy to include processes for maintaining video laryngoscope supplies.

The OIG recommends facility leaders determine appropriate supply storage locations, and for any supplies stored outside these defined locations, implement a process to ensure staff identify and remove expired supplies. The OIG also recommends facility leaders ensure video laryngoscope supplies are readily available and not expired.

General Inspection

Maintaining a safe healthcare environment is an integral component to VHA providing quality care and minimizing patient harm. The OIG's physical inspection of areas in the inpatient,

[38] Department of Veterans Affairs, *VHA HRO Framework*.

[39] The Joint Commission performed hospital, behavioral health, and home care accreditation reviews in July 2022.

[40] VHA requires that supplies in inventory point storerooms (standard supply rooms) be "monitored routinely for proper storage conditions as well as accuracy of inventory balances, expired/outdated items, damaged, or obsolete items." VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[41] The video laryngoscope provides a clear view of structures in the trachea, making it easier for medical professionals to place a tube to support patient breathing. Matthew E. Prekker et al., "Video Versus Direct Laryngoscopy for Tracheal Intubation of Critically Ill Adults," *The New England Journal of Medicine* 389, no. 5 (June 16, 2023): 418-429, https://www.nejm.org/doi/full/10.1056/NEJMoa2301601.

outpatient, and community living center settings focused on safety, cleanliness, infection prevention, and privacy.

The OIG found the community living center's environment to be home-like and generally clean. In all clinical areas inspected, the OIG observed clear exit paths, secure supply rooms, clean refrigerators and ice machines, and biohazard signage posted on soiled utility rooms.

However, the OIG noted dust on patients' bed frames in several clinical areas. The Chief of Environmental Services reported staff immediately cleaned the bed frames, and trainers from environmental services would reeducate all housekeeping staff on proper cleaning processes. Additionally, in the surgical intensive care and 7 South medical/surgical units, the OIG found bottom shelves of supply room carts were less than eight inches off the floor, which could result in contaminated supplies when cleaning the floor.[42]

The OIG also noted overdue preventive maintenance for some mobile medical equipment in the surgical intensive care unit and the community living center. The Assistant Chief of Biomedical Engineering explained that because the equipment is mobile and used in multiple locations, biomedical engineering staff are not always able to locate these items. Additionally, the assistant chief explained the staff rely on logistics and nursing staff to notify them if they find equipment that requires preventive maintenance, which did not always occur. The OIG recommends the Director ensures staff keep patient care areas clean and safe and complete required preventive maintenance for biomedical equipment.

The OIG explored VHA facilities' patient safety processes. The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight findings and recommendations; and implementation of continuous learning processes to identify opportunities for improvement.

Communication of Urgent, Noncritical Test Results

VHA requires diagnostic providers or designees to communicate test results to ordering providers, or designees, within a time frame that allows the ordering provider to take prompt action when needed.[43] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between

[42] VHA Directive 1761.

[43] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

diagnostic and ordering provider teams and their patients.[44] The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

VHA requires facility staff to develop a local policy and service-level workflows that outline the process for communicating test results.[45] Despite having an approved policy in June 2024, staff did not provide the OIG with service-level workflows. During interviews, quality, safety, and value staff stated leaders were still developing the workflows.

In addition, VHA requires facilities to have a process for monitoring the communication of test results to ordering providers and patients.[46] The OIG found facility staff had a process to monitor timely communication of critical test results to ordering providers but lacked a consistent process to monitor ordering providers' communication of urgent, noncritical results to patients.[47] The Associate Chief of Staff for Primary Care said leaders evaluate communication of test results through Ongoing Professional Practice Evaluations.[48] However, the Chief of Staff acknowledged limitations with the evaluations include the small sample size of electronic health records reviewed to confirm providers communicated test results to patients, and evaluations only occur at certain time intervals.

The OIG remains concerned the facility lacked service-level workflows and consistent monitoring processes for the communication of urgent, noncritical test results, which could delay patient care. The OIG recommends leaders develop service-level workflows and processes to monitor communication of test results to patients.

Action Plan Implementation and Sustainability

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[49] The OIG evaluated previous facility action plans in response to

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[44] Daniel Murphy, Hardeep Singh, and Leonard Berlin, "Communication Breakdowns and Diagnostic Errors: A Radiology Perspective," *Diagnosis* 1, no. 4 (August 19, 2014): 253-261, https://doi.org/10.1515/dx-2014-0035.

[45] VHA defines service-level workflows as "a written document that describes the processes for communicating test results for each clinic, service, department, unit or other point of service where tests are ordered." VHA Directive 1088(1).

[46] VHA Directive 1088(1).

[47] The time frame for facility diagnostic imaging audit data was from FY 2021 through April 2024; pathology and laboratory data was from January 2023 through April 2024.

[48] The Ongoing Professional Practice Evaluation (OPPE) process is used to monitor a licensed independent healthcare practitioner's clinical performance. "Any findings of failure to meet expected benchmarks for successful clinical performance during the OPPE review may trigger a clinical performance concern resulting in further review and potential privileging actions." VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023.

[49] VA OIG Directive 308, *Comments to Draft Reports*, April 10, 2014.

oversight report recommendations to determine if action plans were implemented, effective, and sustained.

The Chief of Quality, Safety, and Value stated there were no oversight report recommendations related to the communication of test results and when an agency identifies general patient safety findings, staff monitor action plans for one to one-and-a-half years.

Continuous Learning through Process Improvement

Continuous process improvement is one of VHA's three pillars on the HRO journey toward reducing patient harm to zero.[50] Patient safety programs include process improvement initiatives to ensure facility staff are continuously learning by identifying deficiencies, implementing actions to address the deficiencies, and communicating lessons learned.[51] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

The OIG found quality, safety, and value staff had processes for tracking general patient safety concerns and monitoring improvement actions. The Chief of Quality, Safety, and Value explained the process for reviewing performance measures occurs at weekly meetings, where participants review trends or patterns, and at monthly Quality Executive Board meetings. A systems redesign staff member said when staff identify opportunities for improvement, they implement a workgroup or other formal process to initiate action plans. The staff member further explained that, as part of their program, staff recently implemented a process improvement portal where staff could submit ideas for improvements, noting they received at least 10 suggestions within the previous month.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[52] The OIG also assessed how PACT Act implementation affected the primary care delivery structure. The OIG interviewed staff, analyzed primary care team staffing data, and examined facility enrollment data related to the PACT Act and new patient appointment wait times.

[50] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*.

[51] VHA Directive 1050.01(1).

[52] VHA Directive 1406(1); VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

Primary Care Teams

The Association of American Medical Colleges anticipates a national shortage of 21,400 to 55,200 primary care physicians by the year 2033.[53] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[54] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

The Principal Facility Coordinator for the Patient Centered Management Module stated that at the time of the OIG inspection, the facility had 97 primary care teams, and leaders plan to add 2 or 3 more over the next year. The Acting Deputy ADPCS and the Chief of Staff explained they use productivity metrics and other clinic operational data to determine staffing needs, conduct market analyses for salary adjustments to ensure competitiveness, and offer pay incentives when needed. Additionally, the Associate Chief of Staff for Primary Care credited affiliations with physician and advanced nursing training programs for improving recruitment of local providers. The OIG reviewed information on primary care staffing and found vacancies for five nursing positions and three medical support assistant positions.

Primary care team members said they receive support from float staff (staff who cover vacant positions), and the Chief Nurse for Primary Care added that nurse practitioners covered provider duties while other nursing staff provided team coverage. Primary care staff and the Acting Deputy ADPCS said they can use virtual services through a clinical resource hub to support provider coverage, but this was a new process.[55]

Panel size, or the number of patients assigned to a care team, reflects a team's workload; an optimally sized panel helps to ensure patients have timely access to high-quality care.[56] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[57]

The primary care team members interviewed stated panel sizes were reasonable given their current staffing levels, but a medical support assistant explained that some panels were still receiving new patients despite being full. The OIG determined the primary care team panels

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[53] Tim Dall et al., *The Complexities of Physician Supply and Demand: Projections from 2018 to 2033* (Washington, DC: Association of American Medical Colleges, June 2020).

[54] VA OIG, *OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2023*, Report No. 23-00659-186, August 22, 2023.

[55] "Clinical Resource Hubs (CRH) are VISN-owned and -governed programs that provide support to increase access to VHA clinical services for Veterans." "Patient Care Services," Department of Veterans Affairs, accessed May 22, 2024, https://www.patientcare.va.gov/primarycare/CRH.asp.

[56] "Manage Panel Size and Scope of the Practice," Institute for Healthcare Improvement. On April 19, 2023, the Institute for Healthcare Improvement's website contained this information (it has since been removed from their website).

[57] VHA Directive 1406(1).

averaged 93 percent full in FY 2023 and quarters one and two of FY 2024. The Principal Facility Coordinator for the Patient Centered Management Module explained that 34 of the teams were over 100 percent panel capacity, and the Associate Chief of Staff for Primary Care said they were not able to add new teams in these locations due to space constraints. The associate chief also expressed a desire to add a virtual telehealth team at one location and one or two new teams at the local military base to help balance panel sizes.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[58] Continuous process improvement is also one of the three HRO pillars, so the OIG expects facility and primary care leaders to identify and support primary care process improvements.

During interviews, primary care staff said they were generally comfortable suggesting improvements to leaders. For example, a licensed practical nurse described developing a process to decrease errors in veterans' self-collected specimens for home colon cancer screening by adding a short list of directions inside the kit for collecting and returning the specimen. As a result, there was a decrease in the number of kits that could not be tested. The nurse said leaders shared the process with other clinic teams.

Additionally, a provider discussed a request to change the first appointment time of the day to accommodate morning huddles, which leaders supported. The Associate Chief of Staff for Primary Care and other primary care staff described how each team had chosen a performance improvement project for FY 2024 and will share their successes with other teams and leaders.

The staff also discussed challenges faced during a typical day, including walk-in patients; lack of dedicated personnel to collect blood samples for laboratory tests; increased number of electronic messages from patients; and time-consuming, sometimes repetitive consult processes. Staff stated they spend time sending reminders to patients to schedule their community care appointments and additional time obtaining records after the appointments. The staff said that if patients could not schedule a timely appointment, the consult expired, and they had to restart the process. The Associate Chief of Staff for Primary Care verbalized a desire to improve the consult process and research how another VA facility had streamlined it. The Deputy Chief of Staff said leaders had also elevated this topic to their group's national level meetings for further discussion.

The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. During interviews, primary care

[58] VHA Handbook 1101.10(2).

staff said the PACT Act had not affected their day-to-day work or patient appointment wait times. The OIG reviewed data and noted new patient appointment wait times had decreased from about 22 days in quarter one of FY 2023 to approximately 2 days in quarter two of FY 2024, and wait times for established patients remained approximately 3 to 4 days.

The OIG noted that enrollment had decreased slightly in FYs 2022 and 2023, but leaders said enrollment was increasing in FY 2024 due to staff's efforts to re-enroll veterans, such as contacting them via telephone.

The OIG reviewed the Health Care for Homeless Veterans (HCHV), Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The OIG analyzed enrollment and performance data and interviewed program staff.

Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better equipped to address other life goals. Program staff conduct outreach, case management, and if needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[59]

Identification and Enrollment of Veterans

VHA measures HCHV program success by the percentage of unsheltered veterans who receive a program intake assessment (performance measure HCHV5).[60] VA uses the Department of Housing and Urban Development's point-in-time count as part of the performance measure that "estimates the homeless population nationwide."[61]

The program did not meet the HCHV5 target in FYs 2021 and 2022 but did in FY 2023. The Homeless Program Manager told the OIG that barriers to meeting the target included ongoing staff turnover due to the complex nature of their work and the challenging population they

[59] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[60] VHA sets targets at the individual facility level. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures,* October 1, 2022.

[61] Local Department of Housing and Urban Development offices administer the annual point-in-time count. The count includes those living in shelters and transitional housing each year. Every other year, the count also includes unsheltered individuals. "VA Homeless Programs, Point-in-Time (PIT) Count," Department of Veterans Affairs, accessed May 30, 2023, https://www.va.gov/homeless/pit_count.

served. The manager further reported a recent strategic hiring pause had some effect on their outreach, but the OIG learned that on May 31, 2024, the VA Under Secretary for Health exempted homeless positions from the restriction.[62]

Program staff included the manager, four team supervisors, and various administrative and clinical staff who provided services to veterans. A social worker said the process to identify homeless veterans includes conducting community outreach in areas where homeless people commonly reside, collaborating with community and other city and county agencies that support homeless individuals, and maintaining communication with city and county agencies that serve homeless veterans. The Homeless Program Manager detailed the services provided to veterans at the Hope Center, an off-site community resource center, such as access to showers, laundry, food, and clothing. The center also features veterans' art in the main area and serves as a shelter in the summer and winter months.

Meeting Veteran Needs

VHA measures the percentage of veterans who are discharged from HCHV into permanent housing (performance measure HCHV1) and the percentage of veterans who are discharged due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff" (performance measure HCHV2).[63] The program had a steady increase in discharges to permanent housing from FY 2021 through FY 2022 and met the target in FY 2023. The Homeless Program Manager described barriers to meeting the target as the location of the program's 14 transitional beds, stating 10 are in an adjacent state and not all veterans were able to cross state lines, and the remaining 4 beds were for female veterans and had declining use. Further, the manager said there were limited affordable housing options, and permanent housing was not always the most appropriate solution because some veterans continue to require supportive services that are typically not offered once they are in permanent housing.

[62] Under Secretary for Health (USH) (10), "Specific Purpose Funded Positions and Activities (Homelessness, Suicide Prevention and Women's Health)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23) and Medical Center Directors (00), May 31, 2024.

[63] VHA sets targets for HCHV1 and HCHV2 at the national level each year. For FY 2023, the HCHV1 target was 55 percent or above and the HCHV2 (negative exits) target was 20 percent or below. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

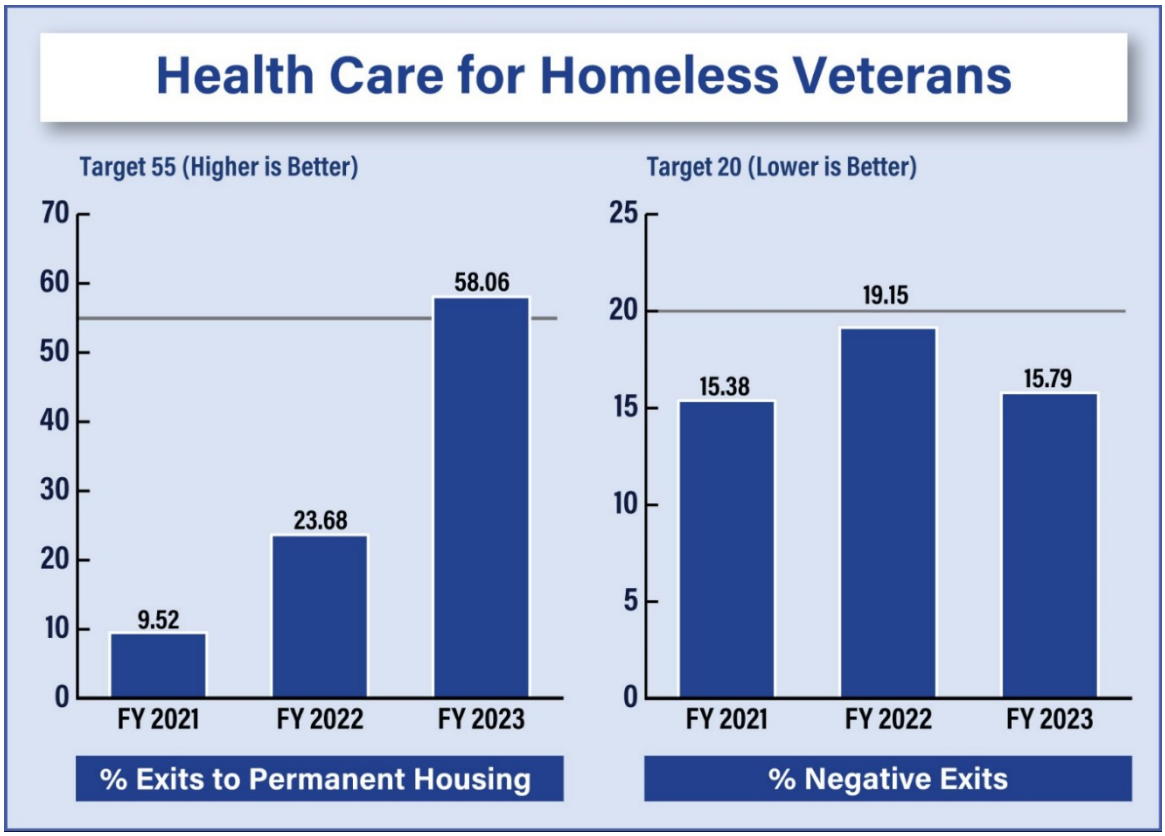

Figure 11. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

The facility met the negative exit target for FY 2021 through FY 2023. A grant and per diem liaison explained that when veterans are discharged from the program, they receive a satisfaction survey and have expressed satisfaction with the program in general. The liaison provided FY 2024 results from approximately 80 veterans, the majority of whom agreed or strongly agreed they were an equal partner in their care, had timely access to services, and participated in services that helped them achieve their goals; and that staff listened, explained content clearly, and expressed interest and understanding of their cultural needs and preferences. The liaison also stated that large resource fairs, referred to as stand-downs, were another way for veterans to provide program feedback.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[64] Veterans Justice Programs serve veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and reentry into society after incarceration. By facilitating access to

[64] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report.*

VHA care and VA services and benefits, the programs aim to prevent veteran homelessness and support sustained recovery.[65]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[66] Since FY 2023, the facility had met the target. The Homeless Program Manager and a staff specialist attributed their success to being fully staffed, which allowed them to complete outreach activities to help identify veterans for the program.

The Outreach and Education Manager stated the program employed three full-time outreach staff and one staff member who also worked in another of the facility's homeless programs. The manager and an Outreach Specialist explained program staff provide outreach services to veterans who are incarcerated, and train police crisis intervention teams to help them identify veterans who may benefit from treatment programs instead of going through the justice system. The specialist said court personnel, law enforcement officers, family members, and other VA staff refer veterans to the program. The specialist added they work with courts in a neighboring state as well.

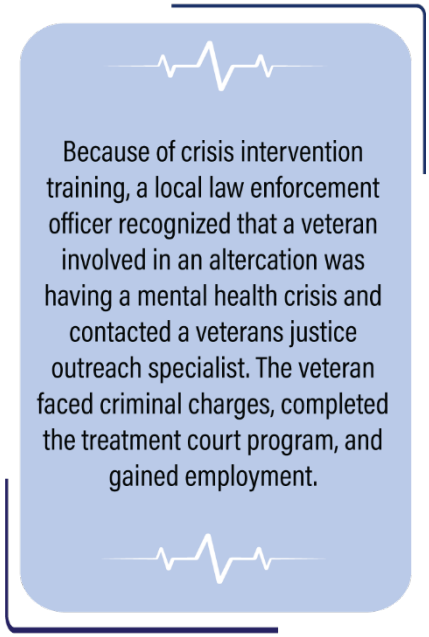

Figure 12. *Veterans Justice Program success story.*
Source: OIG interviews.

Meeting Veteran Needs

The purpose of a treatment court is to keep veterans in the community and functioning at their highest level of independence during treatment, while also allowing program staff to monitor adherence to treatment plans.[67] The Outreach Specialist explained how they support veterans in meeting the program goals of at least six months of recovery, adherence to their treatment plan, and sustained recovery. The specialist also described a federal reentry court program that offers paroled veterans more frequent court supervision following release, but for a shorter period than typical paroles (from 5 to 10 years down to approximately 2 years). The specialist identified

[65] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[66] VHA sets escalating targets for this measure at the facility level each year, with the goal to reach 100 percent by the end of the FY. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

[67] A veterans treatment court is "a treatment court model that brings Veterans together on one docket to be served as a group. A treatment court is a long-term, judicially supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager." VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

transportation as a barrier to attending treatment court programs for veterans living in rural areas, especially those without a driver's license, but said some court appearances were virtual, and sometimes court officials offered veterans transportation vouchers to complete drug testing or attend court hearings.

The specialist reported staff assess veterans to determine the types of services needed. The Outreach and Education Manager described one way staff meet veterans' needs in the court treatment program is by offering after-hours virtual group meetings three times per week to accommodate veterans' work schedules and continue treatment. The specialist explained that prior to the pandemic, staff had hosted legal events and estate planning clinics where veterans could meet with attorneys, but they had challenges restarting the clinics because some of the attorneys had retired.

Housing and Urban Development–Veterans Affairs Supportive Housing

Housing and Urban Development–Veterans Affairs Supportive Housing combines Department of Housing and Urban Development rental vouchers and VA case management services for veterans requiring the most aid to remain in stable housing, including those "with serious mental illness, physical health diagnoses, and substance use disorders."[68] The program uses the housing first approach, which prioritizes rapid acceptance to a housing program followed by individualized services, including healthcare and employment assistance, necessary to maintain housing.[69]

Identification and Enrollment of Veterans

VHA's Housing and Urban Development–Veterans Affairs Supportive Housing program targets are based on point-in-time measurements, including the percentage of housing vouchers assigned to the facility that are being used by veterans or their families (performance measure HMLS3).[70] The facility did not meet the targets for FY 2021 through FY 2023. A supervisor stated the aging infrastructure in the St. Louis area made it hard for housing units to pass local inspections, adding that it has taken longer to house veterans since the pandemic.

Program staff highlighted additional barriers to meeting the target, including lack of veteran engagement, limited transportation, lack of affordable and safe housing, and problems obtaining required documents, such as birth certificates. Staff described efforts to limit the impact of these barriers by outreach staff taking extra time with veterans to gain trust and using vehicles to go

[68] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[69] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[70] VHA sets the HMLS3 target at the national level each year. The FY 2023 target for HMLS3 was 90 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

into the community to engage with the veterans. Additionally, the Homeless Program Manager stated that veterans with chronic health conditions were sometimes limited to first floor units that could be challenging to acquire. The manager added there was no shared electronic information system between facility staff and the public housing authority; instead, a lengthy manual housing application process often took up to four months, which could place vouchers at risk of expiring.

The Homeless Program Manager stated three coordinators and two team supervisors led the program, which had 22 staff who provided case management and administrative support. The manager also explained the Housing and Urban Development–Veterans Affairs Supportive Housing program is the largest homeless program and has 500 housing vouchers that are primarily tenant-based choice vouchers, allowing veterans to choose housing in the community, with an additional 18 project-based vouchers for housing in specific locations.[71]

A program supervisor described identifying veterans through self-referrals such as walk-ins or phone calls, or referrals from other facility staff. The enrollment process consisted of an initial assessment to determine the veteran's eligibility and needs. The supervisor further reported assigning eligible veterans a case manager and referring them to the public housing authority to receive their voucher.

Meeting Veteran Needs

VHA measures how well the Housing and Urban Development–Veterans Affairs Supportive Housing program is meeting veteran needs by using nationally determined targets including the percentage of veterans employed at the end of each month (performance measure VASH3).[72] The facility met the target from FYs 2021 through 2024. The Homeless Program Manager stated that employment was critical because unemployment and underemployment were leading contributors to veterans' homelessness.

Program staff described working with several housing authorities, community shelters, transitional housing programs, veteran-focused organizations, and various nonprofits to assist veterans with housing, food, utility payments, deposits, application fees, rent, and furniture. Additionally, a program supervisor reported staff from all the facility homeless programs met weekly to review veterans' specific needs, establish team assignments, and visit locations frequented by the veterans to attempt to reengage those currently not receiving program services. Additionally, the supervisor and a program lead said a facility occupational therapist provides

[71] Tenant-based vouchers include a contract between the public housing agency and the owner of a single unit for a specific family, which can move with the family if they go to another unit. Project-based vouchers include a contract with multiple units under one contract where supportive services may be provided on-site. Section 8 Housing Choice Vouchers: Revised Implementation of the HUD-Veterans Affairs Supportive Housing Program, 86 Fed. Reg. 53207 (September 27, 2021) (codified at 24 C.F.R. Part 982).

[72] VHA sets the VASH3 target at the national level. For FY 2023, the target was 50 percent or above. VHA Homeless Programs, *Technical Manual: FY 2023 Homeless Performance Measures*.

vital support to aging veterans by providing equipment to support their independence and helping them access home health services.

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains and provided recommendations on systemic issues that may adversely affect patient care. Recommendations do not reflect the overall quality of all services delivered within the facility. However, the OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

OIG Recommendations and VA Response

Finding: Supplies in the clinical locations were expired, which is a repeat finding. Staff maintained the supplies outside standard supply locations, and the facility lacked a process for monitoring the storage.

Recommendation 1

The OIG recommends facility leaders determine appropriate supply storage locations, and for any supplies stored outside these defined locations, implement a process to ensure staff identify and remove expired supplies.

__X__ Concur

____ Nonconcur

Target date for completion: January 30, 2026

Director Comments

The Associate Director Patient Care Services (ADPCS), the Assistant Director (AD) and the Chief of Supply Chain Management have reviewed the current state of Veterans Affairs St. Louis Health Care System (VASTLHCS) supply storage locations, and local processes on monitoring supply expiration compliance. The Chief of Supply Chain Management reviewed current processes and determined appropriate supply locations for the facility to ensure staff have access to appropriate, safe, supplies to support Veteran care. VASTLHCS has implemented the following actions to identify and remove expired supplies outside of these designated supply locations:

1. The Medical Center Director (MCD) has an established comprehensive Environment of Care (EOC) rounding program as required by VHA Directive 1608(1), Comprehensive Environment of Care Program, dated June 21, 2021. The new Chief of Supply Chain Management was re-tasked to fully support the existing Environment of Care rounding program in accordance with St. Louis (STL) Charter 25047, Comprehensive Environment of Care Committee, dated September 1, 2024. The numerator will be the total number of EOC rounds attended by Supply Chain Management (SCM) for inspecting for expired supplies and ensure appropriate disposal. The denominator will be the total number of EOC rounds scheduled. Monitoring for a 90 percent or greater compliance rate for six (6) consecutive months and reported monthly as a standing agenda item at the Quality and Patient Safety Executive Board (QPSEB).
2. The ADPCS in collaboration with Supply Chain Management (SCM) will conduct a full sweep of approved supply storage areas in the Intensive Care Unit (ICU),

Emergency Department (ED), and nursing inpatient units to identify, remove, and properly dispose of any and all expired supplies by May 16, 2025. The numerator will be the total number of approved supply storage areas on each inpatient unit with a completed full sweep inspection of expired supplies. The denominator will be the total number of approved supply storage areas on each inpatient unit. Monitoring for a 90 percent or greater compliance rate for six (6) consecutive months and reported monthly as a standing agenda item at the QPSEB.

3. The ADPCS in collaboration with SCM will develop and standardize inventory lists for each of the approved supply storage areas for the Intensive Care Unit (ICU), Emergency Department (ED), and nursing inpatient units by June 30, 2025. The numerator will be the total number of approved supply storage areas for the Intensive Care Unit (ICU), Emergency Department (ED), and nursing inpatient units that have a completed and standardized inventory list. The denominator will be the total number of approved supply storage areas for the Intensive Care Unit (ICU), Emergency Department (ED), and nursing inpatient units. Monitoring for a 90 percent or greater compliance rate for six (6) consecutive months and reported monthly as a standing agenda item at the QPSEB.
4. The ADPCS, the Chief Supply Chain Management in collaboration with the Learning and Organizational Development (LOD) service will conduct refresher training on proper storage, labeling, First In/First Out (FIFO) practices, rounding and expiration monitoring expectations, for the Intensive Care Unit (ICU), Emergency Department (ED), and nursing inpatient units by July 30, 2025. The numerator will be the total number of nursing staff on each inpatient unit completing refresher training. The denominator will be the total number of nursing staff on that inpatient unit. Monitoring for a 90 percent or greater compliance rate for six (6) consecutive months and reported monthly as a standing agenda item at the QPSEB.

Finding: The type and number of supplies stocked for video laryngoscopes, a piece of airway control equipment, was inconsistent in several patient care areas, and some supplies were expired.

Recommendation 2

The OIG recommends facility leaders ensure video laryngoscope supplies are readily available and not expired.

__X__ Concur

____ Nonconcur

Target date for completion: May 30, 2025

Director Comments

The Chief of Staff (COS), the Associate Chief of Staff (ACOS) Medicine Service, and the Medical Emergency Response Committee (MERC) reviewed relevant VHA and local guidance and policies to ensure the standardization of emergency equipment to include supply expiration monitoring processes. A facility meeting was held on June 7, 2024, with key stakeholders from nursing services, respiratory therapy, sterile processing, anesthesia, critical care, and quality management. Respiratory Therapy, in collaboration with MERC, identified the required supplies with par levels and outlined the cleaning, auditing, and restocking process in VASTLHCS Standard Operating Procedure (SOP) 11-24013, Medical Emergency Response Standard Operating Procedure, Appendix E, dated August 5, 2024. Additionally, standardized supply bags, which are kept on the GlideScopes, were developed for quick turnaround of those items and implemented in August 2024. In October 2024, Respiratory Therapy initiated monthly audits for seven GlideScopes and supply bags (17 required items) kept in the Emergency Department and on the inpatient units to assess the availability and expiration compliance of the stocked supplies.

The Respiratory Therapy Supervisor has been auditing the seven identified Glidescopes and the availability of supplies and expiration status monthly using a standardized checklist that began October 2024 to ensure video laryngoscope availability of supplies and expiration status were readily available and not expired. The Glidescope and the availability of supplies and expiration status met the established target of 90 percent or greater compliance for six (6) consecutive months. The numerator was the total number of Glidescopes (7) and the availability of supplies (17 items) and expiration status that are compliant, available, and without expiration identified. The denominator was the total number of Glidescopes (7), and the availability of supplies (17 items) and expiration status audited. Compliance has been reported to the Accreditation Supervisor from October 2024 through April 2025 with a scheduled reporting of the audits to the QPSEB May 2025.

- October 2024: 116/119 = 97.5%
- November 2024: 118/119 = 99.2%
- December 2024: 118/119 = 99.2%
- January 2025: 112/112 = 100% (Denominator changed due to supply chain disruption with ET tubes)
- February 2025: 111/112 = 99.1% (Denominator changed due to supply chain disruption with ET tubes)
- March 2025: 112/112 = 100%
- April 2025: 117/119 = 98.3%

Finding: The bed frames in several clinical areas were dusty, and bottom shelves on supply room carts in the surgical intensive care unit and the 7 South medical/surgical unit were less than eight inches off the floor, which could result in contamination of supplies during floor cleaning.

Recommendation 3

The OIG recommends the Director ensures staff keep patient care areas clean and safe.

__X__ Concur

____ Nonconcur

Target date for completion: October 31, 2025

Director Comments

The Medical Center Director, the Assistant Director, and the Chief of Environmental Services (EMS) have reviewed VHA and local infection control and EMS cleaning guidance to ensure staff keep patient care areas clean and safe. The Chief of EMS has assigned staff retraining on proper bed cleaning to include annual training competencies, in accordance with VASTLHCS Standard Operating Procedure (SOP) 137-20018, Cleaning Process, dated April 7, 2020. The Chief of Environmental Services will have the EMS Supervisor randomly audit 20 patient care area beds for proper cleanliness monthly. The numerator will be the total number of patient care area beds that are properly cleaned in accordance with VASTLHCS SOP 137-20018 Cleaning Process dated April 7, 2020. The denominator will be the total number of patient care area beds audited. Auditing will continue until 90 percent or greater compliance is met for six (6) consecutive months. Compliance will be monitored and reported monthly as a standing agenda item at the Quality and Patient Safety Executive Board (QPSEB).

The Medical Center Director, the Assistant Director, and the Chief Supply Chain Management have reviewed VHA and local guidance on keeping patient care areas clean and safe. The Chief Supply Chain Management completed an inspection of supply rooms from April 18, 2025, to April 21, 2025, to assess and ensure all storage shelving was at least eight (8) inches from the floor to reduce the risk of contamination of supplies from floor cleaning procedures. All shelving units in supply storage locations were inspected to be at the minimum of 8 inches off the floor, and in compliance with VHA Directive 1761, Supply Chain Management Operations, dated December 30, 2020. Those found to be less than 8 inches off the floor, specifically in the Surgery Intensive Care Unit (SICU) and the 7 South Medical/Surgical Unit, were elevated to the minimum required distance for compliance. Furthermore, SICU and 7 South Medical/Surgical Unit bottom shelving's were dusted by SCM, and plan to ensure dust mitigation during weekly clean utility room inspections, when resupplying those areas, and during EOC rounds. Supply shelving in the SICU and 7 South Medical/Surgical Unit will be tracked and monitored by the Chief SCM and the Office of Quality Management monthly where the results will be presented

to the Quality and Patient Safety Executive Board (QPSEB) for the next six continuous months. The numerator will be the SICU and 7 South Medical/Surgical Unit supply storage area compliance with no dust identified weekly. The denominator will be the SICU, and 7 South Medical/Surgical Unit supply storage areas inspected.

Finding: Preventive maintenance was overdue for some mobile medical equipment located in the surgical intensive care unit and the community living center.

Recommendation 4

The OIG recommends the Director ensures staff complete required preventive maintenance for biomedical equipment.

__X__ Concur

____ Nonconcur

Target date for completion: October 31, 2025

Director Comments

The Medical Center Director, the Associate Director, and the Chief of Biomedical Engineering have reviewed VHA, and local preventive maintenance established guidance for continuous compliance. The Chief of Biomedical Engineering will reinforce the standardized Preventive Maintenance (PM) processes in accordance with the updated Medical Equipment Management Plan (MEMP), dated March 6, 2025. Biomedical Engineering will institute the following to continue PM compliance support and report to the Comprehensive Environment of Care Committee (CEOCC):

1. Reinforce the consistency of reporting medical equipment during the normal PM cycle for equipment.
2. Facility education on identifying and reporting outdated medical equipment.
3. Monthly meetings with service lines to address medical equipment issues.
4. Update PM medical equipment labels with the use of only two labels: 1) Planned Maintenance, and 2) Corrective Action.
5. Standard reporting of PM concerns during daily VASTLHCS tiered Safety-Methods-Equipment-Supplies-Staffing (SMESS) huddles.

The Chief of Biomedical Engineering will audit 50 random biomedical pieces of equipment monthly beginning May 2025 to ensure PMs have been completed in accordance with the biomedical equipment item's requisite PM cycle. The PM completion compliance will continue until 90 percent or greater compliance is met for six (6) consecutive months. The numerator will be the total number of biomedical equipment items that has had proper PM completed. The

denominator will be the total number of biomedical equipment items audited. Compliance will be monitored and reported monthly as a standing agenda item at the Quality and Patient Safety Executive Board (QPSEB).

Finding: Despite having an approved policy in June 2024, quality, safety, and value staff stated service-level workflows were still in development. The OIG also identified that while diagnostic imaging and pathology and laboratory service staff has processes to monitor the timely communication of critical test results to the ordering providers; facility staff lacked a consistent monitoring process to evaluate ordering providers' communication of urgent, noncritical results to patients.

Recommendation 5

The OIG recommends facility leaders develop service-level workflows and processes to monitor communication of test results to patients.

__X__ Concur

____ Nonconcur

Target date for completion: December 31, 2025

Director Comments

The Chief of Staff, the Associate Chiefs of Staff, and the Director, Office of Quality Management have reviewed VASTLHCS Medical Center Policy (MCP) 11-2481, Diagnostic Test Results Reporting Excluding Point of Care Testing, dated June 1, 2024, and VHA Directive 1088(1), Communicating Test Results to Providers and Patients, dated July 11, 2023, amended September 20, 2024. MCP 11-2481 is in the process of being updated to include all required elements, service level workflows, and processes to monitor communication of test results to patients per VHA guidance. VASTLHCS providers will be trained on the revised local policy by the end of June 2025. The Office of Quality Management will perform a random review of 50 outpatient test results from 50 unique outpatients monthly beginning July 2025. Compliance will be monitored as a standing agenda item at the Quality and Patient Safety Executive Board (QPSEB) reporting out monthly. Monitoring will continue until 90 percent or greater compliance is met for six (6) consecutive months. The numerator will be the total number of abnormal or non-critical test results communicated in accordance with VHA Directive 1088(1). The denominator will be the total number of abnormal or non-critical test results reviewed.

Appendix A: Methodology

Inspection Processes

The OIG inspection team reviewed selected facility policies and standard operating procedures, administrative and performance measure data, VA All Employee Survey results, and relevant prior OIG and accreditation survey reports.[1] The OIG distributed a voluntary questionnaire to employees through the facility's all employee mail group to gain insight and perspective related to the organizational culture. The OIG also created a questionnaire for distribution to multiple VSOs.[2] Additionally, the OIG interviewed facility leaders and staff to discuss processes, validate findings, and explore reasons for noncompliance. Finally, the OIG inspected selected areas of the medical facility.

The OIG's analyses relied on inspectors identifying significant information from questionnaires, surveys, interviews, documents, and observational data, based on professional judgment, as supported by Council of Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation.*[3]

Potential limitations include self-selection bias and response bias of respondents.[4] The OIG acknowledges potential bias because the facility liaison selected staff who participated in the primary care panel discussion; the OIG requested this selection to minimize the impact of the OIG inspection on patient care responsibilities and primary care clinic workflows.

HFI directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from June 3 through 6, 2024. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issues.

[1] The All Employee Survey and accreditation reports covered the time frame of October 1, 2020, through September 30, 2023.

[2] The OIG sent surveys to multiple VSO representatives provided by facility staff but received a response from only one.

[3] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation,* December 2020.

[4] Self-selection bias is when individuals with certain characteristics choose to participate in a group, and response bias occurs when participants "give inaccurate answers for a variety of reasons." Dirk M. Elston, "Participation Bias, Self-Selection Bias, and Response Bias," *Journal of American Academy of Dermatology* (2021): 1-2, https://doi.org/10.1016/j.jaad.2021.06.025.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[5] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

Category	Metric	Metric Definition
Population	Total Population	Population estimates are from the US Census Bureau and include the calculated number of people living in an area as of July 1.
	Veteran Population	2018 through 2022 veteran population estimates are from the Veteran Population Projection Model 2018.
	Homeless Population	Part 1 provides point-in-time (PIT) estimates, offering a snapshot of homelessness—both sheltered and unsheltered—on a single night.
	Veteran Homeless Population	Part 1 provides point-in-time (PIT) estimates, offering a snapshot of homelessness—both sheltered and unsheltered—on a single night.
Education	Completed High School	Persons aged 25 years or more with a high school diploma or more, and with four years of college or more are from the US Census Bureau's American Community Survey Summary File. High School Graduated or More fields include people whose highest degree was a high school diploma or its equivalent. People who reported completing the 12th grade but not receiving a diploma are not included.
	Some College	Persons aged 25 years or more with a high school diploma or more and with four years of college or more are from the US Census Bureau's American Community Survey Summary File. High School Graduated or More fields include people who attended college but did not receive a degree, and people who received an associate's, bachelor's, master's, or professional or doctorate degree.
Unemployment Rate	Unemployed Rate 16+	Labor force data are from the Bureau of Labor Statistics' Local Area Unemployment Statistics File for each respective year. Data are for persons 16 years and older, and include the following: Civilian Labor Force, Number Employed, Number Unemployed, and Unemployment Rate. Unemployment rate is the ratio of unemployed to the civilian labor force.
	Veteran Unemployed in Civilian Work Force	Employment and labor force data are from the US Census Bureau's American Community Survey Summary File. Veterans are men and women who have served in the US Merchant Marines during World War II; or who have served (even for a short time), but are not currently serving, on active duty in the US Army, Navy, Air Force, Marine Corps, or Coast Guard. People who served in the National Guard or Reserves are classified as veterans only if they were ever called or ordered to active duty, not counting the 4-6 months for initial training or yearly summer camps.

Category	Metric	Metric Definition
Median Income	Median Income	The estimates of median household income are from the US Census Bureau's Small Area Income Poverty Estimates files for the respective years.
Violent Crime	Reported Offenses per 100,000	Violent crime is the number of violent crimes reported per 100,000 population. Violent crimes are defined as offenses that involve face-to-face confrontation between the victim and the perpetrator, including homicide, forcible rape, robbery, and aggravated assault.
Substance Use	Driving Deaths Involving Alcohol	Alcohol-impaired driving deaths directly measures the relationship between alcohol and motor vehicle crash deaths.
	Excessive Drinking	Excessive drinking is a risk factor for several adverse health outcomes, such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes.
	Drug Overdose Deaths	Causes of death for data presented in this report were coded according to International Classification of Diseases (ICD) guidelines described in annual issues of Part 2a of the National Center for Health Statistics Instruction Manual (2). Drug overdose deaths are identified using underlying cause-of-death codes from the Tenth Revision of ICD (ICD–10): X40–X44 (unintentional), X60–X64 (suicide), X85 (homicide), and Y10–Y14 (undetermined).
Access to Health Care	Transportation	Employment and labor force data are from the US Census Bureau's American Community Survey Summary File. People who used different means of transportation on different days of the week were asked to specify the one they used most often or for the longest distance.
	Telehealth	The annual cumulative number of unique patients who have received telehealth services, including Home Telehealth, Clinical Video Telehealth, Store-and-Forward Telehealth and Remote Patient Monitoring - patient generated.
	< 65 without Health Insurance	Estimates of persons with and without health insurance, and percent without health insurance by age and gender data are from the US Census Bureau's Small Area Health Insurance Estimates file.
	Average Drive to Closest VA	The distance and time between the patient residence to the closest VA site.

**The OIG updates information for the Facility in Context graphics quarterly based on the most recent data available from each source at the time of the inspection.*

Table B.2. Health of the Veteran Population*

Category	Metric	Metric Definition
Mental Health Treatment	Veterans Receiving Mental Health Treatment at Facility	Number of unique patients with at least one encounter in the Mental Health Clinic Practice Management Grouping. An encounter is a professional contact between a patient and a practitioner with primary responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters occur in both the outpatient and inpatient setting. Contact can include face-to-face interactions or telemedicine.
Suicide	Suicide Rate	Suicide surveillance processes include close coordination with federal colleagues in the Department of Defense (DoD) and the Centers for Disease Control and Prevention (CDC), including VA/DoD searches of death certificate data from the CDC's National Death Index, data processing, and determination of decedent Veteran status.
	Veterans Hospitalized for Suicidal Ideation	Distinct count of patients with inpatient diagnosis of ICD10 Code, R45.851 (suicidal ideations).
Average Inpatient Hospital Length of Stay	Average Inpatient Hospital Length of Stay	The number of days the patient was hospitalized (the sum of patient-level lengths of stay by physician treating specialty during a hospitalization divided by 24).
30-Day Readmission Rate	30-Day Readmission Rate	The proportion of patients who were readmitted (for any cause) to the acute care wards of any VA hospital within 30 days following discharge from a VA hospital by total number of index hospitalizations.
Unique Patients	Unique Patients VA and Non-VA Care	Measure represents the total number of unique patients for all data sources, including the pharmacy-only patients.
Community Care Costs	Unique Patient	Measure represents the Financial Management System Disbursed Amount divided by Unique Patients.
	Outpatient Visit	Measure represents the Financial Management System Disbursed Amount divided by the number of Outpatient Visits.
	Line Item	Measure represents the Financial Management System Disbursed Amount divided by Line Items.
	Bed Day of Care	Measure represents the Financial Management System Disbursed Amount divided by the Authorized Bed Days of Care.
Staff Retention	Onboard Employees Stay < 1 Year	VA's AES All Employee Survey Years Served <1 Year divided by total onboard. Onboard employee represents the number of positions filled as of the last day of the most recent month. Usually one position is filled by one unique employee.
	Facility Total Loss Rate	Any loss, retirement, death, termination, or voluntary separation that removes the employee from the VA completely.

Category	Metric	Metric Definition
	Facility Quit Rate	Voluntary resignations and losses to another federal agency.
	Facility Retire Rate	All retirements.
	Facility Termination Rate	Terminations including resignations and retirements in lieu of termination but excluding losses to military, transfers, and expired appointments.

**The OIG updates information for the Facility in Context graphics quarterly based on the most recent data available from each source at the time of the inspection.*

Appendix C: Facility Pictures

Figure C.1. *Facility application for reporting safety or environment of care concerns. (Note: Veteran and employee rounding is the practice of asking consistent questions to key stakeholders to obtain actionable information. This information can be used to improve care and employees' experience.)*
Source: Facility staff.

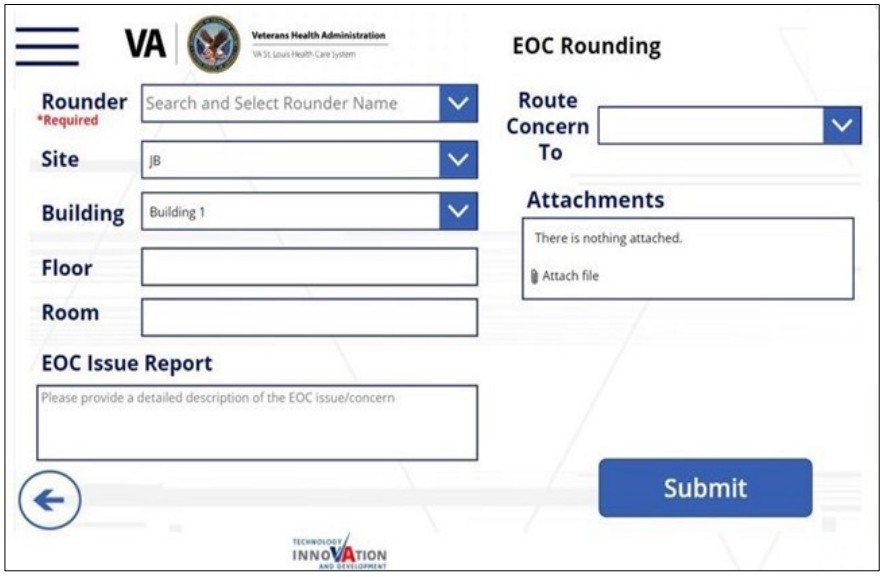

Figure C.2. *Facility application for reporting environment of care concerns. This screen is shown after selecting "Safety/EOC Concern" in Figure C.1. (Note: The Rounder is the person submitting the observation.)*
Source: Facility staff.

Appendix D: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: April 28, 2025

From: Director, VA Heartland Network (10N15)

Subj: Healthcare Facility Inspection (HFI) of the VA St. Louis Healthcare System in Missouri

To: Director, Office of Healthcare Inspections (54HF03)

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

1. Attached is the facilities response to the OIG HFI of the VA St. Louis Health Care System, Missouri draft report.
2. I have reviewed and concur with the facility's response to the findings, recommendations, and submitted action plans.

(Original signed by:)

Patricia L. Hall, PhD, ACHE
Network Director
VA Heartland Network (VISN 15)

Appendix E: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: April 24, 2025

From: Director, VA St. Louis Healthcare System (657)

Subj: Healthcare Facility Inspection (HFI) of the VA St. Louis Healthcare System in Missouri

To: Director, VA Heartland Network (10N15)

1. In response to the findings of the OIG HFI Review of the VA St. Louis Health Care System conducted June 3, 2024, through June 6, 2024, the facility has taken actions to address the five (5) 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:)

Candace A. Ifabiyi, MHA, MSBA, FACHE
Medical Center Director
VA St. Louis Health Care System

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Pursuant to Pub. L. 117-263, section 5274, codified at 5 U.S.C. § 405(g)(6), nongovernmental organizations, and business entities identified in this report have the opportunity to submit a written response for the purpose of clarifying or providing additional context to any specific reference to the organization or entity. Comments received consistent with the statute will be posted on the summary page for this report on the VA OIG website.