



US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Eastern Kansas Health Care System in Topeka

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Figure 1. Colmery-O'Neil VA Medical Center of the VA Eastern Kansas Health Care System in Topeka.

Source: <https://www.va.gov/eastern-kansas-health-care/locations/> (accessed March 11, 2024).

Abbreviations

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



Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Eastern Kansas Health Care System, which includes the Colmery-O'Neil VA Medical Center (Topeka), Dwight D. Eisenhower VA Medical Center (Leavenworth), and multiple outpatient clinics in Kansas and Missouri. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

The OIG initiated an unannounced inspection of the VA Eastern Kansas Health Care System during the week of July 10, 2023. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the healthcare system's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted opportunities for improvement and issued three recommendations to the Associate Director in the Environment of Care area of review. The number of recommendations should not be used as a gauge for the overall quality of care provided at this system. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered

with the delivery of quality health care. The results are detailed throughout the report, and the recommendations are summarized in appendix A on page 19.

VA Comments

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

A handwritten signature in black ink that reads "John D. Daigh Jr., M.D." The signature is written in a cursive style.

JOHN D. DAIGH JR., M.D.
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Purpose and Scope

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

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

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

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

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

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

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

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

Methodology

The VA Eastern Kansas Health Care System includes the Colmery-O’Neil VA Medical Center (Topeka), Dwight D. Eisenhower VA Medical Center (Leavenworth), and multiple outpatient clinics in Kansas and Missouri. General information about the healthcare system can be found in appendix B.

The OIG inspected the healthcare system during the week of July 10, 2023.⁵ During the site visit, the OIG referred concerns that were beyond the scope of this inspection to the OIG’s hotline for further review.

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

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

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

⁵ The OIG’s last comprehensive healthcare inspection of the VA Eastern Kansas Health Care System occurred in November 2019. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in August 2022.

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

Results and Recommendations

Leadership and Organizational Risks

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

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

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

Executive Leadership Position Stability and Engagement

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

At the time of the OIG inspection, the executive team had worked together for approximately one year, although the Director had been in the role since 2012 and the Chief of Staff had served for more than five years. The permanent Assistant Director retired approximately two months prior to the OIG inspection and another staff member was serving as interim Assistant Director.

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

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

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

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

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2022 annual medical care budget of \$504,398,232 had increased by approximately 24 percent compared to the previous year's budget of \$406,670,320.¹⁰ The Director and Associate Director reported spending had increased for community care.¹¹ The Director described using the increased funds to make improvements in the Emergency Department and expand the oncology and hematology/oncology services in Topeka. The Director also discussed conducting a campaign in FYs 2020 and 2021 to bring more veterans to the facility for care. The Director said the campaign, called I Found One, encouraged employees and current patients to bring a veteran friend to the facility, which resulted in a patient increase of approximately 4.5 percent and accounts for much of the increased budget.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."¹² Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical facility leaders.

To assess employee viewpoints, the OIG reviewed results from VA's All Employee Survey from FYs 2020 through 2022 regarding their perceived ability to disclose a suspected violation without fear of reprisal.¹³ Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the healthcare system over time.

The facility's survey results were lower than VHA averages for all three years. To improve results, the ADPCS highlighted a major campaign conducted by executive leaders over the prior FY to educate staff on equal employment opportunity and whistleblower protections and reinforce management support for reporting concerns to supervisors.

¹⁰ Veterans Health Administration (VHA) Support Service Center.

¹¹ "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed March 11, 2024, <https://www.va.gov/communitycare/>.

¹² "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center.

¹³ The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only.

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

All Employee Survey Group	FY 2020	FY 2021	FY 2022
VHA	3.8	3.9	3.9
VA Eastern Kansas Health Care System	3.7	3.8	3.7

Source: VA All Employee Survey (accessed December 27, 2022).

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

Patient Experience

VHA uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to assess patients’ healthcare experiences and compare them to the private sector. VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.¹⁴ The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from FYs 2020 through 2022. Table 2 provides survey results for VHA and the healthcare system over time.

The OIG asked the Director and ADPCS to comment on the inpatient scores, which were below VHA averages for two of three years, indicating patients were less satisfied during those years compared to VHA patients overall. They said that for approximately nine months in FY 2022, leaders combined the medical, surgical, and intensive care units at both medical centers. According to the Director, this approach ensured sufficient staffing, but patients may have been dissatisfied with receiving care from different and unfamiliar personnel, resulting in a lower satisfaction score. The ADPCS added that the healthcare system also had a significant number of newly hired nurses who were still gaining confidence in engaging with patients and providing care.

The system’s scores for both the primary and specialty care surveys indicate a higher level of patient satisfaction compared to VHA patients overall. The Chief of Staff said primary care teams worked effectively and treated patients well. Regarding specialty care, the Director highlighted providing chiropractic and physical therapy care at community clinics, while the Chief of Staff reported increasing the number of providers in orthopedics, optometry, and podiatry.

¹⁴ “Patient Experiences Survey Results,” VHA Support Service Center.

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Healthcare System	VHA	Healthcare System	VHA	Healthcare System
Inpatient: <i>Would you recommend this hospital to your friends and family?*</i>	69.5	67.0	69.7	71.3	68.9	64.9
Patient-Centered Medical Home: <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?†</i>	82.5	85.4	81.9	84.9	81.7	84.2
Specialty Care: <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?†</i>	84.8	85.3	83.3	84.7	83.1	88.5

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 8 and 14, 2022).

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

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

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

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.¹⁵ According to The Joint Commission’s standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.¹⁶ A VA medical facility’s culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

¹⁵ Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; “Quality and Patient Safety (QPS),” Department of Veterans Affairs, accessed October 13, 2021, <https://www.va.gov/QUALITYANDPATIENTSAFETY/>.

¹⁶ The Joint Commission, *Standards Manual*, E-edition, February 19, 2023. A culture of safety is “the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization’s health and safety management.” “Hospital Survey on Patient Safety Culture: User’s Guide,” Agency for Healthcare Research and Quality, July 2018, <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf>.

when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.¹⁷

“A sentinel event is a patient safety event (not primarily related to the natural course of a patient’s illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm).”¹⁸

Additionally, an institutional disclosure is “a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient’s personal representative that an adverse event has occurred during the patient’s care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient’s rights and recourse.”¹⁹ Lastly, a large-scale disclosure is “a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue.”²⁰ To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.²¹

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred during FY 2022 and reviewed the information the acting Patient Safety Manager and the Risk Manager provided. The acting Patient Safety Manager reported evaluating adverse events and reviewing VHA guidance to determine whether they should be classified as sentinel events. The acting Patient Safety Manager described sharing the information with the Quality Management Officer and Risk Manager, and they discussed sentinel events to decide whether leaders should perform an institutional disclosure. The Risk Manager further reported coordinating institutional disclosures after reviewing sentinel events with the Chief of Staff, who, along with the Director, made the final decision.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

¹⁷ Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events (2nd ed.)*, Institute for Healthcare Improvement White Paper, 2011.

¹⁸ The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, Sentinel Event Policy (SE), July 2023. VHA incorporates The Joint Commission’s definition of a sentinel event in VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

¹⁹ VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

²⁰ VHA Directive 1004.08.

²¹ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024. The new directive contains similar language regarding patient safety as the rescinded handbook.)

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.²² To achieve this goal, VHA requires that its medical facility leaders implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.²³ Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.²⁴

VHA implemented the National Center for Patient Safety program to develop a range of patient safety methodologies and practices. VHA's Patient Safety program includes staff assessing system vulnerabilities that may result in patient harm, reporting adverse patient safety events, and focusing on prevention.²⁵ According to The Joint Commission's standards for performance improvement, staff must analyze data to monitor performance and identify trends and improvement opportunities, then implement actions to enhance patient safety.²⁶

The OIG assessed the healthcare center's processes for conducting peer reviews of clinical care.²⁷ Peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."²⁸ Peer reviews are "intended to promote confidential and non-punitive assessments of care" that consistently contribute to quality management efforts at the individual provider level.²⁹

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports. The team requested a list of patient deaths that occurred within 24 hours of inpatient admission and patient suicides that occurred within seven days of discharge from an inpatient mental health unit during FY 2022, and staff reported no patients met these criteria.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

²² Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

²³ VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.

²⁴ VHA Directive 1100.16.

²⁵ VHA Handbook 1050.01; VHA Directive 1050.01(1).

²⁶ The Joint Commission, *Standards Manual*, E-dition, PI.03.01.01, PI.04.01.01, January 1, 2023.

²⁷ A peer review is a "critical review of care performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190.

²⁸ VHA Directive 1190.

²⁹ VHA Directive 1190.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of “all health care professionals who are permitted by law and the facility to practice independently.”³⁰ These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care “without supervision or direction, within the scope of the individual’s license, and in accordance with individually-granted clinical privileges.”³¹

Privileges need to be specific and based on the individual practitioner’s clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP’s credentials and service chief’s recommendation to determine whether “clinical competence is adequately demonstrated to support the granting of the requested privileges,” and submits the final recommendation to the facility director.³² LIPs are granted clinical privileges for a limited time and must be repriviledged prior to their expiration.³³

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs’ professional performance. The Focused Professional Practice Evaluation process occurs when an LIP is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP’s performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.³⁴

VHA’s credentialing process involves the assessment and verification of healthcare practitioners’ qualifications to provide care and is the first step in ensuring patient safety.³⁵ Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office under the chief of staff. VHA also requires facilities to have credentialing and

³⁰ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded and replaced this handbook with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

³¹ VHA Handbook 1100.19.

³² VHA Handbook 1100.19.

³³ VHA Handbook 1100.19.

³⁴ VHA Handbook 1100.19.

³⁵ VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.³⁶

The OIG interviewed key managers and selected and reviewed the privileging folders of 22 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

The OIG made no recommendations.

³⁶ Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo, “Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020,” December 16, 2020.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of VHA’s environment of care program is to ensure “a safe, clean health care environment that provides the highest standards in the health care setting.”³⁷ The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.³⁸

The purpose of this inspection was to determine whether staff at VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG inspected selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.³⁹

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

- Colmery-O’Neil VA Medical Center (Topeka)
 - Community Living Center (6-1C)
 - Emergency Department
 - Inpatient mental health unit (2-3C)
 - Intensive Care Unit
 - Medical/surgical inpatient unit (1-4A)
 - Patient aligned care team clinic (Red)

³⁷ VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. (This directive was in effect at the time of the inspection. VHA amended it September 7, 2023.)

³⁸ VHA Directive 1608. The supply chain management system must meet the needs of its customers, which involves ensuring availability of the right product in the right place and at the right time. VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

³⁹ VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (VHA rescinded and replaced this handbook with VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023.) VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024.)

- Dwight D. Eisenhower VA Medical Center (Leavenworth)
 - Community Living Center
 - Emergency Department
 - Intensive Care Unit
 - Medical/surgical inpatient unit (A2)
 - Patient aligned care team clinic (C5)

Environment of Care Findings and Recommendations

The Joint Commission requires staff to ensure medical facilities are safe and suitable for care.⁴⁰ The OIG found damaged walls in some patient care areas inspected, which could prevent staff from effectively cleaning them.⁴¹ The Deputy Chief of Engineering reported unit staff failed to submit work orders to fix the damage, so engineering staff were unaware of it.

Recommendation 1

1. The Associate Director ensures staff maintain a safe environment by keeping walls in good repair.

⁴⁰ The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, EP 1, January 1, 2022.

⁴¹ The OIG observed wall damage at the Dwight D. Eisenhower VA Medical Center's Intensive Care Unit, patient aligned care team clinic (C5), and Community Living Center.

Healthcare system concurred.

Target date for completion: April 1, 2025

Healthcare system response: The Associate Director, in collaboration with the Associate Director for Patient Care Services, evaluated the recommendation and did not determine any additional reasons for noncompliance. The Associate Director or designee, in collaboration with the Associate Director for Patient Care Services or designee, will ensure that nursing and Environmental Management Services leadership has provided verbal education to staff regarding the importance of entering an Electronic Work Order (EWO), when wall damage is noted. Wall damage will be defined as scratches in the walls, exposed sheetrock, or other types of holes or penetrations in the walls. Basic repainting work order requests will be excluded.

Electronic work orders entered are tracked on an excel spreadsheet on the Engineering SharePoint. Engineering staff will monitor response to wall damage-related work orders for corrective action taken or completion. The numerator will consist of the number of acted upon and completed wall damage-related work orders, and the denominator is the total number of wall damage-related work orders entered, for the observation period. This data will be monitored by Chief of Engineering or designee until a compliance rate at, or above 90 percent is maintained for two consecutive quarters. This will be reported by Chief of Engineering or designee to the Environment of Care Board monthly until closed.

VHA requires staff to check over-the-door alarms in the inpatient mental health unit according to the manufacturer's guidelines.⁴² The OIG found that staff in the inpatient mental health unit (2-3C) at the Colmery-O'Neil VA Medical Center did not follow the manufacturer's guidance for checking over-the-door alarms weekly. If staff do not check alarms as recommended, the alarms may fail to alert when patients are in immediate danger. The Nurse Manager acknowledged being unaware of the requirement to test according to the manufacturer's guidelines.

Recommendation 2

2. The Associate Director ensures staff check over-the-door alarms in the inpatient mental health unit according to the manufacturer's guidelines.

⁴² VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017; VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist (MHEOCC)," October 18, 2022.

Healthcare system concurred.

Target date for completion: April 1, 2025

Healthcare system response: The Associate Director or designee, in collaboration with the Associate Director for Patient Care Services or designee, evaluated and did not determine any additional reasons for noncompliance. The Associate Director or designee, in collaboration with the Associate Director for Patient Care Services or designee, will ensure the inpatient mental health unit nursing staff will begin testing door alarms per manufacturer's recommendation of weekly testing. Door alarm tests will be tracked and logged by the Assistant Nurse Manager or designee on the Mental Health Services SharePoint. The numerator will be the number of inspections that were compliant with over-the-door alarms requirement in the inpatient mental health unit and the denominator is the total number of inspections completed in the inpatient mental health unit. The compliance rate will be 90 percent or above for six consecutive months. This data will be reported by the Accreditation Coordinator or designee to the Environment of Care Board monthly until closed.

VHA requires staff to periodically test panic alarms in the inpatient mental health unit and document VA police response times.⁴³ The OIG found no evidence staff documented police response times for panic alarm testing in the inpatient mental health unit (2-3C) at the Colmery-O'Neil VA Medical Center. If staff do not document response times, police may be unable change their process, if needed, to ensure timely response to emergencies. The Chief of Police reported being unaware of the requirement.

Recommendation 3

3. The Associate Director ensures staff document VA police response times for panic alarm testing in the inpatient mental health unit.

⁴³ VHA Directive 1167; VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist."

Healthcare system concurred.

Target date for completion: April 1, 2025

Healthcare system response: The Associate Director evaluated and did not determine any additional reasons for noncompliance. The Associate Director or designee will ensure that the alarm systems are connected to the Police Operation Center under continuous 24-hour monitoring by Police Services.

The Physical Security Specialist will be responsible to ensure that alarm testing will be conducted monthly to maintain operational readiness of the system and document those results on an alarm excel tracking sheet and file within the Record Control Management System (RCS) folders.

The Physical Security Specialist will conduct rapid response procedures/drills once per quarter and document on the alarm excel tracking sheet to ensure timely response of VA Police Officers to the inpatient mental health unit. The numerator is the number of panic alarm tests with documented police response times and the denominator is the total number of panic alarm tests conducted during the observation period. The compliance rate will be 90 percent or above for six consecutive months. This data will be reported quarterly by the Physical Security Specialist or designee during the Environment of Care Board meetings until closed.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.⁴⁴ Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.⁴⁵ The suicide rate for veterans was higher than for nonveteran adults during 2020.⁴⁶ “Congress, VA, and stakeholders continue to express concern over seemingly limited progress made...to reduce veteran suicide.”⁴⁷

Due to the prevalence of suicide among at-risk veterans, VHA implemented a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.⁴⁸ VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.⁴⁹

VHA requires each medical center and very large community-based outpatient clinic to have a full-time suicide prevention coordinator to track and follow up with high-risk veterans, conduct community outreach activities, and inform leaders of suicide-related events.⁵⁰

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and reviewed relevant documents and the electronic health records of 50 randomly selected patients who had a positive suicide screen in FY 2022 and received primary care services.

⁴⁴ VA Secretary memo, “Agency-Wide Required Suicide Prevention Training,” October 15, 2020.

⁴⁵ “Suicide Prevention: Facts about Suicide,” Centers for Disease Control and Prevention, accessed January 20, 2023.

⁴⁶ VA Office of Mental Health and Suicide Prevention, *2022 National Veteran Suicide Prevention Annual Report*, September 2022.

⁴⁷ Congressional Research Service, “Veteran Suicide Prevention,” IF11886 version 2, July 29, 2021.

⁴⁸ Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy),” November 13, 2020. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy),” November 23, 2022.)

⁴⁹ Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy);” Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Suicide Behavior and Overdose Reporting,” July 20, 2021. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Update to Suicide Behavior and Overdose Reporting,” May 9, 2023.)

⁵⁰ VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021. “Very large CBOCs [community-based outpatient clinics] are those that serve more than 10,000 unique veterans each year.” VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. (VHA rescinded and replaced this handbook with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.)

Mental Health Findings and Recommendations

The OIG made no recommendations.

Report Conclusion

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

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

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

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	<ul style="list-style-type: none"> • None
Quality, Safety, and Value	<ul style="list-style-type: none"> • None
Medical Staff Privileging	<ul style="list-style-type: none"> • None
Environment of Care	<ul style="list-style-type: none"> • Staff maintain a safe environment by keeping walls in good repair. • Staff check over-the-door alarms in the inpatient mental health unit according to the manufacturer's guidelines. • Staff document VA police response times for panic alarm testing in the inpatient mental health unit.
Mental Health: Suicide Prevention Initiatives	<ul style="list-style-type: none"> • None

Appendix B: Healthcare System Profile

The table below provides general background information for this medium complexity (2) affiliated healthcare system reporting to VISN 15.¹

**Table B.1. Profile for VA Eastern Kansas Health Care System (589A5)
(October 1, 2019, through September 30, 2022)**

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Total medical care budget	\$388,936,581	\$406,670,320	\$504,398,232
Number of:			
• Unique patients	37,535	38,929	39,111
• Outpatient visits	423,990	472,587	437,527
• Unique employees§	901	833	813
Type and number of operating beds:			
• Community Living Center	138	138	138
• Domiciliary	171	121	96
• Medicine	36	36	36
• Psychiatry	125	125	125
• Residential psychiatry	10	10	10
Average daily census:			
• Community Living Center	36	28	24
• Domiciliary	69	42	50
• Medicine	12	15	14
• Psychiatry	25	25	15

¹ VHA medical facilities are classified according to a complexity model; a designation of “2” indicates a facility with “medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs.” VHA Office of Productivity, Efficiency & Staffing (OPES), “VHA Facility Complexity Model Fact Sheet,” October 1, 2020. An affiliated healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Average daily census cont. <ul style="list-style-type: none"> • Residential psychiatry 	7	3	4

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

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

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

†October 1, 2020, through September 30, 2021.

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

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: March 25, 2024

From: Director, VA Heartland Network (10N15)

Subj: Comprehensive Healthcare Inspection of the VA Eastern Kansas Health Care System in Topeka

To: Director, Office of Healthcare Inspections (54CH01)

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

Attached is the facilities response to the Comprehensive Healthcare Inspection of the VA Eastern Kansas Health Care System in Topeka draft report.

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, FACHE
Network Director
VA Heartland Network (VISN 15)

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: March 20, 2024

From: Director, VA Eastern Kansas Health Care System (589A5)

Subj: Comprehensive Healthcare Inspection of the VA Eastern Kansas Health Care System in Topeka

To: Director, VA Heartland Network (10N15)

Thank you for the opportunity to review the draft CHIP report for the VA Eastern Kansas Healthcare System. I appreciate the Office of Inspector General's (OIG) extensive work done in collaboration with our staff.

I have reviewed the action plans and projected completion dates. I concur with the plans and have complete confidence that the plans will be effective.

(Original signed by:)

A. RUDY KLOPFER, FACHE
Executive Director/CEO
VA Eastern Kansas Health Care System

OIG Contact and Staff Acknowledgments

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