US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri

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Figure 1. *Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri.*
Source: https://www.va.gov/columbia-missouri-health-care/ (accessed August 16, 2023).

Abbreviations

ADPCS	Associate Director of Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
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 Harry S. Truman Memorial Veterans' Hospital, which includes multiple outpatient clinics in 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 Harry S. Truman Memorial Veterans' Hospital during the week of July 24, 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 hospital'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 seven recommendations to the Medical Center Director and Chief of Staff in the following areas of review: Medical Staff Privileging, Environment of Care, and Mental Health. The number of recommendations should not be used as a gauge for the overall quality of care provided at this hospital. 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 25.

VA Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 28–29, 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.

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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 Harry S. Truman Memorial Veterans' Hospital 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 hospital 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)

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[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 Harry S. Truman Memorial Veterans' Hospital includes multiple outpatient clinics in Missouri. General information about the hospital can be found in appendix B.

The inspection team conducted an on-site review the week of July 24, 2023.[5] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

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 hospital 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.

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[5] The OIG's last comprehensive healthcare inspection of the Harry S. Truman Memorial Veterans' Hospital occurred in November 2019. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in June 2022, and a hospital accreditation follow-up review in February 2023.

[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 hospital'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 hospital 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 hospital had a leadership team consisting of the Medical Center Director (Director), Chief of Staff, Associate Director of Patient Services (ADPCS), Associate Director, Assistant Director, and Executive of High Reliability. 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 Director had served for three months. The Chief of Staff, who had been in the role since 2010, was temporarily assigned as acting VISN 15 Chief Medical Officer, and a medical staff member was covering as the acting Chief of Staff. Additionally, the permanent Assistant Director, appointed in 2020, was serving as acting Associate Director, and

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[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.

other staff were covering the assistant director position in an acting capacity.[10] The ADPCS was assigned in 2019 and the Executive of High Reliability in 2020.

The Director explained that having staff serve in acting leadership positions provided them exposure and experience in the roles and supported promotion opportunities. The Director reported the hospital was a high-reliability organization whose stability came from executive leaders who shared responsibilities; additionally, most executive team members had started their careers at the hospital, which helped staff feel safe bringing forward issues.[11] The Chief of Staff stated executive leaders led high-reliability organization discussions intended to empower staff to help solve workplace issues. The leader further explained the discussions involved the executive team meeting with staff without managers present and asking questions about workplace satisfaction, after which the team debriefed managers and helped identify priority work items.

To help assess executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, ADPCS, acting Associate Director, acting Assistant Director, and Executive of High Reliability regarding their knowledge, involvement, and support of actions to improve or sustain performance.[12]

Budget and Operations

The OIG noted that the hospital's fiscal year (FY) 2022 annual medical care budget of $516,672,413 had increased by approximately 11 percent compared to the previous year's budget of $463,853,003.[13] The acting Associate Director stated the budget was adequate and some expenditures were for construction project contracts, which at the time of the OIG inspection were in the final stages of approval. The leader reported anticipating bringing on 45 new full-time equivalent employees by the end of FY 2023 and replacing a clinic to serve more patients. The ADPCS stated the hospital was an employer of choice in the community, adding that its affiliation with the University of Missouri ensured students had practicum (practical experience in the field) opportunities, and that the hospital employed about 95 percent of the university's nursing students, who completed practicums there, after graduation.

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[10] The Director told the OIG the Chief Financial Officer was covering the assistant director position, but during the week of the OIG review, the officer was on leave and the Executive Assistant to the Director was covering the role.

[11] "An HRO [high-reliability organization] is an organization that experiences fewer than anticipated accidents or events of harm despite operating in highly complex, high-risk environments where even small errors can lead to tragic results." "VHA's Vision for a High Reliability Organization," Department of Veterans Affairs, accessed March 16, 2022, https://www.hsrd.research.va.gov/publications/forum/summer20/default.cfm.

[12] During the OIG on-site review, the permanent Chief of Staff participated in interviews because the acting Chief of Staff was on leave.

[13] Veterans Health Administration (VHA) Support Service Center.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[14] 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.[15] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the hospital over time.

The survey results indicate that hospital staff agreed they could disclose suspected violations. The Director stated that all leaders were accessible for staff to communicate concerns. As a result of COVID-19-related staff burnout, the Executive of High Reliability said the hospital hired a Chief Well-Being Officer in FY 2021, tasked with creating a culture of caring. The Chief of Staff described engaging with National Center for Organization Development personnel, who presented on organizational trauma and psychological safety to managers in December 2022.[16] The leader added that the center had worked with staff whose survey results had declined, and the hospital continued consulting with center staff.

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
Harry S. Truman Memorial Veterans' Hospital	3.9	3.9	3.8

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

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

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[14] "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center.

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

[16] The National Center for Organization Development provides organizational health services to VA, such as individual and organizational assessments, organizational consultation and intervention and business management support. "National Center for Organization Development," Department of Veterans Affairs, accessed October 27, 2022.

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.[17] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the hospital from FYs 2020 through 2022. Table 2 provides survey results for VHA and the hospital over time.

Hospital inpatient scores indicate most patients would recommend the hospital to friends and family; notably, all scores significantly exceeded VHA averages. The Chief of Staff stated the hospital's shared decision-making, patient satisfaction data monitoring, and service recovery process in which executive leaders called patients to ensure their issues had satisfactory resolutions contributed to the scores.

As an example of the executive team's responsiveness to customer feedback, the Chief of Staff said that when patients complained about loud noise on the medical unit, leaders ensured placement of curtains and dividers to mitigate noise and instructed construction teams not to work during patient quiet times. The Chief of Staff also told the OIG that a few years ago, leaders had identified communication issues and subsequently changed how providers communicated with patients; for example, providers began identifying themselves as the patient's doctor when entering a patient room. Additionally, the Chief of Staff said the hospital implemented a Commit to Sit initiative in July 2023, placing chairs in all patient rooms so providers could sit while speaking to patients.[18]

Overall, the hospital's primary and specialty care scores suggest that most respondents were satisfied with the healthcare they received; however, satisfaction declined in FY 2021. The Chief of Staff attributed the decline to decreased access to care due to provider position vacancies but identified strong nursing leadership in primary care teams as a mitigating factor. The Chief of Staff also reported staffing shortages in neurology, anesthesiology, gastroenterology, psychology, and social work and said leaders used special salary rates and incentives, when possible, to recruit and retain employees. The Director described holding weekly meetings with patient advocates to discuss patient care issues.

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[17] "Patient Experiences Survey Results," VHA Support Service Center.

[18] The Commit to Sit initiative is based on research that indicates purposeful interactions between patients and providers can have a positive impact on a patient's healthcare experience. Irina Kleytman and Marianne Youssef, "Commit to Sit to Improve Patient Satisfaction," *Journal of Obstetric, Gynecologic & Neonatal Nursing* 50, no. 5 (August 15, 2021): S2, https://www.jognn.org/article/S0884-2175(21)00144-1/fulltext.

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Hospital	VHA	Hospital	VHA	Hospital
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	78.4	69.7	78.3	68.9	79.4
Patient-Centered Medical Home: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?†*	82.5	90.0	81.9	86.9	81.7	88.5
Specialty Care: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?†*	84.8	88.8	83.3	88.4	83.1	88.7

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 Hospital 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.[19] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[20] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

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[19] Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed January 20, 2023, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

[20] The Joint Commission, *Standards Manual*, E-dition, January 1, 2022. 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.[21]

"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)."[22] 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."[23] 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."[24] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[25]

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred during FY 2022 and reviewed the information staff provided. Leaders and staff were knowledgeable about safety event processes and responsibilities and able to discuss them in detail. For example, the Executive of High Reliability explained staff could report safety events and close calls through a reporting button on the hospital's internal website, an anonymous hotline, secure drop boxes placed throughout the hospital, and the Joint Patient Safety Reporting system, as well as by informing supervisors or other leaders verbally.[26]

The Chief of Staff stated the Risk Manager reviews all sentinel events to determine whether they meet VHA requirements for institutional disclosure before consulting with the Chief of Staff and the ADPCS (when nursing was involved). If the event meets disclosure criteria, the Chief of

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

[22] 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.

[23] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[24] VHA Directive 1004.08.

[25] 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.)

[26] VHA uses the Joint Patient Safety Reporting system for data management of patient safety events such as medical errors and close calls/near misses. "VHA National Center for Patient Safety Frequently Asked Questions," Department of Veterans Affairs, accessed January 11, 2024, https://www.patientsafety.va.gov/about/faqs.asp.

Staff said the Risk Manager calls the patient, family, or patient representative, and the Chief of Staff or designee complete the disclosure.

The Chief of Staff stated executive leaders are transparent with mistakes and use patient safety forums to highlight failures and ask staff for their ideas on ways to handle events differently for better outcomes. The Chief of Staff further explained that when adverse safety events occur, executive leaders work with front-line staff to investigate events to prevent reoccurrence. Every Friday, according to the Chief of Staff, the executive team reviews investigation actions that are due as well as closed actions to ensure that changes made to address prior issues are effective and results are sustained.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[27] 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.[28] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[29]

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.[30] 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.[31]

The OIG assessed the hospital's processes for conducting peer reviews of clinical care.[32] 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."[33] 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.[34]

The OIG team interviewed key managers and staff and reviewed relevant documents.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

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[27] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

[28] VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Prog*rams, July 19, 2022.

[29] VHA Directive 1100.16.

[30] VHA Handbook 1050.01; VHA Directive 1050.01(1).

[31] The Joint Commission, *Standards Manual*, E-dition, PI.03.01.01, PI.04.01.01, January 1, 2022.

[32] 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.

[33] VHA Directive 1190.

[34] 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."[35] 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."[36]

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.[37] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[38]

VHA states the Focused Professional Practice Evaluation (FPPE) is a defined period during which service chiefs assess LIPs' professional performance. The FPPE 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 (OPPE) to ensure the continuous delivery of quality care.[39]

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.[40] 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

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[35] 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.)

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] VHA Handbook 1100.19.

[40] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[41]

The OIG interviewed key managers and selected and reviewed the privileging folders of 30 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

VHA requires clinical service chiefs to regularly complete an OPPE for each LIP.[42] The OIG found service chiefs did not regularly complete OPPEs, and when they did complete them, the time frames between evaluations often ranged from approximately 11 months to just over two and a half years. This resulted in LIPs providing patient care without a timely evaluation of their competencies, which could adversely affect quality of care and patient safety. The Chief of Staff acknowledged being aware service chiefs were not completing OPPEs on time because they had multiple competing priorities during the pandemic and prioritized clinical care over administrative functions.

Recommendation 1

1. The Chief of Staff ensures service chiefs regularly complete Ongoing Professional Practice Evaluations for licensed independent practitioners.

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[41] 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.

[42] VHA Credentialing Directive 1100.21: Standard Operating Procedure–P2, *Frequency of OPPE*, April 19, 2021. (VHA replaced this standard operating procedure with VHA Credentialing Directive 1100.21: Standard Operating Procedure–P13, *Ongoing Professional Practice Evaluation (OPPE)*, January 16, 2024.) VHA Directive 1100.20.

Hospital concurred.

Target date for completion: September 30, 2024

Hospital response: The Chief of Staff reviewed the finding and recommendation with the Credentialing and Privileging Manager. Causes of the finding were associated with credentialing employees not disseminating Ongoing Professional Practice Evaluation forms timely to service chiefs and service chiefs not returning forms timely. The Credentialing and Privileging Manager has ensured credentialing staff are disseminating Ongoing Professional Practice Evaluation forms to service chiefs, two weeks before the Licensed Independent Practitioners' Ongoing Professional Practice Evaluation cycle is ending. The Chief of Staff has communicated to service chiefs the expectation of Ongoing Professional Practice Evaluations being returned to credentialing staff within twenty-one business days, as stated in Medical Center Policy 408, Ongoing Professional Practice Evaluation, dated July 1, 2023. Monthly monitoring of compliance will occur by the Chief of Quality Management with compliance rates being reported by the Credentialing and Privileging Manager to the Clinical Executive Board, quarterly. Compliance will be monitored until 90 percent compliance is maintained for six consecutive months with a target completion date of September 30, 2024. The measure denominator includes a random selection of five providers from each service per month. The data source is PRIVplus, the web-based software utilized by credentialing and privileging to track key aspects of privileging processes. The measure numerator includes the number of Licensed Independent Providers with no more than eight months between Ongoing Professional Practice Evaluation being fully complete if evaluations were due before January 16, 2024, and no more than twelve months if evaluations were due after January 16, 2024.

Furthermore, as part of the reprivileging process, VHA requires an executive committee of the medical staff to review professional practice evaluation data.[43] The OIG found the Clinical Executive Board documented reviewing professional practice evaluations even though some LIPs' profiles did not contain these evaluations. The Clinical Executive Board's failure to review evaluations, while documenting they did so, may undermine the integrity of the process and result in incomplete evidence to support the Director's decision to approve clinical privileges. The Credentialing and Privileging Manager reported copying from a template and pasting the language into the meeting minutes without updating the discussion of each LIP being reviewed. The Chief of Staff acknowledged approving the meeting minutes with documentation the committee reviewed OPPEs that were not in the LIPs' profiles.

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[43] VHA Handbook 1100.19; VHA Directive 1100.21(1). The Clinical Executive Board served as the hospital's executive committee of the medical staff.

Recommendation 2

2. The Chief of Staff ensures the Clinical Executive Board reviews professional practice evaluation data for licensed independent practitioners.

Hospital concurred.

Target date for completion: June 30, 2024

Hospital response: The Chief of Staff reviewed the finding and recommendation with the Credentialing and Privileging Manager. The cause of the finding was associated with Licensed Independent Provider Ongoing Professional Practice Evaluation cycles being listed in the Professional Standards Board agenda without all Ongoing Professional Practice Evaluation forms for each cycle being available to the Professional Standards Board. The Credentialing and Privileging Manager has ensured Licensed Independent Providers are not added to the Professional Standards Board agenda when all Ongoing Professional Practice Evaluation forms are not available for the Ongoing Professional Practice Evaluation cycles being reviewed. Monthly monitoring of compliance will occur by the Chief of Quality Management with compliance rates being reported by the Credentialing and Privileging Manager to the Clinical Executive Board, quarterly. Compliance will be monitored until 90 percent compliance is maintained for six consecutive months with a target completion date of June 30, 2024. The measure denominator includes the number of Ongoing Professional Practice Evaluation cycles associated with privilege renewals documented in the Clinical Executive Board minutes. The measure numerator includes the number of Ongoing Professional Practice Evaluation with data to support review.

VHA requires service chiefs to include service-specific criteria for the ongoing evaluations of LIPs' clinical practices.[44] The OIG found service chiefs did not consistently include service-specific criteria for OPPEs. When evaluations lack relevant criteria to support recommendations to continue privileges, it may negatively affect the delivery of quality patient care. The Chief of Specialty Care reported using an old form that did not include service-specific criteria, while waiting for the new VHA Office of Medical Staff Affairs forms to be implemented.

Recommendation 3

3. The Chief of Staff ensures service chiefs include service-specific criteria in the Ongoing Professional Practice Evaluations of licensed independent practitioners.

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[44] VHA Handbook 1100.19; VHA Directive 1100.21(1). For example, an LIP who works in neurology should also be evaluated based on criteria relevant to the care provided in that specialty.

Hospital concurred.

Target date for completion: June 30, 2024

Hospital response: The Chief of Staff reviewed the finding and recommendation with the Credentialing and Privileging Manager. The cause of the finding was the use of outdated forms that required updating to align with VHA requirements. The Credentialing and Privileging Manager has collaborated with service chiefs to ensure documents sent to service chiefs by credentialing staff are specific to the Licensed Independent Provider. This includes utilizing the facility's Ongoing Professional Practice Evaluation Registered Nurse Coordinator to provide guidance to credentialing and privileging employees regarding specific criteria for each service. Monthly monitoring of compliance will occur by the Chief of Quality Management with compliance rates being reported by the Credentialing and Privileging Manager to the Clinical Executive Board, quarterly. Compliance will be monitored until 90 percent compliance is maintained for six consecutive months with a target completion date of June 30, 2024. The measure denominator includes the number of Ongoing Professional Practice Evaluation cycles associated with privilege renewals documented in the Clinical Executive Board minutes. Ongoing Professional Practice Evaluation cycles with date ranges prior to May 1, 2022, will be excluded from the denominator as new forms were implemented in April 2022. The measure numerator includes the number of Ongoing Professional Practice Evaluation documents with service-specific criteria.

VHA requires the FPPE process "to be defined in advance, using objective criteria accepted by the LIP."[45] The OIG did not find evidence that LIPs routinely accepted the FPPE criteria in advance, which could cause them to misunderstand FPPE expectations during this initial period. The Chief of Specialty Care reported section chiefs had discussions with the new LIPs that included review of the FPPE criteria but did not document the conversations. The OIG did not make a recommendation, but without VHA requiring documentation that LIPs were informed of the criteria used to evaluate their performance, facility leaders cannot effectively monitor compliance.

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[45] VHA Handbook 1100.19; VHA Directive 1100.21(1).

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."[46] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[47]

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.[48]

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:

- Community Living Center
- Emergency Department
- Intensive Care Unit
- Medical/surgical inpatient unit (4 Med)
- Mental health inpatient unit (2B)
- Primary care clinic (Silver Clinic)

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[46] 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.)

[47] 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.

[48] 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.)

Environment of Care Findings and Recommendations

VHA requires staff to test over-the-door alarms per the manufacturer's recommendations for all sleeping room doors in mental health inpatient units.[49] The manufacturer's guidelines recommend staff test the alarms weekly and an outside maintenance provider tests them annually. The OIG found that staff had an outside maintenance provider test the alarms each quarter; however, the unit Nurse Manager acknowledged staff did not consistently test them weekly. If staff do not test over-the-door alarms per the manufacturer's recommendations, the alarms may fail to alert them when patients are in immediate danger. The Nurse Manager reported being aware of the manufacturer's recommendations for weekly testing but acknowledged taking responsibility for completing the task and not assigning a backup when needed.

Recommendation 4

4. The Medical Center Director ensures staff follow the manufacturer's recommendations for testing over-the-door alarms on mental health inpatient unit sleeping room doors.

Hospital concurred.

Target date for completion: June 30, 2024

Hospital response: The Associate Director of Patient Care Services and Associate Chief Nurse reviewed the findings with the Nurse Manager of the Mental Health Inpatient Unit. The cause associated with the finding was the Nurse Manager being the only individual conducting testing. The Nurse Manager developed and disseminated standard work to guide unit nurses in how to conduct weekly testing and included the task on the unit's shift checklist. Monthly monitoring of compliance will occur by the Chief of Quality Management with compliance rates being reported to the Nurse Executive Board quarterly by the Nurse Manager of the Mental Health Inpatient Unit. Compliance will be monitored until 100 percent compliance is maintained for six consecutive months with a target completion date of June 30, 2024. The measure denominator includes the number of alarms requiring testing each month. The measure numerator includes the number of alarms tested each month.

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[49] 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)," April 10, 2023.

The OIG noted the mental health inpatient unit offered two unique therapeutic spaces to improve patients' experiences during their stay.[50] The unit had a sensory room designed to help reduce stress and agitation that was accessible to patients and monitored by nurses. The sensory room had a soothing water feature, vibrating relaxation chair, and calming music. The Nurse Manager reported patients used it as a coping tool and that disruptive behaviors on the unit decreased after the sensory room was opened. The OIG also observed a computer room in the unit, which staff monitored when in use, that allowed patients to access the internet and stay connected while receiving inpatient care.

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[50] The therapeutic environment creates conditions that support mental health recovery. VHA Office of Nursing Services Mental Health Field Advisory Committee, *Psychiatric – Mental Health Nursing Orientation Guidebook*, accessed January 22, 2024, https://www.va.gov/docs/ONS_Psych_Mental_Health_Nursing_Orientation_Guide.pdf.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[51] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[52] The suicide rate for veterans was higher than for nonveteran adults during 2020.[53] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[54]

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.[55] 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.[56]

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.[57]

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.

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[51] VA Secretary memo, "Agency-Wide Required Suicide Prevention Training," October 15, 2020.

[52] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed January 20, 2023.

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

[54] Congressional Research Service, "Veteran Suicide Prevention," IF11886 version 2, July 29, 2021.

[55] 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.)

[56] 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.)

[57] 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

VHA requires designated staff to complete the Comprehensive Suicide Risk Evaluation when the suicide risk screen is positive. In ambulatory care settings, the screen and evaluation should occur on the same calendar day unless it is "not logistically feasible or clinically appropriate," such as in situations where urgent or emergent care is needed.[58] The OIG estimated staff did not complete the suicide risk evaluation for 26 (95% CI: 14 to 38) percent of patients who had a positive screen, which is statistically significantly above the OIG's 10 percent deficiency benchmark.[59] Failure to complete the evaluation poses a safety risk because patients with suicidal thoughts and behaviors might go unnoticed and untreated as a result. The Chief of Primary Care reported primary care providers may have perceived completing the evaluations as a behavioral health staff responsibility, which resulted in missed evaluations.

Recommendation 5

5. The Chief of Staff ensures designated staff complete the Comprehensive Suicide Risk Evaluation the same calendar day, when logistically feasible and clinically appropriate, for all ambulatory care patients with a positive suicide risk screen.

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[58] 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);" 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)."

[59] A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. The 95% confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence intervals 95 percent of the time.

Hospital concurred.

Target date for completion: December 31, 2024

Hospital response: The Chief of Staff reviewed the finding and recommendation with the Chief of Primary Care. The cause was determined to be inconsistencies in hand-off processes between Licensed Practical Nurses and Primary Care Providers when a patient screened positive on the Columbia-Suicide Severity Rating Scale. The Chief of Primary Care provided education and expectations regarding this process as part of the September 2023 Primary Care All Team meeting. The Suicide Prevention Team will ensure daily monitoring of suicide risk identification process fall-outs each business day along with distribution of the fall-outs to the Primary Care clinics. Additionally, the Suicide Prevention team will assist with completion of follow up with the Veteran in the event an appropriate member of the Patient Aligned Care Team is unable to complete the Comprehensive Suicide Risk Evaluation on the same calendar day. Monthly monitoring of compliance will occur by the Chief of Quality Management with compliance rates being reported to the Clinical Executive Board quarterly by the Chief of Primary Care. Compliance will be monitored until 90 percent compliance is maintained for two consecutive quarters with a target completion date of December 31, 2024. The measure denominator includes the number of positive Columbia-Suicide Severity Rating Scales per Columbia-Suicide Severity Rating Scales administered. Cases in which the CSRE is not logistically feasible or clinically appropriate to complete will be excluded. The measure numerator includes the number of same-day CSREs administered when it is logistically feasible or clinically appropriate to complete.

VHA requires suicide prevention coordinators to conduct a minimum of "five outreach activities per month."[60] The OIG found suicide prevention coordinators did not conduct the minimum monthly outreach activities for April, June, and July 2022. Insufficient community outreach activities may affect VHA collaboration within the local community and lead to missed opportunities for timely community intervention for patients in crisis. The Suicide Prevention Program Manager attributed the deficiencies to the lack of handoff when a prior suicide prevention coordinator with established ties to community partners left the organization, in addition to limited opportunities for outreach activities due to the rural location. The manager also reported that training provided to the community was part of outreach efforts; however, community partners preferred attending trainings that resulted in certificates for participants, which the facility did not provide.

Recommendation 6

6. The Chief of Staff ensures suicide prevention coordinators conduct, track, and report a minimum of five suicide prevention outreach activities each month.

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[60] VHA Directive 1160.07.

Hospital concurred.

Target date for completion: June 30, 2024

Hospital response: The Chief of Staff reviewed the finding and recommendation with the Chief of Behavioral Health and the Suicide Prevention Program Manager. It was determined the cause was related to the days of the week the suicide prevention team were most often available to complete the outreach events and due to unexpected cancellations of scheduled outreach events. The Suicide Prevention Program Manager began over-scheduling the number of events each month and pairing outreach events with established community activities. Monthly monitoring of compliance will occur by the Chief of Quality Management with compliance rates being reported by the Suicide Prevention Program Manager, to the Clinical Executive Board quarterly. Compliance will be monitored until 100 percent compliance is maintained for six consecutive months with a target completion date of June 30, 2024. There are two denominators associated with this recommendation. Denominator A represents the number of gatekeeper events required per month and denominator B represents the number of outreach events required per month. There are two numerators associated with this recommendation. Numerator A represents the number of completed gatekeeper events per month and numerator B represents the number of completed outreach events per month.

VHA requires clinical staff to notify the suicide prevention team when patients report suicidal behaviors during the Comprehensive Suicide Risk Evaluation.[61] The OIG found staff did not notify the suicide prevention team for the one patient who reported suicidal behaviors during the evaluation. When providers do not notify the suicide prevention team for patients reporting suicidal behaviors, it may delay further evaluation and mental health intervention. The Suicide Prevention Program Manager could not explain why suicide prevention team members were not notified. The manager also told the OIG that a suicide prevention consult process was created in March 2022 to remedy this deficiency; however, this one patient was evaluated in August 2022.

Recommendation 7

7. The Chief of Staff ensures clinical staff notify the suicide prevention team when patients report suicidal behaviors during the Comprehensive Suicide Risk Evaluation.

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[61] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Suicide Behavior and Overdose Reporting;" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Suicide Behavior and Overdose Reporting."

Hospital concurred.

Target date for completion: June 30, 2024

Hospital response: The Chief of Staff reviewed the finding with the Chief of Primary Care, and it was determined the cause was due to lack of Primary Care Provider awareness of the requirement. The Chief of Primary Care has communicated the requirement to Primary Care Providers along with information that the preferred method of communication is to enter a Suicide Behavior and Overdose Report note in the electronic health record, or the Suicide Risk Evaluation-Comprehensive note as the completion of these notes result in an automated notification to the hospital's Suicide Prevention Team and is viewable to the Suicide Prevention Team via the Suicide Behavior and Overdose Report Dashboard. The Suicide Prevention Team will ensure daily monitoring of completed Comprehensive Suicide Risk Evaluations by accessing data from the corporate data warehouse each business day. The data evaluated will include Suicide Risk Evaluation-Comprehensive notes completed by Primary Care Providers. Each note will be reviewed to detect missed communications to the Suicide Prevention Team. Monthly monitoring of compliance will occur by the Chief of Quality Management with compliance rates being reported by the Chief of Primary Care to the Clinical Executive Board quarterly. Compliance will be monitored until 90 percent compliance is maintained for six consecutive months with a target completion date of June 30, 2024. This will be conducted through 100% chart audit of all medical records where a patient has displayed suicidal behaviors within the last 12 months. The denominator includes the number of CSRE encounters in which a patient reports having suicidal behavior within the most recent twelve months. The numerator includes the number of patients where a notification was provided to the Suicide Prevention Team. Evidence that will be submitted to OIG includes Suicide Behavior and Overdose Reports and Clinical Executive Board minutes.

Report Conclusion

To assist leaders in evaluating the quality of care at their hospital, the OIG conducted a detailed inspection of five clinical and administrative areas and provided seven 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 hospital. 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 seven OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Medical Center Director and Chief of Staff. 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	• None
Quality, Safety, and Value	• None
Medical Staff Privileging	• Service chiefs regularly complete Ongoing Professional Practice Evaluations for licensed independent practitioners. • The Clinical Executive Board reviews professional practice evaluation data for licensed independent practitioners. • Service chiefs include service-specific criteria in the Ongoing Professional Practice Evaluations of licensed independent practitioners.
Environment of Care	• Staff follow the manufacturer's recommendations for testing over-the-door alarms on mental health inpatient unit sleeping room doors.
Mental Health: Suicide Prevention Initiatives	• Designated staff complete the Comprehensive Suicide Risk Evaluation the same calendar day, when logistically feasible and clinically appropriate, for all ambulatory care patients with a positive suicide risk screen. • Suicide prevention coordinators conduct, track, and report a minimum of five suicide prevention outreach activities each month. • Clinical staff notify the suicide prevention team when patients report suicidal behaviors during the Comprehensive Suicide Risk Evaluation.

Appendix B: Hospital Profile

The table below provides general background information for this mid-high complexity (1c) affiliated hospital reporting to VISN 15.[1]

Table B.1. Profile for Harry S. Truman Memorial Veterans' Hospital (589A4)
(October 1, 2019, through September 30, 2022)

Profile Element	Hospital Data FY 2020*	Hospital Data FY 2021[†]	Hospital Data FY 2022[‡]
Total medical care budget	$386,237,078	$463,853,003	$516,672,413
Number of:			
• Unique patients	40,559	41,325	42,105
• Outpatient visits	405,034	466,845	444,698
• Unique employees[§]	1,456	1,499	1,483
Type and number of operating beds:			
• Community living center	41	41	14
• Domiciliary	14	14	14
• Medicine	34	44	44
• Mental health	11	11	11
• Residential rehabilitation	8	8	8
• Surgery	26	26	26
Average daily census:			
• Community living center[‖]	31	24	20
• Domiciliary	13	12	11
• Medicine[#]	39	47	45
• Mental health	8	7	7

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[1] VHA medical facilities are classified according to a complexity model; a designation of "1c" indicates a facility with "medium-high volume, medium risk patients, some complex clinical programs, and medium sized 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	Hospital Data FY 2020*	Hospital Data FY 2021†	Hospital Data FY 2022‡
Average daily census, cont.			
• Residential rehabilitation	4	3	5
• Surgery	8	7	6

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).
‖For FY 2022, the community living center beds were temporarily relocated for expansion of the unit and its average daily census was higher than its number of operating beds.
#For FY 2022, the average daily census for medicine was higher than its number of operating beds. The Chief of Staff reported using beds classified as surgery for medicine patients when no medicine beds were available.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: March 15, 2024

From: Director, VA Heartland Network (10N15)

Subj: Comprehensive Healthcare Inspection of the Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri

To: Director, Office of Healthcare Inspections (54CH03)

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

Attached is the facilities response to the Comprehensive Healthcare Inspection of the VA OIG Draft Report: - CHIP Review of the Harry S. Truman Memorial Veterans' Hospital in Columbia, MO 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: Hospital Director Comments

Department of Veterans Affairs Memorandum

Date: March 14, 2024

From: Director, Harry S. Truman Memorial Veterans' Hospital (589A4)

Subj: Comprehensive Healthcare Inspection of the Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri

To: Director, VA Heartland Network (10N15)

1. Thank you for the opportunity to review and comment on the Office of Inspector General Comprehensive Healthcare Inspection of the Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri. I concur with the findings and recommendations in the report.

2. Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri remains committed to ensuring our Veterans receive exceptional health care.

(Original signed by:)

Chris Myhaver, MHA, FACHE
Medical Center Director

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