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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Kansas City VA Medical Center in Missouri

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Figure 1. *Kansas City VA Medical Center in Missouri.*
Source: https://www.va.gov/kansas-city-health-care/ (accessed January 31, 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 Kansas City VA Medical Center, which includes 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 Kansas City VA Medical Center during the week of June 5, 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 medical center'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 five recommendations to the Medical Center Director in the following areas of review: Leadership and Organizational Risks, 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 medical center. 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 22.

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 25–26, 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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Contents

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 Kansas City VA Medical Center 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 medical center 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 Kansas City VA Medical Center includes multiple outpatient clinics in Kansas and Missouri. General information about the medical center can be found in appendix B.

The inspection team conducted an on-site review during the week of June 5, 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 medical center leaders complete corrective actions. The Medical Center 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 Kansas City VA Medical Center occurred in November 2019. The Joint Commission performed hospital, behavioral health care, and home care accreditation reviews in December 2021.

[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 medical center'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 medical center 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 medical center had a leadership team consisting of the Medical Center Director (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 team had worked together for about two months. The Chief of Staff, hired in September 2014, was the most tenured member. The permanent Director, who was appointed in February 2022, had been temporarily assigned to another VA facility since April 2023. The acting Director and Assistant Director (currently serving as acting Associate Director) were already members of the executive team and had been in their roles since

[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.

April 2018 and September 2021, respectively. The acting Assistant Director was the permanent Chief Diversity and Inclusion Officer, and the ADPCS role was covered by the Deputy ADPCS.

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

Budget and Operations

The OIG noted that the medical center's fiscal year (FY) 2022 annual medical care budget of $2,101,275,474 had increased by about 16 percent compared to the previous year's budget of $1,811,014,912.[10] The leaders agreed that the budget was adequate, and staff salaries and infrastructure were the biggest expenses.

Leaders reported they had closed 15 medical/surgical inpatient beds due to registered nurse staffing shortages and had not reopened them. The acting Associate Director said intensive care and inpatient registered nurse pre- and post-COVID-19 pandemic recruiting challenges included uncompetitive VA salaries and large bonuses offered at community hospitals. The acting ADPCS reported that 14 registered nurses were in the onboarding process and, pending no additional nursing losses, leaders would open the inpatient beds at full capacity by September 2023. The acting ADPCS also said nursing leaders used recruitment and retention incentives, as well as reassigning nurses from other areas in the medical center and paying overtime, to maintain use of current inpatient beds.

Furthermore, the acting Director said lack of consistent leadership, employee shortages in sterile processing services, and relocation of sterilization activities to trailers in July 2021 led to under-processing of medical instruments and limited the number of surgical cases staff could perform. The acting Director added that 1,575 procedures had been canceled and rescheduled at the medical center or referred to community providers since September 2022.[11] The Chief of Staff said the medical center used a community care coordinator who helped patients transition their care to community providers and a surgery care coordinator who monitored patients until their procedures were completed.

The Chief of Staff and acting Associate Director stated hiring delays had negatively affected clinical operations. The acting Director said human resources specialists needed additional training and to improve timeliness and responsiveness to facility requests.

[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 is based on specific eligibility requirements, availability of VA care, and the needs and circumstances of individual Veterans." "Community Care," Department of Veterans Affairs, accessed January 5, 2023, https://www.va.gov/communitycare/.

The leaders also discussed strategies to support medical center employees, including creating a float pool for primary care providers who could fill in during vacancies and providers' absences and a cleaning contract for administrative areas that allowed facility housekeeping employees to focus on cleaning clinical areas.

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 medical center over time.

The medical center's scores were comparable to VHA averages over all three years. The executive leaders reported efforts to become a high-reliability organization, including engaging with staff during hospital walk-arounds and encouraging them to report safety events.[14]

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
Kansas City VA Medical Center	3.9	3.8	3.8

Source: VA All Employee Survey (accessed December 7, 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

[12] "AES Survey History, Understanding Workplace Experience 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.

[14] A high-reliability organization "is an organization with a goal of achieving 'zero harm' in an environment where accidents are expected due to complexity or risk factors." VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[15] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the medical center from FYs 2020 through 2022. Table 2 provides survey results for VHA and the medical center over time.

Patients' satisfaction with their inpatient experiences increased over all three years, whereas satisfaction with primary care decreased and specialty care fluctuated. The Chief of Staff reported believing the old building infrastructure, noise from construction projects, and staffing shortages decreased patient satisfaction. The acting Director reported hiring a veteran experience officer and adding patient champions to improve patient experiences. The acting Associate Director described additional efforts to improve scores, including leaders enhancing the look of the medical center and using veterans signals survey trust scores to identify areas for staff to improve patient interactions.[16] Further, the acting Associate Director said the medical center had its own construction team, which allowed them to complete projects quicker and at lower costs.

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Medical Center	VHA	Medical Center	VHA	Medical Center
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	65.4	69.7	66.6	68.9	66.9
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	85.0	81.9	81.1	81.7	78.4
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	81.9	83.3	84.9	83.1	82.5

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.*

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

[16] Veterans signals is a patient survey used to "identify customer needs and increase service recovery opportunities." "Improving Customer Experiences, Veterans Experience Office FY 2021," Department of Veterans Affairs, accessed June 21, 2023, https://department.va.gov/veterans-experience/.

Identified Factors Related to Possible Lapses in Care and Medical Center 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.[17] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[18] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[19]

"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)."[20] 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."[21] 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."[22] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[23]

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[17] 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/.

[18] The Joint Commission, *Standards Manual*, E-dition, July 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.

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

[20] 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.

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

[22] VHA Directive 1004.08.

[23] 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.)

The OIG requested a list of sentinel events, institutional disclosures, and large-scale disclosures that occurred during FY 2022 and reviewed the information staff provided. Medical center leaders stated patient safety managers and quality management staff provide them a daily report of events employees entered in the Joint Patient Safety Reporting system, and they discuss the events to determine whether they meet The Joint Commission's sentinel event definition.[24] The Chief of Staff said leaders also provide guidance to quality management staff on the next steps to take, such as conducting a root cause analysis, clinical disclosure, or institutional disclosure.[25]

For disclosures, the leaders agreed the Chief of Staff was responsible for the process, but other executive team members and the Risk Manager participate in discussions. The Chief of Staff reported conducting and documenting all institutional disclosures, adding that when absent, the acting Chief of Staff had the responsibility.

Leadership and Organizational Risks Findings and Recommendations

VHA requires leaders to conduct an institutional disclosure when an adverse event causes or may cause the patient's death or serious injury.[26] The Chief Nurse, Patient Safety and Infection Prevention reported that nine sentinel events occurred during FY 2022 and two resulted in patient deaths; one from a delay in care and the other due to an infection following a procedure. The OIG found leaders did not conduct an institutional disclosure for either event. When leaders fail to conduct institutional disclosures, it erodes the trust of patients, patient's representatives, and the public. The Chief Nurse, Patient Safety and Infection Prevention reported that quality management leaders and staff previously lacked knowledge about institutional disclosures, adding they created a sentinel event process document in May 2023, after the events.

Recommendation 1

1. The Medical Center Director ensures leaders conduct institutional disclosures for all applicable sentinel events.

[24] VHA uses the Joint Patient Safety Report 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 December 21, 2022, https://www.patientsafety.va.gov/about/faqs.asp.

[25] A root cause analysis "is a specific type of focused review that is used for all adverse events or close calls requiring analysis." VHA Handbook 1050.01. "Clinical disclosure of adverse events is a process by which the patient's clinician informs the patient or the patient's personal representative, as part of routine clinical care, that a harmful or potentially harmful adverse event has occurred during the patient's care." VHA Directive 1004.08.

[26] VHA Directive 1004.08.

Medical center concurred.

Target date for completion: August 31, 2024

Medical center response: The Medical Center Director reviewed the recommendation and did not identify additional reasons for noncompliance. In order to strengthen internal processes related to conducting institutional disclosures for all applicable sentinel events, a team of stakeholders from the Executive Leadership Team (e.g., Chief of Staff, Associate Director of Patient Care Services, Executive High Reliability) and the Office of High Reliability (e.g., Chief of Quality, the Risk Manager, and Chief Nurse of Patient Safety and Infection Prevention) meet on an ad hoc basis to review all processes and decisions related to identifying and reviewing sentinel events as well as conducting institutional disclosures, as required. This process was implemented effective August 1, 2023.

Development of the Standard of Work documents for Sentinel Event investigations and Institutional Disclosures began in Fiscal Year 2023, Quarter 1 and were finalized on June 21, 2023, and February 13, 2024, respectively.

The Risk Manager is responsible for monitoring compliance and reporting results on the number of Institutional Disclosures conducted each month. Compliance will be monitored and reported monthly to the Quality and Patient Safety Council. The Chief of Staff, Executive High Reliability as well as the Medical Center Director are members of the Quality and Patient Safety Council.

The numerator will be the total number of Institutional Disclosures conducted each month. The denominator will be the total number of sentinel events that meet the criteria for an Institutional Disclosure to be conducted.

During the six-month period from August 1, 2023, through January 31, 2024, a total of 14 adverse events were identified from the Joint Patient Safety Reporting tool, an electronic database utilized by staff to report patient safety events including close calls/near misses, as well as other patient safety concerns.

Based on review of the adverse events, five cases were identified that required an institutional disclosure. An Institutional Disclosure was conducted on three of the five cases as required. The Risk Manager was unable to contact the patient/family in the other two cases. Therefore, communication was sent via certified mail to the families.

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 medical center'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 evaluated peer reviews and patient safety reports. The team also reviewed nine deaths that occurred within 24 hours of inpatient admission during FY 2022.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

[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 Programs*, 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 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.[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

[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

The OIG made no recommendations.

[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.

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."[42] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[43]

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.[44]

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

- Emergency Department
- Inpatient Mental Health Unit (10 West)
- Medical/Surgical Inpatient Unit (8 East)
- Primary Care Clinic (Linwood)
- Surgical Intensive Care Unit
- Women's Health Primary Care Clinic

Environment of Care Findings and Recommendations

VHA requires staff to conduct environment of care inspections "a minimum of once per fiscal year in non-patient care areas, and twice per fiscal year in all areas where patient care is

[42] 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.)

[43] 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.

[44] 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.)

delivered."[45] The OIG reviewed FY 2022 environment of care inspection reports and found staff did not inspect 6 of 80 patient care areas and 1 of 43 non-patient care areas as required.[46] Failure to inspect these areas could result in a lack of proactive identification of unsafe conditions. The Safety Manager attributed the failure to complete all required inspections to safety office staffing shortages in FY 2022, adding that leaders had since resolved the shortage.

Recommendation 2

2. The Medical Center Director ensures staff complete environment of care inspections in patient and non-patient care areas at the required frequency.

[45] VHA Directive 1608.

[46] The OIG found staff did not inspect the following patient care areas twice in FY 2022: magnetic resonance imaging area, Mental Health Clinic, Operation Enduring Freedom/Operation Iraqi Freedom Program space, Silver Clinic, Transition Recovery Building, and Vet Center. The OIG also found staff did not inspect Building 1, first floor, a non-patient care area, during FY 2022.

Medical center concurred.

Target date for completion: August 31, 2024

Medical center response: The Medical Center Director reviewed the recommendation and did not identify additional reasons for noncompliance. The inspection schedule for the comprehensive environment of care rounds was developed by several different staff in FY 2022 related to staffing shortage in Safety. Safety staff are responsible for creating the comprehensive environment of care rounds inspection list; entering data in the electronic tool and database system utilized to identify deficiencies, trends, and actions taken for environment of care rounds compliance; as well as reporting comprehensive environment of care round updates to the Environment of Care Committee monthly.

The Safety Manager is responsible for monitoring compliance and reporting results of the comprehensive environment of care rounds to the Environment of Care Committee. In Fiscal Year 2023, Quarter 1, the staffing shortage in Safety were resolved. Primary and secondary Safety staff were designated to create the comprehensive environment of care inspection schedule each month. These changes will help ensure compliance related to the comprehensive environment of care rounds is reached and sustained.

The numerator is the actual number of areas (patient care areas and non-patient care areas) that will be inspected each month. The denominator is the total number of areas (patient care areas and non-patient care areas) scheduled to be inspected each month.

Monthly audits began in September 2023. Audits will continue until a compliance rate of 100 percent is achieved and then sustained for six consecutive months. Monitoring data will be reported monthly to the Environment of Care Committee meeting, which is chaired by the Assistant Director, a member of the Executive Leadership Team.

VHA requires staff to perform systematic environmental assessments using the Mental Health Environment of Care Checklist to identify and address environmental risks for patients under treatment.[47] The checklist criteria states that all electrical receptacles in the Inpatient Mental Health Unit must be covered by metal plates.[48] The OIG found that none of the electrical receptacles in the Inpatient Mental Health Unit common area had metal plate covers.[49] When an outlet does not have a metal plate cover, a patient could break the plastic cover and use its sharp edges for self-harm or to harm others. The Chief, Facilities Management Service attributed the common area's electrical receptacle materials to the construction design, which did not follow

[47] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017.

[48] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," April 10, 2023.

[49] The Inpatient Mental Health Unit common area consisted of day and group rooms and dining and television areas.

the checklist, adding that staff had entered a work order during the site visit to replace the coverings with metal plates.

Recommendation 3

3. The Medical Center Director ensures staff cover electrical receptacles in the Inpatient Mental Health Unit common area with metal plates.

Medical center concurred.

Target date for completion: August 31, 2024

Medical center response: The Medical Center Director reviewed the recommendation and did not identify additional reasons for noncompliance. The Chief of Facilities was responsible for ensuring that stainless-steel plates were installed on all electrical receptacles in the Inpatient Mental Health unit common area as required. A total of 126 electrical receptacles were identified that needed stainless-steel covers. Installation of the 126 stainless-steel plates began in June 2023 and was completed on August 2, 2023, by Facilities staff.

Beginning in March 2024, ongoing sustainment of compliance will be monitored via required rounding such as monthly unit rounding conducted by Inpatient Mental Health Nurse Manager, the Mental Health Environment of Care Checklist rounds, as well as the regular comprehensive environment of care rounds to this area. Mental Health Environment of Care Checklist rounds and regular comprehensive environment of care rounds are conducted twice yearly.

Chief of Mental Health will communicate with Chief of Facilities on electrical receptacle plates that need to be replaced each month. The Chief of Facilities is responsible for tracking, monitoring compliance, and reporting monthly compliance results of the electrical receptacles needing replaced by stainless-steel covers each month to the Environment of Care Committee. These actions will help ensure compliance related to installation of stainless-steel electrical plates is reached and sustained.

The numerator is the number of electrical receptables covers that are replaced with stainless steel metal plates each month. The denominator is the total number of electrical receptacles covers that need to be replaced with stainless steel metal plates each month.

Monthly audits will continue until a compliance rate of 100 percent is achieved and then sustained for six consecutive months. Monitoring data will be reported monthly to the Environment of Care Committee, which is chaired by the Assistant Director, a member of the Executive Leadership Team.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[50] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[51] The suicide rate for veterans was higher than for nonveteran adults during 2020.[52] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[53]

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.[54] 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.[55]

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.[56]

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

[51] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed February 15, 2023.

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

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

[54] 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.)

[55] 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.)

[56] 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 providers to complete the Comprehensive Suicide Risk Evaluation following a patient's positive suicide risk screen.[57] The OIG estimated that providers did not complete the evaluation after a positive screen for 26 (95% CI: 14 to 38) percent of patients, which is statistically significantly above the OIG's 10 percent deficiency benchmark.[58] When providers fail to evaluate patients for suicide risk, they may miss opportunities to ensure patient safety and coordinate next steps in care. The Chief Nurse, Primary Care said some providers may need additional training on the evaluation process.

Recommendation 4

4. The Medical Center Director ensures providers complete the Comprehensive Suicide Risk Evaluation following a patient's positive suicide risk screen.

[57] 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 Deputy Under Secretary for Health Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)."

[58] 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.

Medical center concurred.

Target date for completion: August 31, 2024

Medical center response: The Medical Center Director reviewed the recommendation and did not identify additional reasons for noncompliance. In May 2022, a feature was added to the patient's electronic health record to alert clinical staff when a patient has a positive suicide screen. Primary Care and Mental Health leadership, and the Suicide Prevention Coordinator met in June 2023, to discuss the non-compliance identified from the site visit. As a result of this meeting, a tool was created to enhance compliance related to completion of the Comprehensive Suicide Risk Evaluation note when the Columbia-Suicide Severity Rating Scale is positive. This tool was disseminated to Primary Care providers during a staff meeting that was held on July 6, 2023.

The Suicide Prevention Coordinator will audit daily all outpatient areas for compliance related to the timely completion and documentation of suicide prevention screening tools.

Beginning in March 2024, the Suicide Prevention Coordinator will conduct monthly chart audits on all patients with a positive Columbia-Suicide Severity Rating Scales (suicide screen) in the outpatient areas until a compliance rate of 100 percent is achieved for six consecutive months. In order to ensure compliance is met and sustained, the Suicide Prevention Coordinator will report monitoring data monthly to the Quality and Patient Safety Council, which includes the Medical Center Director and the Chief of Staff.

The numerator will be the number of records reviewed each month where providers completed Comprehensive Suicide Risk Evaluation following a patient's positive suicide screen and the denominator will be the total number of patients with a positive suicide screen each month.

VHA requires clinical staff to notify the suicide prevention team when a patient reports suicidal behaviors (suicide attempts or preparatory behavior) during the Comprehensive Suicide Risk Evaluation.[59] The OIG found that staff did not notify the suicide prevention team of five of the seven patients who reported suicidal behaviors during the evaluations. Failure to notify the suicide prevention team may delay provision of appropriate services to patients and increase their risk of self-harm. The Suicide Prevention Lead and Chief Nurse, Primary Care reported providers may not be aware of the requirement.

[59] 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."

Recommendation 5

5. The Medical Center Director ensures clinical staff notify the suicide prevention team when patients report suicidal behaviors during Comprehensive Suicide Risk Evaluations.

Medical center concurred.

Target date for completion: August 31, 2024

Medical center response: The Medical Center Director reviewed the recommendation and did not identify additional reasons for noncompliance. In June 2023, Primary Care leadership, Mental Health leadership, and the Suicide Prevention Coordinator met to discuss the non-compliance identified from the site visit. On July 6, 2023, during a Primary Care staff meeting, providers and staff were re-educated by the Chief of Primary Care and the Suicide Prevention Coordinator on the requirements and expectations for notifying the Suicide Prevention Team when patients report suicide behaviors during the Comprehensive Suicide Risk Evaluation.

Since July 2023, the Suicide Prevention Coordinator has been collaborating with the Chief of Staff, clinical Service Chiefs, and the Executive Leadership Team, as appropriate, to ensure internal processes related to the requirements to notify the Suicide Prevention Team when suicide behavior is identified during the Comprehensive Suicide Risk Evaluation. This will help ensure suicide prevention efforts for all patients are strengthened.

Beginning in March 2024, the Suicide Prevention Coordinator will conduct chart audits on all patients that reported suicidal behaviors during an outpatient Comprehensive Suicide Evaluation to ensure the Suicide Prevention Team was notified each month until 100 percent compliance is achieved and sustained for six consecutive months. The Suicide Prevention Coordinator will report monitoring data monthly to the Quality and Patient Safety Council, which includes the Medical Center Director and the Chief of Staff.

The numerator is the number of instances outpatient clinical staff notify the Suicide Prevention Team when a patient reports suicidal behaviors during an outpatient Comprehensive Suicide Evaluation each month. The denominator will be the total number of patients who reported suicidal behavior during an outpatient Comprehensive Suicide Risk Evaluation each month.

Report Conclusion

To assist leaders in evaluating the quality of care at their medical center, the OIG conducted a detailed inspection of five clinical and administrative areas and provided five 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 medical center. 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 five OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Medical Center 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	• Leaders conduct institutional disclosures for all applicable sentinel events.
Quality, Safety, and Value	• None
Medical Staff Privileging	• None
Environment of Care	• Staff complete environment of care inspections in patient and non-patient care areas at the required frequency. • Staff cover electrical receptacles in the Inpatient Mental Health Unit common area with metal plates.
Mental Health: Suicide Prevention Initiatives	• Providers complete the Comprehensive Suicide Risk Evaluation following a patient's positive suicide risk screen. • Clinical staff notify the suicide prevention team when patients report suicidal behaviors during Comprehensive Suicide Risk Evaluations.

Appendix B: Medical Center Profile

The table below provides general background information for this high complexity (1b) affiliated medical center reporting to VISN 15.[1]

Table B.1. Profile for Kansas City VA Medical Center (589)
(October 1, 2019, through September 30, 2022)

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Total medical care budget	$1,694,580,241	$1,811,014,912	$2,101,275,474
Number of:			
• Unique patients	49,135	57,184	55,802
• Outpatient visits	578,059	666,482	648,470
• Unique employees§	6,227	6,284	6,182
Type and number of operating beds:			
• Domiciliary	28	28	28
• Medicine	79	79	79
• Mental health	10	10	10
• Residential rehabilitation	20	20	20
• Surgery	25	25	25
Average daily census:			
• Domiciliary	14	14	18
• Medicine	51	58	58
• Mental health	10	9	10
• Residential rehabilitation	11	4	5

[1] VHA medical facilities are classified according to a complexity model; a designation of "1b" indicates a facility with "medium-high-volume, high-risk patients, many complex clinical programs, and medium-large research and teaching programs." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated medical center is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Average daily census, cont.:			
• Surgery	8	8	8

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 14, 2024

From: Director, VA Heartland Network (10N15)

Subj: Comprehensive Healthcare Inspection of the Kansas City VA Medical Center in Missouri

To: Director, Office of Healthcare Inspections (54CH06)

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

Attached is the facilities response to the Comprehensive Healthcare Inspection of the Kansas City VA Medical Center in Missouri.

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: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: March 14, 2024

From: Director, VA Medical Center, Kansas City (589/00)

Subj: Comprehensive Healthcare Inspection of the Kansas City VA Medical Center in Missouri

To: Director, VA Heartland Network (10N15)

I have reviewed the findings within the report of the Comprehensive Healthcare Inspection of the Kansas City VA Health Care System. I am in agreement with the findings of the review.

Corrective action plans have been established with planned completion dates outlined in this report.

(Original signed by:)

Paul Hopkins, MBA
Medical Center Director

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