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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Kansas City VA Medical Center Missouri

CHIP REPORT | REPORT #18-06504-27 | DECEMBER 12, 2019

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Figure 1. *Kansas City VA Medical Center, MO (Source: https://vaww.va.gov/directory/guide/, accessed on August 26, 2019)*

Abbreviations

ADPCS	associate director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
FPPE	focused professional practice evaluation
FY	fiscal year
LIP	licensed independent practitioner
MST	military sexual trauma
OIG	Office of Inspector General
OSHA	Occupational Safety and Health Administration
OPPE	ongoing professional practice evaluation
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UCC	urgent care center
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Kansas City VA Medical Center (the facility). The inspection covers key clinical and administrative processes that are associated with promoting quality care.

CHIP inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The inspections are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus each year.

The OIG team looks at leadership and organizational risks as well as areas affecting quality patient care. At the time of the inspection, the clinical areas of focus were

1. Quality, safety, and value;
2. Medical staff privileging;
3. Environment of care;
4. Medication management (specifically the controlled substances inspection program);
5. Mental health (focusing on military sexual trauma follow-up and staff training);
6. Geriatric care (spotlighting antidepressant use for elderly veterans);
7. Women's health (particularly abnormal cervical pathology result notification and follow-up); and
8. High-risk processes (specifically the emergency department and urgent care center operations and management).

This unannounced visit was conducted during the week of April 29, 2019. The OIG held interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a broad spectrum of clinical and administrative 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 this facility's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this facility and other Veterans Health Administration (VHA) facilities to identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Inspection Impact

Leadership and Organizational Risks

At the time of the OIG's visit, the facility leadership team consisted of the director, chief of staff, associate director for Patient Care Services (ADPCS), associate director (primarily nonclinical), and assistant director (primarily nonclinical). Organizational communications and accountability were managed through a committee reporting structure, with the Director's Advisory Board having oversight for several working groups. The director chaired the Quality, Safety, and Values Council, which was responsible for tracking, identifying trends in, and monitoring quality of care and patient outcomes.

The facility's leadership team had been working together for 13 months, although several had served in their position for years. The director, chief of staff, ADPCS, and assistant director were permanently assigned March 8, 2015, September 21, 2014, April 16, 2017, and September 18, 2016 respectively. The associate director, the newest member of the leadership team, was assigned April 1, 2018.

The OIG noted that selected employee satisfaction survey results indicated that facility leaders appeared generally engaged and promoted a culture of safety where employees feel safe bringing forward issues and concerns. However, opportunities exist for the ADPCS to improve employee engagement and satisfaction. In two of the four selected patient experience questions, the survey scores for facility leaders were better than the VHA average, and facility leaders had implemented processes and plans to improve patient experiences.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[1] disclosures of adverse patient events, and patient safety indicator data and did not identify any substantial organizational risk factors.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within VHA.[2] Although the leadership team members were knowledgeable within their areas of responsibility about selected SAIL

[1] The definition of sentinel event can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life."

[2] VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a "star rating" system to designate a facility's performance in individual measures, domains, and overall quality. http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 6, 2019, but is not accessible by the public.)

metrics, the leaders should continue to take actions to improve performance of the quality of care metrics and measures likely contributing to the facility's SAIL "2-star" quality rating.[3]

The OIG noted deficiencies in seven of the eight clinical areas reviewed and issued 14 recommendations that are attributable to the facility director, chief of staff, and associate director. These are briefly described below.

Quality, Safety, and Value

The OIG team found there was general compliance with requirements for resuscitation episode review. However, the team identified concerns with the peer review of all applicable deaths within 24 hours of admission to the hospital, peer review of all completed suicides within seven days after discharge from an inpatient mental health unit, and interdisciplinary review of utilization management data.

Environment of Care

The facility complied with many of the performance indicators evaluated. The OIG did not note any issues with the availability of medical equipment and supplies. However, the team identified noncompliance at the parent facility with general safety, infection prevention, nursing station security in the locked inpatient mental health unit, and emergency management processes.

Medication Management

Overall, the OIG team found compliance with requirements for most of the performance indicators evaluated for medication management, including the controlled substances coordinator reports, pharmacy operations and inspections, requirements for controlled substances inspectors, and review of override reports. However, the OIG noted noncompliance with controlled substances area inspections of automated dispensing cabinets.

Mental Health

The OIG team also found general compliance with many of the mental health performance indicators, including the designation of a military sexual trauma (MST) coordinator, tracking of MST-related data, and provision of clinical care. However, the OIG noted a concern with providers completing mandatory MST training.

Geriatric Care

For geriatric patients, the OIG team found general compliance with clinicians documenting reasons for prescribing medications and assessing patient and/or caregiver understanding when

[3] Based on fiscal year 2018, quarter 3 ratings at the time of the site visit.

education was provided. However, the OIG found inadequate patient and/or caregiver education specific to newly prescribed medications and medication reconciliation to minimize duplicative medications and adverse interactions.

Women's Health

The OIG also noted compliance with many of the performance indicators, including requirements for a designated women veterans program manager, clinical oversight of the women's health program, tracking of cervical cancer screening data, communication of abnormal results to patients within the required time frame, and provision of follow-up care when indicated. However, the OIG identified concerns with the Women Veterans Health Committee's core membership and reporting to executive leadership.

High-Risk Processes

The OIG inspection team found general compliance with many of the performance indicators for the operations and management of the emergency department. However, the OIG team identified noncompliance with backup call schedule for emergency department providers.

Summary

In reviewing key healthcare processes, the OIG issued 14 recommendations for improvement directed to the facility director, chief of staff, and associate director. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this facility. The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network director and facility director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 72–73, and the responses within the body of the report for the full text of the directors' comments.) The OIG considers recommendations 7 and 14 closed. 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 provide oversight of healthcare services to veterans. This focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Kansas City VA Medical Center (the facility) is accomplished by examining a broad overview of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and facility leaders so that informed decisions can be made on improving care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a culture to sustain positive change.[4] Investments in a culture of safety and quality improvement with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations.[5] Figure 2 shows the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

To examine risks to patients and the organization when core processes are not performed well, the OIG focused on the following nine areas of clinical and administrative operations that support quality care at the facility:

1. Leadership and organizational risks
2. Quality, safety, and value (QSV)
3. Medical staff privileging
4. Environment of care
5. Medication management (specifically the controlled substances inspection program)
6. Mental health (focusing on military sexual trauma follow-up and staff training)
7. Geriatric care (spotlighting antidepressant use for elderly veterans)
8. Women's health (particularly abnormal cervical pathology results notification and follow-up)

[4] Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/. (The website was accessed on January 24, 2019.)

[5] Institute for Healthcare Improvement, "How risk management and patient safety intersect: Strategies to help make it happen," March 24, 2015. http://www.npsf.org/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen. (The website was accessed on January 24, 2019.)

9. High-risk processes (specifically the emergency department and urgent care center operations and management).[6]

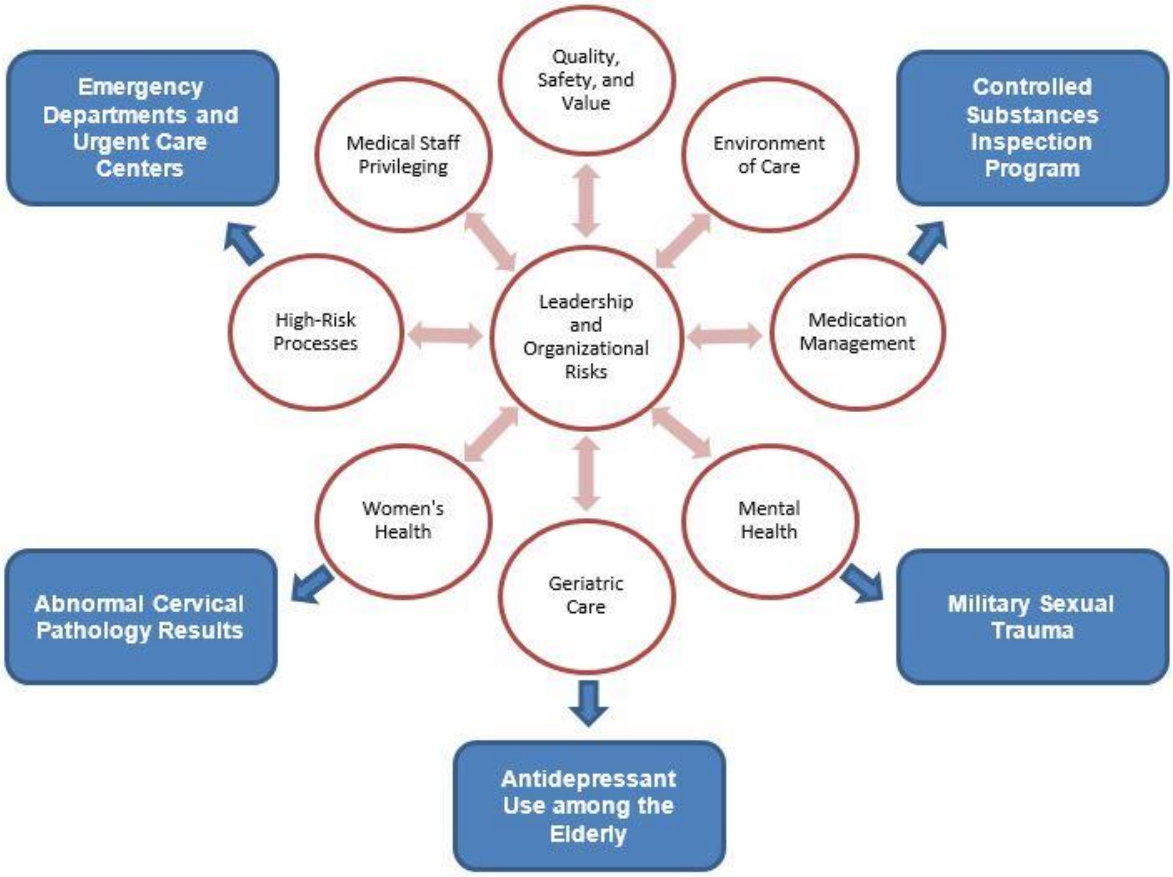

Figure 2. *Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

[6] See Figure 2. CHIP inspections address these processes during FY 2019 (October 1, 2018, through September 30, 2019); they may differ from prior years' focus areas.

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports;[7] physically inspected OIG-selected areas; and discussed processes and validated findings with managers and employees. The OIG also interviewed members of the executive leadership team.

The inspection period examined operations from February 6, 2016, through May 3, 2019, the last day of the unannounced week-long site visit.[8] While on site, the OIG referred issues and concerns beyond the scope of the CHIP inspection to our Hotline management team for further evaluation.

This report's recommendations for improvement target problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the facility completes corrective actions. The facility director's comments submitted in response to the report recommendations appear within each topic area.

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

[7] The OIG did not review VHA's internal survey results, instead focusing on OIG inspections and external surveys that affect facility accreditation status.

[8] The range represents the time period from the last Combined Assessment Program review, which was performed prior to the comprehensive healthcare inspection, to the completion of the unannounced week-long CHIP site visit.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare facility. Leadership and organizational risks can impact the facility's ability to provide care in all of the selected clinical areas of focus.[9] To assess the facility's risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Employee satisfaction
3. Patient experience
4. Accreditation and/or for-cause surveys and oversight inspections
5. Factors related to possible lapses in care
6. VHA performance data

Executive Leadership Position Stability and Engagement

Because each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities. Figure 3 illustrates this facility's reported organizational structure. The facility has a leadership team consisting of the director, chief of staff, associate director for Patient Care Services (ADPCS), associate director (primarily nonclinical), and assistant director (primarily nonclinical). The chief of staff and ADPCS oversee patient care, which requires managing service directors and chiefs of programs and practices.

[9] L. Botwinick, M. Bisognano, and C. Haraden, "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006. www.IHI.org. (The website was accessed on February 2, 2017.)

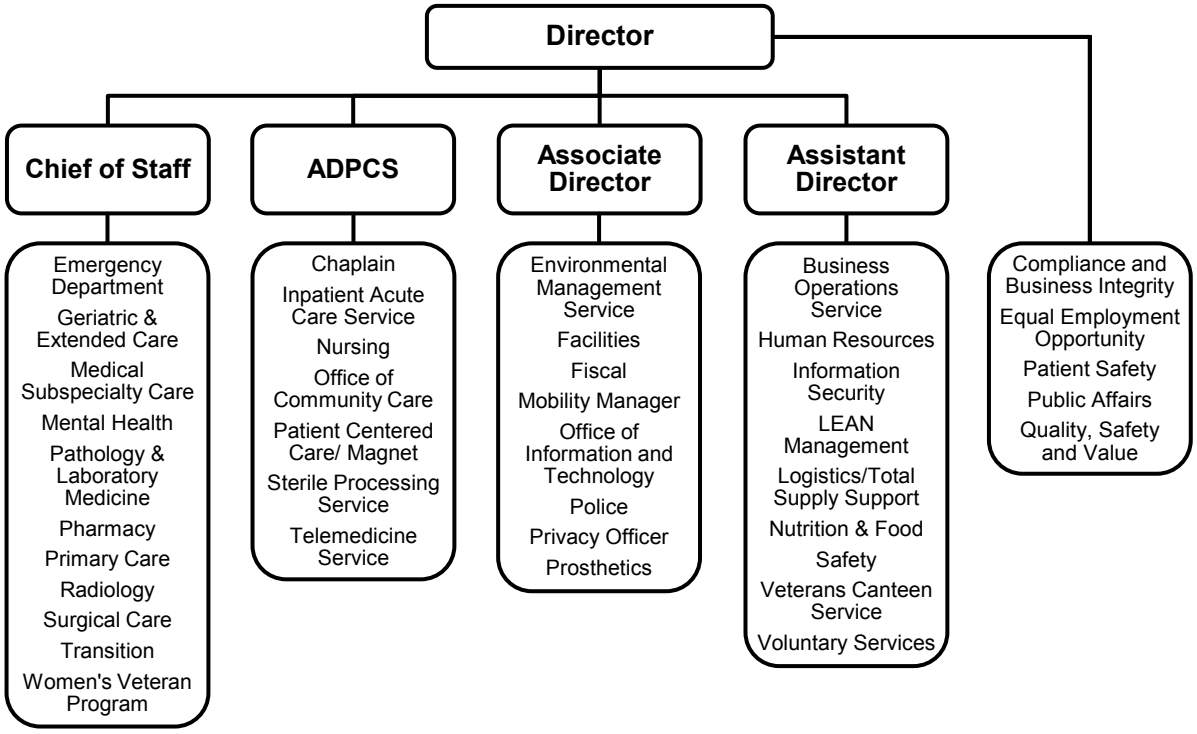

Figure 3. *Facility Organizational Chart*[10]
Source: Kansas City VA Medical Center (received April 29, 2019)

At the time of the OIG site visit, the executive team had been working together for 13 months, although several team members have been in their position for many years (see Table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	March 8, 2015
Chief of staff	September 21, 2014
Associate director for Patient Care Services	April 16, 2017
Associate director	April 1, 2018
Assistant director	September 18, 2016

Source: Kansas City VA Medical Center human resources specialist (received April 29, 2019)

To help assess facility executive leaders' engagement, the OIG interviewed the director, chief of staff, ADPCS, associate director, and assistant director regarding their knowledge of various

[10] At this facility, the director is responsible for Compliance and Business Integrity; Equal Employment Opportunity; Patient Safety; Public Affairs; and Quality, Safety and Value.

performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leadership team members generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, as well as employee and patient survey results. In addition, the executive leaders were generally knowledgeable within their scope of responsibilities about selected Strategic Analytics for Improvement and Learning (SAIL) metrics. These are discussed in greater detail below.

At the facility, the Director's Advisory Board serves as the Executive Committee of the Governing Body. The policy did not designate the director as the chair; however, during interviews, members of the executive team articulated that the director serves in this capacity, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The board oversees various working groups, such as the Compliance Committee, Executive Strategic Planning Committee, Integrated Ethics, and Quality, Safety, and Values.

These leaders are also engaged in monitoring patient safety and care through the Quality, Safety, and Values Committee, which the director chairs. The Quality, Safety, and Values Committee is responsible for tracking and identifying trends and monitoring quality of care and patient outcomes. See Figure 4.

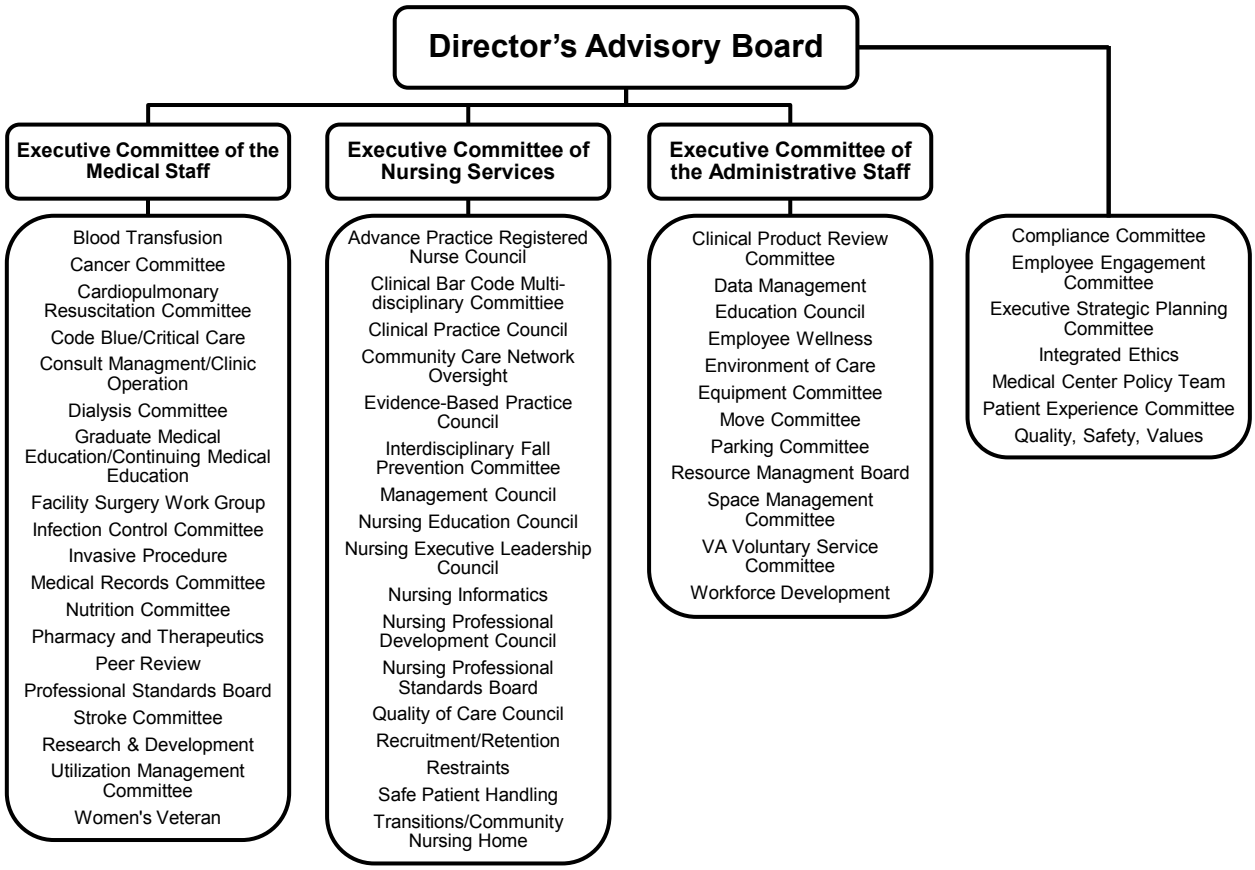

Figure 4. *Facility Committee Reporting Structure*[11]
Source: Kansas City VA Medical Center (received April 30, 2019)

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health. 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 facility leadership. To assess employee attitudes toward facility leaders, the OIG reviewed employee satisfaction survey results that relate to the period of October 1, 2017, through

[11] The Director's Advisory Board directly oversees the Compliance Committee; Employee Engagement Committee; Executive Strategic Planning Committee; Integrated Ethics; Medical Center Policy Team; Patient Experience Committee; and Quality, Safety, and Values.

September 30, 2018.[12] Table 2 provides relevant survey results for VHA, the facility, and selected facility executive leaders.

It summarizes employee attitudes toward these selected facility leaders as expressed in VHA's All Employee Survey. The OIG found the facility average for several selected survey leadership questions was similar or equal to the VHA average.[13] The director, assistant director, associate director, and chief of staff scores were generally all higher than the VHA average. The ADPCS scores were generally lower than the VHA and facility averages, and there appear to be opportunities for the ADPCS to improve employee engagement and satisfaction. In all, employees appear generally satisfied with facility leaders.

Table 2. Survey Results on Employee Attitudes toward Facility Leadership (October 1, 2017, through September 30, 2018)

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Assistant Director Average
All Employee Survey: *Servant Leader Index Composite*[14]	0–100 where HIGHER scores are more favorable	71.7	70.1	85.8	91.1	67.5	87	77.3

[12] Ratings are based on responses by employees who report to or are aligned under the director, chief of staff, ADPCS, associate director, and assistant director.

[13] The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

[14] According to the 2018 VA All Employee Survey Questions by Organizational Health Framework, Servant Leader Index "is a summary measure of the work environment being a place where organizational goals are achieved by empowering others. This includes focusing on collective goals, encouraging contribution from others, and then positively reinforcing others' contributions. Servant Leadership occurs at all levels of the organization, where individuals (supervisors, staff) put others' needs before their own."

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Assistant Director Average
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.3	3.3	4.3	4.4	3.1	3.3	3.7
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.5	4.6	4.4	3.4	3.7	3.8
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.6	4.3	4.5	3.5	3.2	3.9

Source: VA All Employee Survey (accessed March 29, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. Note that the facility and executive leadership team averages for the selected survey questions were generally similar or higher than the VHA average. Facility leaders appear to be maintaining an environment where employees feel safe bringing forth issues or concerns.

Table 3. Survey Results on Employee Attitudes toward the Workplace (October 1, 2017, through September 30, 2018)

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Assistant Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.7	4.3	4.7	3.8	4.7	4.0

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Assistant Director Average
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.7	4.4	4.3	3.7	4.2	4.2
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.5	1.4	0.9	0.8	1.8	1.5	2.0

Source: VA All Employee Survey (accessed March 29, 2019)

Patient Experience

To assess patient attitudes toward facility leaders, the OIG reviewed patient experience survey results that relate to the period of October 1, 2017, through September 30, 2018. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for facility leadership and compares the results to the overall VHA averages.[15]

VHA also collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. The OIG reviewed responses to four relevant survey questions that reflect

[15] Ratings are based on responses by patients who received care at this facility.

patients' attitudes toward facility leaders (see Table 4). For this facility, two patient survey results reflected higher care ratings than the VHA average. Patients appeared generally satisfied with the leadership and care provided. Facility leaders appeared to be actively engaged with patients; for example, the facility implemented a reporting system that captured real-time complaints and allowed staff to provide immediate resolution.

Table 4. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2017, through September 30, 2018)

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	66.9	61.5
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.2	86.5
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.3	77.1
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.5	74.6

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 28, 2018)

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys, including those conducted for cause, by oversight and accrediting agencies to gauge how well leaders respond to identified problems.[16] Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).[17] Indicative of effective leadership, the facility has closed all recommendations for improvement.[18]

At the time of the site visit, the OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[19]

[16] The Joint Commission (TJC) conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or other reported complaints. The outcomes of these types of activities may affect the accreditation status of an organization.

[17] According to VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017, TJC provides an "internationally accepted external validation that an organization has systems and processes in place to provide safe and quality-oriented health care." TJC "has been accrediting VA medical facilities for over 35 years." Compliance with TJC standards "facilitates risk reduction and performance improvement."

[18] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by the accreditation organization or inspecting agency.

[19] According to VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs,* May 9, 2017, the Commission on Accreditation of Rehabilitation Facilities "provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies." VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs. According to the College of American Pathologists, for 70 years it has "fostered excellence in laboratories and advanced the practice of pathology and laboratory science." College of American Pathologists. https://www.cap.org/about-the-cap. (The website was accessed on February 20, 2019.); In accordance with VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016, VHA laboratories must meet the requirements of the College of American Pathologists.

Table 5. Office of Inspector General Inspections/The Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Combined Assessment Program Review of the Kansas City VA Medical Center, Kansas City, Missouri, Report No. 15-04695-231, April 7, 2016*)	February 2016	10	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Kansas City VA Medical Center, Kansas City, Missouri, Report No. 16-00013-242, April 14, 2016*)	February 2016	7	0
TJC Hospital Accreditation	December 2018	42	0
TJC Behavioral Health Care Accreditation		11	0
TJC Home Care Accreditation		8	0

Sources: OIG and TJC (Inspection/survey results verified with the chief of Quality Management on April 30, 2019)

Factors Related to Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 6 lists the reported patient safety events from February 6, 2016 (the prior comprehensive OIG inspection), through May 3, 2019.[20]

[20] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the Kansas City VA Medical Center is a high complexity (1b) affiliated facility as described in Appendix B.)

Table 6. Summary of Selected Organizational Risk Factors (February 6, 2016, through May 3, 2019)

Factor	Number of Occurrences
Sentinel Events[21]	2
Institutional Disclosures[22]	16
Large-Scale Disclosures[23]	0

Source: Kansas City VA Medical Center's chief of Quality Management (received May 1, 2019)

The OIG also reviewed patient safety indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[24] The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. Table 7 summarizes patient safety indicator data from January 1, 2017, through December 31, 2018.

[21] The definition of sentinel event can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life."

[22] According to VHA Directive 1004.08, *Disclosure of Adverse Events To Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") as "a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or [his or her] 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] According to VHA Directive 1004.08, VHA defines large-scale disclosures of adverse events (sometimes referred to as "notifications") as "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] Agency for Healthcare Research and Quality. https://www.qualityindicators.ahrq.gov/. (The website was accessed on December 11, 2017.)

Table 7. Patient Safety Indicator Data
(January 1, 2017, through December 31, 2018)

Indicators	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 15	Facility
Pressure ulcer	0.70	0.87	0.84
Death among surgical inpatients with serious treatable conditions	112.98	126.51	127.27
Iatrogenic pneumothorax[25]	0.17	0.15	0.10
Central venous catheter-related bloodstream infection	0.14	0.00	0.00
In-hospital fall with hip fracture	0.09	0.11	0.11
Perioperative hemorrhage or hematoma	2.56	2.28	3.27
Postoperative acute kidney injury requiring dialysis	1.00	1.10	0.65
Postoperative respiratory failure	4.38	6.04	3.95
Perioperative pulmonary embolism or deep vein thrombosis	2.97	2.41	1.78
Postoperative sepsis	3.56	3.56	2.69
Postoperative wound dehiscence (rupture along incision)	0.81	1.04	0.00
Unrecognized abdominopelvic accidental puncture or laceration	1.00	0.58	0.66

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

The patient safety indicator measures for death among surgical inpatients with serious treatable conditions and perioperative hemorrhage or hematoma show a higher reported rate than VISN 15 and VHA. One patient safety indicator measure—unrecognized abdominopelvic accidental puncture or laceration rate is higher than VISN 15, and the measures for pressure ulcer and in-hospital fall with hip fracture show a higher reported rate than VHA.

Five patients developed a pressure ulcer. Three cases were reviewed individually and in aggregate. In two cases, clinicians did not identify clinical concerns but noted issues with coding and documentation. One patient case was referred to a nursing leader to discuss clinical concern with the involved nursing staff. The remaining two cases, which occurred in 2017, were not reviewed because the facility did not initiate trending reviews until July 2018.

[25] According to Northwestern Memorial Hospital, "A Pneumothorax is a type of lung injury that allows air to leak into the area between the lungs and the chest wall, which causes mild to severe chest pain and shortness of breath. An Iatrogenic Pneumothorax is caused by medical treatment, often as an incidental event during a procedure such as a pacemaker insertion." Northwestern Medicine. http://www.nmh.org/nm/quality-lung-injury-due-to-medical-care. (The website was accessed on March 6, 2019.)

Six surgical patients with serious treatable conditions died. All cases were reviewed individually and in aggregate, and one case was found to be incorrectly coded as having had surgery when the surgery was not done because of the patient's unstable condition. Of the actual five cases, clinicians determined that three patients received appropriate care and two did not. One patient case was reviewed by a VISN physician consultant and returned with no provider or system issues identified. For the second case, the chief of Surgery re-educated surgical staff of the importance of co-management by medical teams and timeliness of medical consults to prevent future reoccurrences.

For the in-hospital fall with hip fracture measure, one patient event was reportedly coded incorrectly. This patient had a total hip replacement due to degenerative arthritis (deterioration of the joint cartilage and underlying bone) and did not fall during his inpatient stay.

Seven patients experienced perioperative hemorrhage or hematoma. Six cases were reviewed at a surgery morbidity and mortality conference, and it was determined that care was appropriate. One patient had minor complications, which did not require medical intervention.

One patient had an unrecognized abdominopelvic accidental puncture/laceration; however, the injury was identified and repaired. A peer review was completed, and the reviewer did not identify any improvement actions.

The OIG also reviewed patient safety indicator data for FY 2019, quarter 1 (the most recent data), and the previous four quarters to identify any potential trends that may impact patient safety or increase the risk for patient harm. It is important to note that although the data are collected and reported by quarter, each set of quarterly data represents potential complications or patient safety events over an eight-quarter or two-year period. Further, it is possible for a facility measure to exceed the VHA rate due to a single incident and for that measure to vary above or below the VHA rate over time due to differences in the number of patients treated. Figure 5 illustrates the time frames covered by the data reviewed.

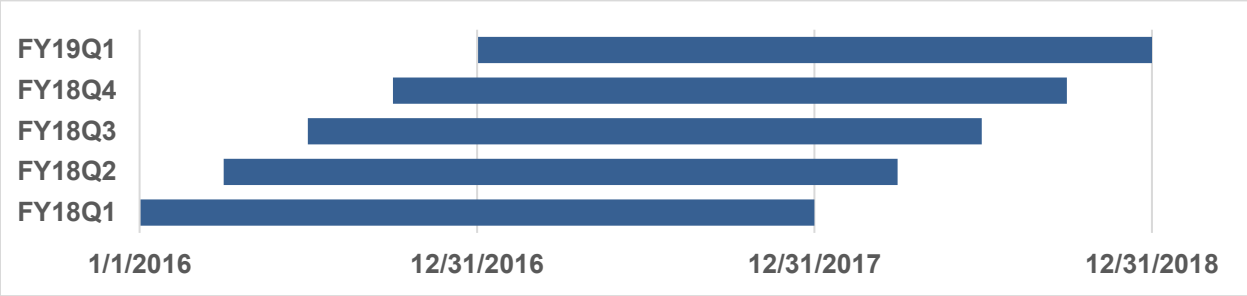

Figure 5. *Associated Time Frames for Quarterly Patient Safety Indicator Data*
Source: VA OIG
FY19Q1 = fiscal year 2019, quarter 1
FY18Q4 = fiscal year 2018, quarter 4
FY18Q3 = fiscal year 2018, quarter 3
FY18Q2 = fiscal year 2018, quarter 2
FY18Q1 = fiscal year 2018, quarter 1

Table 8 summarizes patient safety indicator data for FY 2018, quarter 1 (FY18Q1) through FY 2019, quarter 1 (FY19Q1), which includes potential complications from October 1, 2017, through December 31, 2018.

Table 8. Patient Safety Indicator Data Trending (October 1, 2017, through December 31, 2018)

Indicators	Site	Reported Rate per 1,000 Hospital Discharges				
		FY18Q1	FY18Q2	FY18Q3	FY18Q4	FY19Q1
Pressure ulcer	VHA	0.88	n/a[26]	0.76	0.74	0.70
	Facility	0.63	n/a	0.34	0.51	0.84
Death among surgical inpatients with serious treatable conditions	VHA	118.96	113.92	114.89	113.42	112.98
	Facility	103.45	140.00	145.83	117.65	127.27
Iatrogenic pneumothorax	VHA	0.19	0.17	0.15	0.17	0.17
	Facility	0.00	0.10	0.10	0.10	0.10
Central venous catheter-related bloodstream infection	VHA	0.14	0.15	0.16	0.16	0.14
	Facility	0.00	0.00	0.00	0.00	0.00
In-hospital fall with hip fracture	VHA	0.09	0.08	0.09	0.09	0.09
	Facility	0.20	0.11	0.23	0.11	0.11
Perioperative hemorrhage or hematoma	VHA	2.58	2.62	2.59	2.61	2.56
	Facility	1.24	0.95	1.43	2.78	3.27
	VHA	0.80	0.65	0.96	0.89	1.00

[26] According to VHA's Inpatient Evaluation Center, pressure ulcer data are not available for the time frame of April 1, 2016, through March 31, 2018.

Indicators	Site	Reported Rate per 1,000 Hospital Discharges				
		FY18Q1	FY18Q2	FY18Q3	FY18Q4	FY19Q1
Postoperative acute kidney injury requiring dialysis	Facility	1.13	1.31	0.00	0.00	0.65
Postoperative respiratory failure	VHA	5.34	5.11	4.88	4.54	4.38
	Facility	7.30	5.33	3.93	2.31	3.95
Perioperative pulmonary embolism or deep vein thrombosis	VHA	3.26	3.09	3.05	2.97	2.97
	Facility	1.59	1.81	0.92	1.77	1.78
Postoperative sepsis	VHA	3.96	3.72	3.70	3.55	3.56
	Facility	5.16	3.35	2.06	2.64	2.69
Postoperative wound dehiscence (rupture along incision)	VHA	1.04	1.00	0.93	0.82	0.81
	Facility	0.00	0.00	0.00	0.00	0.00
Unrecognized abdominopelvic accidental puncture or laceration	VHA	1.21	1.02	1.07	1.00	1.00
	Facility	0.62	0.71	0.67	0.00	0.66

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.
n/a = Not applicable because during the review period, there were no surgical discharges with serious treatable complications (pressure ulcers).

Two measures (death among surgical inpatients with serious treatable conditions and in-hospital fall with hip fracture) are higher than the VHA average for at least four of the five quarters reviewed, one measure (perioperative hemorrhage or hematoma) is higher for the last two quarters, and two measures (postoperative respiratory measure and postoperative sepsis) were higher for at least one of the first two quarters.

For deaths among surgical inpatients with serious treatable conditions, the OIG noted that the observed trend was largely due to six patients who died while hospitalized from July 2016 through September 2017, and one patient in FY 2018, quarter 2. There were no reported cases in FY 2018, quarters 3 and 4. The rate declined in FY 2018, quarter 4, because one patient's admission date fell outside the two-year time frame. However, the rate increased in FY 2019, quarter 1, due to one patient's death in October 2018.

For in-hospital fall with hip fracture, the reported rate includes two patients who sustained this injury in FY 2016 and a third patient who fell while hospitalized in April 2018.

The measure for perioperative hemorrhage or hematoma has trended near or above the VHA average for the last two quarters due to four new patients who experienced perioperative hemorrhage or hematoma. The facility identified the increased rate, discussed the cases at a morbidity and mortality conference, and had already implemented action plans.

The facility's postoperative respiratory failure rates were above the VHA rate during the first two quarters due to 12 patients who were admitted from October 2015 through January 2018 (nine in FY 2016, two in FY 2017, and one in FY 2018).

For postoperative sepsis, the facility rate was above the VHA rate due to nine patients who were admitted from September 2015 through September 2017.

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[27]

VA also uses a star-rating system where facilities with a "5-star" rating are performing within the top 10 percent of facilities and "1-star" facilities are performing within the bottom 10 percent of facilities. Figure 6 describes the distribution of facilities by star rating.[28] As of June 30, 2018, the facility was rated as "2-star" for overall quality.

[27] VHA Support Service Center (VSSC), The Strategic Analytics for Improvement and Learning (SAIL) Value Model, http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 7, 2019, but is not accessible by the public.)

[28] According to the methods established by the SAIL Model, this is based on normal distribution ranking of the quality domain for 130 VA Medical Centers.

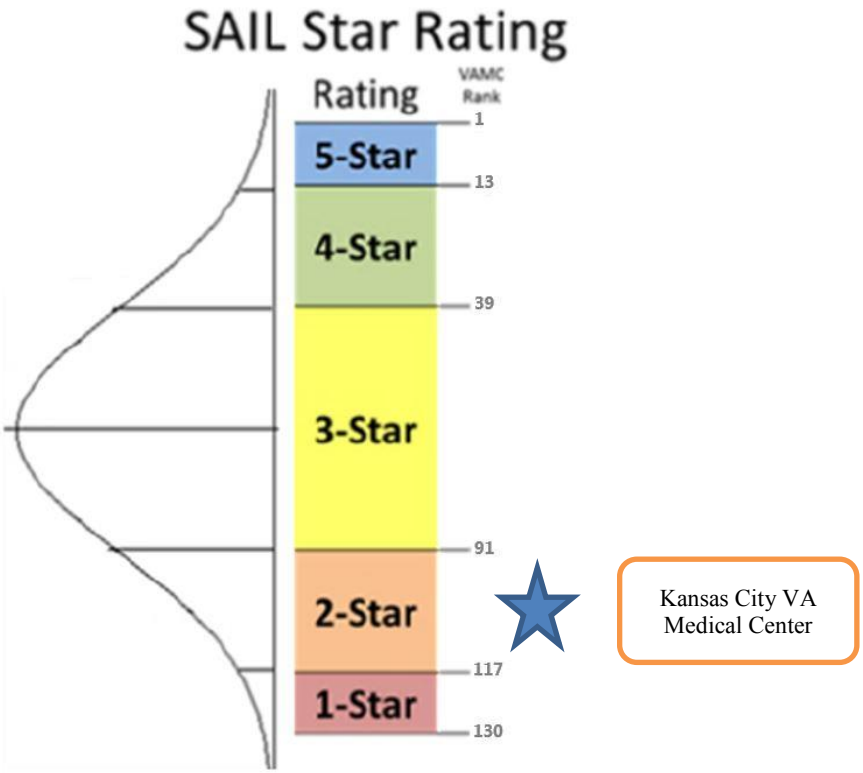

Figure 6. *Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)*
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed March 29, 2019)

Figure 7 illustrates the facility's quality of care and efficiency metric rankings and performance compared with other VA facilities as of September 30, 2018. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of physician capacity, rating (of) specialty care (SC) provider, and best place to work). Metrics that need improvement and were likely the reason for the facility's "2-star" rating are denoted in orange and red (for example, complications, mental health (MH) continuity (of) care, registered nurse (RN) turnover, and call responsiveness).[29]

[29] For information on the acronyms in the SAIL metrics, please see Appendix D.

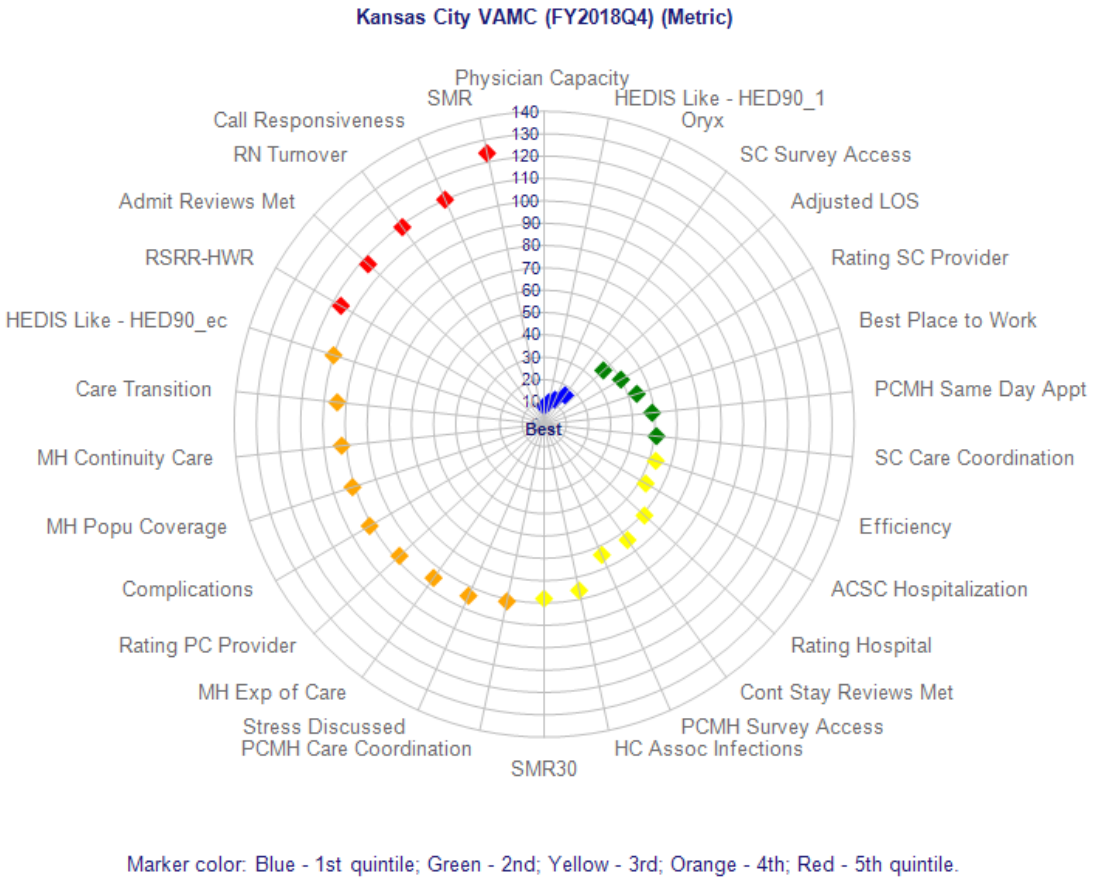

Figure 7. *Facility Quality of Care and Efficiency Metric Rankings (as of September 30, 2018)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). Data definitions are provided in Appendix D.

Leadership and Organizational Risks Conclusion

The facility's executive leadership team appeared relatively stable, with all positions permanently filled for one year prior to the OIG's on-site visit. Selected survey scores related to employee satisfaction with facility leaders were generally similar to or better than VHA averages. However, the OIG noted opportunities for the ADPCS to improve employee satisfaction. Patient experience survey data revealed that two of four scores related to satisfaction with the facility were above VHA averages. The facility leaders seemed actively engaged with employees and patients and were working to sustain and further improve employee and patient engagement and satisfaction. The leaders appeared to support efforts to improve and maintain patient safety, quality care, and other positive outcomes (such as initiating plans to maintain positive perceptions of the facility through active stakeholder engagement). The OIG's review of the facility's accreditation findings, sentinel events, disclosures, and patient safety indicator data

did not identify any substantial organizational risk factors. The leadership team was knowledgeable within their scope of responsibility about selected SAIL metrics but should continue to take actions to improve performance of measures contributing to the facility SAIL "2-star" quality rating.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care that involves coordinating care among members of the healthcare team. To meet this goal, VHA must foster a culture of integrity and accountability in which personnel are vigilant and mindful, proactively risk-aware, and committed to consistently providing quality care, while seeking continuous improvement.[30] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[31] VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.[32]

In determining whether the facility implemented and incorporated several OIG-selected key functions of VHA's Enterprise Framework for QSV into local activities, the inspection team evaluated protected peer reviews of clinical care,[33] utilization management (UM) reviews,[34] patient safety incident reporting with related root cause analyses,[35] and cardiopulmonary resuscitation (CPR) episode reviews.[36]

When conducted systematically and credibly, protected peer reviews reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and

[30] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013. (This VHA directive was scheduled for recertification on or before the last working day of August 2018 but was rescinded on October 24, 2019.)

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

[32] VHA Directive 1026.

[33] The definition of a peer review can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. 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, to identify learning opportunities for improvement, to provide confidential communication of the results back to the clinician, and to identify potential system or process improvements.

[34] The definition of utilization management can be found within VHA Directive 1117(1), *Utilization Management Program,* July 9, 2014 (amended January 18, 2018). Utilization management involves the "forward-looking evaluation of the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria." The January 2018 version of the directive was in effect at the time of the April 2019 review. Subsequently, the directive was replaced by VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019), which expired on July 31, 2019. The utilization management definition remained consistent in both versions of the directive.

[35] The definition of a root cause analysis can be found within VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (This VHA Handbook was scheduled for recertification on or before the last working date of March 2016 and has not been recertified.) A root cause analysis is "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."

[36] VHA Directive 1177, *Cardiopulmonary Resuscitation*, August 28, 2018.

nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[37]

The UM program, a key component of VHA's framework for quality, safety, and value, provides vital tools for managing the quality and the efficient use of resources. It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.[38]

Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the facility.[39]

VHA has also issued guidance to support its strategic priority of providing personalized, proactive, patient-driven care and to ensure that the provision of life-sustaining treatments, including CPR, is aligned with patients' values, goals, and preferences. VHA requires that each facility establishes a CPR Committee or equivalent that fully reviews each episode of care in which resuscitation was attempted. The ongoing review and analysis of high-risk healthcare processes is essential for ensuring patient safety and the provision of high-quality care. VHA also has established requirements for basic life support and advanced cardiac life support training and certification for clinicians responsible for administering life-sustaining treatments.[40]

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:[41]

- Protected peer reviews
    - Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
    - Implementation of improvement actions recommended by the Peer Review Committee
    - Completion of final reviews within 120 calendar days

[37] VHA Directive 1190.

[38] VHA Directive 1117(1).

[39] VHA Handbook 1050.01.

[40] VHA Directive 1177, VHA Handbook 1004.03, *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, January 11, 2017.

[41] For CHIP reviews, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

  - Quarterly review of Peer Review Committee's summary analysis by the Medical Executive Committee
  - Peer review of all applicable deaths within 24 hours of admission to the hospital
  - Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[42]
- UM
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Annual completion of a minimum of eight root cause analyses[43]
  - Inclusion of required content in root cause analyses (generally)
  - Submission of completed root cause analyses to the National Center for Patient Safety within 45 days
  - Provision of feedback about root cause analysis actions to reporting employees
  - Submission of annual patient safety report to facility leaders
- Resuscitation episode review
  - Evidence of a committee responsible for reviewing resuscitation episodes
  - Confirmation of actions taken during resuscitative events being consistent with patients' wishes
  - Evidence of basic or advanced cardiac life support certification for code team responders
  - Evaluation of each resuscitation episode by the CPR Committee or equivalent

[42] VHA Directive 1190.

[43] According to VHA Handbook 1050.01, "the requirement for a total of eight [root cause analyses] and Aggregated Reviews is a minimum number, as the total number of [root cause analyses] is driven by the events that occur and the [Safety Assessment Code] (SAC) score assigned to them. At least four analyses per fiscal year must be individual [root cause analyses], with the balance being Aggregated Reviews or additional individual [root cause analyses]."

Quality, Safety, Value Conclusion

The OIG found compliance with the resuscitation episode review. However, the team identified concerns with the peer review of all applicable deaths within 24 hours of admission to the hospital, peer review of all completed suicides within seven days after discharge from an inpatient mental health unit, and interdisciplinary review of UM data that warranted recommendations for improvement.

Specifically, VHA requires that peer reviews be completed for all applicable deaths within 24 hours of admission.[44] From March 29, 2018 through March 29, 2019, the OIG found that one of three applicable deaths within 24 hours of admission was not peer reviewed. This resulted in missed opportunities for overall improvement of care at the facility. A clinician reviewed the case and classified the death as expected; however, clinical managers could not provide electronic health record documentation to support the classification. Clinical managers believed that facility efforts met peer review program requirements.

Recommendation 1

1. The chief of staff ensures that clinicians peer review all applicable deaths within 24 hours of admission and monitors clinicians' compliance.

Facility concurred.

Target date for completion: May 2020

Facility response: The communication processes among stakeholders (e.g., Peer Review Coordinator, Utilization Management clinical staff) were streamlined in October 2019 to ensure peer reviews are completed on all applicable deaths within 24 hours of admission.

Compliance will be monitored by the Peer Review Coordinator/Risk Manager to ensure applicable cases were peer reviewed. Results from monitoring will be reported to the Peer Review Committee monthly until 90% or greater compliance is demonstrated for six consecutive months.

VHA also requires facilities to peer review each "[c]ompleted outpatient suicide [that occurs] within 7 days after discharge from inpatient Mental Health treatment or residential care."[45] From March 29, 2018, through March 29, 2019, the facility staff did not peer review a suicide that occurred within seven days after discharge from an inpatient mental health unit. At the time of the OIG inspection, the case was on the next scheduled Peer Review Committee meeting (May 2019) agenda. However, six months had passed since the time of death. This resulted in missed opportunities to identify issues in the provision of patient care in the practice of one or more

[44] VHA Directive 1190.

[45] VHA Directive 1190.

healthcare providers and to implement process improvements beneficial to the prevention of suicide. The peer review coordinator stated the reason for delay was due to changes in personnel and the peer review process.

Recommendation 2

2. The chief of staff verifies that clinicians complete peer reviews of all completed suicides that occur within seven days after discharge from inpatient mental health treatment or residential care units and monitors clinicians' compliance.

Facility concurred.

Target date for completion: May 2020

Facility Response: The communication processes among stakeholders (e.g., Peer Review Coordinator, Mental Health / Suicide Prevention Team) were streamlined in October 2019 to ensure peer reviews are done for all completed suicides that occur within seven days after discharge from the inpatient mental health treatment and/or residential care units.

Compliance will be monitored by the Peer Review Coordinator/Risk Manager to ensure applicable cases were peer reviewed. Results from monitoring will be reported to the Peer Review Committee monthly until 90% or greater compliance is demonstrated for six consecutive months.

VHA requires interdisciplinary review of UM data. This process must include, but is not limited to, participation by representatives from UM, medicine, nursing, social work, case management, mental health, and chief business office revenue-utilization review.[46] The OIG reviewed four quarters of UM Committee meeting minutes and found no representation from social work or chief business office revenue-utilization review. As a result, the UM Committee performed reviews and analyses without the perspective of key social work and utilization review colleagues. The QSV program manager was unaware that the current UM Committee membership did not meet requirements.

Recommendation 3

3. The facility director makes certain that all required representatives consistently participate in interdisciplinary reviews of utilization management data and monitors representatives' compliance.

[46] VHA Directive 1117(1).

Facility concurred.

Target date for completion: May 2020

Facility Response: On May 1, 2019, Utilization Management (UM) Committee membership was updated to include all required representatives. UM Committee meetings will be held quarterly. UM Coordinator will monitor meeting attendance for six consecutive months or two consecutive quarters to ensure required members are represented and attend meetings 90% of the time. Compliance will be reported to the Executive Committee of the Medical Staff.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all healthcare professionals who are permitted by law and the facility to practice independently"—"without supervision or direction, within the scope of the individual's license, and in accordance with individually granted clinical privileges." These healthcare professionals are also referred to as licensed independent practitioners (LIPs).[47]

Clinical privileges need to be specific, based on the individual's clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical Staff and approved by the director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to their expiration.[48]

VHA defines the focused professional practice evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance. The FPPE typically occurs at the time of initial appointment to the medical staff or the granting of new additional privileges." "The on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation (OPPE), is essential to confirm the quality of care delivered."[49]

According to TJC, the "FPPE for Cause" should be used when a question arises regarding a privileged provider's ability to deliver safe, high-quality patient care. The "FPPE for Cause" is limited to a particular time frame and customized to the specific provider and related clinical concerns.[50] Federal law requires VA facilities to report to the National Practitioner Data Bank when facilities take adverse clinical privileging actions, accept the surrender of clinical privileges, or restrict clinical privileges when the action is related to professional competence or professional conduct of LIPs.[51]

To determine whether the facility complied with requirements for privileging, the OIG interviewed key managers and selected and reviewed the privileging folders of several medical staff members:

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[47] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (This VHA Handbook was scheduled for recertification on or before the last working date of October 2017 and has not been recertified.)

[48] VHA Handbook 1100.19.

[49] VHA Handbook 1100.19.

[50] Office of Safety and Risk Awareness, Office of Quality and Performance, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, July 2016 (Revision 2).

[51] VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports*, December 28, 2009. (This VHA Handbook was scheduled for recertification on or before the last working date of December 2014 and has not been recertified.)

- Ten solo or few (less than two in a specialty) practitioners hired within 18 months before the site visit or were privileged within the prior 12 months[52]
- Ten LIPs hired within 18 months before the site visit
- Twenty LIPs re-privileged within 12 months before the visit
- Two providers who underwent a FPPE for cause within 12 months prior to the visit

The OIG evaluated the following performance indicators:

- Privileging
  - Privileges requested by the provider
    - Facility-specific
    - Service-specific
    - Provider-specific[53]
  - Approval of privileges for a period of less than, or equal to, two years
- Focused professional practice evaluations
  - Criteria defined in advance
  - Use of required criteria in FPPEs for selected specialty LIPs
  - Results and time frames clearly documented
  - Evaluation by another provider with similar training and privileges
  - Executive Committee of the Medical staff's consideration of FPPE results in its decision to recommend continuing the initially granted privileges
- Ongoing professional practice evaluations
  - Criteria specific to the service or section
  - Use of required criteria in OPPEs for selected specialty LIPs

[52] The 18-month period was from October 29, 2017, through April 29, 2019. The 12-month review period covered April 29, 2018, through April 29, 2019; VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016, refers to a solo practitioner as being one provider in the facility that is privileged in a particular specialty. The OIG considers "few practitioners" as being fewer than three providers in the facility that are privileged in a particular specialty.

[53] According to VHA Handbook 1100.19, facility-specific means that privileges are granted only for procedures and types of services performed at the facility; service-specific refers to privileges being granted in a specific clinical service, such as neurology; and provider-specific means that the privileges should be granted to the individual provider based on their clinical competence and capabilities.

  - Service chief's determination to recommend continuation of current privileges was based in part on the results of OPPE activities
  - Evaluation by another provider with similar training and privileges
  - Executive Committee of the Medical staff's decision to recommend continuing privileges based on OPPE results
- Focused professional practice evaluations for cause
  - Clearly defined expectations/outcomes
  - Time-limited
  - Provider's ability to practice independently not limited for more than 30 days
  - Shared with the provider in advance
- Reporting of privileging actions to National Practitioner Data Bank

Medical Staff Privileging Conclusion

Generally, the facility met requirements as reflected by the performance indicators above. The OIG made no recommendations.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct environment of care inspection rounds and resolve issues in a timely manner. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.[54]

The purpose of this facet of the OIG inspection was to determine whether the facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, such as in the locked inpatient mental health unit. The inspection team also looked at facility compliance with emergency management processes.[55]

VHA requires its facilities to have the "capacity for [providing] mental health services for veterans with acute and severe emotional and/or behavioral symptoms causing a safety risk to self or others, and/or resulting in severely compromised functional status. This level of care is typically provided in an inpatient setting;" however, for facilities that do not have inpatient mental health services, that "capacity" could mean facilitating care at a nearby VA or non-VA facility.[56]

VHA requires managers to establish a comprehensive emergency management program to ensure the continuity of patient care and hospital operations in the event of a natural disaster or other emergency. This includes conducting a hazard vulnerability analysis and developing an emergency operations plan. These requirements are meant to support facilities' efforts to identify and minimize harm from potential hazards, threats, incidents, and events related to healthcare and other essential services.[57] Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,[58]

[54] VHA Directive 1608, *Comprehensive Environment of Care (CEOC Program)*, February 1, 2016.

[55] Applicable requirements for high-risk areas and emergency management include those detailed in or by various VHA Directives, Joint Commission hospital accreditation standards, Occupational Safety and Health Administration, American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), and National Fire Protection Association (NFPA).

[56] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (This VHA Handbook was scheduled for recertification on or before the last working date of September 2018 and has not been recertified.)

[57] VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

[58] VHA Directive 1028, *Electrical Power Distribution Systems*, July 25, 2014. (This VHA Directive was scheduled for recertification on or before the last working date of July 2019 and has not been recertified.)

Occupational Safety and Health Administration,[59] and National Fire Protection Association standards.[60] The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.[61]

In all, the OIG team inspected 12 patient care areas, including eight inpatient units—surgical unit, medical units (8 East and 8 West), medical and surgical intensive care units, progressive care stepdown, post-anesthesia care, and the locked mental health unit. In addition, the team inspected four outpatient areas—primary care, emergency department, outpatient mental health, and women's health. The team also inspected the Warrensburg VA Clinic. The inspection team reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent facility
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies
- Community based outpatient clinic
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies
- Locked inpatient mental health unit
  - Mental health environment of care rounds
  - Nursing station security

[59] The Occupational Safety and Health Administration (OSHA) is part of the US Department of Labor. OSHA's mission is to assure safe and healthy working conditions "by setting and enforcing standards and by providing training, outreach, education, and assistance." https://www.osha.gov/about.html. (This website was accessed on June 28, 2018.)

[60] The National Fire Protection Association (NFPA) is a global nonprofit organization "devoted to eliminating death, injury, property, and economic loss due to fire, electrical, and related hazards." https://www.nfpa.org/About-NFPA. (This website was accessed on June 28, 2018.)

[61] TJC. Environment of Care standard EC.02.05.07.

- Public area and general unit safety
- Patient room safety
- Infection prevention
- Availability of medical equipment and supplies

- Emergency management
  - Hazard vulnerability analysis (HVA)
  - Emergency operations plan (EOP)
  - Emergency power testing and availability

Environment of Care Conclusion

The parent facility and the representative community based outpatient clinic met many of performance indicators, including environmental cleanliness, privacy, and women veterans program requirements.[62] The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified concerns with the availability of safety data sheets, clean and soiled equipment storage, security of the mental health nursing station, and leadership approval of the hazard vulnerability analysis and the emergency operations plan that warranted recommendations for improvement.

The Occupational Safety and Health Administration (OSHA)[63] requires employers to maintain copies of safety data sheets for each hazardous chemical and ensure that they are readily accessible to employees in their work area.[64] In 3 of 11 applicable areas inspected, the OIG found that employees were unable to immediately access safety data sheet information.[65] This could potentially delay actions required to resolve or neutralize a biochemical hazard. The Safety Officer acknowledged the difficulty of accessing the icon (desktop shortcut) to electronically view the safety data sheets.

Recommendation 4

4. The associate director ensures electronic safety data sheets are readily accessible to employees and monitors compliance.

[62] Medical unit 8 West, surgical inpatient, and medical intensive care unit.

[63] OSHA is part of the United States Department of Labor and created by Congress with the Occupational Safety and Health Act of 1970 "to ensure safe and healthful working conditions for [workers] by setting and enforcing standards and by providing training, outreach, education and assistance." https://www.osha.gov/aboutosha. (The website was accessed on August 20, 2019.)

[64] OSHA standard 1910.1200(g)(8).

[65] Surgical intensive care unit, progressive care unit, and primary care clinic.

Facility concurred.

Target date for completion: May 2020

Facility Response: The Environment of Care refresher training course and exam were updated in January 2019 with information on how to access the online Safety Data Sheet database. All staff are required to complete this course annually.

In addition, the Safety Office worked with the Office of Information and Technology to update the home page of the Kansas City VA Medical Center SharePoint site with the link to directly access the online Safety Data Sheets. Email communication was sent to all staff on May 2, 2019 showing the updated location of the link to the online Safety Data Sheet database. Furthermore, the online Safety Data Sheet database was updated in September 2019 with chemical inventories from all service lines.

In order to ensure and maintain compliance with this recommendation, the Safety Officer and / or his designee will randomly survey five staff during weekly Environment of Care rounds to demonstrate how to access the online Safety Data Sheets. A total of 20 staff will be surveyed each month beginning November 2019. Compliance will be monitored for a minimum of six consecutive months with a goal of 90% or greater accuracy. Results will be reported monthly to the Environment of Care Committee until this recommendation is closed.

TJC requires hospitals to minimize the possibility of transmitting infections by ensuring that dirty and used equipment are stored separately from clean equipment.[66] The OIG team found that dirty equipment was not separated from clean equipment in two patient care areas inspected. This resulted in lack of assurance of a clean and safe patient care environment that minimizes the spread of infection. The chief of environmental management services stated the reason for noncompliance was due to active construction throughout the facility, which limited storage areas for medical equipment.

Recommendation 5

5. The associate director confirms that unit managers store clean and dirty medical equipment separately and monitors managers' compliance.

[66] TJC. Environment of Care standard EC.02.02.01.

Facility concurred.

Target date for completion: May 2020

Facility response: The Associate Chief Nurse of both Inpatient and Outpatient Services and Deputy Associate Director of Patient Care Services met with the Nurse Managers in October 2019 to provide instruction on the correct process for storage of clean and dirty equipment.

In order to ensure compliance, a total of 15 random spot checks of clean and dirty medical equipment rooms throughout the medical center (e.g., inpatient and outpatient areas) will be completed monthly. The Associate Chief Nurse of Inpatient Services/Deputy Associate Director of Patient Care Services; the Associate Chief Nurse of Outpatient Service and/or their designees will monitor until 90% or greater compliance is demonstrated for six consecutive months. Monitoring data will be reported to the Environment of Care Committee.

VHA requires facilities with inpatient mental health units to ensure nursing stations are secured from unauthorized access and that counters should be tall and wide to prevent younger, more agile patients from climbing over a counter.[67] The OIG team found that the mental health's nursing station counter did not prevent unauthorized entry. This could result in an unsafe situation for staff and patients. The nurse manager stated that, due to the way the countertop was constructed, the facility was unable to insert a wall or increase the height of the countertop.

Recommendation 6

6. The associate director ensures the mental health nursing station prevents unauthorized entry and monitors compliance.

[67] VHA Mental Health Environment of Care Checklist, November 15, 2018.

Facility concurred.

Target date for completion: March 2020

Facility Response: The existing inpatient mental health unit (i.e., the East wing) has a nursing station/reception area that does not have a window barrier. This area was designed without the window barrier to maintain a therapeutic milieu with patients. However, there is another, attached area that is locked where nursing and other staff can complete required tasks such as documentation. Prevention of unauthorized entry into the existing inpatient mental health unit (i.e., the East wing) is monitored 24/7 by staff located in the nursing station. Clinical interventions as well as deployment of disruptive behavior teams also are utilized in the event a patient and/or family member attempts an unauthorized entry into the nurse's station. Compliance is monitored daily by staff to ensure safety and through the Mental Health environment of care rounds which are each completed every six months.

A construction project for a new locked mental health unit, approved by the Executive Committee of the Medical Staff as well as the Executive Leadership Team in March 2019, will include a nursing station with a window barrier and is expected to be completed in March 2020. Once a change in the functionality of the East wing is implemented (e.g., from a locked unit to an unlocked detox unit) the window barrier will not be required, and the Mental Health Environment of Care Checklist is not applicable. To support closure of this recommendation, the facility will provide evidence of compliance with the requirement for the new locked mental health unit (i.e., West wing) once construction is completed. Compliance will be reported to the Executive Committee of the Medical Staff.

VHA also requires facilities to have a comprehensive emergency management plan that includes an annual review of the hazard vulnerability analysis and the emergency operations plan. This review is to be documented, evaluated by the Environment of Care Safety and Engineering Committee, and approved by the executive leadership team.[68] The OIG team found that the Emergency Management Subcommittee reviewed the emergency operations plan and the hazard vulnerability analysis but there was no evidence of approval by the executive leaders. This resulted in a lack of assurance that the facility is prepared for contingency operations during emergencies. The current emergency management coordinator stated that, prior to assuming the position, the coordinator position was vacant for some time and an assigned interim coordinator covered the vacancy as a collateral duty, which resulted in a lack of program oversight.

[68] VHA Directive 0320.01.

Recommendation 7

7. The associate director ensures that the hazard vulnerability analysis and the emergency operations plan are approved by executive leadership and monitors compliance.[69]

Facility concurred.

Target date for completion: October 2019

Facility Response: The Emergency Operations Plan and Hazard Vulnerability Analysis were approved by the members of the Executive Leadership Team (e.g., Director, Chief of Staff, Associate Director, Assistant Director, and the Associate Director for Patient Care Services) on June 7, 2019. In order to ensure compliance, review of the Emergency Operations Plan and Hazard Vulnerability Analysis was added as an annual, standing agenda item to the Emergency Management Committee [a subcommittee of the Environment of Care Committee] effective June 2019.

In addition, a review of the Emergency Operations Plan along with recommended revisions will be completed by the Facility Emergency Manager and presented to the Emergency Management Committee for their review prior to the annual approval deadline of June 2020. Any revisions to the Emergency Operations Plan will be approved and documented in the Emergency Management Committee minutes. Emergency Management Committee activities are also reviewed and approved by the Environment of Care Committee, both of which are chaired by the Assistant Director. The new approval date for the Emergency Operations Plan is recorded in the minutes when concurrence is received from the Executive Leadership Team. This process will be completed annually. Closure of this recommendation is requested based on evidence provided.

[69] The OIG reviewed evidence sufficient to demonstrate that the facility had completed improvement actions and therefore closed the recommendation before the report's release.

Medication Management: Controlled Substances Inspection Program

The Controlled Substances Act divides controlled drugs into five categories based on whether they have an accepted medical treatment use in the United States, their relative potential for abuse, and the likelihood of causing dependence if abused.[70] Diversion of controlled substances by healthcare workers—the transfer of legally prescribed controlled substances from the prescribed individual to others for illicit use—remains a serious problem that can increase patient safety issues and elevate the liability risk to healthcare facilities.[71]

VHA requires that facility managers implement and maintain a controlled substances inspection program to minimize the risk for loss and diversion and to enhance patient safety. Requirements include the appointment of controlled substances coordinator(s) and controlled substances inspectors, implementation of procedures for inventory control, and inspections of the pharmacy and clinical areas with controlled substances.[72]

To determine whether the facility complied with requirements related to controlled substances security and inspections, the OIG team interviewed key managers and reviewed inspection reports; monthly summaries of findings, including discrepancies, provided to the facility director; inspection quarterly trend reports for the prior two completed quarters;[73] and other relevant documents. The OIG evaluated the following performance indicators:

- Controlled substances coordinator reports
  - Monthly summary of findings to the director
  - Quarterly trend reports to the director
  - Quality Management Committee's review of monthly and quarterly trend reports
  - Actions taken to resolve identified problems
- Pharmacy operations
  - Staff restrictions for monthly review of balance adjustments[74]
- Requirements for controlled substances inspectors

[70] Drug Enforcement Agency Controlled Substance Schedules. https://www.deadiversion.usdoj.gov/schedules/. (The website was accessed on March 7, 2019.)

[71] American Society of Health-System Pharmacists, "ASHP Guidelines on Preventing Diversion of Controlled Substances," *American Journal of Health-System Pharmacists* 74, no. 5 (March 1, 2017): 325-348.

[72] VHA Directive 1108.02(1), *Inspection of Controlled Substances*, November 28, 2016 (amended March 6, 2017).

[73] The two quarters were from October 1, 2018, through March 31, 2019.

[74] Controlled substances balance adjustment reports list transactions in which the pharmacy vault inventory balance was manually adjusted.

  - No conflicts of interest
  - Appointed in writing by the director for a term not to exceed three years
  - Hiatus of one year between any reappointment
  - Completion of required annual competency assessment
- Controlled substances area inspections
  - Completion of monthly inspections
  - Rotations of controlled substances inspectors
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of controlled substances orders
  - Performance of routine controlled substances inspections
- Pharmacy inspections
  - Monthly physical counts of the controlled substances in the pharmacy
  - Completion of inspections on day initiated
  - Security and verification of drugs held for destruction[75]
  - Accountability for all prescription pads in pharmacy
  - Verification of hard copy controlled substances prescriptions
  - Verification of twice a week (three-days apart) inventories of the main vault[76]
  - Quarterly inspections of emergency drugs
  - Monthly checks of locks and verification of lock numbers
- Facility review of override reports[77]

[75] According to VHA Directive 1108.02(1), the Destructions File Holding Report "lists all drugs awaiting local destruction or turn-over to a reverse distributor." Controlled substances inspectors "must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report."

[76] VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010. (This handbook was rescinded on May 1, 2019, and replaced by VHA Directive 1108.01, *Controlled Substances Management*.)

[77] When automated dispensing cabinets are used, nursing staff can override and remove medications prior to the pharmacists' review of medications ordered by the providers.

Medication Management Conclusion

The OIG team found general compliance with requirements for most of the performance indicators evaluated, including the controlled substances coordinator reports, pharmacy operations and inspections, requirements for controlled substances inspectors, and review of override reports. However, the OIG identified noncompliance with controlled substances area inspections.

VHA requires controlled substances inspection program staff to conduct reconciliation of one random day's dispensing from the pharmacy to every automated dispensing cabinet (ADC) and one day's return of stock to the pharmacy from every ADC.[78] In four of the six months of inspection reports reviewed for the 10 non-pharmacy areas selected, the OIG found that controlled substances inspection program staff did not reconcile one random day's return of stock to the pharmacy from every ADC. Missed reconciliations may cause delays in identifying drug diversion activities. Program managers cited lack of staff training, which resulted in controlled substance inspectors reviewing incorrect reports for reconciliation.

Recommendation 8

8. The facility director ensures that controlled substances inspection program staff complete reconciliation of one random day's return of stock to the pharmacy from every automated dispensing cabinet during monthly inspections and monitors program staff compliance.

Facility concurred.

Target date for completion: January 2020

Facility response: After a review of controlled substance inspection processes it was determined that the Controlled Substance Coordinator (CSC) and/or Alternate Controlled Substance Coordinator (ACSC) should complete the report reconciliation for one random day's return of stock to the pharmacy from every automated dispensing cabinet as part of their core work during monthly inspections. This updated process was implemented in May 2019. The facility will provide evidence of reconciliation from Automated Dispensing Cabinet (ADC) to Pharmacy for five non-pharmacy areas (e.g., Emergency Department, Surgical inpatient unit [5-West], Anesthesia, Surgical Intensive Care Unit, Operating Room number one). Evidence of compliance will be monitored for six consecutive months to ensure 90% or greater compliance is achieved. Monitoring data will be reported to the Executive Leadership Team via the Medical Center Director Joint Leadership Council (formerly, the Quality, Safety, Values committee).

[78] VHA Directive 1108.02(1).

Mental Health: Military Sexual Trauma Follow-Up and Staff Training

The Department of Veterans Affairs uses the term "military sexual trauma" (MST) to refer to a "psychological trauma, which in the judgment of a mental health professional employed by the Department [of Veterans Affairs], resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training."[79] "MST is an experience, not a diagnosis or a mental health condition." Although posttraumatic stress disorder is commonly associated with MST, other frequently associated diagnoses include depression and substance use disorders.[80]

VHA requires that the facility director designates an MST coordinator to support national and VISN-level policies related to MST-related care and serve as a source of information; establish and monitor MST-related staff training and informational outreach; and communicate MST-related issues, services, and initiatives with leadership.[81] Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.[82]

VHA requires that all veterans and potentially eligible individuals seen in VHA facilities be screened for experiences of MST with the required MST clinical reminder in the computerized patient record system.[83] Those who screen positive must have access to appropriate MST-related care.[84] VHA also requires that evidence-based mental health care be available to all veterans with mental health conditions related to MST. Patients requesting or referred for mental health services must receive an initial evaluation within 24 hours of the referral to identify urgent care needs and a more comprehensive diagnostic evaluation within 30 days.[85]

The MST coordinator may provide clinical care to individuals experiencing MST and is thus subject to the same mandatory training requirements as mental health and primary care providers.[86] All mental health and primary care providers must complete MST mandatory

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[79] VHA Directive 1115, *Military Sexual Trauma (MST) Program*, May 8, 2018.

[80] Military Sexual Trauma. https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf. (The website was accessed on November 17, 2017.)

[81] VHA Directive 1115.

[82] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008 (amended November 16, 2015). (This VHA Handbook was scheduled for recertification on or before the last working date of September 2013 and has not been recertified.)

[83] VHA Directive 1115 states that "MST-related care is not subject to the minimum active duty service requirement set forth in 38 U.S.C. 5303A; Veterans may therefore be able to receive MST-related care even if they are not eligible for VA health care under other treatment authorities."

[84] VHA Directive 1115.

[85] VHA Handbook 1160.01.

[86] VHA Directive 1115.

training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.[87]

To determine whether the facility complied with the requirements related to MST follow-up and training, the OIG inspection team reviewed relevant documents and staff training records and interviewed key employees. The team also reviewed the electronic health records of 50 outpatients who had a positive MST screen from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

- Designated facility MST coordinator
  - Establishes and monitors MST-related staff training
  - Establishes and monitors informational outreach
  - Communicates MST-related issues, services, and initiatives with local leaders
- Evidence of tracking MST-related data
- Provision of clinical care
  - Referral for MST-related care to patients with positive MST screens
  - Initial evaluation within 24 hours of referral for mental health services
  - Comprehensive diagnostic and treatment planning evaluation within 30 days of referral for mental health services
- Completion of MST mandatory training requirement for mental health and primary care providers

Mental Health Conclusion

Generally, the OIG inspection team found compliance with many of the performance indicators, including the designation of an MST coordinator, tracking of MST-related data, and provision of clinical care. However, the OIG team noted a deficiency with completion of MST mandatory training requirements for mental health and primary care providers that warranted a recommendation for improvement.

Specifically, VHA requires that all primary care and mental health providers complete the MST mandatory training; for those hired after July 1, 2012, this training must be completed no later

[87] VHA Directive 1115.01, *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017; Acting Deputy Under Secretary for Health for Operations and Management, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers,* February 2, 2016.

than 90 days after entering their position.[88] The OIG team found that for five of thirteen providers hired after July 1, 2012, three did not complete training within 90 days and two were not assigned the training. This could potentially prevent clinicians from providing appropriate counseling, care, and service to veterans who experienced MST.[89] The MST coordinator believed that training was timely for the three previously mentioned providers and was unaware that the last two providers were not assigned MST mandatory training.

Recommendation 9

9. The chief of staff makes certain that providers complete military sexual trauma mandatory training within the required time frame and monitors providers' compliance.

Facility concurred.

Target Date for Completion: December 2019

Facility Response: The Military Sexual Trauma Coordinator worked in conjunction with the Kansas City, MO Domain Manager to receive and review compliance deficiency reports for the assigned Military Sexual Trauma training required for Primary Care and Mental Health providers. Providers are required to complete the mandatory training within 90-days of being hired. Provider compliance is monitored monthly via the compliance deficiency reports.

Fiscal Year 2019 data received October 2019 from the Military Sexual Trauma Dashboard reports includes the following data:

- 160 assigned Mental Health Providers assigned MST training, 156 compliant (97.50% compliance)
- 97 assigned Primary Health Providers assigned MST training, 94 compliant (96.91% compliance)

MST Coordinator will monitor compliance for a minimum of six consecutive months (i.e., June – December 2019) to ensure mandatory training is completed within 90 days for all designated staff. Compliance will be reported to the Executive Committee of the Medical Staff for oversight.

[88] VHA Memorandum, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers (VAIQ 7663786)*, February 2, 2016, refers to specific MST training requirements for providers assuming their position before or after July 1, 2012.

[89] VHA Directive 1115.

Geriatric Care: Antidepressant Use among the Elderly

VA's National Registry for Depression reported that "11 [percent] of veterans aged 65 years and older have a diagnosis of major depressive disorder."[90] The VA/DoD Clinical Practice Guideline (CPG) describes depression as "a common mental disorder that presents with depressed mood, loss of interest or pleasure in regular activities, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration." This can lead to poor quality of life, decreased productivity, and increased mortality from suicide.[91]

According to the Centers for Disease Control and Prevention, older adults are at increased risk for experiencing depression because "80 [percent] of older adults have at least one chronic health condition and 50 [percent] have two or more." Further, "most older adults see an improvement in [their] symptoms when treated with antidepression drugs, psychotherapy, or a combination of both."[92]

The American Geriatrics Society revised the Beers Criteria in 2015 to include lists of potentially inappropriate medications to be avoided. Potentially inappropriate medication use in older adults continues to be associated with confusion, falls, and mortality.[93] The criteria provide guidelines that help to improve the safety of prescribing certain medications including antidepressants for older adults.

TJC requires clinicians to educate patients and families about the "safe and effective use of medications."[94] In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.[95] Further, TJC requires clinicians to perform medication reconciliation by comparing the medication a patient is actually taking to the new medications that are ordered for the patient and resolving any discrepancies.[96] The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

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[90] Hans Peterson, "Late Life Depression," *U.S. Department of Veterans Affairs*, Mental Health Featured Article, March 1, 2011. https://www.mentalhealth.va.gov/featureArticle_Mar11LateLife.asp. (The website was accessed on March 8, 2019.)

[91] *VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder*, April 2016. https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf. (The website was accessed November 20, 2018.)

[92] Centers for Disease Control and Prevention, "Depression is Not a Normal Part of Growing Older," January 31, 2017. https://www.cdc.gov/aging/mentalhealth/depression.htm. (The website was accessed on March 8, 2019.)

[93] American Geriatrics Society 2015 Beers Criteria Update Expert Panel, "American Geriatrics Society 2015 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults." http://www.sigot.org/allegato_docs/1057_Beers-Criteria.pdf. (The website was accessed on March 22, 2018.)

[94] TJC. Provision of Care, Treatment, and Services standard PC.02.03.01.

[95] VHA Directive 1164, *Essential Medication Information Standards*, June 26, 2015.

[96] TJC. National Patient Safety Goal standard NPSG.03.06.01.

remission. Monitoring includes assessment of symptoms, adherence to medication and psychotherapy, and any adverse effects. The CPG also recommends that treatment planning includes patient education about treatment options, including risks and benefits.[97]

To determine whether the facility complied with requirements concerning use of antidepressants among the elderly, the OIG inspection team interviewed key employees and managers. The team also reviewed the electronic health records of 37 randomly selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.[98] The OIG evaluated the following performance indicators:

- Justification for medication initiation
- Evidence of patient and/or caregiver education specific to the medication prescribed
- Clinician evaluation of patient and/or caregiver understanding of the education provided
- Medication reconciliation

Geriatric Care Conclusion

The OIG team found compliance with providers documenting the reason for prescribing medications and evaluating patient/caregiver understanding of education, when education was provided. However, OIG inspectors identified that providers did not provide adequate patient and/or caregiver education specific to newly prescribed medications or reconcile patients' medications.

Specifically, TJC requires that clinicians educate patients and families about "the safe and effective use of medications" and that the patient's medical record contains information that reflects the patient's care, treatment, and services.[99] The OIG team estimated that clinicians provided this education to 73 percent of the patients at the facility, based on electronic health records reviewed.[100] Providing medication education is critical to ensuring that patients or their caregivers have the information they need to manage their own health at home. Clinical managers were aware of the requirement, believed that clinicians provide education, and cited the inconsistent method of documenting phone contacts with patients for new medications as a reason for noncompliance.

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[97] *VA/DoD Clinical Practice Guidelines for the Management of Major Depressive Disorder.*

[98] The seven selected antidepressant medications are Amitriptyline, Clomipramine, Desipramine, Doxepin (>6mg/day), Imipramine, Nortriptyline, and Paroxetine.

[99] TJC. Provision of Care, Treatment, and Services standard PC.02.03.01; TJC. Record of Care, Treatment, and Services standard RC.02.01.01.

[100] The OIG is 95 percent confident the true compliance rate is somewhere between 57.7 and 86.6 percent, which is statistically significantly below the 90 percent benchmark.

Recommendation 10

10. The chief of staff makes certain that clinicians provide and document patient and/or caregiver education about newly prescribed medications and monitors clinicians' compliance.

Facility concurred.

Target date for completion: May 2020

Facility Response: Inpatient providers and Pharmacy staff routinely provide and document patient and / or caregiver education about newly prescribed medications particularly through discharge planning. However, since this is less routine for outpatient providers, they were reminded /re-educated by the Chief of Staff in June 2019 of the importance of providing and documenting patient and / or caregiver education about newly prescribed medications.

Pharmacy/Quality, Safety, and Value will monitor compliance by completing chart audits. A random sample of 50 charts will be audited each month until a compliance of 90% or greater is achieved for six consecutive months. Monitoring data will be reported to the Executive Committee of the Medical Staff.

According to TJC, the required process of medication reconciliation is when "a clinician compares the medications a patient should be using (and is actually using) to the new medications that are ordered for the patient and resolves any discrepancies."[101] Additionally, VHA requires that clinicians review and reconcile medications relevant to the episode of care.[102]

The OIG team estimated that clinicians performed medication reconciliation for 59 percent of the patients at the facility, based on electronic health records reviewed.[103] Failure to reconcile medications increases the risk that there may be duplications, omissions, and interactions in the patient's actual drug regimen. Clinical managers were aware of the requirement and believed that clinicians were reconciling medications but were not consistently documenting the reconciliation.

Recommendation 11

11. The chief of staff ensures clinicians reconcile medications and maintain accurate medication information in patients' electronic health records and monitors clinicians' compliance.

[101] TJC. National Patient Safety Goal standard NPSG.03.06.01.

[102] VHA Directive 1164, *Essential Medication Information Standards*, June 26, 2015.

[103] The OIG is 95 confident that the true compliance rate is somewhere between 43.3 and 75.1 percent, which is statistically significantly below the 90 percent benchmark.

Facility concurred.

Target date for completion: May 2020

Facility Response: Inpatient providers and Pharmacy staff routinely reconcile patient medications and document in patients' electronic health records. However, since this is less routine for outpatient providers, they were reminded / re-educated by the Chief of Staff in June 2019 of the importance of reconciling medications in order to maintain accurate medication information in patients' electronic health records.

Pharmacy/Quality, Safety, and Value will monitor compliance by completing chart audits. A random sample of 50 charts will be audited each month until a compliance of 90% or greater is achieved for six consecutive months. Monitoring data will be reported to the Executive Committee of the Medical Staff.

Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up

Each year, about 12,000 women in the United States are diagnosed with cervical cancer.[104] Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.[105] In addition to HPV infection, other risk factors for cervical cancer include smoking, human immunodeficiency virus (HIV) infection, use of oral contraceptives for five or more years, and having given birth to three or more children.[106] Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.[107]

VA is authorized to provide "gender-specific services, such as Papanicolaou tests (Pap smears)," to eligible women veterans. Further, VHA requires that all eligible and enrolled women veterans have access to appropriate services and preventative care. That care would include age-appropriate screening for cervical cancer.[108]

VHA requires that each facility have a "full-time Women Veterans Program Manager (WVPM) to execute comprehensive planning for women's health care." VHA also requires a medical director or clinical champion to be responsible for the clinical oversight of the women's health program. Each facility must also have a "Women Veterans Health Committee (WVHC) comprised of appropriate facility leadership and program directors, which develops and implements a Women's Health Program strategic plan." The Women Veterans Health Committee must meet at least quarterly and report to the executive leaders. The facility must also have a process to ensure the collecting and tracking of data related to cervical cancer screenings.[109]

VHA has established time frames for notifying patients of abnormal cervical pathology results. Abnormal cervical pathology results must be communicated to patients within seven calendar days from the date the results are available to the ordering provider. Communication of the

[104] Centers for Disease Control and Prevention. "Cervical Cancer" *Inside Knowledge* fact sheet, December 2016. https://www.cdc.gov/cancer/cervical/pdf/cervical_facts.pdf. (The website was accessed on February 28, 2018.)

[105] Centers for Disease Control and Prevention. *Basic Information About Cervical Cancer*. February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)

[106] Centers for Disease Control and Prevention. *What Are the Risk Factors for Cervical Cancer?* February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/risk_factors.htm. (The website was accessed on March 8, 2019.)

[107] Centers for Disease Control and Prevention. *Basic Information About Cervical Cancer*. February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)

[108] VHA Directive 1330.01(2), *Health Care Services for Women Veterans,* February 15, 2017 (amended July 24, 2018).

[109] VHA Directive 1330.01(2).

results to patients must be documented. The facility must ensure that appropriate follow-up care is provided to patients with abnormal results.[110]

To determine whether the facility complied with selected VHA requirements for the notification and follow-up care of abnormal cervical pathology results, the OIG inspection team reviewed relevant documents and interviewed selected employees and managers. The team also reviewed the electronic health records of 18 women veteran patients, between ages 21 and 65, who had an abnormal pap smear or test from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

- Appointment of a women veterans program manager
- Appointment of a women's health medical director or clinical champion
- Facility Women Veterans Health Committee
  - Core membership
  - Quarterly meetings
  - Reports to clinical executive leaders
- Collection and tracking of cervical cancer screening data
  - Notification of patients due for screening
  - Completed screenings
  - Results reporting
  - Follow-up care
- Communication of abnormal results to patients within required time frame
- Provision of follow-up care for abnormal cervical pathology results, if indicated

Women's Health Conclusion

Generally, the OIG team found compliance with many of the performance indicators, including requirements for a designated women veterans program manager and medical director, clinical oversight of the women's health program, tracking of data related to cervical cancer screenings, communication of results to patients, and follow-up care when indicated. However, the OIG inspectors identified concerns with the Women Veterans Health Committee that warranted recommendations for improvement.

Specifically, VHA requires that the core membership of the Women Veterans Health Committee includes a women veterans program manager; a women's health medical director;

[110] VHA Directive 1330.01(2).

"representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED [emergency department], radiology, laboratory, quality management, business office/Non-VA Medical Care; and a member from executive leadership."[111] From June 2018 through April 2019, the committee lacked representation from gynecology, emergency department, radiology, laboratory, quality management, business office/non-VA care, and executive leadership. This resulted in a lack of expertise and oversight in the review and analysis of data as the committee planned and carried out improvements for quality and equitable care for women veterans.[112] The women's health medical director and the previous women veterans program manager were unaware of the core membership requirement.

Recommendation 12

12. The chief of staff makes certain that the Women Veterans Health Committee includes all required core members and monitors the committee's compliance.

Facility concurred.

Target date for completion: May 2020

Facility response: On May 1, 2019, the Women Veterans Health Committee and Committee Charter was updated by the Chief of Staff to include the VHA required core members. Service line leadership were requested to identify and provide back-up representatives as needed to maintain compliance with Women Veterans Health Committee core membership.

Women Veterans Health Committee meetings will be held quarterly. Women Veterans Health Coordinator will monitor meeting attendance for six consecutive months or two consecutive quarters to ensure required members are represented and attend meetings 90% of the time. Compliance will be reported to the Executive Committee of the Medical Staff.

According to VHA, each facility's Women Veterans Health Committee is required to meet at least quarterly and report to executive leadership with signed minutes.[113] The OIG team reviewed Women Veterans Health Committee meeting minutes, and program managers confirmed the committee did not report to executive leadership. Failure to report activities to executive leadership has the potential to impede oversight and support of the women's health program. The women's health medical director and the previous women veterans program manager cited patient care workload demands and collateral duties, respectively, as reasons for noncompliance.

[111] VHA Directive 1330.01(2).
[112] VHA Directive 1330.01(2).
[113] VHA Directive 1330.01(2).

Recommendation 13

13. The chief of staff ensures the Women Veterans Health Committee reports to executive leaders and monitors the committee's compliance.

Facility concurred.

Target date for completion: May 2020

Facility Response: The Women Veterans Health Committee and Committee Charter was updated by the Chief of Staff to include the requirement to report meeting minutes to the Executive Committee of the Medical Staff.

Women Veterans Health Committee meetings and minutes are recorded from these meetings. Compliance will be monitored via quarterly reporting (e.g., submission of the signed minutes) to the Chief of Staff, for inclusion on the Executive Committee of the Medical Staff agenda. Compliance will be monitored for a minimum of six consecutive months or two consecutive quarters with a goal of 90% or greater compliance.

High-Risk Processes: Operations and Management of Emergency Departments and Urgent Care Centers

VHA defines an emergency department as a "unit in a VA medical facility that has acute care medical and/or surgical inpatient beds and whose primary responsibility is to provide resuscitative therapy and stabilization in life-threatening situations." An urgent care center (UCC) "provides acute medical care for patients without a scheduled appointment who are in need of immediate attention for an acute medical or mental health illness and/or minor injuries."[114] A variety of emergency services may exist, dependent on "capability, capacity, and function of the local VA medical facility;" however, emergency care must be uniformly available in all VHA emergency departments and UCCs.[115]

Because the emergency department or UCC is often the first point of contact for patients seeking treatment of unexpected medical issues, a care delivery system with appropriate resources and services must be available to deliver prompt, safe, and appropriate care. VHA requires that each emergency department provide "unrestricted access to appropriate and timely emergency medical and nursing care 24 hours a day, 7 days a week." VHA UCCs are also required to provide access and timely care during established operational hours. VHA also requires that "evaluation, management, and treatment [are] provided by qualified personnel with the knowledge and skills appropriate to treat those seeking emergency care."[116]

TJC noted that patient flow problems pose a persistent risk to quality and safety and established standards for the management of the flow of patients in the emergency department and the rest of the hospital. Managing the flow of patients prevents overcrowding, which can "undermine the timeliness of care and, ultimately, patient safety." Effective management processes that "support patient flow [in the emergency department or UCC settings] (such as admitting, assessment and treatment, patient transfer, and discharge) can minimize delays in the delivery of care."[117]

The VHA national director of Emergency Medicine developed the Emergency Medicine Improvement initiative to improve the quality of emergent and urgent care provided through VA emergency departments and UCCs. As part of this initiative, all VA emergency departments and UCCs must use the Emergency Department Integration Software (EDIS) tracking program to document and manage the flow of patients.[118]

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[114] VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016 (amended March 7, 2017).

[115] VHA Directive 1101.05(2).

[116] VHA Directive 1101.05(2).

[117] TJC. Leadership standard LD.04.03.11.

[118] VHA Directive 1101.05(2); The Emergency Medicine Management Tool (EMMT) uses data collected from EDIS to generate productivity metrics. The use of EDIS and EMMT are key tools in accomplishing Emergency Medicine Improvement initiative goals.

VA emergency departments and UCCs must also be designed to promote a safe environment of care.[119] Managers must ensure medications are securely stored,[120] a psychiatric intervention room is available,[121] and equipment and supplies are readily accessible to provide gynecologic and resuscitation services. VHA also requires emergency departments to have communication systems available to accept requests by local emergency medical services for transporting unstable patients to VA emergency departments.[122]

The OIG examined the clinical risks of the emergency department/UCC areas by evaluating the staffing; the provision of care, including selected aspects of mental health and women's health; and the reduction of patient safety risks to optimize quality care and outcomes in those areas. In addition to conducting manager and staff interviews, the OIG team reviewed emergency department staffing schedules, committee minutes, and other relevant documents. The OIG evaluated the following performance indicators:

- General
  - Presence of an emergency department or UCC
  - Availability of acute care medical and/or surgical inpatient beds in facilities with emergency departments
  - Emergency department/UCC operating hours
  - Workload capture process
- Staffing for emergency department/UCC
  - Dedicated medical director
  - At least one licensed physician privileged to staff the department at all times
  - Minimum of two registered nurses on duty during all hours of operation
  - Backup call schedules for providers
- Support services for emergency department/UCC
  - Access during regular hours, off hours, weekends, and holidays
  - On-call list for staff required to respond
  - Licensed independent mental health provider available as required for the facility's complexity level

[119] VHA Directive 1101.05(2).

[120] TJC. Medication Management standard MM.03.01.01.

[121] A psychiatric intervention room is where individuals experiencing a behavioral health crisis, including serious disturbances, agitation, or intoxication may be taken immediately on arrival.

[122] VHA Directive 1101.05(2).

  - Telephone message system during non-operational hours
  - Inpatient provider available for patients requiring admission
- Patient flow
  - EDIS tracking program
  - Emergency department patient flow evaluation
  - Diversion policy
  - Designated bed flow coordinator
- General safety
  - Directional signage to after-hours emergency care
  - Fast tracks[123]
- Medication security and labeling
- Management of patients with mental health disorders
- Emergency department participation in local/regional emergency medical services (EMS) system, if applicable
- Women veteran services
  - Capability and equipment for gynecologic examinations
- Life support equipment

High-Risk Processes Conclusion

The facility generally complied with many of the performance indicators used by the OIG team to assess the operations and management of the emergency department. However, the OIG identified the lack of a backup call schedule for emergency department providers that warranted a recommendation for improvement.

Specifically, VHA requires that emergency departments have a written "staffing contingency plan that includes a back-up call schedule to address situations where expedient mobilization of provider resources are needed."[124] The OIG team found that the facility lacked a backup call schedule for the emergency department providers. This could impact the facility's ability to provide uninterrupted and timely patient care. The emergency department director was unaware of the requirement.

[123] The emergency department fast track is a designated care area within the emergency department domain where lower acuity patients are assessed and treated.

[124] VHA Directive 1101.05(2).

Recommendation 14

14. The chief of staff makes certain that the emergency department director maintains a backup call schedule for emergency department providers and monitors the director's compliance.[125]

Facility concurred.

Target date for completion: October 2019

Facility Response: An Emergency Department (ED) Physician backup call schedule was developed; approved by the Chief of Staff and Emergency Department stakeholders (e.g., Inpatient Nursing Services, Emergency Department staff including physicians and the Nurse Manager); and implemented in May 2019. The backup call schedule includes pertinent / detailed information including shift definitions, physician coverage per shift, and guidelines for coverage such as expected availability and arranging for alternative/additional coverage as needed (e.g., physician illness, increase in patient demands).

The backup call schedule was communicated by the Emergency Department Director to Emergency Department stakeholders via email and verbally in May 2019. Compliance has been maintained continuously (i.e., 100%) since May 2019 when the backup call schedule was permanently posted above the monthly ED schedule in the physician work room.

We request closure of this recommendation based on the evidence provided.

[125] The OIG reviewed evidence sufficient to demonstrate that the facility had completed improvement actions and therefore closed the recommendation before the report's release.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Accreditation and/or for-cause surveys and oversight inspections • Factors related to possible lapses in care • VHA performance data	Fourteen OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the director, chief of staff, and associate director. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer reviews • UM reviews • Patient safety • Resuscitation episode review	• Clinicians complete peer reviews of all completed suicides that occur within seven days after discharge from inpatient mental health treatment or residential care units.	• Clinicians complete peer reviews for all applicable deaths within 24 hours of admission. • All required representatives consistently participate in interdisciplinary reviews of UM data.
Medical Staff Privileging	• Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank	• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Parent facility
	  ○ General safety
	  ○ Environmental cleanliness and infection prevention
	  ○ General privacy
	  ○ Women veterans program
	  ○ Availability of medical equipment and supplies
	• Community based outpatient clinic
	  ○ General safety
	  ○ Environmental cleanliness and infection prevention
	  ○ General privacy
	  ○ Women veterans program
	  ○ Availability of medical equipment and supplies
	• Locked inpatient mental health unit
	  ○ Mental health environment of care rounds
	  ○ Nursing station security
	  ○ Public area and general unit safety
	  ○ Patient room safety
	  ○ Infection prevention
	  ○ Availability of medical equipment and supplies
	• Emergency management
	  ○ Hazard vulnerability analysis (HVA)
	  ○ Emergency operations plan (EOP)
		• The nursing station in the mental health unit is secured from unauthorized access.	• Staff have immediate access to safety data sheets.
			• Clean and dirty medical equipment is stored separately.
			• The hazard vulnerability analysis and the emergency operations plan are approved by executive leadership.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	○ Emergency power testing and availability		

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Controlled Substances Inspections	• Controlled substances coordinator reports • Pharmacy operations • Controlled substances inspector requirements • Controlled substances area inspections • Pharmacy inspections • Facility review of override reports	• None	• Controlled substances inspection program staff reconcile one random day's return of stock to pharmacy from every automated dispensing cabinet during monthly inspections.
Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training	• Designated facility MST coordinator • Evidence of tracking MST-related data • Provision of clinical care • Completion of MST mandatory training requirement for mental health and primary care providers	• None	• Providers complete MST mandatory training within the required time frame.
Geriatric Care: Antidepressant Use among the Elderly	• Justification for medication initiation • Evidence of patient and/or caregiver education specific to the medication prescribed • Clinician evaluation of patient and/or caregiver understanding of the education provided • Medication reconciliation	• Clinicians provide and document patient/caregiver education about newly prescribed medications. • Clinicians review and reconcile medications.	• None
Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up	• Appointment of a women veterans program manager • Appointment of a women's health medical director or clinical champion • Facility Women Veterans Health Committee • Collection and tracking of cervical cancer screening data	• None	• The Women Veterans Health Committee includes all required core members. • The Women Veterans Health Committee reports to executive leadership.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	• Communication of abnormal results to patients within required time frame • Provision of follow-up care for abnormal cervical pathology results, if indicated		
High-Risk Processes: Operations and Management of Emergency Departments and UCCs	• General • Staffing for emergency department/UCC • Support services for emergency department /UCC • Patient flow • General safety • Medication security and labeling • Management of patients with mental health disorders • Emergency department participation in local/regional EMS system • Women veteran services • Life support equipment	• None	• A backup call schedule is maintained for emergency department providers.

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this high complexity (1b) affiliated[126] facility reporting to VISN 15.[127]

Table B.1. Facility Profile for Kansas City VA Medical Center (589) (October 1, 2015, through September 30, 2018)

Profile Element	Facility Data FY 2016[128]	Facility Data FY 2017[129]	Facility Data FY 2018[130]
Total medical care budget in dollars	$399,231,047	$399,081,236	$450,345,208
Number of:			
• Unique patients	60,298	49,903	49,238
• Outpatient visits	557,894	571,100	600,483
• Unique employees[131]	1,578	1,750	1,634
Type and number of operating beds:			
• Domiciliary	28	28	28
• Medicine	79	79	79
• Mental health	10	10	10
• Residential psychology	0	0	20
• Surgery	25	25	25
Average daily census:			
• Domiciliary	20	19	18
• Medicine	44	50	53
• Mental health	11	11	11
• Residential psychology	–	–	0

[126] Associated with a medical residency program.

[127] The VHA medical centers are classified according to a facility 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."

[128] October 1, 2015, through September 30, 2016.

[129] October 1, 2016, through September 30, 2017.

[130] October 1, 2017, through September 30, 2018.

[131] Unique employees involved in direct medical care (cost center 8200).

Profile Element	Facility Data FY 2016[128]	Facility Data FY 2017[129]	Facility Data FY 2018[130]
• Surgery	12	11	9

Source: VHA Support Service Center, and VA Corporate Data Warehouse
Note: The OIG did not assess VA's data for accuracy or completeness.

VA Outpatient Clinic Profiles[132]

The VA outpatient clinics in communities within the catchment area of the facility provide primary care integrated with women's health, mental health, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table B.2. provides information relative to each of the clinics.

Table B.2. VA Outpatient Clinic Workload/Encounters and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2017, through September 30, 2018)[133]

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[134] Provided	Diagnostic Services[135] Provided	Ancillary Services[136] Provided
Warrensburg, MO	589G1	6,413	2,029	Cardiology Hematology/Oncology Eye	n/a	Pharmacy Weight Management
Belton, MO	589GB	5,245	1,089	Cardiology Endocrinology Hematology/Oncology	n/a	Pharmacy Weight Management
Paola, KS	589GC	3,268	859	Cardiology Endocrinology Hematology/Oncology	n/a	Pharmacy Weight Management

[132] Includes all outpatient clinics in the community that were in operation as of February 8, 2019.

[133] The definition of an "encounter" can be found in VHA Directive 2010-049, *Encounter and Workload Capture for Therapeutic and Supported Employment Services Vocational Programs*, October 14, 2010. (This directive expired on October 31, 2015, and has not been updated.) An encounter is a "professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition."

[134] Specialty care services refer to non-primary care and non-mental health services provided by a physician.

[135] Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

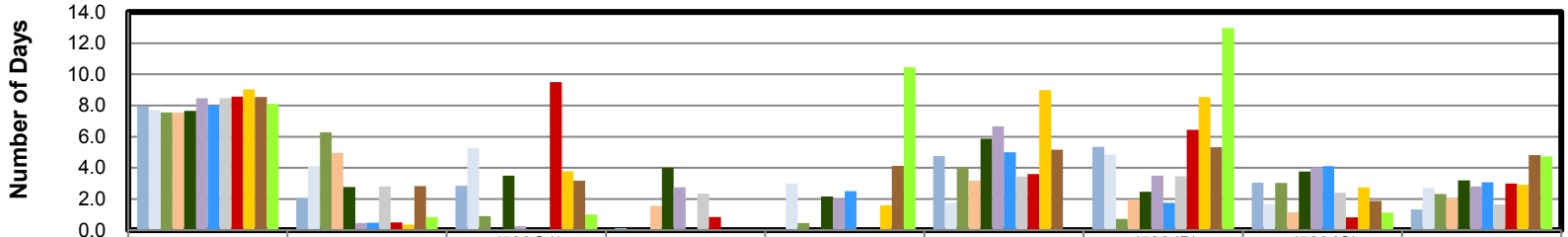
[136] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[134] Provided	Diagnostic Services[135] Provided	Ancillary Services[136] Provided
Nevada, MO	589GD	5,099	718	Cardiology Hematology/Oncology	Nuclear med	Pharmacy Weight Management
Cameron, MO	589GZ	1,967	183	Cardiology Hematology/Oncology	n/a	Pharmacy Weight Management
Excelsior Springs, MO	589JB	4,741	1,398	n/a	n/a	Pharmacy Weight Management
Shawnee, KS	589JC	5,734	406	Cardiology Endocrinology Pulmonary/Respiratory disease	n/a	Nutrition Pharmacy Weight Management
Kansas City, MO	589JF	21,997	11,713	Cardiology Endocrinology Gastroenterology Hematology/Oncology Nephrology Pulmonary/Respiratory disease Anesthesia GYN	Radiology	Pharmacy Weight Management
Overland Park, KS	589QA	554	n/a	Cardiology Endocrinology Hematology/Oncology	Nuclear med	Nutrition

Source: VHA Support Service Center and VA Corporate Data Warehouse
Note: The OIG did not assess VA's data for accuracy or completeness.
n/a = Not applicable

Appendix C: Patient Aligned Care Team Compass Metrics[137]

Quarterly New PC Patient Average Wait Time in Days



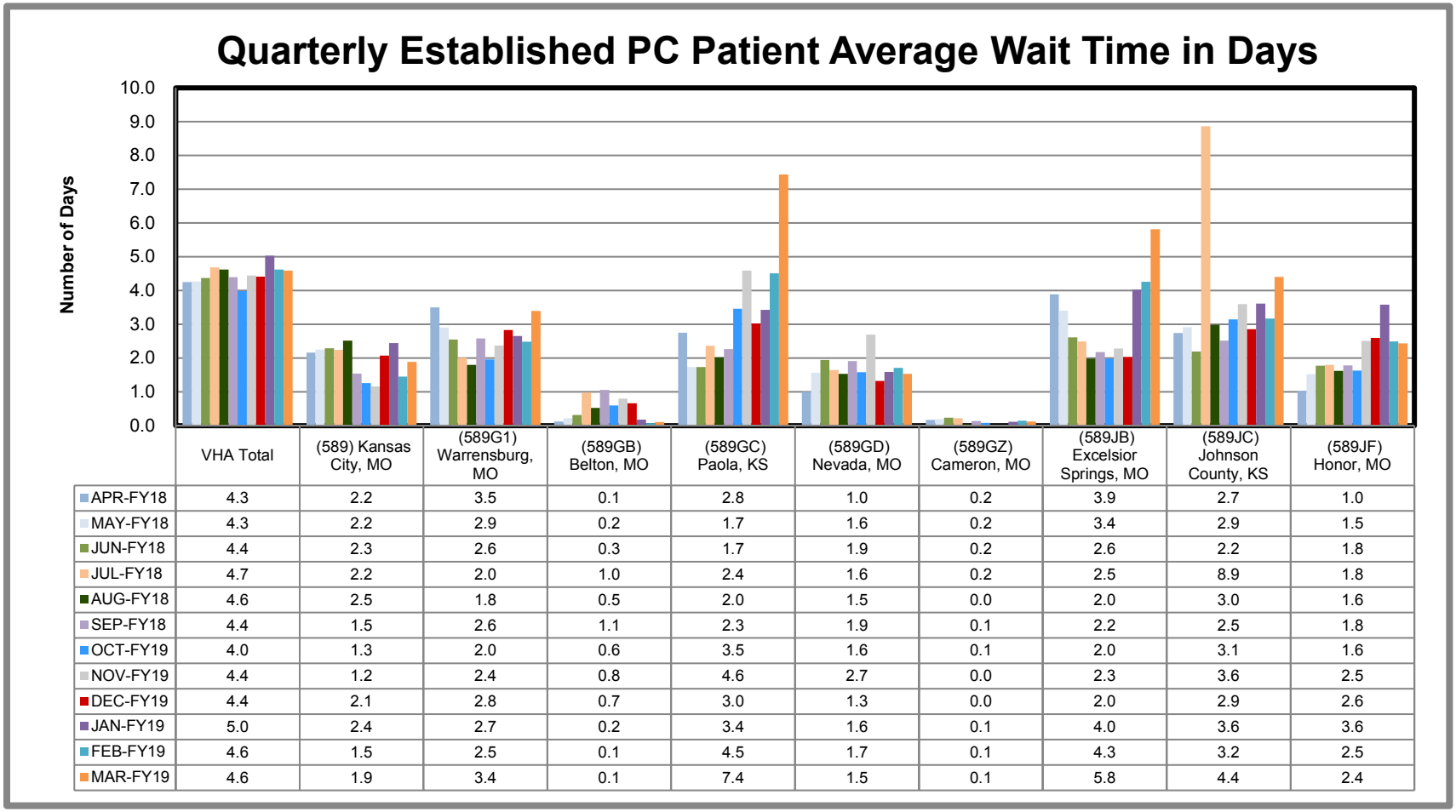
	VHA Total	(589) Kansas City, MO	(589G1) Warrensburg, MO	(589GB) Belton, MO	(589GC) Paola, KS	(589GD) Nevada, MO	(589JB) Excelsior Springs, MO	(589JC) Johnson County, KS	(589JF) Honor, MO
APR-FY18	7.9	2.1	2.9	0.1	0.0	4.8	5.4	3.0	1.3
MAY-FY18	7.7	4.1	5.3	0.0	3.0	1.8	4.9	1.7	2.7
JUN-FY18	7.6	6.3	0.9	0.0	0.5	4.0	0.7	3.0	2.3
JUL-FY18	7.5	5.0	0.0	1.6	0.0	3.2	2.0	1.2	2.0
AUG-FY18	7.7	2.8	3.5	4.0	2.2	5.9	2.5	3.8	3.2
SEP-FY18	8.5	0.5	0.3	2.8	2.0	6.7	3.5	4.0	2.8
OCT-FY19	8.0	0.5	0.0	0.0	2.5	5.0	1.8	4.1	3.1
NOV-FY19	8.5	2.8	0.0	2.3	0.0	3.4	3.5	2.4	1.7
DEC-FY19	8.6	0.5	9.5	0.8	0.0	3.6	6.4	0.8	3.0
JAN-FY19	9.0	0.4	3.8	0.0	1.6	9.0	8.5	2.8	2.9
FEB-FY19	8.5	2.8	3.2	0.0	4.1	5.2	5.3	1.9	4.8
MAR-FY19	8.1	0.9	1.0	0.0	10.4	0.0	13.0	1.1	4.7

Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Cameron, MO (589GZ), and Overland Park, KS (589QA), as no workload/encounters or services were reported.

Data Definition: "The average number of calendar days between a New Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date." Note that prior to FY15, this metric was calculated using the earliest possible create date.

[137] Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 13, 2018.



	VHA Total	(589) Kansas City, MO	(589G1) Warrensburg, MO	(589GB) Belton, MO	(589GC) Paola, KS	(589GD) Nevada, MO	(589GZ) Cameron, MO	(589JB) Excelsior Springs, MO	(589JC) Johnson County, KS	(589JF) Honor, MO
APR-FY18	4.3	2.2	3.5	0.1	2.8	1.0	0.2	3.9	2.7	1.0
MAY-FY18	4.3	2.2	2.9	0.2	1.7	1.6	0.2	3.4	2.9	1.5
JUN-FY18	4.4	2.3	2.6	0.3	1.7	1.9	0.2	2.6	2.2	1.8
JUL-FY18	4.7	2.2	2.0	1.0	2.4	1.6	0.2	2.5	8.9	1.8
AUG-FY18	4.6	2.5	1.8	0.5	2.0	1.5	0.0	2.0	3.0	1.6
SEP-FY18	4.4	1.5	2.6	1.1	2.3	1.9	0.1	2.2	2.5	1.8
OCT-FY19	4.0	1.3	2.0	0.6	3.5	1.6	0.1	2.0	3.1	1.6
NOV-FY19	4.4	1.2	2.4	0.8	4.6	2.7	0.0	2.3	3.6	2.5
DEC-FY19	4.4	2.1	2.8	0.7	3.0	1.3	0.0	2.0	2.9	2.6
JAN-FY19	5.0	2.4	2.7	0.2	3.4	1.6	0.1	4.0	3.6	3.6
FEB-FY19	4.6	1.5	2.5	0.1	4.5	1.7	0.1	4.3	3.2	2.5
MAR-FY19	4.6	1.9	3.4	0.1	7.4	1.5	0.1	5.8	4.4	2.4

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Overland Park, KS (589QA), as no workload/encounters or services were reported.
Note: The OIG did not assess VA's data for accuracy or completeness.
Data Definition: "The average number of calendar days between an Established Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date."

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[138]

Measure	Definition	Desired Direction
ACSC hospitalization	Ambulatory care sensitive conditions hospitalizations	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit reviews met	Percent acute admission reviews that meet interqual criteria	A higher value is better than a lower value
APP capacity	Advanced practice provider capacity	A lower value is better than a higher value
Best place to work	All employee survey best places to work score	A higher value is better than a lower value
Call responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Care transition	Care transition (Inpatient)	A higher value is better than a lower value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Comprehensiveness	Comprehensiveness (PCMH)	A higher value is better than a lower value
Cont stay reviews met	Percent acute continued stay reviews that meet interqual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Efficiency/capacity	Efficiency and physician capacity	A higher value is better than a lower value
Employee satisfaction	Overall satisfaction with job	A higher value is better than a lower value

[138] VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL)* (last updated December 26, 2018). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 7, 2019, but is not accessible by the public.)

Measure	Definition	Desired Direction
HC assoc infections	Health care associated infections	A lower value is better than a higher value
HEDIS like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
HEDIS like – HED90_1	HEDIS-EPRP based PRV TOB BHS	A higher value is better than a lower value
HEDIS like – HED90_ec	HEDIS-eOM based DM IHD	A higher value is better than a lower value
MH wait time	Mental health care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH continuity care	Mental health continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH exp of care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH popu coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	ORYX	A higher value is better than a lower value
PC routine care appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC urgent care appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PCMH care coordination	PCMH care coordination	A higher value is better than a lower value
PCMH same day appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH survey access	Timely appointment, care and information (PCMH)	A higher value is better than a lower value
Physician capacity	Physician capacity	A lower value is better than a higher value
PC wait time	PC wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value

Measure	Definition	Desired Direction
Rating hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RN turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-COPD	30-day risk standardized mortality rate for COPD	A lower value is better than a higher value
RSMR-pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-COPD	30-day risk standardized readmission rate for COPD	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value

Measure	Definition	Desired Direction
SC care coordination	SC (specialty care) care coordination	A higher value is better than a lower value
SC routine care appt	Timeliness in getting a SC routine care appointment (specialty care)	A higher value is better than a lower value
SC survey access	Timely appointment, care and information (specialty care)	A higher value is better than a lower value
SC urgent care appt	Timeliness in getting a SC urgent care appointment (specialty care)	A higher value is better than a lower value
Seconds pick up calls	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty care wait time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value
Telephone abandonment rate	Telephone abandonment rate	A lower value is better than a higher value

Source: VHA Support Service Center

Appendix E: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: November 7, 2019

From: Director, VA Heartland Network (10N15)

Subj: Comprehensive Healthcare Inspection of the Kansas City VA Medical Center, MO

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

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

1. I have reviewed the Comprehensive Healthcare Inspection of the Kansas City, MO VA Medical Center, and concur with the facility's response.

(Original signed by:)

William P. Patterson, MD, MSS
VA Heartland Network (VISN 15)

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

Appendix F: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: November 7, 2019

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

Subj: Comprehensive Healthcare Inspection of the Kansas City VA Medical Center, MO

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:)

DAVID ISAACKS, FACHE
Director

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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