DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

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

CHIP REPORT | REPORT #19-06850-208 | JULY 23, 2020

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Figure 1. *Kansas City VA Medical Center in Kansas City, MO (Source: https://vaww.va.gov/directory/guide/, accessed on January 28, 2020)*

Abbreviations

ADPCS	Associate Director for Patient Care Services
CBOC	community-based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
FPPE	focused professional practice evaluation
FY	fiscal year
HRS	high risk for suicide
LIP	licensed independent practitioner
LST	life-sustaining treatments
LSTD	life-sustaining treatments decision
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
QSV	quality, safety, and value
RME	reusable medical equipment
SAIL	Strategic Analytics for Improvement and Learning
SLB	state licensing board
SOP	standard operating procedure
SPC	suicide prevention coordinator
SPS	Sterile Processing Services
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WH-PCP	women's health primary care provider

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Kansas City VA Medical Center. 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, and at the time of the inspection, focused on the following clinical areas:

1. Quality, safety, and value
2. Medical staff privileging
3. Environment of care
4. Medication management (targeting long-term opioid therapy for pain)
5. Mental health (focusing on the suicide prevention program)
6. Care coordination (spotlighting life-sustaining treatment decisions)
7. Women's health (examining comprehensive care)
8. High-risk processes (emphasizing reusable medical equipment)

The unannounced visit was conducted during the week of November 18, 2019, at the Kansas City VA Medical Center and Shawnee VA Clinic. The OIG held interviews and reviewed processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this medical center'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 medical center and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

Leadership and Organizational Risks

At the time of the OIG's visit, the medical center's leadership team consisted of the Medical Center Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Associate Director, and Assistant Director. Organizational communications and accountability were managed through a committee reporting structure with the Director's Advisory Board having oversight for several working groups. The leaders monitored patient safety and care through the Quality, Safety, and Values Committee which was responsible for tracking and trending quality of care and patient outcomes.

When the team conducted this inspection, the medical center's executive leadership team appeared stable with all positions permanently assigned. The Director, appointed in September 2019, was the newest member of the leadership team. The Chief of Staff, the most tenured leader, was assigned in September 2014. The Associate Director, ADPCS, and Assistant Director had served in their positions since April 2018, April 2017, and September 2016, respectively.

The OIG noted that employee satisfaction survey results, specifically the Servant Leader Index Composite, revealed opportunities for the ADPCS to create a work environment where employees feel engaged and empowered.[1] Medical center patients appeared generally satisfied with the inpatient and specialty care provided. The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and did not identify any substantial organizational risk factors.[2]

The VA Office of Operational Analytics and Reporting adapted the Strategic Analytics for Improvement and Learning (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.

[1] According to the 2019 VA All Employee Survey Questions by Organizational Health Framework, the 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." http://aes.vssc.med.va.gov/Documents/SL_Index_FieldGuide.pdf. (The website was accessed on March 18, 2020, but is not accessible by the public.)

[2] 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."

The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[3]

The executive leaders, except for the newly assigned Director, appeared generally knowledgeable within their scope of responsibilities about VHA data and/or medical center-level factors contributing to specific poorly performing SAIL quality measures. In individual interviews, the executive leadership team members, apart from the new Director, were able to speak knowledgeably about actions taken during the previous 12 months to improve organizational performance, employee satisfaction, or patient experiences. However, the OIG noted that only 6 of 29 quality metrics that VHA uses to compare facilities showed high performance, indicating multiple opportunities exist for improvement.

The OIG noted areas for improvement in seven of eight clinical areas reviewed and issued 20 recommendations that are directed to the Director, Chief of Staff, ADPCS, and Associate Director. These are briefly described below.

Quality, Safety, and Value

The medical center complied with requirements for establishment of a committee responsible for quality, safety, and value oversight functions and protected peer reviews. However, the OIG noted a concern with the root cause analysis process.

Medical Staff Privileging

The OIG identified deficiencies with focused and ongoing professional practice evaluations and healthcare provider exit review processes.[4]

Environment of Care

The medical center largely met environmental cleanliness, privacy, and the selected inpatient mental health requirements at the medical center. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG noted concerns with

[3] VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL) Value Model*, https://vaww.vssc.med.va.gov/vsscenhancedproductmanagement/displaydocument.aspx?documentid=9428. (The website was accessed on March 6, 2020, but is not accessible by the public.)

[4] The definitions of focused professional practice evaluation and ongoing professional practice evaluations can be found within 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). An ongoing professional practice evaluation is "the ongoing monitoring of privileged providers to confirm the quality of care delivered and ensures patient safety." A focused professional practice evaluation is "a time-limited process whereby the clinical leadership evaluates the privilege-specific competence of a provider who does not yet have documented evidence of competently performing the requested privilege(s) at the facility."

medication safety at the medical center and patient privacy and information technology security at the Shawnee VA Clinic.

Medication Management

The OIG observed compliance with many elements of expected performance, including pain screening and justification for concurrent therapy with benzodiazepines. However, the OIG found deficiencies with aberrant behavior risk assessment, urine drug testing, informed consent, patient follow-ups, and quality measure oversight.

Mental Health

The medical center complied with the requirements for a suicide prevention coordinator, suicide safety plans, patient follow-up for missed appointments, outreach activities, and suicide prevention training for new nonclinical employees. However, the OIG noted a concern with annual suicide prevention refresher training.

Care Coordination

Generally, the medical center met expectations for life-sustaining treatment decisions progress notes and supervision of designees. However, the OIG determined that the medical center had no formal multidisciplinary committee for reviewing life-sustaining treatment plans.

High-Risk Processes

The medical center met many of the requirements for the proper operations and management of reprocessing reusable medical equipment. The OIG identified noncompliance with requirements for the annual risk analysis, airflow monitoring, environmental safety, equipment storage, and continuing education.

Conclusion

The OIG conducted a detailed inspection across nine key areas (one nonclinical and eight clinical) and subsequently issued 20 recommendations for improvement to the Medical Center Director, Chief of Staff, ADPCS, and Associate Director. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this medical center. The intent is for medical center 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 Medical Center Director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes F and G, pages 83–84, and the responses within the body of the report for the full text of the directors' comments.) The OIG has received evidence of compliance and considers recommendations 1, 7, 16, 17, 18, and 19 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities providing healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the Kansas City VA Medical Center examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and medical center leaders so that informed decisions can be made to improve care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.[1] Investments in a culture of safety and continuous quality improvement, in concert with robust leadership and communication, significantly contribute to positive patient outcomes.[2] Figure 2 illustrates 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, the OIG focused on core processes in the following nine areas of administrative and clinical operations:

1. Leadership and organizational risks
2. Quality, safety, and value (QSV)
3. Medical staff privileging
4. Environment of care
5. Medication management (targeting long-term opioid therapy for pain)
6. Mental health (focusing on the suicide prevention program)
7. Care coordination (spotlighting life-sustaining treatment decisions)
8. Women's health (examining comprehensive care)
9. High-risk processes (emphasizing reusable medical equipment)[3]

[1] 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 September 25, 2019.)

[2] Jamie Leviton and Jackie Valentine, "How risk management and patient safety intersect: Strategies to help make it happen," *Institute for Healthcare Improvement and National Patient Safety Foundation (NPSF)*, March 24, 2015.

[3] See Figure 2. CHIP inspections address these processes during FY 2020 (October 1, 2019, through September 30, 2020); they may differ from prior years' focus areas.

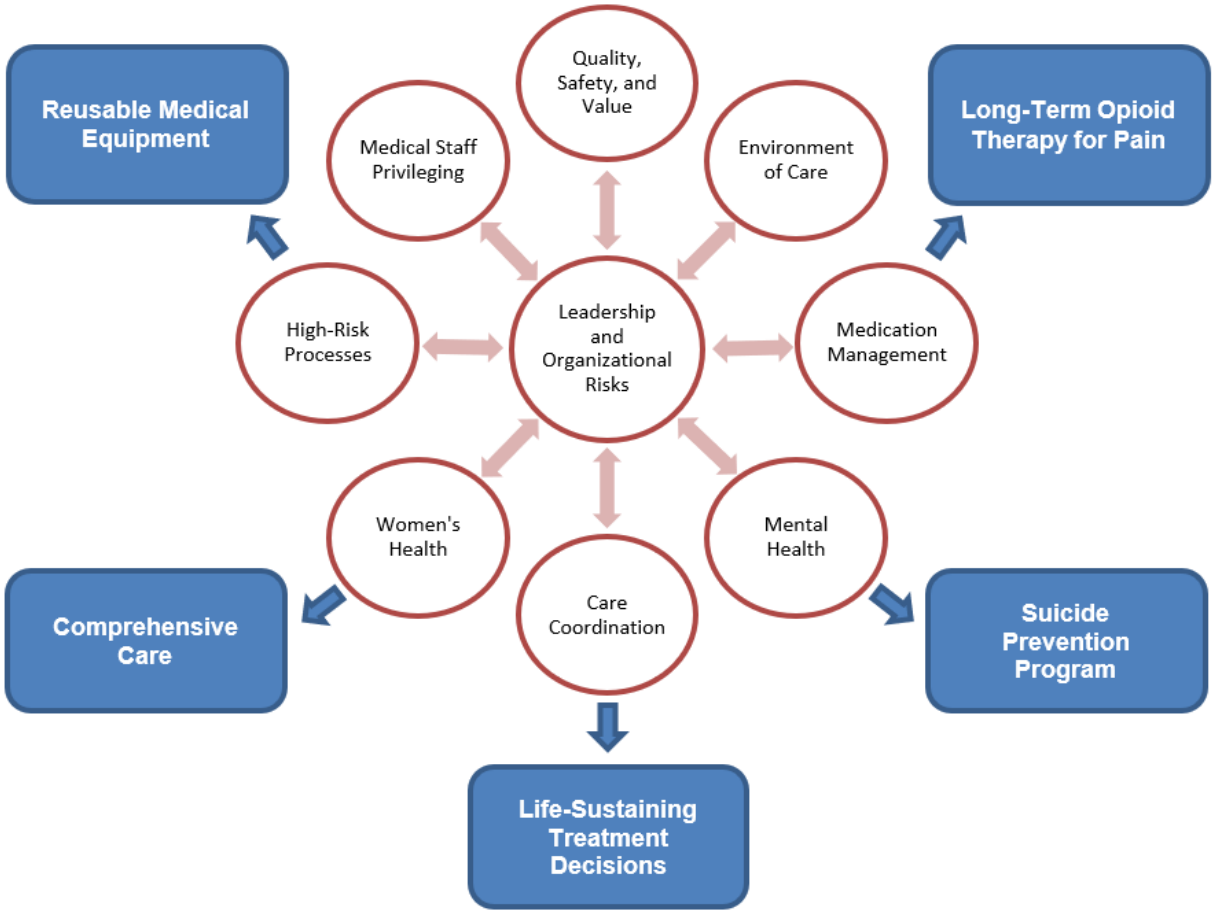

Figure 2. *Fiscal Year (FY) 2020 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

Methodology

The Kansas City VA Medical Center includes multiple outpatient clinics in Kansas and Missouri. Additional details about the types of care provided by the medical center can be found in Appendixes B and C.

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.[4]

The OIG team also selected and physically inspected the Shawnee VA Clinic and the following areas of the medical center:

- Acute mental health unit
- Emergency department
- Intensive care units (medical and surgical)
- Medical/surgical inpatient units (5West, 8East, and 8West)
- Outpatient clinics (podiatry and primary care clinics)
- Post-anesthesia care unit
- Progressive care unit
- Sterile processing services areas
- Substance abuse recovery and rehabilitation treatment program
- Women's health clinic

The OIG inspection team also interviewed executive leaders and discussed processes, validated findings, and explored reasons for noncompliance with staff.

The inspection period examined operations from May 4, 2019, through November 22, 2019, the last day of the unannounced multiday site visit.[5] The OIG did not receive any complaints beyond the scope of the CHIP inspection.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, §7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence within a specified scope and

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

[5] The range represents the time period from the prior CHIP inspection to the completion of the unannounced, multiday CHIP site visit in November 2019.

methodology and makes recommendations to VA leadership, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA medical center. Leadership and organizational risks can impact the medical center's ability to provide care in the clinical focus areas.[6] To assess the medical center's risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Employee satisfaction
3. Patient experience
4. Accreditation surveys and oversight inspections
5. Identified factors related to possible lapses in care and medical center response
6. VHA performance data (medical center)

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 medical center's reported organizational structure. The medical center has a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Associate Director, and Assistant Director. The Chief of Staff and ADPCS oversee patient care which requires managing service directors and chiefs of programs and practices.

[6] 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 November 6, 2019.)

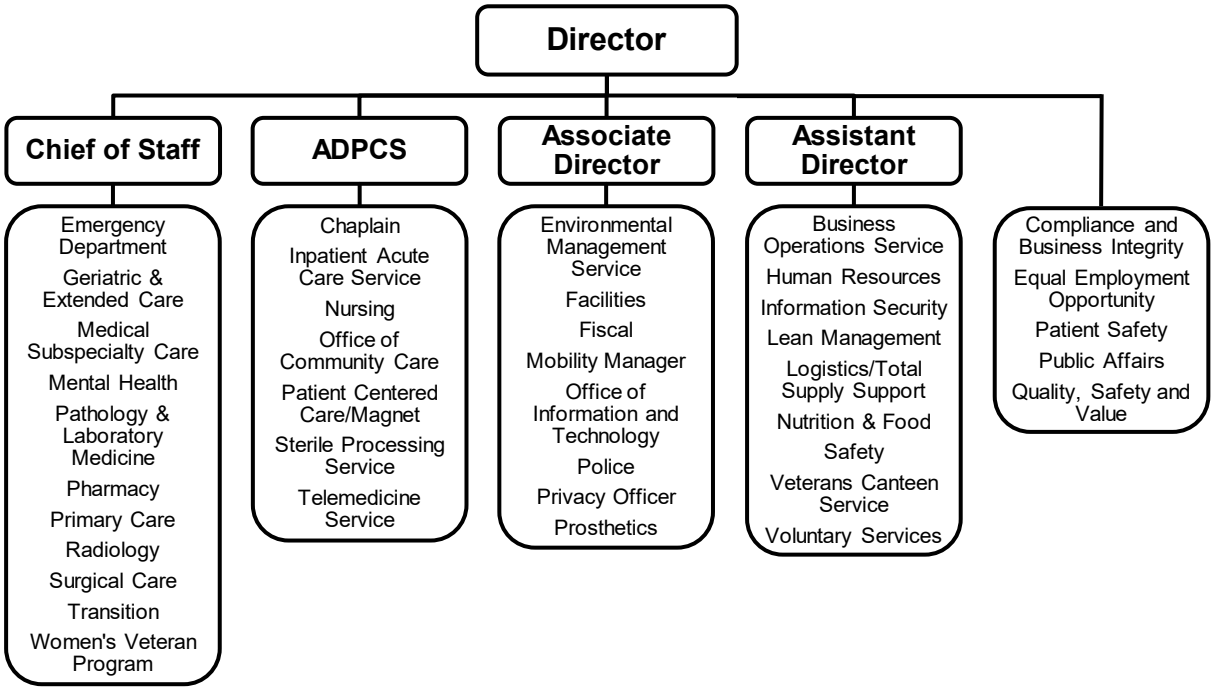

Figure 3. *Kansas City VA Medical Center Organizational Chart*
Source: Kansas City VA Medical Center (received November 18, 2019)

At the time of the OIG site visit, the executive team had been working together as a group for two months since the appointment of the Medical Center Director, although several team members had been in their positions for more than two years (see Table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	September 3, 2019
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 Officer (received November 18, 2019)

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

The leaders appeared generally knowledgeable 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, except for the Director who acknowledged being new to the position, appeared extremely knowledgeable within their scope of responsibilities about selected VHA SAIL quality measures. These are discussed in greater detail below.

The Director's Advisory Board serves as the Executive Committee of the Governing Body.[7] The medical center 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 Director's Advisory Board oversees various working groups, such as the Executive Committees of the Medical Staff, Nursing Services, and Administrative Staff and the Patient Experience Committee.

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.

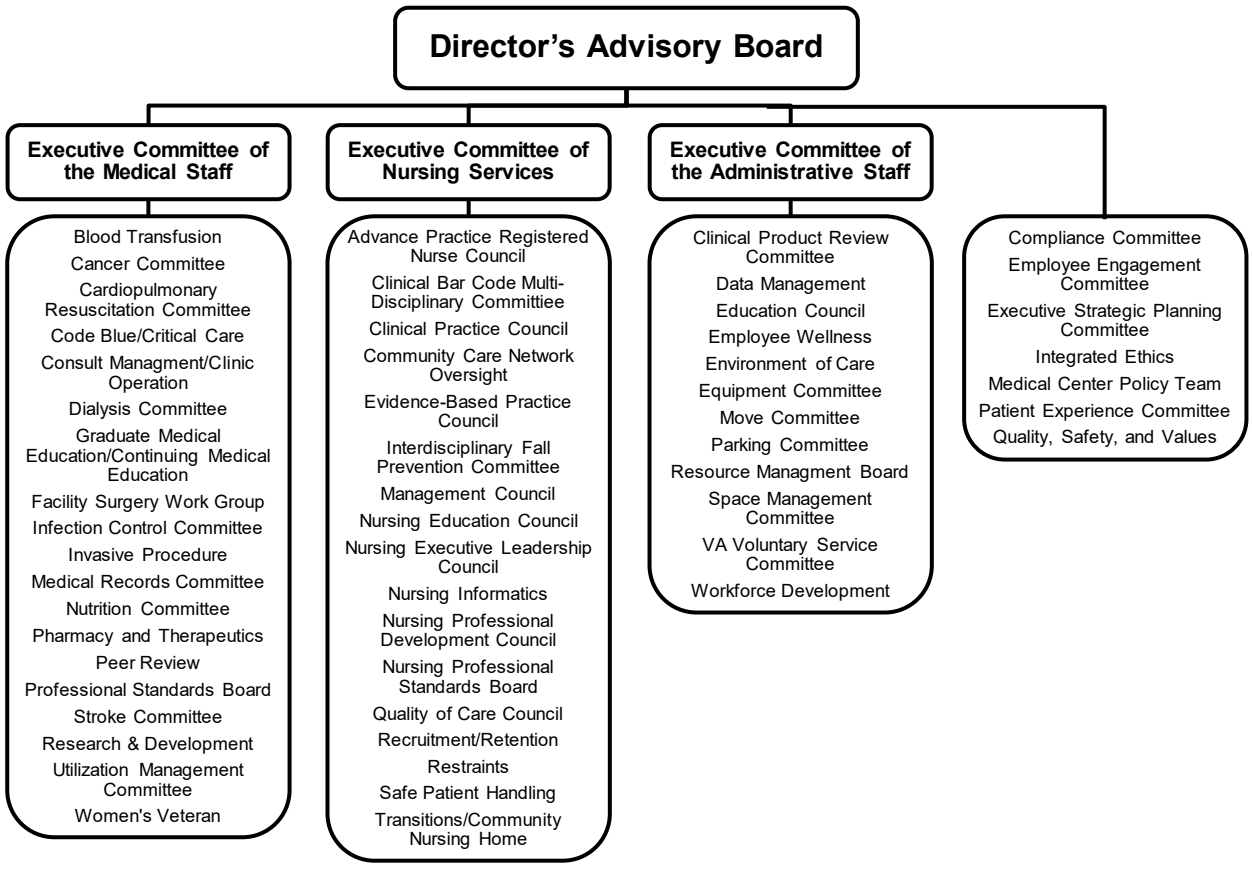

Figure 4. *Medical Center Committee Reporting Structure*
Source: Kansas City VA Medical Center (received November 18, 2019)

[7] Kansas City VA Medical Center, Medical Center Policy 00-11Q-021, *Director's Advisory Board*, April 17, 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 medical center leadership.

To assess employee attitudes toward medical center leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey that relate to the period of October 1, 2018, through September 30, 2019.[8] Table 2 provides relevant survey results for VHA, the medical center, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG noted that the overall medical center and executive leader averages for the Servant Leader Index Composite were higher than those for VHA with the exception of the ADPCS whose score was markedly lower. The ADPCS appeared to have opportunities to create a work environment where employees feel engaged and empowered. For the remaining survey questions, scores for the executive team members were generally similar to or higher than VHA averages.[9]

[8] 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. It is important to note that the 2019 All Employee Survey results are not reflective of employee satisfaction with the current Director.

[9] 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.

Table 2. Survey Results on Employee Attitudes toward Medical Center Leaders (October 1, 2018 through September 30, 2019)

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *Servant Leader Index Composite*[10]	0–100 where higher scores are more favorable	72.6	73.6	87.8	76.9	57.7	83.1	82.1
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.4	3.3	4.7	3.6	3.1	4.1	2.9
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.6	4.6	3.7	3.5	4.5	3.4
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.5	4.4	3.6	3.6	4.4	3.3

Source: VA All Employee Survey (accessed October 8, 2019)

[10] According to the 2019 VA All Employee Survey Questions by Organizational Health Framework, the 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." http://aes.vssc.med.va.gov/Documents/SL_Index_FieldGuide.pdf. (The website was accessed on March 18, 2020, but is not accessible by the public.)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[11] The medical center average for the selected survey questions was similar to the VHA average. Scores for the executive leaders were generally better than those for VHA and the medical center.

Table 3. Survey Results on Employee Attitudes toward the Workplace (October 1, 2018, through September 30, 2019)

Questions/ Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. 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	3.8	4.6	3.9	3.9	4.7	4.3
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	4.6	4.0	3.4	4.3	4.1
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)	1.4	1.4	1.1	1.4	1.1	0.9	1.7

Source: VA All Employee Survey (accessed October 8, 2019)

[11] 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. Again, it is important to note that the 2019 All Employee Survey results are not reflective of employee satisfaction with the current Director.

Patient Experience

To assess patient experiences with the medical center, which directly reflect on its leaders, the OIG team reviewed patient experience survey results that relate to the period of October 1, 2018, through June 30, 2019. 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 VHA and the medical center.[12]

VHA also collects SHEP data from Inpatient, Patient-Centered Medical Home, and Specialty Care Surveys. The OIG reviewed responses to four relevant survey questions that reflect patients' attitudes toward their healthcare experiences (see Table 4). For this medical center, the patient survey results generally reflected similar or higher care ratings than the VHA average, except for the outpatient Patient-Centered Medical Home result which highlights opportunities for leaders to improve patient experiences.

Table 4. Survey Results on Patient Experience (October 1, 2018, through June 30, 2019)

Questions	Scoring	VHA Average	Medical Center 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.	68.1	68.1
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.	84.9	88.9
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.	77.3	71.8

[12] Ratings are based on responses by patients who received care at this medical center.

Questions	Scoring	VHA Average	Medical Center Average
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.	78.0	81.5

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed October 9, 2019)

In 2015, women represented 9.4 percent of the total veteran population in the United States, and it is projected that women will represent 16.3 percent of living veterans by 2043. Further, from 2005 to 2015, the number of women veterans using VA health care increased by 46.4 percent, from almost 240,000 to 455,875.[13] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant survey questions that reflect patients' experiences by gender (see Tables 5–7), including those for Inpatient, Patient-Centered Medical Home, and Specialty Care Surveys. The OIG noted that the results for male inpatient respondents were generally similar to or more favorable than the corresponding VHA averages. Both male and female patients' specialty care experiences were also generally more positive than all VHA patients nationally. However, male and female respondents' experiences with outpatient Patient-Centered Medical Home were generally less favorable than all VHA patients nationally.

[13] VA National Center for Veterans Analysis and Statistics, *The Past, Present and Future of Women Veterans*, February 2017.

Table 5. Inpatient Survey Results on Experiences by Gender (October 1, 2018, through June 30, 2019)

Questions	Scoring	VHA[14]		Medical Center[15]	
		Male Average	Female Average	Male Average	Female Average
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.3	83.6	84.8	–[16]
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.7	83.0	84.6	–
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	68.5	62.0	69.0	–

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed October 9, 2019)

[14] The VHA averages are based on 34,077–34,469 male and 1,647–1,665 female respondents, depending on the question.

[15] The Kansas City VA Medical Center averages are based on 257–262 male and six female respondents, depending on the question.

[16] Data are not available due to a low number of respondents.

Table 6. Patient-Centered Medical Home Survey Results on Patient Experiences by Gender (October 1, 2018, through June 30, 2019)

Questions	Scoring	VHA[17]		Medical Center[18]	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.8	43.2	55.7	36.7
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	59.8	49.5	57.6	75.1
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	71.0	64.8	64.8	59.8

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed October 9, 2019)

[17] The VHA averages are based on 60,437–183,790 male and 4,400–9,816 female respondents, depending on the question.

[18] The Kansas City VA Medical Center averages are based on 645–1,792 male and 31–73 female respondents, depending on the question.

Table 7. Specialty Care Survey Results on Patient Experiences by Gender (October 1, 2018, through June 30, 2019)

Questions	Scoring	VHA[19]		Medical Center[20]	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	48.3	44.4	56.5	–[21]
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	56.3	53.9	61.9	76.0
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	69.9	69.4	69.1	72.4

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed October 9, 2019)

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.[22] Table 8

[19] The VHA averages are based on 50,373–158,294 male and 2,617–8,357 female respondents, depending on the question.

[20] The Kansas City VA Medical Center averages are based on 369–1,064 male and 6–45 female respondents, depending on the question.

[21] The SHEP inpatient composite percentages are weighted to reflect the numbers of patients at different locations and respondent characteristics (i.e., age, gender). Weighted response percentages cannot be derived from the N (number of results) for fewer than 30 respondents at a location. Introduction page of VISN Patient Experience FY report. http://vaww.car.rtp.med.va.gov/programs/shep/shepReportsOuthQLImp.aspx. (The website was accessed on March 10, 2020, but is not accessible by the public.)

[22] The Joint Commission 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.

summarizes the relevant medical center inspections most recently performed by the OIG.[23] Of note, at the time of the OIG visit, the report for the previous OIG comprehensive healthcare inspection conducted in April 2019 was recently published.[24] Therefore, 12 recommendations remain open because insufficient time had elapsed to close the recommendations.

At the time of the site visit, the OIG team also noted the medical center's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[25]

Table 8. Office of Inspector General Inspection

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection of the Kansas City VA Medical Center Missouri,* Report No. 18-06504-27*,* December 12, 2019)	April 2019	14	12

Source: OIG and TJC (inspection/survey results verified with the QSV Chief on November 19, 2019)

Identified Factors Related to Possible Lapses in Care and Medical Center Response

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a medical center, 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. The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors.

[23] A Joint Commission survey had not been performed since the previous OIG comprehensive healthcare inspection conducted in April 2019.

[24] VA Office of Inspector General, *Comprehensive Healthcare Inspection Program Review of the Kansas City VA Medical Center*, Missouri, Report No. 18-06504-27, December 12, 2019.

[25] 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 9 lists the reported patient safety events from May 4, 2019 (the prior OIG comprehensive healthcare inspection), through November 22, 2019.[26]

Table 9. Summary of Selected Organizational Risk Factors (May 4, 2019, through November 22, 2019)

Factor	Number of Occurrences
Sentinel Events[27]	1
Institutional Disclosures[28]	4
Large-Scale Disclosures[29]	0

Source: Kansas City VA Medical Center QSV Chief (received November 19, 2019)

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.[30]

[26] 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.)

[27] 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."

[28] 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."

[29] 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."

[30] VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL) Value Model*, https://vaww.vssc.med.va.gov/vsscenhancedproductmanagement/displaydocument.aspx?documentid=9428. (The website was accessed on March 6, 2020, but is not accessible by the public.)

Figure 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2019. Of note, Figure 5 uses blue and green data points to indicate high performance (for example, capacity and adjusted length of stay (LOS)). Metrics that need improvement are denoted in orange and red (for example, call responsiveness, complications, registered nurse (RN) turnover, and health care (HC) associated (Assoc) infections). It is important to note that of the 29 quality of care measures, only six indicated high performance for the medical center.[31] Multiple opportunities exist for this medical center to improve performance.

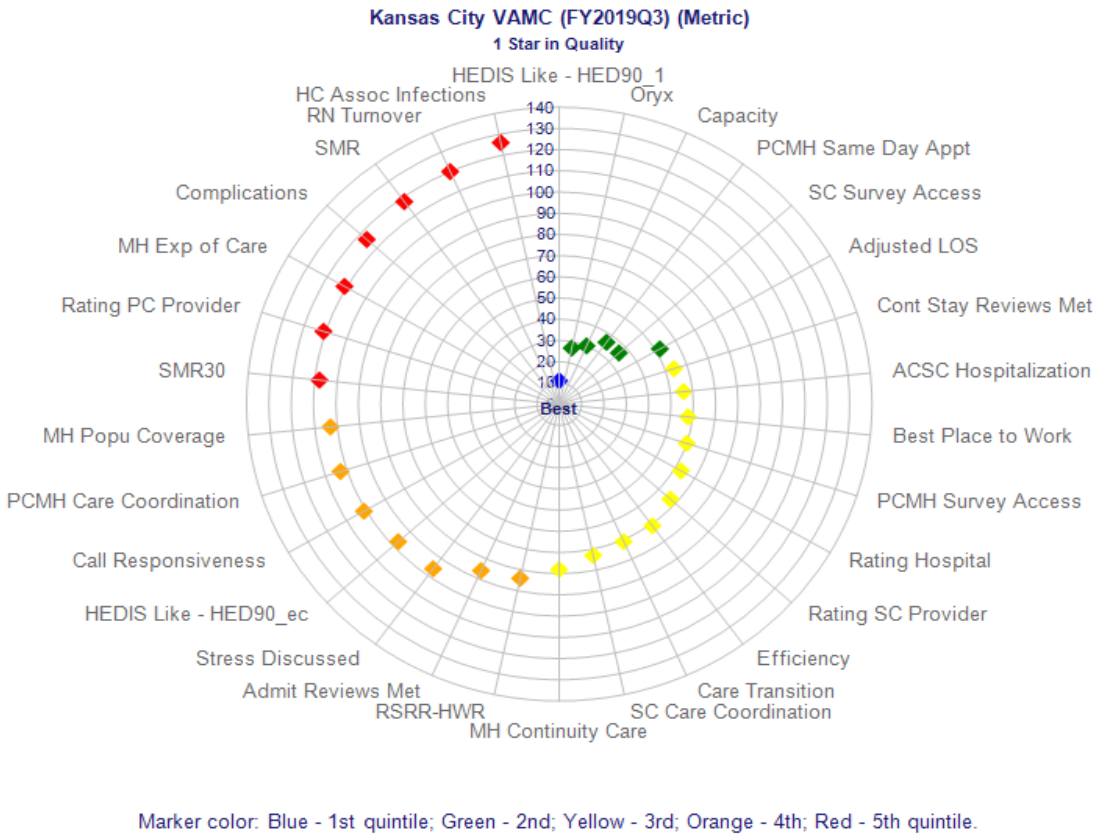

Figure 5. *Medical Center Quality of Care and Efficiency Metric Rankings (as of June 30, 2019)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

Leadership and Organizational Risks Conclusion

The medical center's executive leadership team appeared stable with all positions filled at the time of the OIG's on-site inspection. Specific survey items related to employees' satisfaction with the medical center executive leaders revealed opportunities for the ADPCS to improve employee satisfaction by creating an environment where employees feel engaged and

[31] For information on the acronyms in the SAIL metrics, please see Appendix E.

empowered. Medical center patients appeared generally satisfied with the inpatient and specialty care provided. The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. In individual interviews, the executive leaders, except for the newly appointed Director, were able to speak knowledgeably about actions taken during the previous 12 months to maintain or improve employee satisfaction and patient experiences. In addition, the executive leaders were generally knowledgeable within their scope of responsibilities about VHA data and/or medical center-level factors contributing to specific poorly performing SAIL quality measures. However, the OIG noted that only 6 of 29 VHA quality metrics showed high performance compared to other facilities—indicating multiple opportunities exist for improvement.

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.[32] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and to maintain Joint Commission accreditation.[33] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[34]

To determine whether VHA facilities have implemented and incorporated OIG-identified key processes for quality and safety into local activities, the inspection team evaluated the medical center's committee responsible for quality, safety, and value (QSV) oversight functions; its ability to review data, information, and risk intelligence; and its ability to ensure that key QSV functions are discussed and integrated on a regular basis. Specifically, OIG inspectors examined the following requirements:

- Review of aggregated QSV data
- Recommendation and implementation of improvement actions
- Monitoring of fully implemented improvement actions

The OIG reviewers also assessed the medical center's processes for conducting protected peer reviews of clinical care.[35] Protected peer reviews, when conducted systematically and credibly, reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[36] The OIG team examined the completion of the following elements:

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

[33] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.

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

[35] 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. In the context of protected peer reviews, "protected" refers to the designation of review as a confidential quality management activity under 38 U.S.C. 5705 as "a Department systematic health-care review activity designated by the Secretary to be carried out by or for the Department for improving the quality of medical care or the utilization of health-care resources in VA facilities."

[36] VHA Directive 1190.

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- 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[37]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee
- Quarterly review of Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Next, the inspection team assessed the medical center's utilization management (UM) program, a key component of VHA's framework for quality, safety, and value, which provides vital tools for managing the quality and the efficient use of resources.[38] 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.[39] Inspectors reviewed several aspects of the UM program:

- Completion of at least 80 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
- Implementation and monitoring of improvement actions recommended by the interdisciplinary UM group

Finally, the OIG reviewers assessed the medical center's reports of patient safety incidents with related root cause analyses.[40] 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 medical center vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly

[37] VHA Directive 1190.

[38] According to VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014, amended April 30, 2019, UM reviews include evaluating the "appropriateness, medical need, and efficiency of health care services according to evidence-based criteria."

[39] VHA Directive 1117(2).

[40] The definition of a root cause analysis can be found within VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. 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."

communicate potential and actual causes of harm to patients throughout the medical center.[41] The medical center was assessed for its performance on several dimensions:

- Annual completion of a minimum of eight root cause analyses[42]
- Inclusion of required content in root cause analyses
- 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 medical center leaders

The OIG reviewers 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.[43]

Quality, Safety, and Value Findings and Recommendations

The OIG determined that the medical center complied with requirements for establishment of a committee responsible for QSV oversight functions and protected peer reviews. However, the OIG identified that the UM Committee lacked consistent representation from two required members based on four quarters of meeting minutes reviewed. This is a repeat finding from the April 2019 OIG CHIP site visit for which the medical center's improvement actions remain in progress.[44] The OIG reviewers made no new recommendation.

Further, the OIG identified a concern with submission of completed root cause analyses to the National Center for Patient Safety within 45 days.

VHA requires that a root cause analysis be timely and submitted to the National Center for Patient Safety within 45 days of becoming aware that an analysis is required.[45] The OIG found

[41] VHA Handbook 1050.01.

[42] 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]."

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

[44] VA Office of Inspector General, Comprehensive *Healthcare Inspection Program Review of the Kansas City VA Medical Center, Missouri*, Report No. 18-06504-27, December 12, 2019.

[45] VHA Handbook 1050.01.

that three of five root cause analyses reviewed were not submitted within 45 days.[46] A delay in completing and submitting root cause analyses potentially hinders timely identification and correction of system vulnerabilities that contribute to patient harm events. The Patient Safety Manager attributed the delay to the former Director conducting additional reviews with the executive team prior to approving each analysis for submission to the National Center for Patient Safety.

Recommendation 1

1. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that the Patient Safety Manager submits each root cause analysis to the National Center for Patient Safety within the required time frame.[47]

[46] National Center for Patient Safety (NCPS) is the Department of Veterans Affairs National Center for Patient Safety, established to lead VA's patient safety efforts and develop and nurture a culture of safety throughout Veterans Health Administration. The goal is nationwide reduction and prevention of inadvertent harm to patients as a result if their care. NCPS provides a confidential, non-punitive electronic reporting system that allows users from around the country to electronically document patient safety information. This centralized secure database allows for lessons to be learned that can benefit the entire VHA healthcare system.

[47] The OIG reviewed evidence sufficient to demonstrate that the medical center had completed improvement actions and therefore closed the recommendation before publication of the report.

Medical center concurred.

Target date for completion: Completed

Medical center response: The current Medical Center Director along with Patient Safety evaluated additional reasons for noncompliance. Previously, each root cause analysis was presented to the Executive Leadership Team within the 45-day timeframe allotted by National Center for Patient Safety. In some cases, the former Medical Center Director withheld concurrence until additional information could be ascertained. The reasons for non-compliance of late root cause analysis submissions were discussed by Executive Leadership and Patient Safety to ensure the development of strong plans of action that would support good outcomes.

In order to strengthen internal process related to timely submission of root cause analyses, Patient Safety has been collaborating with Service Chiefs and the Executive Leadership Team to ensure they are advised of the root cause analysis team findings and action recommendations prior to the final presentation to the Medical Center Director and the Executive Leadership Team. Since Patient Safety has been collaborating with key stakeholders, concurrence has been gained prior to the final presentation of the root cause analysis findings, and root cause analyses have been submitted in a timely manner.

Furthermore, seven root cause analyses were completed from October 1, 2019 through April 30, 2020. The completed root cause analyses were submitted to the National Center for Patient Safety within the required time frame as noted from the "*Root Cause Analyses Sent to National Center for Patient Safety Tracking Report*" created from the National Center for Patient Safety database.

Specifically, October 2019, root cause analyses cases DW0015 and DW0016 were submitted at 43 days and 44 days, respectively. November 2019, root cause analyses cases DW0017 and DW0018 were both submitted at 45 days. January 2020, root cause analyses cases DW0019 and DW0020 were submitted at 38 and 44 days, respectively. March 2020, root cause analysis case DW0021 was submitted at 41 days. Furthermore, there were no required root cause analysis submissions for the months of December 2019; February 2020; and April 2020.

The aggregated data was reviewed for the first seven months of Fiscal Year 2020 (October 1, 2019 through April 30, 2020). The cumulative compliance rate is 100%. Closure is requested for this recommendation based on the supporting documentation provided.

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).[48]

Clinical privileges need to be specific and based on the individual practitioner'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 reprivileging prior to their expiration.[49]

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 process occurs when a provider is hired at the facility and granted initial privileges and before any new medical privileges are granted. Additionally, VA facilities must continuously monitor the performance of their providers. VHA requirements state that "the on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation (OPPE), is essential to confirm the quality of care delivered."[50] The OIG examined various requirements for FPPEs and OPPEs:

- FPPEs
  - Establishment of criteria in advance
  - Use of minimum criteria for selected specialty LIPs[51]
  - Clear documentation of the results and time frames
  - Evaluation by another provider with similar training and privileges
- OPPEs
  - Application of criteria specific to the service or section
  - Use of minimum criteria for selected specialty LIPs[52]
  - Evaluation by another provider with similar training and privileges

[48] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[49] VHA Handbook 1100.19.

[50] VHA Handbook 1100.19.

[51] VHA Acting Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016.

[52] VHA Acting DUSHOM, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016.

The OIG also determined whether service chiefs recommended continuing the LIPs' current privileges based in part on the results of OPPE activities and if the medical center's Executive Committee of the Medical Staff decided to recommend continuing privileges based on FPPE and OPPE results.

Further, VA must put processes in place to reasonably ensure that its healthcare staff meet or exceed professional practice standards for delivering patient care. When there is a serious concern regarding a current or former licensed practitioner's clinical practice, VA has an obligation to notify state licensing boards (SLBs) and to subsequently respond to inquiries from SLBs concerning the licensed practitioner's clinical practice.[53] Further, "VA medical facility Directors must designate an individual, and backup, to be responsible for the SLB reporting process. This individual will be the subject matter expert (SME) for the facility…and ensure oversight of the exit review process, including receipt, review, and maintenance of the Provider Exit Review Forms."[54] The OIG reviewers assessed whether the medical center's staff

- Designated an individual and backup responsible for the SLB reporting process,
- Completed forms within the required time frame and with required oversight, and
- Reported results to SLBs when indicated.

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

- One solo/few practitioner who underwent initial or reprivileging during the previous 12 months[55]
- Ten LIPs hired within 18 months before the site visit
- Twenty LIPs privileged within 12 months before the visit
- Twenty LIPs who left the medical center in 12 months before the visit

Medical Staff Privileging Findings and Recommendations

The OIG identified weaknesses with FPPE, OPPE, and provider exit review processes.

For FPPEs, VHA requires the criteria "to be defined in advance, using objective criteria accepted by the practitioner."[56] The OIG reviewers found that all 11 FPPEs reviewed for

[53] VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, December 22, 2005.

[54] VHA Notice 2018-05, *Amendment to VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards*, February 5, 2018.

[55] 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 less than three providers in the facility that are privileged in a particular specialty. The 12-month review period was from November 4, 2018, through November 4, 2019.

[56] VHA Handbook 1100.19.

LIPs hired within the previous 18 months, including the one solo/few LIP, lacked evidence that the LIPs were aware of the FPPE criteria in advance. This could result in LIPs' misunderstanding of FPPE expectations. The Associate Chief of Staff/Acting Deputy Chief of Staff was unaware of the requirement to inform practitioners of the defined criteria and believed that the current practice of notifying newly-hired providers of the FPPE process during onboarding/orientation met standards.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures clinical managers define in advance, communicate, and document expectations for focused professional practice evaluations in the providers' profiles.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff along with the Medical Staff Affairs Coordinator met to determine additional reasons for non-compliance. Specifically, Focused Professional Practice Evaluation procedures were re-evaluated to determine appropriate measures to strengthen internal processes. It was determined the Focused Professional Practice Evaluation forms did not ensure that criteria were accepted by the practitioner because there was no standardized means to validate this. Therefore, the Focused Professional Practice Evaluation document entitled, "*Monitor and Evaluation of Practitioner's Performance*" form was revised. This form is utilized for Initial Focused Professional Practice Evaluation appointment and Focused Professional Practice Evaluation for added privileges. In addition, a statement clarifying that criteria must be determined prior to the Executive Committee of Medical Staff / Professional Standards Board meeting where the request will be discussed was added as well as a place for the practitioner to acknowledge the Focused Professional Practice Evaluation criteria. Furthermore, the revised form was presented for review to the Executive Committee of Medical Staff / Professional Standards Board meeting held in December 2019. The form was approved in February 2020. The newly revised Focused Professional Practice Evaluation form was fully implemented in March 2020 and is being utilized for all Focused Professional Practice Evaluations for initial or added privileges.

The Chief of Staff will ensure compliance is monitored ongoing by providing oversight to Focused Professional Practice Evaluation processes including audits that will be completed on 100% of the Focused Professional Practice Evaluation "*Monitor and Evaluation of Practitioner's Performance*" forms. Compliance will be monitored monthly and any pending acknowledgments of the Focused Professional Practice Evaluation by the provider will be followed through 100% completion.

This new process requires that all Focused Professional Practice Evaluations include the provider acknowledgement prior to closure. Audits began in March 2020 and will continue monthly until a compliance of 90% or greater is achieved for two-consecutive quarters. The denominator will be the total number of Focused Professional Practice Evaluation "*Monitor and Evaluation of Practitioner's Performance*" forms reviewed. The numerator will be the total number of forms that accurately included the provider's acknowledgement of the criteria prior to closure.

Monitoring data will be reported quarterly to the Executive Committee of Medical Staff / Professional Standards Board until this recommendation is closed.

VHA requires that the determination to continue current privileges is based, in part, on OPPE activities such as direct observation, clinical pertinence reviews, and clinical discussions.[57] VHA

[57] VHA Handbook 1100.19.

also requires the Executive Committee of the Medical Staff recommend continuing privileges based on OPPE results. Committee minutes must indicate the materials reviewed and the rationale for the conclusion. The committee's recommendation is then submitted to the Medical Center Director for approval.[58] For 9 of 20 practitioners who were reprivileged within the last 12 months, service chiefs could not demonstrate that determination to continue privileges was based in part on OPPE activities. Consequently, the Executive Committee of the Medical Staff's decision, through the Professional Standards Board, to recommend continuation of privileges was not based on OPPE data. This resulted in inadequate data to support decisions to continue clinical privileges for these LIPs. The Chief of Quality, Safety, and Values attributed the noncompliance to the lack of a defined process to collect and maintain supporting OPPE data, resulting in the service chiefs' failure to provide evidence to the credentialing and privileging staff, Professional Standards Board, and Executive Committee of the Medical Staff.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that service chiefs' reprivileging recommendations are based on ongoing professional practice evaluation activities.

[58] VHA Handbook 1100.19.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff along with the Quality, Safety, and Value leadership met to determine additional reasons for non-compliance. A review of Ongoing Professional Practice Evaluation processes was completed that included discussion with Quality, Safety, and Value and executive leadership. As a result, the Medical Staff Affairs Coordinator was given direct oversight of Ongoing Professional Practice Evaluation processes. This change was effective as of February 2020. At this time, Ongoing Professional Practice Evaluation requirements were informally reviewed and reinforced with all Service Chiefs during the Executive Committee of the Medical Staff / Professional Standards Board meeting. Formal review and reinforcement of Ongoing Professional Practice Evaluation processes are scheduled to occur in the June 2020 Executive Committee of the Medical Staff / Professional Standards Board meeting.

The Chief of Staff will ensure compliance is monitored by providing oversight to Ongoing Professional Practice Evaluation processes. Audits will be completed on 100% of all reprivileging requests for inclusion of Service Chief acknowledgment that the provider's Ongoing Professional Practice Evaluation was reviewed as part of the recommendation for continuation/renewal of clinical privileges. Furthermore, the Chief of Staff via the Chief, Quality, Safety, and Value along with the Medical Staff Affairs Coordinator will maintain Ongoing Professional Practice Evaluation data that will be used to support renewal of privileges.

Audits began in June 2020 and will continue monthly until a compliance of 90% or greater is achieved for two-consecutive quarters. The denominator will be the total number of reprivileging requests reviewed. The numerator will be the total number of forms that accurately included the Service Chief acknowledgment that the provider's Ongoing Professional Practice Evaluation was reviewed as part of the recommendation for continuation/renewal of clinical privileges.

Monitoring data will be reported quarterly to the Executive Committee of Medical Staff / Professional Standards Board until this recommendation is closed.

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that the Executive Committee of the Medical Staff's decision to recommend continuation of privileges is based on ongoing professional practice evaluation results.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff along with the Medical Staff Affairs Coordinator met to determine additional reasons for non-compliance. It was determined that inclusion of the reference to providers' most recent Ongoing Professional Practice Evaluation in Executive Committee of the Medical Staff; and Executive Committee of the Medical Staff / Professional Standards Board meeting minutes was found to be inconsistent. As a result, the Chief of Staff has ensured that the most recent results of the Ongoing Professional Practice Evaluation are included in Executive Committee of the Medical Staff / Professional Standards Board meeting minutes. Furthermore, at the beginning of each Ongoing Professional Practice Evaluation cycle, Service Chiefs are reminded that determination to continue privileges is based in part on Ongoing Professional Practice Evaluation activities. In addition, the medical staff are reminded of this via verbal communication from the Chief of Staff in Executive Committee of the Medical Staff/Professional Standards Board meetings as well as regular staff meetings held throughout the year.

Inclusion of the reference to providers' most recent Ongoing Professional Practice Evaluation in Executive Committee of the Medical Staff / Professional Standards Board meeting minutes was found to be inconsistent. In order to ensure compliance, the Chief of Staff verifies the Ongoing Professional Practice Evaluation information is included for Executive Committee of the Medical Staff / Professional Standards Board approval, for each provider being considered for renewal of clinical privileges, by reviewing and drafting the write-up for the minutes. Secondary and tertiary administrative reviews of requests for reprivileging occur as well to ensure that the provider's Ongoing Professional Practice Evaluation results are considered as part of the renewal of privileges.

The Chief of Staff will monitor compliance by ensuring the data from the audits described in Recommendation 3 regarding reprivileging requests for the provider's Ongoing Professional Practice Evaluation are included in the Executive Committee of the Medical Staff / Professional Standards Board meeting minutes. Audits began in June 2020 and will continue monthly until a compliance of 90% or greater is achieved for two-consecutive quarters. Monitoring data will be reported quarterly to the Executive Committee of Medical Staff / Professional Standards Board until this recommendation is closed.

VHA requires "Provider Exit Review forms be completed within 7 calendar days of departure of a licensed health care professional" to ensure timely reporting of practitioners who fail to meet accepted professional practice standards of care to SLBs.[59] For the 20 providers that departed the medical center in the previous 12 months, the OIG found that 16 providers' exit forms were not completed within seven calendar days. This could have resulted in delayed reporting of

[59] VHA Notice 2018-05.

healthcare professionals providing substandard quality of care to SLBs. The Medical Staff Privileging Manager attributed the noncompliance to the service chiefs' failure to notify credentialing and privileging staff timely when providers had cleared the facility.

Recommendation 5

5. The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that provider exit review forms are completed within seven calendar days of licensed healthcare professionals departing the medical center.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Medical Center Director, the Chief of Staff, as well as the Medical Staff Affairs Coordinator evaluated additional reasons for non-compliance. The current process used to ensure receipt of completed exit reviews within seven-days of the departure of a clinician is dependent upon the timely completion of a clearance request via the Electronic Protocols Application Software (ePAS). It was discovered that the process does not effectively capture when a clinician departs the facility because there is no time-based requirement for the submission and subsequent completion of the clearance ePAS request.

The Medical Center Director will ensure ongoing compliance. Specifically, the Medical Affairs Staff Coordinator who oversees credentialing and privileging of all clinicians, will send monthly reminders to all supervisory staff to complete exit reviews within seven-days of a clinical employee's departure. In addition, audits will be completed on 100% of all appropriate departures using the Human Resources Gains & Losses Report to identify departments/services that are below 90% compliance. Follow-up training and communication will be provided to those areas as well.

Monthly audits will begin in June 2020 and will continue until a compliance of 90% or greater is achieved for two-consecutive quarters. The denominator will be the total number of appropriate clinician departures. The numerator will be the total number of exit interviews completed within seven days of a clinician's departure.

Monitoring data will be reported quarterly to the Executive Committee of Medical Staff / Professional Standards Board until this recommendation is closed.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct Comprehensive Environment of Care Inspection Rounds and to resolve issues in a timely manner. The goal of the Comprehensive 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.[60]

The purpose of this facet of the OIG inspection was to determine whether the medical center maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the medical center met requirements in selected areas that are often associated with higher risks of harm to patients, such as in the inpatient mental health unit where patients with active suicidal ideation or attempts are treated. Inspectors reviewed several aspects of the medical center's environment:

- Medical center
  - General safety
  - Special use spaces
  - Environmental cleanliness and infection prevention
  - Privacy
  - Accommodation and privacy for women veterans
  - Logistics
- Inpatient mental health unit
  - General safety
  - Special use spaces
  - Environmental cleanliness and infection prevention
  - Privacy
  - Accommodation for women veterans
  - Logistics
- Community-based outpatient clinic (CBOC)
  - General safety
  - Special use spaces

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

- Environmental cleanliness and infection prevention
- Privacy
- Privacy for women veterans
- Logistics

During its review of the environment of care, the OIG team inspected the Shawnee VA Clinic and the following 13 patient care areas of the Kansas City VAMC:

- Acute mental health unit
- Emergency department
- Intensive care units (medical and surgical)
- Medical/surgical inpatient units (5West, 8East, and 8West)
- Outpatient clinics (podiatry and primary care clinics)
- Post-anesthesia care unit
- Progressive care unit
- Substance abuse recovery and rehabilitation treatment program
- Women's health clinic

The inspection team reviewed relevant documents and interviewed key employees and managers.

Environment of Care Findings and Recommendations

The inspection team observed compliance with general cleanliness and selected inpatient mental health unit requirements at the medical center. The team did not note any issues with the availability of medical equipment and supplies. However, the OIG noted concerns with the medical center's special use spaces, and specifically, medication storage, and clinic privacy.

Regarding medication storage, VHA requires multidose medications to be labeled with an expiration date upon opening.[61] In 2 of the 13 areas inspected at the medical center, the OIG found six open and undated multidose medication vials.[62] This resulted in the lack of assurance of safe medication administration practices. Nurse managers attributed the improper storage of open multidose vial medications to a lack of attention to detail by nursing staff.

[61] VHA Directive 1108.06, *Inpatient Pharmacy Services*, February 8, 2017.

[62] Medical intensive care and medical-surgical (5West) units.

Recommendation 6

6. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and makes certain that nursing staff label multidose medication vials with an expiration date upon opening.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Associate Director of Patient Care Services, the Associate Chief Nurses of both Inpatient and Outpatient Services, and the Deputy Associate Director of Patient Care Services met with the Nurse Managers in May 2020 to evaluate additional reasons for non-compliance and provide instruction on the correct process for labeling multidose vials upon opening. A review of the findings, including discussions with staff, was completed. It was confirmed that there were no specific issues other than the areas simply not labeling the vial upon opening. Re-education was provided to staff by the Nurse Educators regarding the importance of labeling multi-use vials when opened, to assure they are within the appropriate date range prior to use.

The Associate Director of Patient Care Services will ensure compliance via monthly, random spot checks. A minimum of 10 random spot checks of medication rooms / refrigerators will be completed monthly throughout the medical center (e.g., inpatient and outpatient areas). The denominator will be the total number of medication rooms / refrigerators checked each month. The numerator will be number of medication rooms / refrigerators that have a multi-use vial inappropriately labeled. 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 two-consecutive quarters.

Monitoring data will be reported quarterly to the Environment of Care Committee until this recommendation is closed.

VHA requires privacy curtains in examination rooms to shield patients from view when the door is opened.[63] At the Shawnee VA Clinic, the OIG did not find privacy curtains in any of the examination rooms. This resulted in a lack of full visual privacy for patients while in the examination room. The nurse manager believed that keeping the examination room door closed provided adequate privacy and that privacy curtains were not needed.

[63] VHA Handbook 1101.10(1), *PACT Handbook*, May 26,2017.

Recommendation 7

7. The Associate Director evaluates and determines any additional reasons for noncompliance and ensures that privacy curtains are installed in all examination rooms at the Shawnee VA Clinic.[64]

Medical center concurred.

Target date for completion: Completed

Medical center response: The Associate Director along with the Nurse Manager, Shawnee VA Clinic, evaluated additional reasons for noncompliance. A review of the findings, including discussions with staff, was completed. It was confirmed that there were no specific issues other than the Nurse Manager and staff believed that keeping the examination room door closed provided adequate privacy and that privacy curtains were not needed.

Furthermore, the Nurse Manager, Shawnee VA Clinic, met with staff in November / December 2019 to review processes for ensuring patient privacy during exams until long-term resolution could be determined. Currently, standard practice at the clinic is that exam room doors are closed when occupied and doors are secured (locked) when intimate exams (e.g., Pap exams) are being conducted with Veterans. Nonetheless, staff were reminded to continue exercising professional etiquette when entering exam rooms such as by knocking before entering a room and following standard practices for ensuring doors are appropriately locked. In addition, staff have been reminded during monthly meetings of this process as well as the need to ensure patient's privacy when visiting the clinic.

The Associate Director provided oversight to the process of the installation of privacy curtains. Specifically, the Nurse Manager worked with Interior Design as well as with the contracted company that installed the curtains.to determine an appropriate solution for the installation of curtains in each of the exam rooms. The proposal for curtains was submitted by Interior Design to contracting services in early April 2020. The vendor received the purchase order the end of April 2020 and shipped the exam room curtains and tracks directly to the Shawnee VA Clinic. Installation of the curtains was completed May 22, 2020. Closure of this recommendation is requested.

VHA also requires facilities to maintain records of visitor access to areas where information systems reside.[65] The OIG team found no evidence of a visitor sign-in log to the information technology room at the Shawnee VA Clinic. This may result in unauthorized access to information systems storing personally identifiable information. The information technology

[64] The OIG reviewed evidence sufficient to demonstrate that the medical center had completed improvement actions and therefore closed the recommendation before publication of the report.

[65] VA Handbook 6500, *Risk Management Framework for VA Information Systems-Tier3: VA Information Security Program*, March 10, 2015.

technician was unaware there was no visitor sign-in log and acknowledged that it should be available at all times.

Recommendation 8

8. The Associate Director evaluates and determines any additional reasons for noncompliance and ensures a record of visitor access for the information technology room is maintained at the Shawnee VA Clinic.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Associate Director along with the Office of Information Technology Area Manager evaluated additional reasons for noncompliance. In their review, it was determined that there were no specific issues other than the visitor log had been inadvertently removed prior to the OIG Inspection Team's visit to the Shawnee VA Clinic. The facility Information Technology Specialist immediately replaced the log while the Office of the Inspector General Inspection Team was onsite. In addition, the Office of Information Technology's standard of practice is to either affix visitor logs on the door of the Information Technology communication closet or nearby such as on an adjacent wall.

Information Technology staff continue to monitor visitor access at the Shawnee VA Clinic as required by ensuring the visitor log is affixed to or nearby the communication closet. Also, visitors are escorted to and from the communication closet and are required to sign in and out on the log sheet.

In addition, a "roving" Information Technology Specialist is assigned to visit each VA Clinic monthly to pull and scan the visitor log(s) for audit purposes. Quarterly audits are completed by the Area Manager and Information Systems Security Officer to ensure visitors / personnel not on the authorized access list have signed in and out on the visitor log.

The Associate Director along with the Area Manager, who began his responsibilities in April 2020, reviewed the current process for pulling and scanning the visitor logs to determine appropriate measures to strengthen internal processes. As a result of this evaluation, a checklist was created for the "roving" Information Technology Specialist to use when visiting the VA Clinics. The checklist will be utilized to help ensure consistency and accuracy of the quarterly audits being completed.

Furthermore, the "roving" Information Technology Specialist will visit the facility weekly. The checklist will be completed, scanned, saved, and reviewed by the Area Manager and / or his designee. This will begin in May 2020 and will help ensure compliance is being met at the Shawnee VA Clinic. The denominator will be the total number of weekly checks completed in a month. The numerator will be the number of checklists completed accurately each month. The Area Manager and / or his designee will monitor until 90% or greater compliance is demonstrated for two-consecutive quarters.

Monitoring data will be reported quarterly to the Environment of Care Committee until this recommendation is closed.

Medication Management: Long-Term Opioid Therapy for Pain

Opioid medications are known to cause dependence, tolerance, abuse, and accidental overdose.[66] The opioid crisis is a national public health emergency with, on average, 130 Americans dying every day from an opioid overdose.[67] Long-term opioid use is of particular concern in the veteran population where there is a high incidence of posttraumatic stress disorder, major depressive disorder, alcohol use, substance abuse, and suicide attempts.[68] These disorders coupled with high-dose opioid use can potentially lead to an increased risk of overdose compared to the general population.[69]

VHA requires routine assessments of pain and the completion of an opioid risk assessment before initiating patients on long-term opioid therapy and recommends against the therapy for patients with untreated substance use disorders. VHA also recommends avoiding drugs capable of inducing fatal interactions, such as opioids with benzodiazepines.[70] Healthcare providers are required to conduct initial and random ongoing urine drug testing during opioid therapy.[71] To achieve VHA's vision of providing patient-driven healthcare, practitioners are also required to obtain informed consent from patients and to provide education about the risks, benefits, and alternatives prior to initiating long-term opioid therapy.[72] VHA recommends evaluating patients receiving continued opioid therapy for improvement of pain and opioid-related adverse events at least every three months and more frequently as doses increase.[73]

The OIG reviewers assessed staff's provision of pain management using long-term opioid therapy:

- Completion of initial screening for pain
- Assessment of aberrant behavior risk
- Avoidance of concurrent therapy with benzodiazepines

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[66] World Health Organization. "Information sheet on opioid overdose," August 2018. https://www.who.int/substance_abuse/information-sheet/en/. (This website was accessed on November 6, 2019.)

[67] Centers for Disease Control and Prevention. "Opioid Overdose, Understanding the Epidemic," December 19, 2018. https://www.cdc.gov/drugoverdose/epidemic. (The website was accessed on November 6, 2019.)

[68] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*, Version 3.0. February 2017. https://www.healthquality.va.gov/guidelines/Pain/cot/. (The website was accessed November 6, 2019.)

[69] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

[70] According to the U.S. Department of Justice's Drug Enforcement Administration, benzodiazepines "are a class of drugs that produce central nervous system (CNS) depression and that are most commonly used to treat insomnia and anxiety." https://www.deadiversion.usdoj.gov/drug_chem_info/benzo.pdf. (The website was accessed December 1, 2019.)

[71] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

[72] VHA Directive 1005, *Informed Consent for Long-Term Opioid Therapy for Pain,* May 13, 2020

[73] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

- Completion of urine drug testing with intervention, when indicated
- Documentation of informed consent
- Timely follow-up with patients included required elements

VHA also requires facilities to establish a multidisciplinary pain management committee "to provide oversight, coordination, and monitoring of pain management activities and processes." Monitoring measures include, but are not limited to, adherence to published clinical practice guidelines, timeliness of treatment, adequacy of pain control, medication safety, appropriate use of stepped care treatment, patient satisfaction, and quality of life.[74] The OIG examined the following indicators for program oversight and evaluation:

- Performance of pain management committee activities
- Monitoring of quality measures
- Following the quality improvement process

The OIG interviewed key employees and managers and reviewed relevant documents and the electronic health records of 11 outpatients who had newly-dispensed (no VA dispensing in previous six months) long-term opioids for pain, daily or intermittently for 90 or more calendar days through VA from July 1, 2018, through June 30, 2019. The team considered whether providers acted in accordance with guidelines for the provision of pain management and the medical center's oversight process for evaluating pain management outcomes and quality.

Medication Management Findings and Recommendations

The medical center addressed many of the indicators of expected performance, including pain screening and justification for concurrent therapy with benzodiazepines. However, the OIG found deficiencies with aberrant behavior risk assessment, urine drug testing, informed consent, patient follow-up, and quality measure oversight.

VA/DoD clinical practice guidelines recommend that providers complete a behavior risk assessment, including history of substance abuse,[75] mental health problems or disorders, and

[74] VHA Directive 2009-053, *Pain Management*, October 28, 2009.

[75] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*, Version 3.0. February 2017. https://www.healthquality.va.gov/guidelines/Pain/cot/. (The website was accessed November 6, 2019.)

aberrant drug-related behaviors[76] prior to initiating long-term opioid therapy.[77] The OIG determined that clinicians completed a behavior risk assessment in 36 percent of the patients reviewed.[78] This may have resulted in providers prescribing opioids for patients at high risk for misuse. The Chief of Primary Care reported that because risk assessments were often documented by other clinicians during varied episodes of care, providers believed requirements were met.

Recommendation 9

9. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that clinicians complete a behavior risk assessment that includes a history of substance abuse, mental health problems or disorders, and aberrant drug-related behaviors on all patients prior to initiating long-term opioid therapy.

[76] Examples of aberrant drug related behaviors include "lost prescriptions, multiple requests for early refills, unauthorized dose escalation, apparent intoxication, and frequent accidents." *Pain Management, Opioid Safety, VA Educational Guide* (2014), July 2014. https://www.va.gov/PAINMANAGEMENT/docs/OSI_1_Tookit_Provider_AD_Educational_Guide_7_17.pdf. (The website was accessed on September 17, 2019.)

[77] *Pain Management, Opioid Safety, VA Educational Guide* (2014), July 2014. https://www.va.gov/PAINMANAGEMENT/docs/OSI_1_Tookit_Provider_AD_Educational_Guide_7_17.pdf. (The website was accessed on September 17, 2019.)

[78] Confidence intervals are not included because the data represents every patient in the study population.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff evaluated additional reasons for non-compliance. As a result, a multidisciplinary team comprised of representatives from Pharmacy, Pain Management, Psychology, Medicine, and Health Information Technology were designated to further review the findings to identify reasons for noncompliance. It was determined that the process for documenting the assessment was fragmented secondary to varying methods of documentation by clinicians. In addition, a method for addressing specific concerns, patient outcomes, or behavior was lacking. This information was considered and incorporated into the development of the action plan.

In order to ensure ongoing compliance of this recommendation, two note templates have been considered for development. The Point of Care Risk Review note template was in development at the time of visit. It has been validated and prepared for testing by prescribers in Pilot Clinics. The Chief of Staff will provide oversight on the development, implementation, and appropriate use of the Point of Care Risk Review note template to ensure compliance with this recommendation.

Furthermore, the KC-Controlled Substance Prescribing Note was completed May 2020. This was developed because opioid medications are hidden in the ordering menu and are only available through an order set. Completion of the KC-Controlled Substance Prescribing Note allows the prescriber to access the order set to order controlled substances. The KC-Controlled Substance Prescribing Note will be piloted in June 2020 within selected clinics (e.g., specialty and primary care clinics). Feedback from the pilot will be presented to the Pain Committee for consideration and incorporation into the note title. Final recommendations will be made to the Executive Committee of the Medical Staff for approval with an anticipated implementation date of August 2020.

Since development of the Point of Care Risk Review note template and the KC-Controlled Substance Prescribing Note will ensure compliance with this recommendation, the Executive Committee of the Medical Staff will monitor progress of this initiative monthly until the note templates are fully implemented.

Initial education on the approved note title will be provided by the Pain Management Clinical Pharmacy Specialist. In addition, ongoing education to key stakeholders will be completed quarterly by the Pain Committee. Furthermore, the Chief Health Information Officer along with the Opioid Safety Initiative Committee will monitor adherence with first fills via a Monitoring Report until 90% compliance is demonstrated for two-consecutive quarters. The denominator will be a 20 randomly chosen first fills in a month; the numerator will be the number of first fills completed accurately.

Monitoring data will be reported quarterly to the Executive Committee of the Medical Staff until this recommendation is closed.

VA/DoD clinical practice guidelines also recommend that providers "obtain urine drug testing prior to initiating or continuing long-term opioid therapy and periodically thereafter".[79] The OIG found that clinicians conducted initial urine drug screening in 73 percent of the patients reviewed.[80] This resulted in providers' inability to identify whether the remaining 27 percent of patients had substance use disorders, determine potential diversion, and ensure patients adhered to the prescribed medication regimen. The Chief of Primary Care reported that providers believed they were acting (ordering urine drug tests) in accordance to the requirement.

Recommendation 10

10. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that providers consistently conduct urine drug testing as required for patients on long-term opioid therapy.

[79] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

[80] Confidence intervals are not included because the data represents every patient in the study population.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff evaluated additional reasons for non-compliance. As a result, a multidisciplinary team comprised of representatives from Pharmacy, Pain Management, Psychology, Medicine, and Health Information Technology were designated to further review the findings to identify reasons for noncompliance. It was determined that the timeline for urine drug screening was not defined. This information was considered and incorporated into the development of the action plan.

The Chief of Staff will ensure compliance by providing oversight to the development and implementation of the required processes for long-term opioid use. The Point of Care Risk Review note template was in development at the time of visit. It has been validated and prepared for testing by prescribers in Pilot Clinics. Development and implementation of the Point of Care Risk Review note template will ensure compliance with this recommendation.

The note template includes data objects for automatic inclusion of the most recent urine drug screen on file in the Computerized Patient Record System (CPRS). Note template instructions are also included to ensure the urine drug screen is completed within 30 days before or after opioids are started. Providers will determine if a new urine drug screen is needed and will order/obtain, as appropriate.

The Pain Committee will educate providers through a Chief of Staff email by June 2020. Education will include the appropriate urine drug screen timeframe. Ongoing education and reminders will be provided on a quarterly basis as well. Furthermore, a report for urine drug screens will be completed by the Chief Health Information Officer within 30 days before or after the initiation of opioids. The Opioid Safety Initiative Committee will review urine drug screen compliance quarterly and report findings and recommendation, as appropriate, to Pain Committee for concurrence and/or approval of recommendations.

Since development of the Point of Care Risk Review note template will ensure compliance with this recommendation, the Executive Committee of the Medical Staff will monitor progress of this initiative monthly until the note template is fully implemented.

Furthermore, the Opioid Safety Initiative Committee will monitor adherence with urine drug screen compliance until 90% compliance is demonstrated for two-consecutive quarters. The denominator will be 20 randomly chosen urine drug screens in a month; the numerator will be the number of urine drug screens completed accurately.

Monitoring data will be reported quarterly to the Executive Committee of the Medical Staff until this recommendation is closed.

VHA requires providers to obtain and document informed consent prior to the initiation of therapeutic treatments that have a significant risk of complication or morbidity, including

long-term opioid therapy. VHA also recommends that the informed consent conversation cover the risks and benefits of opioid therapy as well as alternative therapies.[81] The OIG determined that clinicians documented informed consent prior to initiating long-term opioid therapy in 36 percent of the patients at the medical center.[82] The remaining 64 percent of the patients, therefore, may have been receiving treatment without knowledge of the risks associated with long-term opioid therapy, including opioid dependence, tolerance, addiction, and intentional or unintentional fatal overdose. The Chief of Primary Care stated that most physicians would not consider obtaining consent because the patients' prescribed therapy did not appear to meet long-term opioid therapy criteria.

Recommendation 11

11. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that providers consistently obtain and document informed consent prior to initiating patients on long-term opioid therapy.

[81] VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009, revised September 20, 2017; VHA Directive 1005, *Informed Consent for Long-Term Opioid Therapy for Pain*, May 13, 2020.

[82] Confidence intervals are not included because the data represents every patient in the study population.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff evaluated additional reasons for non-compliance. As a result, a multidisciplinary team comprised of representatives from Pharmacy, Pain Management, Psychology, Medicine, and Health Information Technology were designated to further review the findings to identify reasons for noncompliance. Guidelines for obtaining and documenting informed consent prior to the initiation of therapeutic treatments such as long-term opioid therapy were reviewed.

The Chief of Staff will ensure compliance by providing oversight to the development and implementation of the required processes for long-term opioid use. Specifically, information from the VHA Directive, Centers for Disease Control and Prevention and the Comprehensive Addiction and Recovery Act (CARA) Guidelines of 2016 was reviewed. As a result, the Kansas City VA Medical Center will now require, for all opioids prescribed for greater than four days, that the patient receive education within the VHA publication "Safe and Responsible Use of Opioids for Chronic Pain" and complete the Consent for Long Term Opioids for Pain in I-Med Consent prior to starting opioid therapy. This new requirement will ensure compliance with this recommendation.

Education will be disseminated in June 2020 by the Pain Committee through the Chief of Staff to pertinent clinical service line chiefs for education throughout service lines. Furthermore, monitoring reports including the first date of opioid released to the Veteran along with the date of consent will be reviewed ongoing by the Chief Health Information Officer will be completed by the Chief Health Information Officer within 30 days before or after the initiation of opioids.

Since informed consent will be required for all opioids prescribed for greater than four days, this action, when fully implemented, will ensure compliance with this recommendation. The Executive Committee of the Medical Staff will monitor progress of this initiative monthly until this initiative is fully implemented.

Furthermore, the Chief Health Information Officer will monitor providers' adherence to completing the required consent until 90% compliance is demonstrated for two-consecutive quarters. The denominator will be 20 randomly chosen charts in a month; the numerator will be the number of I-med consents completed appropriately.

Monitoring data will be reported quarterly to the Executive Committee of the Medical Staff until this recommendation is closed.

VA/DoD clinical practice guidelines also recommend that clinicians follow up with patients within three months after initiating long-term opioid therapy and assess patients' adherence

to their pain management plan of care.[83] The OIG found that clinicians assessed adherence to the pain management plan of care in 60 percent of the patients reviewed.[84] For the remaining patients, failure to assess those patients' adherence can result in missed opportunities to evaluate the benefits of continued opioid therapy. The Chief of Primary Care believed requirements were met and that clinicians followed up with patients and completed required assessments.

Recommendation 12

12. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that clinicians follow up with patients receiving long-term opioid therapy includes an assessment of adherence to the pain management plan of care.

[83] *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

[84] Confidence intervals are not included because the data represents every patient in the study population.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff evaluated additional reasons for non-compliance. As a result, a multidisciplinary team comprised of representatives from Pharmacy, Pain Management, Psychology, Medicine, and Health Information Technology were designated to further review the findings to identify reasons for noncompliance. It was determined that the process for documenting the assessment was fragmented secondary to varying methods of documentation by clinicians. In addition, a method for addressing specific concerns, patient outcomes, or behavior was lacking. This information was considered and incorporated into the development of the action plan.

The Chief of Staff will ensure compliance by providing oversight to the development and implementation of the required processes for long-term opioid use. In order to ensure ongoing compliance of this recommendation, two note templates have been considered for development. The Point of Care Risk Review note template was in development at the time of visit. It has been validated and prepared for testing by prescribers in Pilot Clinics. Development of the Point of Care Risk Review note template will ensure compliance with this recommendation.

Furthermore, the KC-Controlled Substance Prescribing Note was completed May 2020. This was developed because opioid medications are hidden in the ordering menu and are only available through an order set. Completion of the KC-Controlled Substance Prescribing Note allows the prescriber to access the order set to order controlled substances. The KC-Controlled Substance Prescribing Note will be piloted in June 2020 within selected clinics (e.g., specialty and primary care clinics). Feedback from the pilot will be presented to the Pain Committee for consideration and incorporation into the note title. Final recommendations will be made to the Executive Committee of the Medical Staff (ECMS) for approval with an anticipated implementation date of August 2020.

Since development of the Point of Care Risk Review note template and the KC-Controlled Substance Prescribing Note will ensure compliance with this recommendation, the Executive Committee of the Medical Staff will monitor progress of this initiative monthly until the note templates are fully implemented.

Initial education on the approved note title will be provided by the Pain Management Clinical Pharmacy Specialist. In addition, ongoing education to key stakeholders will be completed quarterly by the Pain Committee. Furthermore, the Chief Health Information Officer along with the Opioid Safety Initiative Committee will monitor adherence with first fills via a Monitoring Report until 90% compliance is demonstrated for two-consecutive quarters. The denominator will be a 20 randomly chosen first fills in a month; the numerator will be the number of first fills completed accurately.

Monitoring data will be reported quarterly to the Executive Committee of the Medical Staff until this recommendation is closed.

VHA requires the facilities' multidisciplinary pain management committee to monitor the quality of pain assessment and effectiveness of interventions.[85] The OIG did not find documented evidence that the Pain Committee monitored the quality of pain assessment and effectiveness of pain management intervention, based on two quarters of meeting minutes reviewed. This resulted in lack of oversight, coordination, and monitoring of pain management strategies to ensure compliance with evidence-based standards of care. The Director of the Integrated Pain Clinic was unaware that the Pain Committee was required to monitor quality measures and stated that pain management outcomes and quality were discussed in other committee meetings.

Recommendation 13

13. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that the Pain Management Committee monitors the quality of pain assessments and the effectiveness of pain management interventions.

[85] VHA Directive 2009-053, *Pain Management*, October 28, 2009.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff evaluated additional reasons for non-compliance. As a result, a multidisciplinary team comprised of representatives from Pharmacy, Pain Management, Psychology, Medicine, and Health Information Technology were designated to further review the findings to identify reasons for noncompliance. It was determined that the process for documenting the assessment was fragmented secondary to varying methods of documentation by clinicians. In addition, a method for addressing specific concerns, patient outcomes, or behavior was lacking. This information was considered and incorporated into the development of the action plan.

The Chief of Staff will ensure compliance by providing oversight to the development and implementation of the required processes for long-term opioid use. The Point of Care Risk Assessment note will be modified through the Pain Committee to include a section for chronic medication prescribing. Specifically, two closed ended questions will be added to minimize prescriber documentation requirements for chronic medications. Facility-wide opioid prescribing is tracked through the Opioid Safety Initiative Committee for comparison to VISN and National averages. This information will be reported to Pain Committee quarterly with ongoing monitoring by the Executive Committee for the Medical Staff.

Since development and modification of the Point of Care Risk Review note template will ensure compliance with this recommendation, the Executive Committee of the Medical Staff will monitor progress of this initiative monthly until the note template is fully implemented.

Furthermore, the Pain Committee will monitor adherence with chronic medication prescribing via chart reviews until 90% compliance is demonstrated for two-consecutive quarters. The denominator will be 20 randomly chosen charts of patients prescribed opioids in a month; the numerator will be the number of charts that were completed accurately.

Monitoring data will be reported quarterly to the Executive Committee of the Medical Staff until this recommendation is closed.

Mental Health: Suicide Prevention Program

In 2017, suicide was the 10th leading cause of death, with approximately 47,000 lives lost across the United States.[86] The suicide rate was 1.5 times greater for veterans than for non-veteran adults and estimated to represent approximately 22 percent of all suicide deaths in the United States.[87] Veterans who recently used VHA services had higher rates of suicide than other veterans and non-veterans.[88]

VHA has identified suicide prevention as a top priority and implemented various evidence-based approaches to reduce the veteran suicide rate. In addition to expanded mental health services and community outreach, VHA has developed comprehensive screening and assessment processes to identify at-risk patients.[89]

VHA requires that each medical center and very large CBOC have a full-time suicide prevention coordinator (SPC) to track and follow up with high-risk veterans, develop a process for responding to referrals from hotlines such as the Veteran Crisis Line, and conduct community outreach activities.[90] The OIG examined various requirements related to SPCs:

- Assignment of a full-time SPC
- Tracking and follow-up of high-risk veterans
  - Patients' completion of four appointments within the required time frame
  - Safety plan completion within the required time frame
  - Mental health teams' contacts with patients for missed appointments
- Provision of suicide prevention training for nonclinical employees at new employee orientation
- Completion of at least five outreach activities per month

VHA also requires that any patient determined to be at high risk for suicide be added to the facility high-risk list and have a High Risk for Suicide (HRS) Patient Record Flag (PRF) placed

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[86] Centers for Disease Control and Prevention. *Preventing Suicide*. https://www.cdc.gov/violenceprevention/suicide/fastfact.html. (accessed March 4, 2020).

[87] Office of Mental Health and Suicide Prevention, *VA National Suicide Data Report 2005-2016*, September 2018; Department of Veterans Affairs, *National Strategy for Preventing Veteran Suicide 2018-2028*.

[88] Veterans who recently used VHA services are defined as having an encounter in the calendar year of death or in the previous year; Office of Mental Health and Suicide Prevention, *VA National Suicide Data Report 2005-2016.*

[89] *VA Office of Mental Health and Suicide Prevention Guidebook*, June 2018.

[90] According to VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015, very large CBOCs are those that serve more than 10,000 unique veterans each year. The Veterans Crisis Line connects veterans with qualified responders through a confidential toll-free hotline, online chat, and text-messaging service to receive confidential support 24 hours a day. Community outreach activities are described in VHA Handbook 1160.01.

in his or her electronic health record "as soon as possible but no later than 1 business day after such determination by the SPC."[91] According to VHA, "Some studies indicate that up to two-thirds of patients who commit suicide have seen a physician in the month before their death…The primary purpose of the High Risk for Suicide PRF is to communicate to VA staff that a veteran is at high risk for suicide and the presence of a flag should be considered when making treatment decisions."[92] The HRS PRF is reviewed at least every 90 days and depending on changes to the suicide risk status, will remain active or be removed.[93] Additionally, VHA requires designated high-risk patients to have a completed suicide safety plan and four face-to-face visits with an acceptable provider within the first 30 days of designation.[94]

The OIG noted that from July 1, 2018, to June 30, 2019 (the time frame for this retrospective review), VHA required that "Any patient determined to be High Risk for Suicide [by the licensed independent provider] must have a[n] HRS Flag placed in his or her chart as soon as possible but no later than 24 hours after such determination."[95] However, on January 16, 2020, the Deputy Undersecretary for Health for Operations and Management changed the requirement for the HRS PRF placement to be "as soon as possible but no later than 1 business day after determination by the SPC."[96] VHA further provided additional clarifying information:

- The "SPC exclusively controls the HRS-PRF and must limit their use to patients who meet the criteria of being placed on the facility high-risk suicide list."
- "The time frame of placing the flag begins once the SPC makes the determination that an HRS-PRF is warranted."
- The SPC's determination process "may be beyond 24 hours after a referral, due to case consultation and review."[97]

The OIG is concerned that the updated requirement may result in delayed placement of HRS PRFs for at-risk patients. Without defined time frames for SPC determination that the HRS PRF is warranted, patients identified as at-risk for suicide could have flags placed in his or her chart

[91] VHA DUSHOM Memorandum, *Update to High Risk for Suicide Patient Record Flag Changes*, January 16, 2020.

[92] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.

[93] *VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care, Suicide Prevention Coordinator Guide*, January 5, 2018; VHA DUSHOM Memorandum, *High Risk for Suicide Patient Record Flag Changes*, October 3, 2017.

[94] A safety plan is a written list of coping strategies and support sources for use during or preceding suicidal crises. Face-to-face visits may be performed as telephone visits if requested by the patient. The requirement for four face-to-face visits within 30 days of designation can be found in *VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care, Suicide Prevention Coordinator Guide*.

[95] VHA DUSHOM Memorandum, *High Risk for Suicide Patient Record Flag Changes*, October 3, 2017.

[96] VHA DUSHOM Memorandum, *Update to High Risk for Suicide Patient Record Flag Changes*, January 16, 2020.

[97] VHA, *Response to Questions by VA OIG Office of Healthcare Inspections from February 12, 2020*, received February 19, 2020.

several days after referral. For example, the current requirement would allow for a patient to be identified as high risk for suicide and referred to the SPC on Monday, the SPC to assess the patient for risk and determine the need for an HRS PRF on the following Friday, and the SPC to place an HRS PRF on the subsequent Monday (a week after referral).

On March 27, 2020, VHA also updated existing policy requirements to allow the review of HRS PRFs to "occur no earlier than 10 days before and no later than 10 days after the 90-day due date."[98]

Inspectors examined the completion of several requirements:

- Review of HRS PRFs within the required time frame
- Completion of at least four mental health visits within 30 days of HRS PRF placement
- Appropriate follow-up for no-show high-risk appointments
- Completion of suicide safety plans with the required elements within the required time frame

All VHA employees must complete suicide risk and intervention training within 90 days of entering their position. Clinical staff (including physicians, psychologists, dentists, registered nurses, physician assistants, pharmacists, social workers, case managers, and Vet Center counselors) must complete Suicide Risk Management Training for Clinicians, and nonclinical staff must complete Operation S.A.V.E. training.[99] VHA also requires that all staff receive annual refresher training.[100] In addition, suicide prevention coordinators are required to provide in-person Operation S.A.V.E. training as part of orientation for nonclinical employees.[101]

To determine whether the medical center complied with OIG-selected suicide prevention program requirements, the inspection team interviewed key employees and reviewed

- Relevant documents,

[98] VHA Notice 2020-13, *Inactivation Process for Category I High Risk for Suicide Patient Record Flags*, March 27, 2020.

[99] Operation S.A.V.E. is a VA gatekeeper training program provided by suicide prevention coordinators to veterans and those who serve veterans. The acronym "S.A.V.E" summarizes the steps needed to take in recognizing and responding to a veteran in suicidal crisis. The training was designed for non-clinical employees and includes food service workers, registration clerks, volunteers, and police. It should also be viewed by ancillary/support staff or any other category not covered by the clinical training.

[100] VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees*, December 22, 2017.

[101] The training was designed for nonclinical employees and includes food service workers, registration clerks, volunteers, and police. It should also be viewed by ancillary/support staff or any other category not covered by the clinical training. VHA DUSHOM Memorandum, *Suicide Awareness Training*, April 11, 2017.

- The electronic health records of 40 randomly selected outpatients whose electronic health records were flagged as high risk for suicide from July 1, 2018, to June 30, 2019, and
- Staff training records.

Mental Health Findings and Recommendations

The medical center met the requirements associated with a designated SPC, suicide safety plans, patient follow-up for missed appointments, and suicide prevention training for new employees.

The OIG noted concerns with reviewing HRS PRFs within the required time frame. VHA required that all patients with an HRS PRF be reevaluated at least every 90 days and there is documented justification for continuing or discontinuing the flag.[102] The OIG determined that none of the 40 patients with an HRS flag were reevaluated at least every 90 days. However, based upon the updated requirement that HRS PRFs be reviewed up to 10 days prior to or after the due date for reevaluation, the OIG found that 39 of the 40 patients were reviewed within the expected time frame (observed range was 92–101 days).

Additionally, the OIG identified noncompliance with annual suicide prevention refresher training.

VHA requires that all employees (clinical and nonclinical) receive annual suicide prevention refresher training.[103] The OIG found that 4 of 16 staff due to complete annual refresher training (clinical and nonclinical) did not receive the required training at or within one year of initial training. Lack of training could prevent staff from providing optimal treatment to patients at risk for suicide. The Chief of Mental Health and the SPC attributed the noncompliance to a lack of oversight and sole reliance on VHA national Talent Management System training alerts to prompt staff to complete the required training.[104]

Recommendation 14

14. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures all staff receive annual suicide prevention refresher training.

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[102] *VA's Integrated Approach to Suicide Prevention: Ready Access to Care, Suicide Prevention Coordinator Guide*.

[103] VHA Directive 1071.

[104] VHA Employee Education System (ESS) is responsible for refining and producing training program modules in collaboration with Mental Health Services (MHS) and field-based subject matter experts and implementing and maintaining the web-based training programs in the VHA Talent Management System (TMS) https://www.tms.va.gov/. (The website was accessed on January 3, 2020, but is not accessible by the public.)

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff, the Chief of Mental Health, and the Suicide Prevention Coordinator evaluated additional reasons for non-compliance. It was determined that noncompliance was related to a lack of oversight and sole reliance on VHA National Talent Management System training alerts to prompt staff to complete the required training. In addition, multiple suicide refresher courses have been utilized as refresher courses and assigned to staff depending on their job title. The Kansas City, MO Domain Manager/Designated Learning Officer confirmed this has contributed to issues with noncompliance.

However, the Designated Learning Officer recently received communication from the VHA Talent Management System Integration Manager that suicide prevention refresher course options are in process of being simplified. For example, several courses are being retired and / or course content is being integrated into fewer courses, thus decreasing the number of suicide prevention refresher course options. This process became effective April 2020.

The Chief of Staff will ensure compliance by providing oversight to the development and implementation of the required processes for staff to complete suicide refresher training. The Suicide Prevention Coordinator will work in conjunction with the Designated Learning Officer to receive and review compliance deficiency reports for the annual suicide prevention refresher training required for all employees (clinical and nonclinical). In addition, the Suicide Prevention Coordinator will work with facility supervisors through communication of deficiency reports to enhance compliance of course completion. This will help ensure all staff complete the required training at or within one year of initial training.

Furthermore, the Suicide Prevention Coordinator will monitor staff compliance with annual suicide refresher training via a compliance deficiency report. Monitoring will continue until 90% compliance is demonstrated for two quarters. The denominator will be all employees required to complete annual suicide refresher training in a month. The numerator will be the number of staff who completed the training within the required time frame.

Monitoring data will be reported quarterly to the Executive Committee of the Medical Staff until this recommendation is closed.

Care Coordination: Life-Sustaining Treatment Decisions

Life-sustaining treatments (LSTs) are intended to extend the life of a patient expected to die soon without medical intervention. Life-sustaining treatments may include artificial nutrition, hydration, and mechanical ventilation. VHA issued the Life-Sustaining Treatment Decisions (LSTD) handbook to standardize practices related to discussing and documenting goals of care and LSTD. Per VHA, the goal is to encourage personalized, proactive, patient-driven treatment plans for veterans with serious illness by "…eliciting, documenting, and honoring patients' values, goals, and preferences."[105]

VA healthcare facilities were expected to fully implement new procedures outlined in the LSTD policy by July 12, 2018.[106] Implementation requirements included initiating conversations about the goals of care. A goals of care conversation is a discussion between a healthcare provider and a patient or surrogate to help define the patient's values, goals, and preferences for care and, based on the discussion, make choices about starting, limiting, or ceasing LSTs.[107] VHA requires practitioners to initiate goals of care conversations with high-risk patients—including hospice patients or their surrogates—within a time frame that meets the medical needs of the patient or at the time of a triggering event.[108]

The OIG noted that from July 1, 2018, to June 30, 2019 (the time frame for this retrospective review), VHA policy defined the elements of a goals of care conversation to be documented in an LST progress note in the electronic health record, which included:

- Decision-making capacity,
- Identification of a surrogate if the patient loses decision-making capacity,
- Patient or surrogate understanding of the patient's condition,
- Goals of care,
- Plan of care for the use of LST, including whether cardiopulmonary resuscitation will be attempted in the event of cardiac arrest, and
- Informed consent for the LST plan.

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[105] VHA Handbook 1004.03(1), *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, January 11, 2017, amended March 19, 2020.

[106] According to VHA Handbook 1004.03(1), the medical facility must fully implement handbook requirements within 18 months of publication.

[107] According to VHA Handbook 1004.03(1), a surrogate is legally authorized under VA policy to serve as the decision maker on behalf of the patient should the patient lose decision-making capacity.

[108] VHA Directive 1139, *Palliative Care Consult Teams (PCCT) And VISN Leads*, June 14, 2017, defines hospice patients as individuals diagnosed with a terminal condition with a life expectancy of six months or less if the disease runs its projected course. According to VHA Handbook 1004.03(1), triggering events requiring goals of care conversations include those "prior to referral or following admission (e.g., within 24 hours) to VA or non-VA hospice."

However, on March 19, 2020, VHA amended the requirements related to documenting patients' goals of care. Although the elements of the goals of care conversation are still required, the LST progress note must document at a minimum:

- Decision-making capacity,
- Goal(s) of care,
- Plan of care for the use of LST, and
- Informed consent for the LST plan.

The OIG is concerned that VHA's updated requirement could mislead practitioners to only address those goals of care conversation elements that are required to be documented in the LST progress note.

The medical center was assessed for its adherence to requirements for goals of care conversations:

- Completion of LSTD notes
- Timely documentation of LSTD
- Inclusion of required elements in LSTD documentation
- Completion of LSTD note/orders by an authorized provider or delegation to a designee met all requirements

VHA also requires facilities to appoint a multidisciplinary committee that reviews proposed LST plans for patients who lack both decision-making ability and a surrogate. The committee must be composed of three or more diverse disciplines (for example, social workers, nurses, and physicians) and include one or more members of the facility's Ethics Consultation Service.[109] Inspectors examined if the medical center established an LSTD committee that was comprised of a multidisciplinary membership, which included representation from Ethics Consultation Service, and reviewed proposed LST plans.

To determine whether the medical center complied with the OIG-selected requirements related to LSTD for hospice patients, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 40 hospice patients who had triggering events from July 12, 2018, through June 30, 2019.

Care Coordination Findings and Recommendation

The medical center complied with performance expectations for LSTD progress notes and supervision of designees.

[109] VHA Handbook 1004.03(1).

With VHA's original requirements that were in place when these patients received care[110] , the OIG estimated that

- 45 percent of patients' LST progress notes addressed identification of a surrogate if the patient loses decision-making capacity,[111]
- 24 percent of patients' LST progress notes addressed previous advance directive(s), state-authorized portable orders, and/or LST notes, and[112]
- 42 percent of patients' LST progress notes addressed the patient's or surrogate's understanding of the patient's condition.[113]

However, VHA no longer requires these elements to be documented in the LST progress note.[114] The OIG remains concerned that this change could result in practitioners' not addressing these important goals of care conversation elements.

Additionally, the OIG found that the medical center lacked a committee to review LST plans.

VHA requires a multidisciplinary committee appointed by the Director to review life-sustaining treatment plans for patients who lack decision-making capability and do not have a decision-making surrogate.[115] The OIG determined that the medical center lacked a multidisciplinary committee. Failure to ensure that life-sustaining treatment plans are reviewed by a multidisciplinary committee may impede effective decision-making for initiation, limitation, or discontinuation of LSTs on behalf of incapacitated patients.[116] Program managers stated awareness of requirements and believed an ad hoc team not appointed by the Director met the intent of the requirement.

Recommendation 15

15. The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that a multidisciplinary life-sustaining treatment decisions committee is established to review all proposed plans.

[110] VHA Handbook 1004.03(1).

[111] The OIG estimated that 95 percent of the time, the true compliance rate is between 28.6 and 62.5 percent, which is statistically significantly below the 90 percent benchmark.

[112] The OIG estimated that 95 percent of the time, the true compliance rate is between 10.3 and 39.4 percent, which is statistically significantly below the 90 percent benchmark.

[113] The OIG estimated that 95 percent of the time, the true compliance rate is between 26.3 and 59.4 percent, which is statistically significantly below the 90 percent benchmark.

[114] VHA Handbook 1004.03(1).

[115] VHA Handbook 1004.03(1).

[116] University of Washington School of Medicine, *Ethics Committees, Programs and Consultation*, accessed June 4, 2019; VHA Handbook 1004.03.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Chief of Staff evaluated additional reasons for non-compliance with life-sustaining treatment decision procedures to determine appropriate measures to strengthen internal processes. Although a champion was previously responsible for assisting with life-sustaining treatment decision program roll out and adherence with program guidelines, no formal charter had been written. As a result, executive leadership recognizes the need to formally charter a multi-disciplinary committee and to establish clear lines of accountability for purposes of oversight. A new Life-Sustaining Treatment Decision Coordinator, with broader facility scope, has been identified and provided time dedicated to advance the life-sustaining treatment decision initiative. This will enable the facility to better provide for the needs of the Veterans.

A charter was drafted for the Life-Sustaining Treatment Decision Committee and currently is under review by the Chief of Staff and the Executive Leadership Team. The charter is expected to be finalized by June 2020. Representatives from Nursing (e.g., Inpatient Clinical Nurse Specialist and Inpatient Nursing); Palliative Care; Social Work; Psychology/Integrated Ethics Council Member; as well as Chaplain services have been recommended for committee membership.

The overall mission of the Life-Sustaining Treatment Decision Committee will be to consider the procedural and ethical validity of the recommended life-sustaining treatment plan for the patient who lacks decision-making capacity and has no surrogate. Specifically, the Committee will function as the patient's advocate by determining whether the proposed life-sustaining treatment plan is consistent with the patient's wishes or in the patient's best interests as well as review information provided by the practitioner.

Committee meetings will be implemented as soon as possible after the charter is signed with the first meeting anticipated to be held in June 2020. Meetings will be scheduled at least quarterly for general life-sustaining treatment decision process review. In addition, meetings will be expected to be convene within 48 hours of a practitioner request, or as soon as reasonably possible if over a weekend or holiday, and in a timeframe that meets the clinical needs of the patient.

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 two-consecutive quarters with a goal of 90% or greater compliance. The denominator will be the total number of Life-Sustaining Treatment Decision consults requested by providers that occurs in a quarter. The numerator will be the actual number of Life-Sustaining Treatment Decision consults closed in the quarter.

Monitoring data will be reported quarterly to the Executive Committee of the Medical Staff until this recommendation is closed.

Women's Health: Comprehensive Care

Women represented 9.4 percent of the veteran population as of September 30, 2017.[117] According to data released by the National Center for Veterans Analysis and Statistics in May 2019, the total veteran population and proportion of male veterans are projected to decrease while the proportion of female veterans are anticipated to increase.[118] To help the VA better understand the needs of the growing women's veteran population, efforts have been made by VHA to identify and address the urgent needs "by examining health care use, preferences, and the barriers Women Veterans face in access to VA care."[119] Additionally, a VA report in 2016 on suicide among veterans pointed out concerning trends in suicide among women veterans and discussed "the importance of understanding suicide risk among women veterans and developing gender-tailored suicide prevention strategies."[120]

VHA requires that all eligible and enrolled women veterans have access to timely, high-quality, and comprehensive healthcare services in a sensitive and safe environment. Facilities must, therefore, ensure availability of appropriate resources, services, and staffing ratios.[121] VHA also requires delivery of quality care to all women veterans accessing VA emergency services. In addition, VHA requires facilities to establish a multidisciplinary women veteran health committee "that develops and implements a Women's Health Program strategic plan to guide the program and assist with carrying out improvements for providing high-quality equitable care for women Veterans."[122]

To determine whether the medical center complied with OIG-selected VHA requirements to provide comprehensive healthcare services to women veterans, the inspection team reviewed relevant documents and interviewed selected managers and staff on the following requirements:

- Provision of care requirements

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[117] National Center for Veterans Analysis and Statistics, "VETPOP2016 LIVING VETERANS BY AGE GROUP, GENDER, 2015-2045," Table 1L. https://www.va.gov/vetdata/Veteran_Population.asp. (The website was accessed on November 14, 2019.)

[118] National Center for Veterans Analysis and Statistics, "Veteran Population," May 3, 2019. https://www.va.gov/vetdata/docs/Demographics/VetPop_Infographic_2019.pdf. (The website was accessed on September 16, 2019.)

[119] U.S. Department of Veterans Affairs, *Study of Barriers for Women Veterans to VA Health Care Final Report*, April 2015. https://www.womenshealth.va.gov/docs/Womens%20Health%20Services_Barriers%20to%20Care%20Final%20Report_April2015.pdf. (The website was accessed on September 16, 2019.)

[120] U.S. Department of Veterans Affairs, Health Services Research & Development, Forum, *Concerning Trends in Suicide Among Women Veterans Point to Need for More Research on Tailored Interventions*, Suicide Prevention, Spring 2018. https://www.hsrd.research.va.gov/publications/forum/spring18/default.cfm?ForumMenu=Spring18-5. (The website was accessed on September 16, 2019.)

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

[122] VHA Directive 1330.01(2).

- Designated Women's Health Patient Aligned Care Team established
- Primary Care Mental Health Integration services available
- Gynecologic care coverage available 24/7
- Gynecology care accessible
- Facility women health primary care providers designated
- CBOC women's health primary care providers designated
- Emergency contraception accessible

- Oversight of program and monitoring of performance improvement data
  - Women Veterans Health Committee established
    - Quarterly meetings held
    - Core members attend
    - Quality assurance data collected and tracked
    - Reports made to clinical executive leaders
- Assignment of required staff
  - Women Veterans Program Manager position filled
  - Women's Health Medical Director or clinical champion on staff
  - Maternity Care Coordinator position filled
  - Women's health clinical liaison is assigned at each CBOC

Women's Health Findings and Recommendation

The OIG found that the medical center complied with requirements for the provision of care for women veterans' and each of the staffing elements reviewed. However, upon reviewing meeting minutes, the OIG found that the Women Veterans Health Committee lacked representation from pharmacy, emergency department, radiology, laboratory, and quality management. This is a repeat finding from the April 2019 OIG CHIP site visit, for which the medical center's improvement actions remain in progress.[123] The OIG made no new recommendation.

[123] VA Office of Inspector General, *Comprehensive Healthcare Inspection Program Review of the Kansas City VA Medical Center, Missouri*, Report No. 18-06504-27, December 12, 2019.

High-Risk Processes: Reusable Medical Equipment

Reusable medical equipment (RME) includes devices or items designed by the manufacturer to be used for multiple patients after proper decontamination, sterilization, and other processing between uses. VHA requires that facilities have a Sterile Processing Services (SPS) "to ensure proper reprocessing and maintenance of critical and semi-critical reusable medical equipment…"[124] The goal of SPS is to "...provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[125] To ensure this, VHA requires facilities to conduct the following activities:

- Maintain a current inventory list of all RME
- Have standard operating procedures (SOPs) that are based on current manufacturer's guidelines and reviewed at least triennially
- Use CensiTrac® Instrument Tracking System for tracking reprocessed instruments[126]
- Perform annual risk analysis and report results to the VISN SPS Management Board
- Monitor data for reprocessing and storing RME
- Conduct annual airflow/ventilation system inspections[127]

VHA requires strict controls that closely monitor climate, storage, and sterilization parameters and additionally requires that quality assurance documentation of this monitoring be maintained for a minimum of three years.[128] The required documentation includes high-level disinfectant solution testing, eyewash station maintenance records, and quality assurance records for RME reprocessing and sterilization.[129]

In addition, RME reprocessing areas must be clean, restricted, and airflow-controlled. All areas where RME reprocessing occurs must have safety data sheets, an unobstructed eyewash station,

[124] VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.

[125] Association for Professionals in Infection Control and Epidemiology, *APIC Text of Infection Control and Epidemiology,* Chapter 107: Sterile Processing, April 26, 2019. https://text.apic.org/toc/infection-prevention-for-support-services-and-the-care-environment/sterile-processing#book_section_17348. (The website was accessed on May 14, 2019.)

[126] VHA DUSHOM Memorandum, *Instrument Tracking Systems for Sterile Processing Services*, January 1, 2019.

[127] VHA Directive 1116(2).

[128] VHA Directive 1116(2); VHA DUSHOM Memorandum, *Interim Guidance for Heating, Ventilation and Air Conditioning (HVAC) Requirements Related to Reusable Medical Equipment (RME) Reprocessing and Storage*, September 5, 2017.

[129] VHA Directive 7704(1), *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*, February 16, 2016.

personal protective equipment available for immediate use, and SOPs readily available to guide the reprocessing of RME.[130]

VHA also requires facilities to provide training for staff who reprocess RME; this training must be provided and documented prior to the reprocessing of equipment. The required training includes mandatory initial competencies, continued annual and essential staff competency assessments, and monthly continuing education. This ensures that staff have sufficient aptitude, knowledge, and skills to effectively and safely reprocess and sterilize RME.[131]

To determine whether the medical center complied with OIG-selected requirements, the inspection team examined relevant documents and training records; conducted physical inspections of the SPS and gastroenterology clean scope rooms; and interviewed key managers and staff on the following:

- Requirements for administrative processes
  - RME inventory file is current
  - SOPs are based on current manufacturer's guidelines and reviewed at least triennially
  - CensiTrac® System used
  - Risk analysis performed and results reported to the VISN SPS Management Board
  - Airflow checks made
  - Eyewash station checked
  - Daily cleaning schedule maintained
- Monitoring of quality assurance
  - High-level disinfectant solution tested
  - Bioburden tested
- Physical inspections of reprocessing and storage areas
  - Traffic restricted
  - Airflow monitored
  - Personal protective equipment available
  - Area is clean

[130] VHA Directive 1116(2).

[131] VHA Directive 1116(2).

  - Eating or drinking in the area prohibited
  - Equipment properly stored
  - Required temperature and humidity maintained
- Completion of staff training, competency, and continuing education
  - Required training completed in a timely manner
  - Competency assessments performed
  - Monthly continuing education received

High-Risk Processes Findings and Recommendations

The medical center met many of the requirements for the proper operations and management of RME reprocessing. However, the OIG identified noncompliance with the annual risk analysis, air flow monitoring, environmental safety, equipment storage, and continuing education.

VHA requires that the SPS Chief performs an annual risk analysis and reports the results to the VISN SPS Management Board.[132] The OIG determined that the medical center conducted a risk analysis; however, the SPS Chief was unable to provide evidence of reporting the results to the VISN SPS Management Board. Lack of reporting the results to the VISN SPS Management Board prevents VISN leadership from identifying potential process failures, estimating the likelihood that such a failure will occur, assessing the consequences if that failure occurs, and assessing how prepared the facility is to manage the failure. The SPS Chief stated that, due to the sudden loss of the previous SPS Chief, the reporting requirement was not communicated to current SPS leaders.

Recommendation 16

16. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and makes certain that the Sterile Processing Services Chief reports the annual risk analysis results to the Veterans Integrated Service Network Sterile Processing Services Management Board.[133]

[132] VHA Directive 1116(2).

[133] The OIG reviewed evidence that sufficiently demonstrated that the medical center had completed improvement actions and therefore closed the recommendation before publication of the report.

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Associate Director for Patient Care Services evaluated additional reasons for noncompliance to determine appropriate measures to strengthen internal processes. The sudden loss of the previous Sterile Processing Services Chief created a gap in communication and loss of information and annual requirements. In addition, the retirement of the Quality Management Officer at the VISN level perpetuated this gap in communication. When identified as a gap during the Office of the Inspector General review an investigation was completed to identify the needs and clearly understand the processes required. Furthermore, the new Chief of Sterile Processing Services re-evaluated processes to determine appropriate measures to strengthen internal processes. During the time the new Sterile Processing Services Chief has been in her position she has been working closely with Nursing Executive Leadership (i.e., Associate Director for Patient Care Services and the Deputy Associate Director for Patient Care Services to refine and streamline Sterile Processing Services processes and ensure there is continuity in communication of the annual reporting needs. The new Quality Management Officer and new staff at the VISN will ensure continuity in communication for the foreseeable future as well.

The Associate Director for Patient Care Services will ensure compliance by providing oversight to the development and implementation of the required processes for Sterile Processing Services. Specifically, this year the annual Risk Analysis was completed by the Chief of Sterile Processing Services in collaboration with Nursing Executive Leadership. The Risk Analysis tool includes data on the type of Reusable Medical Equipment or reprocessing task along with information related to complexity, usual level of bioburden, Spaulding Classification, specialized cleaning instructions, frequency, and risk to patient if reprocessing failure. Scoring instructions for reprocessing of Critical and Semi-Critical Reusable Medical Equipment to determine frequency of competency review that is needed is also included. The final Risk Analysis was submitted to the VISN 15 Sterile Processing Services Management Board on May 19, 2020.

In order to ensure ongoing compliance, the Sterile Processing Services Chief will update the Risk Analysis tool at least quarterly and with the addition of any new equipment to reflect current inventory of type of Reusable Medical Equipment or reprocessing task. Monitoring data will be reported quarterly to the Reusable Medical Equipment Committee. Closure is requested for this recommendation based on the supporting documentation provided.

Despite VHA requiring a strict airflow requirement in all areas where RME is reprocessed, the OIG found that staff did not monitor airflow in the gastroenterology clinic clean scope rooms (M3.217 and M3.221).[134] Failure to evaluate and maintain air quality standards can lead to the spread of healthcare-associated infections. Additionally, the OIG observed that one of two

[134] VHA Directive 1116(2).

gastroenterology scope rooms had damaged flooring (tiles) preventing adequate cleaning, which may result in an increased risk of exposure to infectious microorganisms. The Gastroenterology Nurse Manager was unaware of the damaged tiles and stated that the clean scope rooms have been temporarily relocated due to construction and were inadvertently left off the facility's airflow monitoring list.

Recommendation 17

17. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures that airflow is monitored in the gastroenterology clinic clean scope rooms.[135]

[135] The OIG reviewed evidence sufficient to demonstrate that the medical center had completed improvement actions and therefore closed the recommendation before publication of the report.

Medical center concurred.

Target date for completion: Completed

Medical center response: The Associate Director for Patient Care Services along with the Nurse Manager of Gastroenterology evaluated additional reasons for noncompliance to determine appropriate measures to strengthen internal processes. The Nurse Manager of Gastroenterology affirms an analysis of the situation was done in collaboration with the Chief of Facilities. A report and recommendations for remedy was discussed and approved by the Associate Director for Patient Care Services.

The Associate Director for Patient Care Services will ensure compliance by providing oversight to the air exchange checks. The Chief of Facilities Management Services assured the Associate Director for Patient Care Services and the Nurse Manager of Gastroenterology that the Gastroenterology Rooms M3.217 and M3.221 were added to the Facilities Management Services quarterly air exchange room checks. This information was forwarded onto the Gastroenterology Nurse Manager for review and confirmation. Quarterly air exchange checks will continue until the Gastroenterology Suite services are re-located to the newly renovated area anticipated to occur by September 2020. The initial check was done on November 20, 2019, both rooms readings achieved compliance readings. The second quarterly check was completed on February 4, 2020 with readings within compliance. The third quarterly check due May 2020 was not done due to the COVID-19 organization response in which the Gastroenterology Services were curtailed.

In addition, the scopes were moved to the clean storage cabinets within the high-level disinfection area because of the COVID-19 organization response. This was completed on March 20, 2020. On March 2, 2020, prior to the scopes being moved, quarterly air exchange checks were completed by Facilities Management Services on the high-level disinfection rooms (i.e., V3-624A and V3-624B) where the scopes were to be stored. Both rooms achieved compliance. Quarterly checks of the high-level disinfection rooms will be completed by Facilities Management Services again in June 2020. Scopes will continue to be stored in the high-level disinfection area until Gastroenterology Services move services and equipment to the newly renovated area.

Air exchange in the scope storage rooms have been monitored by Facilities Management Services for three quarters with 100% compliance. Closure of the recommendation is requested based on the supporting documentation provided.

Recommendation 18

18. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures that damaged flooring or tiles are repaired or replaced in the gastroenterology clean scope storage room.[136]

Medical center concurred.

Target date for completion: Completed

Medical center response: The Associate Director for Patient Care Services along with the Nurse Manager of Gastroenterology evaluated additional reasons for noncompliance to determine appropriate measures to strengthen internal processes. Affirmation was received that no additional reasons were identified as to the damaged floor not being identified and remedied by either the Nurse Manager or Associate Director for Patient Care Services. The Associate Director for Patient Care Services approved and ensured completion of the work orders submitted for flooring repair for Room M3.217. The work order was submitted on November 20, 2019 for temporary upgrades to be completed. Work was completed on November 25, 2019.

Furthermore, this room (i.e., M3.217) is currently no longer used for scope storage. The Gastroenterology Services were curtailed during the organizational response to COVID-19 (e.g., March 2020 – May 2020). As a result, the Gastroenterology scopes were relocated to the high-level disinfection clean storage cabinets. This move was completed on March 20, 2020. Gastroenterology endoscopes will remain in the high-level disinfection clean storage cabinets until the Gastroenterology Services move to the newly renovated area anticipated in September 2020. Closure of this recommendation is requested based on the supporting documentation provided.

VHA requires that high-level disinfected endoscopes "be hung so that no part of the scope touches the bottom of the cabinet and in sufficient space for storage of multiple endoscopes without touching."[137] The inspection team found that three high-level disinfected endoscopes in the gastroenterology scope storage cabinet were touching other scopes. Correct storage of endoscopes reduces the risk of contamination or damage to equipment. The Gastroenterology Nurse Manager stated that a new employee suspended the endoscopes in a manner that that did not prevent the endoscopes from touching other scopes.

[136] The OIG reviewed evidence sufficient to demonstrate that the medical center had completed improvement actions and therefore closed the recommendation before publication of the report.

[137] VHA Directive 1116(2).

Recommendation 19

19. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures that high-level disinfected endoscopes are stored properly.[138]

Medical center concurred.

Target date for completion: Completed

Medical center response: The Associate Director for Patient Care Services along with the Nurse Manager of Gastroenterology evaluated additional reasons for noncompliance to determine appropriate measures to strengthen internal processes. As a result, the Nurse Manager of Gastroenterology affirmed the noncompliance finding of improperly hung scope(s) with tips touching base of cabinet was indeterminate as to root cause. Contributing factors were determined to be non-documented training and competency of all Gastroenterology and High-Level Disinfection staff.

The Associate Director for Patient Care Services will ensure compliance by providing oversight to the development and implementation of a competency checklist and staff training. The action plan included immediate remedial one-on-one training of all Gastroenterology and high-level disinfection staff regarding the proper process of hanging endoscopes. Furthermore, an Endoscope Handling annual competency was developed with formal training and demonstration of competency of all Gastroenterology staff and high-level disinfection staff. Staff training was completed at 100% on May 29, 2020. There are 21 Gastroenterology staff: 19 were trained; two are currently on extended leave. All six of the high-level disinfection staff were trained. Closure of this recommendation is requested based on the supporting documentation provided.

VHA requires SPS staff participate in continuing education sessions at least once per month.[139] For August and September 2019, the OIG did not find evidence of monthly continuing education for all 10 selected SPS staff. This resulted in a potential knowledge gap in the technical aspects of reprocessing duties. The SPS Chief was aware of the ongoing training requirement and stated that the lapse was due to the unexpected absence of the staff responsible for continuing education.

Recommendation 20

20. The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures Sterile Processing Services staff receive monthly continuing education.

[138] The OIG reviewed evidence sufficient to demonstrate that the medical center had completed improvement actions and therefore closed the recommendation before publication of the report.

[139] VHA Directive 1116(2).

Medical center concurred.

Target date for completion: December 31, 2020

Medical center response: The Associate Director for Patient Care Services evaluated additional reasons for noncompliance to determine appropriate measures to strengthen internal processes. The sudden loss of the previous Sterile Processing Services Chief, significant staffing changes, and turnover created a lapse in attention to the training needs and requirements for ongoing staff. The focus was on new staff and attempts to ensure competency core procedures. During the time the new Sterile Processing Services Chief has been in her position she has been working closely with Nursing Executive Leadership (i.e., Associate Director for Patient Care Services and the Deputy Associate Director for Patient Care Services) to refine and streamline Sterile Processing Services processes and will develop a training schedule for staff and will report monthly to the Associate Director for Patient Care Services that educational requirements have been completed.

The Associate Director for Patient Care Services will ensure compliance by providing oversight to the development and implementation of the required processes for Sterile Processing Services. Specifically, the annual Risk Analysis which determines timelines for competency assessments/requirements was completed by the Chief of Sterile Processing Services in collaboration with Nursing Executive Leadership. The final Risk Analysis was submitted to the VISN 15 Sterile Processing Services Management Board on May 19, 2020. The Risk Analysis tool includes data on the type of Reusable Medical Equipment or reprocessing task along with information related to complexity, usual level of bioburden, Spaulding Classification, specialized cleaning instructions, frequency, and risk to patient if reprocessing failure. Scoring instructions for reprocessing of Critical and Semi-Critical Reusable Medical Equipment to determine frequency of competency review that is needed is also included.

The completed Risk Analysis provides updated guidance for the competency education / in-service training required for Sterile Processing Services staff. Compliance of staff participation in scheduled continuing education / in-service sessions will be monitored for two-consecutive quarters until 90% compliance is reached. The denominator will be the total number of staff required to receive competency training each month. The numerator will be the number of staff who attended competency training each month.

Monitoring data will be reported quarterly to the Reusable Medical Equipment Committee.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

The intent is for medical center 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	Requirements	Conclusion
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Accreditation surveys and oversight inspections • Factors related to possible lapses in care and medical center response • VHA performance data (facility or medical center)	Twenty 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, ADPCS, and Associate Director. See details below.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV Committee • Protected peer reviews • UM reviews • Patient safety	• None	• The Patient Safety Manager submits each root cause analysis to the National Center for Patient Safety within the required time frame.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Privileging	• FPPEs • OPPEs • Provider exit reviews and reporting to state licensing boards	• Service chiefs' reprivileging recommendations are based on OPPE activities. • The Executive Committee of the Medical Staff's decision to recommend continuation of privileges is based on OPPE results. • Provider exit review forms are completed within seven calendar days of licensed healthcare professionals departing the medical center.	• Clinical managers define in advance, communicate, and document expectations for FPPEs in the providers' profiles.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Medical center
	  ○ General safety
	  ○ Special use spaces
	  ○ Environmental cleanliness and infection prevention
	  ○ Privacy
	  ○ Accommodation and privacy for women veterans
	  ○ Logistics
	• Inpatient mental health unit
	  ○ General safety
	  ○ Special use spaces
	  ○ Environmental cleanliness and infection prevention
	  ○ Privacy
	  ○ Accommodation for women veterans
	  ○ Logistics
	• Community-based outpatient clinic
	  ○ General safety
	  ○ Special use spaces
	  ○ Environmental cleanliness and infection prevention
	  ○ Privacy
	  ○ Privacy for women veterans
	  ○ Logistics
		• Nursing staff label multidose medication vials with an expiration date upon opening.
		• Privacy curtains are installed in all examination rooms at the Shawnee VA Clinic.
			• A record of visitor access for the information technology room is maintained at the Shawnee VA Clinic.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Long-Term Opioid Therapy	• Provision of pain management using long-term opioid therapy • Program oversight and evaluation	• Clinicians complete a behavior risk assessment that includes a history of substance abuse, mental health problems or disorders, and aberrant drug-related behaviors on all patients prior to initiating long-term opioid therapy. • Providers consistently conduct urine drug testing as required for patients on long-term opioid therapy. • Providers consistently obtain and document informed consent prior to initiating patients on long-term opioid therapy. • Clinicians follow up with patients receiving long-term opioid therapy includes an assessment of adherence to the pain management plan of care.	• The Pain Management Committee monitors the quality of pain assessments and the effectiveness of pain management interventions.
Mental Health: Suicide Prevention Program	• Designated facility suicide prevention coordinator • Provision of suicide prevention care • Completion of suicide prevention training requirements	• None	• All staff receive annual suicide prevention refresher training.

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination: Life-Sustaining Treatment Decisions	• LSTD multidisciplinary committee • Goals of care conversation documentation • LSTD note/orders completed by an authorized provider or delegated	• None	• A multidisciplinary life-sustaining treatment decisions committee is established to review all proposed plans.
Women's Health: Comprehensive Care	• Provision of care • Program oversight and performance improvement data monitoring • Staffing requirements	• None	• None
High-Risk Processes: Reusable Medical Equipment	• Administrative processes • Data monitoring • Physical inspection • Staff training	• High-level disinfected endoscopes are stored properly.	• The SPS Chief consistently reports the annual risk analysis results to the VISN Sterile Processing Services Management Board. • Airflow is monitored in the gastroenterology clinic clean scope rooms. • Damaged flooring or tiles are repaired or replaced in the gastroenterology clean scope storage rooms. • SPS staff receive monthly continuing education.

Appendix B: Medical Center Profile

The table below provides general background information for this high complexity (1b) affiliated[1] facility reporting to VISN 15.[2]

Table B.1. Profile for Kansas City VA Medical Center (589) (October 1, 2016, through September 30, 2019)

Profile Element	Medical Center Data: FY 2017[3]	Medical Center Data: FY 2018[4]	Medical Center Data: FY 2019[5]
Total medical care budget in dollars	$399,081,236	$450,345,208	$493,250,940
Number of:			
• Unique patients	49,903	49,238	49,356
• Outpatient visits	571,100	600,483	611,629
• Unique employees[6]	1750	1634	1704
Type and number of operating beds:			
• Domiciliary	28	28	28
• Medicine	79	79	79
• Mental Health	10	10	10
• Residential rehabilitation	0	20	20
• Surgery	25	25	25
Average daily census:			
• Domiciliary	19	19	21
• Medicine	52	54	54
• Mental health	11	11	12
• Residential rehabilitation	–	1	9
• Surgery	10	9	9

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

[1] Associated with a medical residency program.

[2] 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."

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

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

[5] October 1, 2018, through September 30, 2019.

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

Appendix C: VA Outpatient Clinic Profiles[1]

The VA outpatient clinics in communities within the catchment area of the medical center provide primary care integrated with women's health, mental health, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table C.1. provides information relative to each of the clinics.

Table C.1. VA Outpatient Clinic Workload/Encounters and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2018, through September 30, 2019)[2]

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
Warrensburg, MO	589G1	6,010	1,926	Dermatology Eye Hematology/ Oncology	n/a	Pharmacy Weight management
Belton, MO	589GB	6,842	1,270	Endocrinology Hematology Oncology	n/a	Nutrition Pharmacy Weight management

[1] Includes all outpatient clinics in the community that were in operation as of August 27, 2019. The OIG omitted (589QA) Overland Park, KS, as no data were reported.

[2] 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. An encounter is a "professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition."

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

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

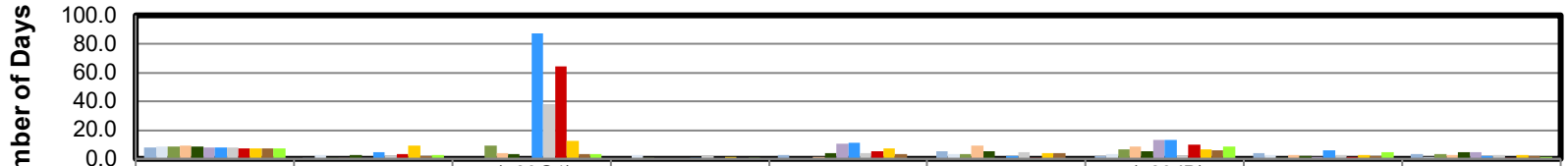
[5] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[3] Provided	Diagnostic Services[4] Provided	Ancillary Services[5] Provided
Paola, KS	589GC	3,641	436	Hematology Oncology	n/a	Pharmacy Weight management
Nevada, MO	589GD	5,039	790	Hematology Oncology	Nuclear med	Pharmacy Weight management
Cameron, MO	589GZ	1,939	246	Hematology Oncology	n/a	Pharmacy Weight management
Kansas City, MO	589HK	1,112	n/a	n/a	n/a	n/a
Excelsior Springs, MO	589JB	5,014	1,576	Hematology Oncology	n/a	Pharmacy Weight management
Shawnee, KS	589JC	9,983	547	Gastroenterology Pulmonary/ Respiratory disease	n/a	Pharmacy Weight management
Kansas City, MO	589JF	24,000	10,009	Anesthesia Endocrinology Gynecology Pulmonary/ Respiratory disease	Radiology	Pharmacy Weight management

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 D: Patient Aligned Care Team Compass Metrics[1]

New Primary Care Patient Average Wait Time in Days

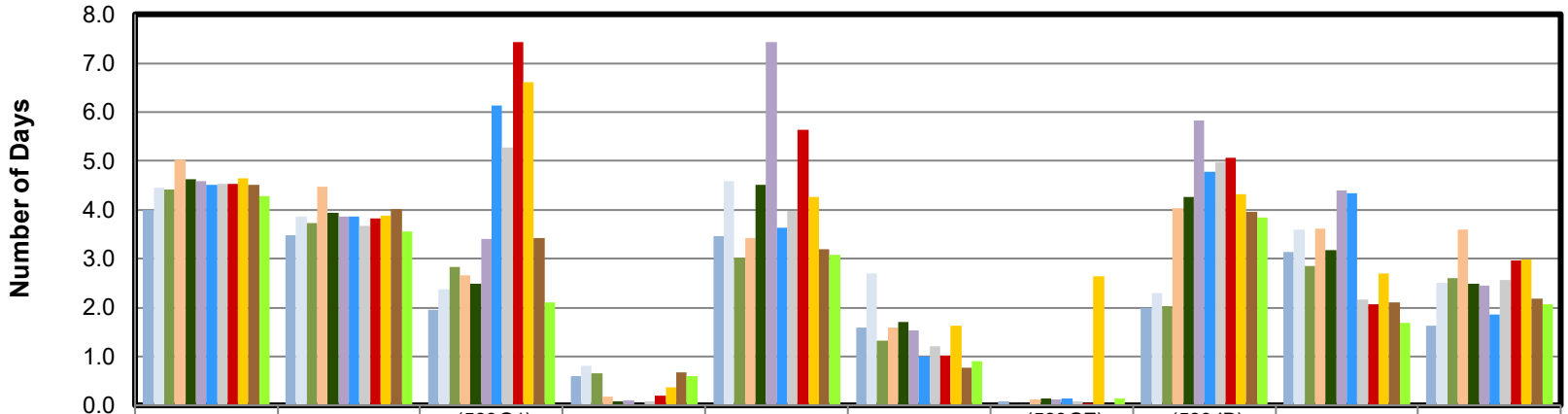


	VHA Total	(589) Kansas City, MO	(589G1) Warrensburg, MO	(589GB) Belton, MO	(589GC) Paola, KS	(589GD) Nevada, MO	(589JB) Excelsior Springs, MO	(589JC) Shawnee, KS	(589JF) Honor, MO
OCT-FY19	8.0	0.5	0.0	0.0	2.5	5.0	1.8	4.1	3.1
NOV-FY19	8.5	2.8	0.0	2.3	0.0	3.4	3.5	2.4	1.7
DEC-FY19	8.6	0.5	9.5	0.8	0.0	3.6	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
APR-FY19	7.8	4.6	87.6	0.1	10.9	2.1	13.2	5.7	1.9
MAY-FY19	7.6	2.1	38.5	2.2	4.1	4.4	2.0	2.9	2.5
JUN-FY19	7.6	3.1	64.2	0.0	5.0	1.0	10.0	1.4	0.9
JUL-FY19	7.3	9.2	12.5	1.4	7.0	4.0	6.6	2.8	2.5
AUG-FY19	7.4	2.3	3.6	0.0	3.3	3.8	5.8	2.1	2.3
SEP-FY19	7.3	2.8	3.0	0.6	0.0	0.0	8.9	4.4	1.6

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (589QA) Overland Park, KS, and (589GZ) Cameron, MO, as no data were reported. The OIG has on file the medical center's explanation for the increased wait times for (589G1) Warrensburg, MO.
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.

[1] Department of Veterans Affairs, *Patient Aligned Care Teams Compass Data Definitions*, accessed October 21, 2019.

Established Primary Care Patient Average Wait Time in Days



	VHA Total	3V15	(589G1) Warrensburg, MO	(589GB) Belton, MO	(589GC) Paola, KS	(589GD) Nevada, MO	(589GZ) Cameron, MO	(589JB) Excelsior Springs, MO	(589JC) Shawnee, KS	(589JF) Honor, MO
OCT-FY19	4.0	3.5	2.0	0.6	3.5	1.6	0.1	2.0	3.1	1.6
NOV-FY19	4.4	3.9	2.4	0.8	4.6	2.7	0.0	2.3	3.6	2.5
DEC-FY19	4.4	3.7	2.8	0.7	3.0	1.3	0.0	2.0	2.9	2.6
JAN-FY19	5.0	4.5	2.7	0.2	3.4	1.6	0.1	4.0	3.6	3.6
FEB-FY19	4.6	3.9	2.5	0.1	4.5	1.7	0.1	4.3	3.2	2.5
MAR-FY19	4.6	3.9	3.4	0.1	7.4	1.5	0.1	5.8	4.4	2.4
APR-FY19	4.5	3.9	6.1	0.0	3.6	1.0	0.1	4.8	4.3	1.9
MAY-FY19	4.5	3.7	5.3	0.1	4.0	1.2	0.1	5.0	2.2	2.6
JUN-FY19	4.5	3.8	7.4	0.2	5.6	1.0	0.0	5.1	2.1	3.0
JUL-FY19	4.6	3.9	6.6	0.4	4.3	1.6	2.6	4.3	2.7	3.0
AUG-FY19	4.5	4.0	3.4	0.7	3.2	0.8	0.0	4.0	2.1	2.2
SEP-FY19	4.3	3.6	2.1	0.6	3.1	0.9	0.1	3.8	1.7	2.1

Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted (589QA) Overland Park, KS as no data were reported.

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 E: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[1]

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
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
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
HC assoc infections	Health care associated infections	A lower value is better than a higher 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 continuity care	Mental health continuity of care (FY14Q3 and later)	A higher value is better than a lower value

[1] VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL)* (last updated September 30, 2019). https://vaww.vssc.med.va.gov/vsscenhancedproductmanagement/displaydocument.aspx?documentid=9428. (The website was accessed on March 6, 2020, but is not accessible by the public.)

Measure	Definition	Desired Direction
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
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
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
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
SC care coordination	SC (specialty care) care coordination	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
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
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center

Appendix F: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 3, 2020

From: Director, VA Heartland Network (10N15)

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

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

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

I have reviewed and concur with the facility's response to the findings, recommendations, and submitted action plans.

(Original signed by:)

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

Appendix G: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: May 22, 2020

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. Thank you for helping us move forward on our journey towards high reliability.

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

(Original signed by:)

DAVID ISAACKS, FACHE
Director

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