US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Kansas City Healthcare System in Missouri

Healthcare Facility Inspection	25-00204-215	August 13, 2026

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Executive Summary

The VA Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the VA Kansas City Healthcare System (the facility) from April 1 through 3, 2025. Facility leaders and staff provided updated information in December 2025 and June 2026. The facility is rated as *high complexity* and in fiscal year 2025, provided direct care to 56,067 unique patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

Overall, the OIG inspection did not reveal issues that warranted recommendations for corrective actions in any of the five domains.

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement.
- **Primary Care.** The OIG assessed whether primary care teams were staffed according to VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care* and Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*.[3]
- **Veteran-Centered Safety Net.** The inspection also evaluated facility programs that offer support services to vulnerable veterans who are experiencing or at risk of homelessness, or recently incarcerated.

[1] VHA classifies facilities based on their complexity level. High-complexity facilities have "medium-high volume, high-risk patients, many complex clinical programs, and medium-large research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." "Trip Pack - Operational Statistics Table FY2026 Through February," VHA Support Service Center, accessed April 1, 2026, https://reports.vssc.med.va.gov/ReportViewer. (This web page is not publicly accessible.)

[2] See appendix A for a description of the OIG's inspection methodology.

[3] VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026; VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

What the OIG Recommended

The OIG made no recommendations.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the report (see appendixes B and C).[4] No further action is required.

DAVID C. KRULAK, MD, MPH, MBA
Assistant Inspector General
for Healthcare Inspections

[4] In December 2025, VA announced plans to reorganize and consolidate its Veterans Integrated Service Networks (VISNs) from 18 networks to 5, with the new structure taking effect on June 1, 2026. All VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles within the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise.

Abbreviations

FY	fiscal year
HCHV	Health Care for Homeless Veterans
HUD-VASH	Housing and Urban Development–Veterans Affairs Supportive Housing
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Contents

Introduction

The Office of Inspector General's (OIG's) Office of Healthcare Inspections focuses on overseeing the Veterans Health Administration (VHA), which offers care to more than nine million enrolled veterans through its 1,380 healthcare facilities.[5] VHA's vast care delivery structure requires sustained and thorough OIG oversight to ensure the nation's veterans receive high-quality care.

The OIG established the Healthcare Facility Inspection program to routinely evaluate VHA medical facilities on an approximately three-year cycle. Healthcare Facility Inspection reports provide insight into the experience of staff working in VHA facilities and veterans receiving care. They inform veterans, the public, and Congress about the conditions for care delivery and patient safety and highlight specific corrective actions leaders and staff can take. Each inspection focuses on five domains and assesses facilities' adherence to VA standards and other governing authorities:

Culture: VA supports a system of shared values that shape an organization's behavioral norms. Effective responses to system shocks as well as favorable employee and veteran experiences are elements of positive organizational culture.[6]

Environment of Care: Medical facilities must maintain safety, cleanliness, and accessibility. VHA established a comprehensive program that addresses physical spaces, equipment and systems, privacy, and other concerns.[7]

Patient Safety: VHA programs identify and reduce system vulnerabilities and risks of harm to veterans.[8]

Primary Care: Facilities must comply with directives and guidance governing the VHA multidisciplinary care model.[9]

Veteran-Centered Safety Net: VA offers coordinated medical care and social support services to vulnerable individuals, including those experiencing homelessness or recent incarceration.[10]

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[5] "About Us," VA, last updated June 2, 2026, https://department.va.gov/vha/about-us.

[6] Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11, https://doi.org/10.1136/bmjopen-2017-017708.

[7] VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

[8] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

[9] VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026.

[10] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

The VA Kansas City Healthcare System (the facility) opened in 1952 on a 40-acre site and provides care to veterans in western Missouri and eastern Kansas.[11] In fiscal year (FY) 2025, the facility's medical care budget was approximately $665 million, and it had 162 operating beds with more than 56,000 enrolled veterans.[12]

Figure 1. *Facility photo.*
Source: "VA Kansas City Health Care," VA, accessed April 1, 2025, https://www.va.gov/kansas-city-health-care.

The OIG inspected the facility from April 1 through 3, 2025. Executive leaders referred to throughout this report include the Medical Center Director (Director), Chief of Staff, Associate Director, Assistant Director, interim Associate Director for Patient Care Services, and interim Executive for High Reliability. The newest member of the team, the Chief of Staff, was assigned in November 2024, and the Associate Director, assigned in April 2018, was the most tenured.

CULTURE

The OIG team examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's daily operations), and both employees' and veterans' experiences.[13] The OIG administered its own facility-wide questionnaire, interviewed executive and facility leaders and employees, and considered data from patient advocates.[14]

[11] "About Us," VA, accessed April 23, 2025, https://www.va.gov/kansas-city-health-care/about-us.

[12] "Trip Pack - Operational Statistics Table FY2026 Through February," VHA Support Service Center, accessed April 1, 2026, https://reports.vssc.med.va.gov/ReportViewer. (This web page is not publicly accessible.)

[13] Valerie M. Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies," *BMJ Quality and Safety* 28 (2019): 74–84, https://doi.org/10.1136/bmjqs-2017-007573.

[14] Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Patient Advocate," VA, last updated May 9, 2022, https://www.va.gov/patientadvocate. For more information on the OIG's data collection methods, see appendix A.

System Shocks

In an interview with OIG inspectors, executive leaders reported several system shocks. Two of the events they detailed were attributed to (1) the Department of Government Efficiency (DOGE) workforce optimization and cost efficiency initiatives and (2) severe weather.[15]

Executive leaders said these actions caused a cardiologist (heart specialist) to decline a job offer due to uncertainty with federal employment and required them to cancel the telephone operators' contract in June 2025. The OIG reviewed the operators' call volume data and found they had averaged more than 30,000 calls per month between January and March 2025. Leaders stated they had to shift the operators' responsibilities to administrative staff until they received approval to hire 15 telephone operators. They were uncertain whether VHA would approve these positions and anticipated it would take 6 to 12 months to reduce the workload on administrative staff. Because of the staffing challenges, executive leaders reported pulling staff from other areas of the facility, such as those who work on veteran travel claims, to cover the calls, and said the changes did not affect access to care. The OIG team reviewed updated information provided by the facility's deputy chief business officer in June 2026 and learned the facility did not hire 15 telephone operators. The facility will begin a new telephone operator contract in October 2026 and has continued to cover telephone operator duties with existing employees since the previous telephone operator contract ended in June 2025.

Additionally, executive leaders discussed weather events (a tornado and two blizzards) that disrupted operations at a community-based outpatient clinic and the main facility. The tornado hit the clinic in Nevada, Missouri, during the OIG's visit in April 2025. The Director reported that wind damaged the building, caused a power outage, and destroyed a flagpole. The Director also stated that staff knew where to shelter to keep occupants safe, which prevented any injuries, and personnel resumed operations the following day.

Executive leaders said the two blizzards occurred about a month apart in January and February 2025. The first blizzard exposed weaknesses in communications with patients and with preparation for winter storms. There were also limited places for employees to sleep. Specifically, leaders did not have a standardized approach to communicate with patients to reschedule appointments when the National Weather Service issued a winter storm watch. Also, employees did not have personal care items for an overnight stay, and the facility lacked separate male and female sleeping quarters. The Director reported working at the facility along with other

[15] One initiative the executive leaders asserted caused a system shock required all executive agencies to eliminate "waste, bloat, and insularity" by initiating "large-scale reductions in force" and to "hire no more than one employee for every four employees that depart." Implementing The President's 'Department of Government Efficiency' [DOGE] Workforce Optimization Initiative, 90 Fed. Reg. 9669 (Feb. 14, 2025). Another required each executive agency to "review all existing covered contracts" and "terminate or modify" them to reduce or reallocate spending within the federal government. Implementing The President's 'Department of Government Efficiency' Cost Efficiency Initiative, 90 Fed. Reg. 11095 (Mar. 3, 2025).

leaders during the blizzards, and despite the challenges, they received positive feedback from employees for their support and availability during the events.

After the first blizzard, leaders recognized the importance of establishing an incident command center for future winter storm watches, preparing employees for overnight stays, and designating gender-appropriate sleeping quarters.[16] Executive leaders completed action plans within five months following the first blizzard, including a fact sheet that outlined a list of items for staff to bring for an overnight stay, which proved effective in preparing for the second blizzard.

Employee Experiences

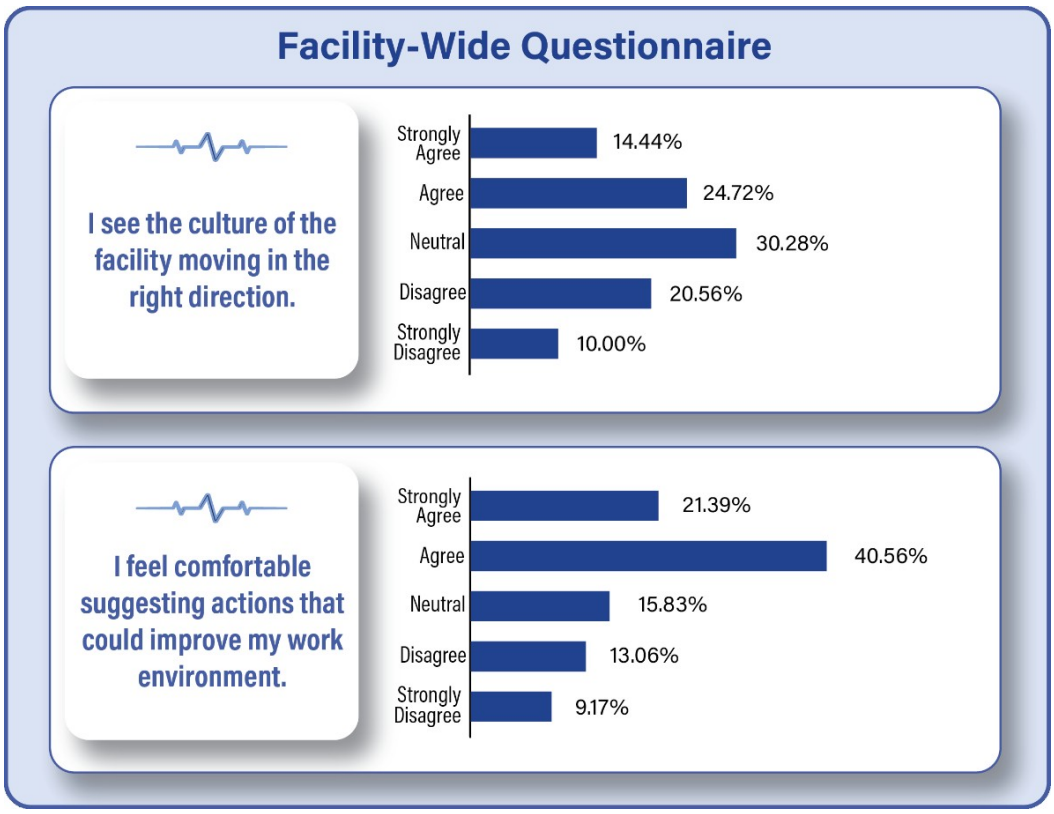

Figure 2. *Employee perceptions of facility culture.*
Source: OIG analysis of selected questionnaire responses.

About 62 percent of respondents to the OIG-administered questionnaire indicated they feel comfortable suggesting actions that could improve their work environment and around 39 percent reported the facility's culture was moving in the right direction, as shown in figure 2. Executive leaders attributed the negative responses about the culture to instability in the medical center director role (five interim and permanent directors had served in the past five years before

[16] An incident command center provides a "standardized organizational structure" to manage emergencies. VHA Directive 0320.02, *Veterans Health Administration Health Care Continuity Program*, January 22, 2020.

April 2025). The Chief of Staff stated the current Director promoted cohesiveness and accountability, which had a positive effect on employees throughout the facility.

Executive leaders said they communicated with employees through various meetings, emails, newsletters, and routine visits to work areas. Executive leaders also stated the chief well-being officer holds *Listen, Sort, and Empower* sessions (focused on teaching and enabling staff to take actions to improve their individual area) and helps implement the facility's *Re-Engaging, Inspiring, and Supporting Employees* program (peer support for employees who witnessed or experienced a stressful event).

Other examples of executive leaders' actions to improve employee experiences included their support for Thursday farmers markets at the facility where local farmers sell products to employees and veterans. Executive leaders also planned to install vending machines with healthy food options on every other floor of the facility.

Veteran Experiences

In response to an OIG questionnaire, a patient advocate reported two common complaints from veterans that involved (1) disagreements with their treatment plan and care as well as (2) lack of confidence or trust in clinicians. To address the complaints, executive leaders created tools for veterans to document their concerns and share them with their healthcare team. They also appointed employees as veteran experience champions to address issues identified as soon as possible.

A leader said they measured success by assessing employees' timeliness in resolving veterans' concerns in VA's patient advocate tracking system (a tool used to monitor and prioritize veteran feedback).[17] The OIG reviewed documents and determined facility staff resolved them in an average of three and a half days.

Attention to environmental design improves patients' and staff's safety and experience.[18] The OIG team assessed how a facility's physical features may shape the veteran's perception and experience of health care they receive. The team also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

[17] VA, "New Patient Advocate Tracking System Empowers VA Employees to Resolve Issues on the Spot," news release, March 4, 2020, https://news.va.gov/72212/patsr.

[18] "Informing Healing Spaces through Environmental Design: Thirteen Tips," VA, last updated May 1, 2024, https://www.va.gov/WholeHealth/Healing-Spaces.

The inspectors examined compliance with key VA and VHA guidelines and standards, as well as with Architectural Barriers Act and Joint Commission standards. Best practice principles from academic literature were also considered.[19]

General Inspection

Facility leaders told the OIG that recent national hiring pauses including the hiring freeze (in effect from January 20, 2025, to October 15, 2025), had hindered their ability to bring on shuttle drivers who transport veterans from their residences to appointments.[20] The facility went from an average of 14 drivers to 7 or 8 at the time of the inspection in April 2025. To address this issue, leaders use a rideshare service to transport veterans, as well as making use of options like home-based primary care and telehealth.

The OIG team observed signs that directed veterans to parking and building locations. The main entrance had a passenger loading zone, power-assisted doors, and available wheelchairs. The lobby was generally clean and well-lit, with seating areas. There were also maps near the elevators and directional signs throughout the building.

Figure 3. *Accessibility tools available to veterans with impairments.*
Source: OIG analysis of questionnaire responses, translation services instruction card, and observations.

[19] VA, *Integrated Wayfinding & Recommended Technologies*, December 2012; VA, *VA Signage PG-18-10, Design Manual*, May 16, 2023, revised February 19, 2025; VA, *VA Barrier Free Design Standard*, January 1, 2017, revised May 1, 2025; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook,* 2025; Access Board, *Architectural Barriers Act (ABA) Standards,* 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2025.

[20] Implementing The President's 'Department of Government Efficiency' Workforce Optimization Initiative, 90 Fed. Reg. 9669; Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025). Shortly after the hiring freeze memorandum was issued, the Acting Secretary provided guidance and identified a list of exempted "positions critical to delivering care to Veterans in" VHA. Acting Secretary, "Hiring Freeze Guidance," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, January 21, 2025. As of December 1, 2025, VA adopted new policies for filling vacancies and creating new positions in compliance with the executive order for Ensuring Continued Accountability for Federal Hiring. Executive Order 14356, 90 Fed. Reg. 48387 (Oct. 20, 2025); Assistant Secretary for Human Resources and Administration (006), "Updated Department of Veterans Affairs Hiring Guidance (VIEWS 13474675)," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, December 1, 2025.

As figure 3 indicates, inspectors observed multiple accessibility features. For example, volunteers at the information desk reported they help veterans with impairments get to their destination and communicate in writing or request translation services when needed.

However, some crosswalks at the facility lacked detectable warning surfaces for people with visual impairments at points where walkways transitioned onto roadways. These surfaces serve as a critical safety feature to alert them to approaching traffic, and VA's *PG-18-10, Site Design Manual* states facilities should install them "anywhere a walkway transitions into a vehicle roadway."[21] The interim chief of facilities management explained that leaders had a planned project to enhance the parking areas, which included warning surfaces, but it was on hold due to funding limitations. The OIG team reviewed updated information provided by staff in December 2025 and determined that leaders planned to complete construction in FY 2027; therefore, the OIG did not make a recommendation.

VHA Directive 1608(1), *Comprehensive Environment of Care Program* requires healthcare facilities to maintain a clean environment to avoid infection sources and transmission. In April 2025, the Associate Director reported 25 current housekeeping staff vacancies and explained that leaders had not filled them all because of national hiring pauses. The chief of the environmental management service added that some staff are on extended leave, but contracted staff help keep common areas clean.

Inspectors noted clear exit paths, medical equipment with evidence of current preventive maintenance, and secured supplies and medications. However, the OIG also observed dirty light fixtures and floors, as well as dust on ventilation grills and supply shelves. Additionally, staff stored some items in corrugated boxes, which is an infection control concern because the boxes are considered contaminated, and per VHA Directive 1761, *Supply Chain Management Operations* corrugated boxes must not come into contact with clean items.[22] The OIG reviewed updated information in December 2025 from facility leaders and determined they ensured facility staff removed the corrugated boxes and kept the areas clean. Therefore, the OIG did not make a recommendation.

Additionally, the OIG found liquid nitrogen (used in clinical procedures) in a location where staff could not explain how they maintained adequate ventilation, as required. The inspection team reviewed the manufacturer's safety data sheet (a document that explains information about a chemical) for liquid nitrogen, which states staff must use and store it in an area with adequate ventilation, which reduces exposure to fatal concentrations of the gas.[23] In December 2025, the team reviewed updated information and confirmed that staff completed training on liquid

[21] VA, *PG-18-10*, *Site Design Manual*, February 2013, revised March 1, 2024.

[22] VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[23] Liquid nitrogen is a substance that displaces oxygen in the atmosphere and can cause oxygen deprivation if not used properly. Occupational Safety and Health Standards, 29 C.F.R. § 1910.1200 (2024).

nitrogen and relocated the containers to meet ventilation requirements. Therefore, the OIG did not make a recommendation.

The OIG inspectors examined the facility's patient safety processes. They focused on communication procedures for urgent but noncritical test results, the sustainability of changes made by leaders in response to previous oversight recommendations, and improvement projects.

Communication of Urgent but Noncritical Test Results

The facility had processes to inform healthcare providers who order tests about urgent but noncritical test results; follow up on the results with patients; identify a designee to communicate test results when a provider was unavailable or had left the facility; and transmit results outside of regular clinic hours and during care transitions. In addition, the facility had a written policy and service-level workflows that explain the roles of various team members in the communication process, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[24] In an interview, facility leaders said quality management staff report External Peer Review Program data quarterly to the Executive Committee of the Medical Staff and leaders monitor data to ensure staff comply with VHA Directive 1088(1).[25]

Action Plans and Process Improvements

The inspection team evaluated oversight reports about the facility for the past three years, including those from the OIG and The Joint Commission.[26] The facility did not have previous OIG or Joint Commission findings related to test result communication or recommendations that were open (not yet fully addressed) for more than a year. Facility leaders credited their success to using a Joint Commission web-based program that helped staff create action plans and then collect and analyze data to support those plans for OIG recommendations as well. Additionally, the Quality Patient Safety Committee tracks action plan implementation, monitors compliance with the plans, and reports monthly to the Executive Committee of the Medical Staff to ensure sustained improvement.

[24] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

[25] VHA established the External Peer Review Program communicating test results measure as a way for facility leaders to review compliance and ensure identified problems are addressed. VHA Directive 1088(1).

[26] VA OIG, *Comprehensive Healthcare Inspection of the Kansas City VA Medical Center in Missouri*, Report No. 23-00119-156, April 25, 2024; The Joint Commission, *Final Accreditation Report Kansas City Veterans Affairs Medical Center*, November 22, 2024.

Leaders said the facility has established methods to develop process improvement activities. Improvement activities typically originate from action plans developed in response to oversight recommendations or from incidents staff submit to the Joint Patient Safety Reporting system (a database VA staff use to document patient safety events).[27] The patient safety manager explained that staff investigate the incidents, implement corrective actions, and track the actions to determine if they improve patient safety. The OIG reviewed incidents in the Joint Patient Safety Reporting system and found no significant trends related to the communication of test results.

The OIG assessed whether primary care teams were staffed in compliance with VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care* and Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*.[28] The inspection team interviewed staff, analyzed primary care team staffing data, and examined new patient appointment wait times.

Primary Care Teams

The facility had the following vacancies at the time of the inspection in April 2025 across 40 primary care teams: three providers, two registered nurses, five licensed practical nurses, and nine medical support assistants. Facility leaders said they were actively working to fill these vacancies by seeking exceptions until the hiring freeze had been lifted.[29]

Panel sizes (the number of patients assigned to a care team) averaged 93 percent of the baseline capacity of 1,200, as recommended in VHA Directive 1406(3). Wait times for established patients averaged 3 days, and new patients averaged 20 days. The Code of Federal Regulations (title 38, section 17.4040) states that patients may be referred to community providers if the wait time is greater than 20 days.[30]

Primary care staff said they felt supported and encouraged by leaders to present best practices and process improvement projects in various forums. Facility leaders partnered with primary care staff to implement the following projects to increase efficiency:

[27] VHA National Center for Patient Safety, *JPSR [Joint Patient Safety Reporting] Guidebook*, *Version 6.0*, October 2025.

[28] VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

[29] Hiring Freeze, 90 Fed. Reg. 8247.

[30] 38 C.F.R. § 17.4040 (2024).

- A VHA electronic application to detect appointment cancellations and automatically contact patients to reschedule[31]
- Elimination of unnecessary and redundant electronic notifications to reduce the time providers spend reviewing medical records

Staff and facility leaders explained that because of these projects, primary care staff had more time to address patients' needs and experienced increased job satisfaction.

The OIG reviewed the Health Care for Homeless Veterans (HCHV), Housing and Urban Development–Veterans Affairs Supportive Housing (HUD-VASH), and Veterans Justice Programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The inspection team analyzed enrollment and performance data and interviewed facility program staff.

Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[32]

During this inspection, VHA used three performance measures to determine the success of each medical facility's program. The first, HCHV5, measured the percentage of veterans who received an HCHV program intake assessment.[33] However, this fiscal year (FY 2026), VHA no longer uses intake percentage as a performance measure. The second measure used during the inspection, HCHV1, measured the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional

[31] "VA Employee Technical Innovation Reduces Nationwide Appointment No-Shows," DigitalVA, January 7, 2020, https://digital.va.gov/va-employee-technical-innovation-reduces-nationwide-appointment-no-shows.

[32] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[33] VHA's goal is for facility program staff to perform intake assessments for all identified veterans by the end of each fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*, October 1, 2023; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*, November 2024.

residences for veterans with mental health or substance use conditions).[34] Finally, HCHV2 measured the percentage of veterans who are discharged from the program's contracted emergency residential services or low-demand safe haven beds due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff (referred to as negative exits)."[35]

Performance and Improvement Highlights

The program supervisor said the facility's HCHV program operates a walk-in clinic and has emergency department staff and on-call social workers to assist veterans who need immediate shelter. The program also has an outreach worker who helps veterans with transportation, housing, and supportive services. The facility's performance on the three metrics in effect at the time of the inspection follows:

- The facility's HCHV program surpassed the intake assessment (HCHV5) target for FY 2024 and met the mid-year target for FY 2025. Facility program leaders credited the improved score to staff collaborating with community partners to create a list of veterans to enroll in the program.[36]
- The target on veterans' exits to permanent housing (HCHV1) was met for FY 2024 through quarter one of FY 2025. The supervisor attributed this to VA contractors who acted as emergency residential services liaisons—establishing strong relationships with landlords and remaining knowledgeable about available properties.

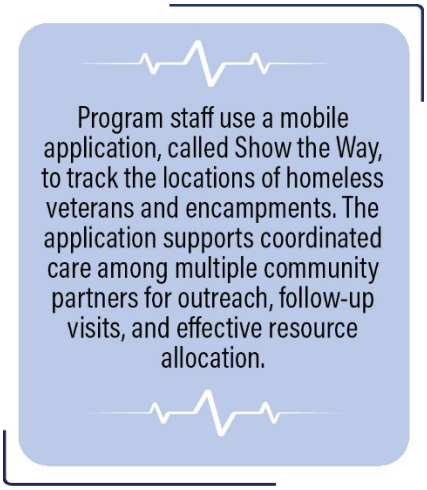

Figure 4. *Show the Way mobile application to help track veterans living on the street and in encampments.*
Source: OIG interview with the homeless program manager.

[34] VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*. Contract residential services programs include both contracted emergency residential services and low-demand safe haven programs. For contracted emergency residential services, veterans can usually stay from 30 to 90 days. For low-demand safe havens a veteran can typically stay between 4 to 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

[35] VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

[36] "Continuum of Care Program," Department of Housing and Urban Development, accessed April 16, 2025, https://www.hud.gov/program/coc.

- However, the program did not meet the negative exit (HCHV2) target for FY 2024 through quarter one of FY 2025. Program and contract staff continued to work together on this target by promoting harm-reduction strategies; for example, instead of discharging a veteran for a single rule violation, they tried to address the behavior.

Housing and Urban Development–Veterans Affairs Supportive Housing

The HUD-VASH program combines HUD rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including "serious mental illness, physical health diagnoses, and substance use disorders."[37] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[38]

VHA measures how well the program meets veterans' needs by using nationally determined targets, including the number of housing vouchers assigned to the facility currently used by veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[39]

Performance and Improvement Highlights

- The facility's program did not meet the voucher use (HMLS3) target for FY 2024 through quarter one of FY 2025. Program staff explained that 391 of the 397 vouchers were assigned to eligible veterans, but they were not yet permanently housed. Facility program leaders identified challenges with limited affordable housing and properties that did not pass inspections; in response, they pursued options such as assisted living and shared living spaces.
- The facility exceeded the employment (VASH3) target for FY 2024 through quarter one of FY 2025. The program supervisor credited a new employment specialist who identified job opportunities, hosted job fairs, and helped veterans build resumes and prepare for interviews.
- The program supervisor shared that staff built strong relationships with community partners through an annual stand-down (outreach) event and weekly meetings with Supportive Services for Veteran Families, Catholic Charities, Salvation Army, and

[37] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[38] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[39] VHA sets the target for facilities to provide a minimum of 90 percent of their allotted housing vouchers to participants and at least 50 percent of the participants in the facility's program should be employed. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

other community partners.[40] These partners provide multiple resources, such as financial assistance for rental deposits, application fees, and moving expenses; food; and furniture and household essentials.

Veterans Justice Program

The Veterans Justice Program serves veterans throughout all stages of the criminal justice process—from contact with law enforcement to court appearances and their reentry into life in the community after incarceration.[41] Recognizing incarceration as a strong predictor of homelessness on release, the program focuses on connecting veterans to VA health care, services, and benefits. VHA sets a target for the number of veterans entering the Veterans Justice Program each fiscal year (performance measure VJP1).[42]

Veterans justice outreach specialists described strong connections with community partners. For example, paramedics treated a veteran with a recent double leg amputation for multiple falls. The amputation was connected to the veteran's military service, but they had never received VHA care. A social worker embedded with the paramedics' crisis intervention team referred the veteran to the program, and facility staff helped the veteran get VHA home, primary, and wound care; caregiver support; mental health treatment; and transportation to appointments.

Figure 5. *VHA and community crisis intervention team collaboration to support veterans. Source: OIG interview with facility leaders.*

Performance and Improvement Highlights

- The facility's program did not meet the enrollment (VJP1) target for FY 2024 but did meet the mid-year target for FY 2025. Program staff said they previously counted only veterans in treatment courts as enrolled for the measure, but they now know how to account for all veterans they assist.[43]
- Program staff also reported they receive referrals from judicial staff, law enforcement officials, and community mental health liaisons. For example, a liaison at a county jail screens inmates for veteran status, notifies facility

[40] A "VA2K event encourages people to live active lifestyles and allows participants to support homeless Veterans through voluntary donations of food and clothing items." "Whole Health, VA2K Walk & Roll," VA, last updated March 6, 2026, https://www.va.gov/wholehealth.

[41] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[42] VHA sets escalating targets for this measure at the facility level each year, with the goal to enroll all identified veterans by the end of the fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

[43] "A treatment court is a long-term, judicially supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager." VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

program staff, and sets up video calls to facilitate enrollments.

- Facility program staff also said they participated in crisis intervention team councils and training, including a three-day event focusing on available resources for veterans that policing personnel can offer when helping a veteran in crisis.

Conclusion

To assist leaders in evaluating the quality of care at the Kansas City facility, the OIG conducted an inspection across five domains. Based on the overall positive findings, no recommendations for corrective action are included in this report. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

As to the OIG's Healthcare Facility Inspection program of VHA medical facilities across the nation, OIG leaders are aware of the ongoing transformation to VHA's management structure that could affect future areas of oversight. The OIG will monitor VHA's change management and maintain its focus on risks to the effectiveness and efficiency of VA programs, operations, and services that can affect the health and welfare of veterans and their families.

Appendix A: Methodology

The OIG team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[44] The OIG administered voluntary questionnaires to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. The team inspected the facility from April 1 through 3, 2025. The OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected various areas of the medical facility.

The team's analyses relied on inspectors identifying significant information from questionnaires, surveys, interviews, documents, and observational data, based on professional judgment, as supported by Council of Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation.*[45]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[46] The OIG acknowledges potential bias because the facility liaison selected employees who participated in the interviews; the OIG asked for this selection to minimize the impact of the inspection on patient care responsibilities and primary care clinic workflows.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. During site visits, the team refers concerns that are beyond the scope of the inspections to the OIG's hotline management personnel for further review.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issues.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[47] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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[44] The accreditation reports covered the time frame of October 1, 2021, through September 30, 2024—the most recent available at the time of the inspection.

[45] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation,* December 2020.

[46] Self-selection bias is when individuals with certain characteristics choose to participate in a group, and response bias occurs when participants "give inaccurate answers for a variety of reasons." Dirk M. Elston, "Participation Bias, Self-Selection Bias, and Response Bias," *Journal of American Academy of Dermatology* (2021): 1-2, https://doi.org/10.1016/j.jaad.2021.06.025.

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

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.

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 15, 2026

From: Director, VA Heartland Network (10N15)

Subj: Healthcare Facility Inspection of the VA Kansas City Healthcare System in Missouri

To: Director, Office of Healthcare Inspections (54HF01)

Chief Integrity and Compliance Officer (10OIC)

Thank you for the opportunity to review the Healthcare Facility Inspection of the VA Kansas City Healthcare System in Missouri. I reviewed the documentation and concur with the submitted response.

Should you need further information, contact the Veterans Integrated Services Network Quality Management Officer.

(Original signed by:)

Ahmad Batrash, MD, FACP
VISN 15 Interim Network Director

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 10, 2026

From: Director, VA Kansas City Healthcare System (589)

Subj: Healthcare Facility Inspection of the VA Kansas City Healthcare System in Missouri

To: Director, VA Heartland Network (10N15)

We appreciate the opportunity to review and comment on the OIG report, Healthcare Facility Inspection of the VA Kansas City Healthcare System in Missouri.

I have reviewed the documentation and concur with the response as submitted.

Should you need further information, please contact the Chief of Quality Management and Patient Safety.

(Original signed by:)

Eddaliss Gonzalez-Ruiz
Associate Director of Patient Care Services
for
Paula Roychaudhuri, FACHE
Acting Executive Medical Center Director

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Miquita Hill-McCree, MSN, RN, Director Mark Bartuska, MHA, RN, Team Leader Elisa Gomez, MSN, RN Kristie Van Gaalen, BSN, RN
Other Contributors	Kevin Arnhold, FACHE Jolene Branch, MS, RN Richard Casterline Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Daphney Morris, MSN, RN Sachin Patel, MBA, MHA Ronald Penny, BS Joan Redding, MA Larry Ross Jr., MS April Terenzi, BA, BS Dan Zhang, MSC

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Pursuant to Pub. L. No. 117-263 § 5274, codified at 5 U.S.C. § 405(g)(6), nongovernmental organizations, and business entities identified in this report have the opportunity to submit a written response for the purpose of clarifying or providing additional context to any specific reference to the organization or entity. Comments received consistent with the statute will be posted on the summary page for this report on the VA OIG website.