Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-01261-03

Healthcare Inspection

Follow-Up of Quality of Care, Management, and Operations Iowa City VA Health Care System Iowa City, Iowa

October 21, 2014

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Senator Charles E. Grassley to follow up on a prior inspection at the Iowa City VA Health Care System, Iowa City, IA. We previously evaluated the overall quality of care, management, and operations and an allegation that concerns expressed by staff "have been largely ignored" and published *Review of Quality of Care, Management, and Operations, Iowa City VA Health Care System, Iowa City, Iowa,* Report No. 12-02263-269, August 29, 2012. For the current inspection, we assessed the implementation and progress of the action plans developed in response to OHI recommendations from the 2012 report and evaluated a new allegation that "nothing had changed in Iowa City."

We noted overall improvements in the delineation of organizational lines of authority and responsibility, as well as in the efforts to communicate both laterally and vertically throughout the system.

In response to recommendations from the 2012 report, we found that the system had enhanced the amount of information shared at various meetings, practices related to documentation and tracking, and its reporting schedule and expectations for both committees and service lines. Multiple changes within middle management had been made to strengthen oversight and minimize staff having temporarily assigned duties. In addition, the system had implemented processes to increase interaction, support, and communication with its community based outpatient clinics. Since the prior report, a new policy was created regarding the management of drug shortages, and the system has incorporated its drug shortage policy into its overall medication management policy.

We did not substantiate the allegation that "nothing had changed." We found that high quality medical care had been maintained. While some concerns remain in limited areas regarding blame, fear of retaliation, and reactionary leadership, the system is working to create a culture and environment that feels safe and non-retaliatory. The system acknowledged the need for continued progress in these areas. As such, the system's challenge is to continue further along the path of improvement while sustaining the positive changes to date. We made no recommendations.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the report. (See Appendixes A and B, pages 10–11, for the Directors' comments.) No further action is required.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Senator Charles E. Grassley to follow up on a prior report at the Iowa City VA Health Care System (system), Iowa City, IA. In addition, we evaluated a new allegation received by Senator Charles E. Grassley that "nothing had changed in Iowa City" since OIG's visit in 2012.

Background

The system includes a tertiary care university-affiliated teaching hospital with 83 acute medical, surgical, and psychiatric beds and provides outpatient care at the parent facility and at 10 community based outpatient clinics (CBOCs), 7 in Iowa and 3 in Illinois. The system is part of Veterans Integrated Service Network (VISN) 23 and serves veterans in 33 counties in eastern Iowa, 16 counties in western Illinois, and 1 county in northern Missouri.

In the prior report, we evaluated the overall quality of care, management, and operations and that concerns expressed by staff "have been largely ignored" and published *Review of Quality of Care, Management, and Operations, Iowa City VA Health Care System, Iowa City, Iowa,* Report No. 12-02263-269, August 29, 2012. During this review we assessed the continued implementation and progress of the action plans developed in response to OHI recommendations from the 2012 report. The recommendations included that:

- The VISN Director ensure that system leaders take appropriate action in response to identified problems, and communicate action plans to staff.
- System leaders clarify organizational lines of authority and responsibility, to include expectations for committee reporting.
- System leaders strengthen processes to ensure that all required participants or their designees consistently attend environment of care (EOC) rounds and that fire and life safety inspections are conducted annually at the CBOCs.
- System leaders establish written policies for the management of drug shortages.

System Leadership

Following our initial inspection, critical positions, including the Chief of Staff (COS), Associate Director for Operations, and most recently, Director, remained in transition. Leadership within the system is a quadrad structure with a Director, Associate Director for Operations, Associate Director of Patient Care Services (ADPCS)/Nurse Executive, and COS. Changes in three of these four positions have occurred since our 2012 onsite visit; the position without turnover is that of the ADPCS.

At the time of the original inspection (May 2012), the Director was detailed to the VISN and serving as the Acting Director of the Minneapolis VA Health Care System. Therefore, the system had an Acting Director. As of February 3, 2014, the system has a new Acting Director due to the retirement of the previous Director.

The Associate Director for Operations position, which had been filled 5 months prior to our May 2012 visit, has subsequently been vacated. This position is now held in an acting capacity.

In November 2013, the system engaged a recruitment firm to look for qualified COS and Director of Medicine candidates. At the time of the original inspection, the COS position was being filled in an acting capacity. After 33 months with an Acting COS, the system hired a permanent COS in May 2014. While not part of the quadrad, the Director of Medicine is an integral position that has been filled in an acting capacity since October 2012.

Throughout fiscal year (FY) 2013, the system was able to bring on many full-time employee equivalents (FTE) to fill staffing gaps in a variety of services. Two enhancements to nursing service leadership included hiring five new nursing supervisor positions to work off-tours[1] and weekends and the creation of the Deputy Associate Director of Patient Care Services position in August 2013.

Scope and Methodology

Prior to our visit, in an effort to provide a baseline comparison, OIG conducted an Employee Assessment Review (EAR) survey regarding patient care and working conditions that was identical to the survey conducted in 2012.

In addition, we reviewed extensive system documentation, including: performance data; staff satisfaction information; EOC policies, fire drills, and inspection schedules; patient safety data; meeting minutes and tracking logs for the All Employee Forums (AEF), Clinical Executive Board (CEB), and Performance Improvement Council (PIC); local organizational Medical Center Memorandums; FY 2013 and FY 2014 committee reporting schedules; 2014 system strategic planning documents; and other external reviews from 2013.

We conducted a site visit on May 7, 2014. We interviewed the Acting Director, the ADPCS, nursing clinical and administrative managers, CBOC/Primary Care Clinic (PCC) clinical and administrative managers, the Acting Director of Medicine, pharmacy representatives, the outgoing Acting COS and new COS, Patient Safety Managers, and Acting Associate Director for Operations.

An OIG phone line, specific to this review, was staffed on May 7–8, 2014, to allow staff to call and express any concerns regarding the system. The phone number was provided to the system quality manager and patient safety managers to communicate to

[1] Off-tours are considered weekend, holidays, evening and night shifts.

staff who approached them with related questions and concerns, and OIG team members had cards with the number available while they were onsite. We received no calls.

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

Inspection Results

A. Follow-Up on Prior Report

All four of the prior recommendations from *Review of Quality of Care, Management, and Operations, Iowa City VA Health Care System, Iowa City, Iowa,* Report No. 12-02263-269 (August 29, 2012) were formally closed by OHI as of June 18, 2013. However, during this review, each area was reassessed to ensure that process improvements had been maintained.

1. ***We recommended that the VISN Director ensure that system leaders take appropriate action in response to identified problems, and communicate action plans to staff.***

We found that the system has improved communication of action plans to staff. Improvements in discussion and documentation of action plans and related relevant information enable staff to review meeting minutes and learn where issue areas are in the improvement cycle.

The system has enhanced the AEFs. AEFs are Town Hall meetings open to all staff with the goal of sharing information relevant to employees of the health care system. AEFs were held 9 months during FY 2013. For those who are unable to attend, the system posts AEF minutes to a SharePoint site accessible to all employees. Frequent reports at the forums included policy updates with rationale for any changes, budget (including FTE status and hiring), construction updates, changes in leadership responsibility (at the system and VISN), upcoming inspections, and a question and answer session. The Finance Board meetings have been opened up to staff, with new managers often attending as part of their orientation. Minutes and reports from the Finance Board meetings are also posted and available to all staff. In addition, in an effort to ensure staff are aware of pending construction projects that may impact their work, construction engineers have met with nurse managers to communicate next steps. Communications to staff consistently included the action plans for issues of concern, as well as the status of the implementation of those actions.

The current process for all committees, sub-committees, and work groups to document and track performance improvement processes is the utilization of a formalized system-wide plan-do-study-act (PDSA) form. Demonstrated use of the form can be found in the minutes reviewed, and items can be identified as being monitored and tracked to closure.

2. ***We recommended that system leaders clarify organizational lines of authority and responsibility, to include expectations for committee reporting.***

Overall, we found that the system has implemented and maintained a robust reporting schedule for both committees and service lines. The newly established fiscal year reporting schedules give clear guidance and expectations regarding the items to be

reported, the responsible party, and related performance measures. General improvement trends noted include enhanced item tracking through monitoring and closure, more comprehensive reports, increased use of PDSA forms, and reporting from a wider representation of system staff rather than all reports coming from one service, provider type, or individual.

While the upper levels of organizational structure have not significantly changed, multiple changes occurred within the organizational structure of middle management and the various services. Within the nursing service, the Deputy Director of Patient Care Services position was established in order to assist in overall management and communication. Five full-time nursing manager positions were created to improve oversight and support during off-tour shifts. Supervisory clerk positions were also put in place to provide clerks with a direct supervisor to address questions and concerns. PCC and CBOC leadership now includes a nurse administrator and physician leader working closely together. Staff reported a significant increase in leadership availability and presence at the CBOCs. In the area of pharmacy, a second Associate Chief position was created for outpatient services. Overall, with the addition of these clearly defined positions, staff have fewer temporarily assigned duties due to gaps in staffing and are able to focus on their designated roles and responsibilities.

3. ***We recommended that processes be strengthened to ensure that all required participants or their designees consistently attend EOC rounds and that all fire and life safety inspections are conducted annually at the CBOCs.***

OIG reviews subsequent to the initial hotline report confirm compliance in the area of EOC. The OIG conducted both a Combined Assessment Program (CAP) review[2] and a CBOC review[3] within 6 months of the original inspection at Iowa City; there were no EOC findings in either review. In addition, minutes of the AEFs, CEB, and PIC contain documentation that reflects increased interaction, support, and communication with CBOCs throughout the organization. CBOC staff reported timely attention is given by their leadership to EOC and equipment concerns when raised.

4. ***We recommended that the system establish written policies for the management of drug shortages.***

This recommendation had been previously closed after a new policy was created to address drug shortages. The system has since incorporated its drug shortage policy into its overall medication management policy. Pharmacy communications demonstrated actions taken to manage drug shortages. Staff were able to articulate the policies and processes intended to be used to identify, mitigate, and manage drug

[2] *Combined Assessment Program Review of the Iowa City VA Health Care System, Iowa City, IA,* February 4, 2013, Report No. 12-03745-93

[3] *Community Based Outpatient Clinic Reviews at Iowa City VA Health Care System, Iowa City, IA,* February 19, 2013, Report No. 12-03854-114

shortages and provided OHI with examples where the process had been implemented. Since the policy went into effect, the system has successfully managed drug shortages.

B. System Change

In early 2014, OHI was contacted by Senator Charles E. Grassley's office expressing concerns related to Iowa City staff reports that "nothing has changed" since our initial review in 2012.

To assess for system change we examined the same four overarching areas that were the subject of the prior 2012 inspection: Quality of Care, Management Effectiveness, Staff Morale, and System Operations. Specific items were re-evaluated for the presence or absence of change. We did not substantiate the new allegation that nothing has changed since our previous 2012 visit.

Issue 1: Quality of Care

Performance Data

Since the time of the original report, VHA has continued to collect data from each of its facilities to allow comparisons of performance. The ASPIRE dashboard is one tool used to depict how each VA Medical Center measures up to quality goals. The dashboard documents quality and safety goals for all VA Hospitals and the measured performance of each facility. The data shows strengths and opportunities for improvement at the national, regional, and local hospital level. The database lists many "measures," the goal for each measure, and the actual performance. An example would be the goal for all veterans age 18–85 with high blood pressure to have blood pressure readings below 140/90; the data in the dashboard shows the percentage of veterans meeting that blood pressure goal. For the 21 measures reviewed in the first quarter FY 2014 ASPIRE report, the system was within 10 percent of the goal or better for 14 of the measures. None of the measures was more than 30 percent from the goal. The previous lowest performing measure, the rate of pressure ulcers, was discussed and monitored by the PIC. The system has made notable improvement in this area shifting from being more than 30 percent from the goal in 2012 to now being within 20 percent of the goal.

In addition to those measures reported in the ASPIRE report, each site tracks a number of other inpatient and outpatient measures of quality. In the time period since the last report, the system worked closely with a consultant to address Inpatient Evaluation Center (IPEC) measures of concern, specifically morbidity and mortality data. System PDSA efforts, have resulted in overall improvements.

Issue 2: Management Effectiveness

We reviewed directives, policies, data collection, and analyses relevant to quality and patient safety. We examined processes that identify areas needing improvement, implementation of identified actions to mitigate patient care risks, and evaluation of

implemented actions. In addition, we examined leadership's involvement and support of the processes.

In the original report we noted that fear of retribution led staff to avoid reporting incidents. In addition, staff had limited knowledge on how to report incidents and reporting brought about limited change. In our follow-up, we found progress in both enhancements to system reporting programs, as well as in the encouragement and recognition of staff for bringing concerns forward for both potential and actual events. Improvement actions identified through internal review processes were found to be in place and/or in progress with an evaluation of the effectiveness of the change also being conducted. The system's patient safety program is in alignment with directive requirements.[4]

Although these enhancements were evident, discussions during the onsite inspection revealed that in select areas staff continue to experience a reactionary response when reporting issues, resulting in continued fear of blame and retaliation. Staff stated they did not consistently receive leadership support in the reporting of incidents and believed that not having permanent senior leadership contributed to the challenge of addressing these issues.

Issue 3: Staff Morale

To gather information from system employees, OHI conducted an EAR survey regarding patient care and working conditions. All staff, paid and volunteer, received an e-mail invitation on February 2, 2014 to respond anonymously through a dedicated OIG internet portal. Individuals responding to the survey could, if they wished, provide specific details and contact information. We maintained the confidentiality of all EAR survey respondents and ensured content consistency between the 2012 and 2014 versions.

The EAR survey received 450 responses through February 17, 2014, with 126 commenting on a condition of concern. Prior EAR surveys were conducted in 2012 and in 2013 as part of the system's CAP review. Results from all three EAR surveys were reviewed and demonstrated an overall decrease in the number of responses, comments, and concerns.

Analysis of responses to the EAR surveys afforded an opportunity to evaluate trends over time and focus on issues that might otherwise receive less attention. The principal categories of reported concerns were consistent among all three surveys with staffing, communication, and quality of care issues most often reported. Our review found that the number of concerns reported in 2014 for all areas was significantly reduced when compared to the previous 2012 and 2013 EAR surveys. While the majority of responses identified a specific area of concern, EAR survey responders did report that changes had occurred and improvements in the system had been noted.

[4] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011

The VHA All Employee Survey (AES) is an annual voluntary survey asking questions in the areas of job satisfaction, organizational assessment, civility, and culture. We reviewed the status of the system's AES scores for FY 2011, FY 2012, and FY 2013. Employee response to the surveys indicated stable and positive results overall. In addition, during interviews staff indicated an improved culture with an increase in civility across the board. On average, the system had FY 2013 scores consistently above the mean for the seven facilities surveyed in VISN 23.

Issue 4: System Operations

Access to Care

VHA is currently restructuring its standard for measuring wait times. Historically, VHA used a 14 day standard for measuring access to care. When we used that standard, we found that compared with the other 7 facilities in VISN 23, the system had a better rate of access than 5 of the facilities in 2014.[5]

Access to specific clinical areas for both new and established patients is also monitored. The data available at the time of this report indicates that the system was providing timely access for established patients with much longer waits for new patients.

VHA recently conducted a national access audit of wait time practices and published the results on June 9, 2014. VHA reviewed the system but did not flag it as requiring further review and investigation.

Staffing

In the original report we noted widespread concern about vacancies not being filled, the process for hiring new staff being inadequate, positions remaining vacant for prolonged periods of time, the lack of a consistent approach to nurse staffing across shifts and areas of the hospital, and nurses being pulled to areas of the hospital where they do not normally work. A review of recent staff turnover found rates comparable to other VA facilities. Interviews with staff confirmed that the process for sharing the status of vacant positions has improved significantly as has the timeliness for filling of vacant positions. Human Resources has been given blanket authority to backfill clinical positions in target service lines. Nursing staff reported significant and positive changes in the approach to nurse staffing across shifts with the addition of five off-tour nursing supervisors providing stability and consistency.

Conclusions

We found that the system has sustained the action plans that were implemented in response to the original report from 2012.

[5] VSSC: Top 50 Clinics (FY2012) - All Patients- Greater than 14 days.

We did not substantiate the new allegation that nothing has changed since our previous 2012 visit. To the contrary, much has improved with the added management positions, enhanced communications, and new reporting structures. While some concerns remain in limited areas regarding blame, fear of retaliation, and reactionary leadership, the system is working to create a culture and environment that feels safe and non-retaliatory. Performance improvement actions that are appropriately focused on system-level issues promote the psychological safety imperative for ongoing cultural change. Transformation to an environment in which frontline staff feels comfortable disclosing errors, including their own, while maintaining professional accountability and systems analysis based organizational processes must engage all levels of staff and is an evolving process that takes time and engaged, permanent leadership.

In summary, the system acknowledged the need for continued progress in these areas. As such, the system's challenge is to continue further along the path of improvement while sustaining the positive changes to date.

We made no recommendations.

Appendix A

VISN Director Comments

Department of
Veterans Affairs

Memorandum

Date: September 9, 2014

From: Director, Veterans Integrated Service Network (10N23)

Subj: Healthcare Inspection - Follow-Up of Quality of Care, Management, and Operations, Iowa City VA HCS, Iowa City, IA

To: Director, Seattle Office of Healthcare Inspections (54SE)

Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. The purpose of this Memorandum is to acknowledge receipt of the Follow-Up of Quality of Care, Management, and Operations, Iowa City, Iowa Draft Report. No recommendations were made, and we suggest this item be closed.

2. If you have any questions or would like to discuss this response, please contact 319-339-7100.

(*original signed by*:)
Janet P. Murphy, MBA

Appendix B

System Director Comments

Department of
Veterans Affairs

Memorandum

Date: September 9, 2014

From: Acting Director**,** Iowa City VA Health Care System (636/00)

Subj: Healthcare Inspection - Follow-Up of Quality of Care, Management, and Operations, Iowa City VA HCS, Iowa City, IA

To: Director, VA Midwest Health Care Network (10N23)

1. The purpose of this Memorandum is to acknowledge receipt of the Follow-Up of Quality of Care, Management, and Operations, Iowa City, Iowa Draft Report. No recommendations were made, and we suggest this item be closed.

2. If you have any questions or would like to discuss this response, please contact me at 319-339-7100.

(original signed by:)
Dawn Oxley

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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Appendix D

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