Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-02073-106

Healthcare Inspection
Administrative Irregularities, Leadership Lapses, and Quality of Care Concerns
VA Central Iowa Health Care System
Des Moines, Iowa

March 31, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to a request by Senators Charles Grassley and Tom Harkin, both of whom received allegations of ongoing administrative irregularities, leadership lapses, and quality of care concerns over the past 2 years at the VA Central Iowa Health Care System.

The multiple allegations included the following: a current Service Line Director (Physician A) was not qualified for the position, lacked the necessary leadership skills, did not select appropriate candidates for physician positions, and inappropriately performed skin biopsies. In addition, growing discontent with facility leadership was causing high nursing staff turnover rates, and facility leadership had not addressed clinicians' concerns regarding the resulting impact on patient care, personnel retention, staff morale, and the medical education mission.

We did not substantiate that Physician A was not qualified for the position of Service Line Director. Physician A was board certified and met VA qualifications and grade requirements. However, Physician A did not meet Accreditation Council for Graduate Medical Education's (ACGME) Residency Review Committee standards to be appointed the Acting Director of a specific unit within the Service Line. We did not substantiate the allegation that Physician A had inappropriately performed skin biopsies.

We substantiated that Physician A selected a physician who was deemed unqualified for a Service Line position by other facility physicians and did not consistently include medical educators in the selection process of physician staff whose duties would include teaching medical learners.

We did not substantiate the allegation that Physician A obstructed the cardiology consult process or that nursing staff turnover rate was high and due to discontent with facility leadership.

We found that the facility did not consistently complete Focused Professional Practice Evaluations as required. We substantiated that a decline in staff morale was reflected in the All Employee Survey results and in the VHA Strategic Analytics for Improvement and Learning data.

We substantiated that staff were unclear as to who was authorized to perform out of Operating Room airway management and that facility documentation was incomplete.

We recommended that the VISN Director ensure that a director of the particular Service Line unit referenced above is appointed that meets ACGME requirements and that the facility Director ensure (a) that the selection of physicians who will be participating in medical educational activities is conducted within the standards of the ACGME's Residency Review Committee, (b) a standardized process for the management of cardiology consults is implemented, (c) Focused Professional Practice Evaluations for licensed independent practitioners are consistently completed, and (d) a comprehensive

list of staff authorized to perform out of Operating Room airway management is maintained.

Comments

The Acting Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 13–17 for the Directors' comments.) We will follow up on the planned actions until they are completed.

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 in response to a request by Senators Charles Grassley and Tom Harkin, both of whom received allegations of ongoing administrative irregularities, leadership lapses, and quality of care concerns over the past 2 years at the VA Central Iowa Health Care System (VACIHCS) (facility). The purpose of this inspection was to review those allegations.

Background

Facility Profile

The facility is part of Veterans Integrated Service Network (VISN) 23, VA Midwest Health Care Network. It is the result of the 1997 merger of the Des Moines and Knoxville, IA, VA Medical Centers, which are located approximately 40 miles apart.

The facility provides acute and specialized medical and surgical services, outpatient clinics[1] including post-traumatic stress disorder care and comprehensive critical care in a level 2 Medical-Surgical Intensive Care Unit (MICU/SICU). Level 2 MICU/SICUs require continuous availability of sophisticated equipment, specialized nurses, and physicians with critical care training.[2] The facility offers a full range of mental health, rehabilitation, and long-term care to veterans and covers a large geographical area of the Midwest. Special programs for intervention in alcohol and drug treatment, Alzheimer's disease, and homelessness are provided in the overall continuum of care. The facility has 32 acute care, 9 MICU/SICU, 60 domiciliary, 113 community living center, and 37 psychiatric beds.

The facility is organized into clinical service lines, which are multidisciplinary as opposed to the traditional organizational model of single discipline departments.[3] The seven service lines at the facility are: Primary and Specialty Medicine (PSM), Surgery and Specialty Care (SSC), Mental Health (MH), Extended Care and Rehabilitation (EC&R), Pathology and Laboratory Medicine (P&LM), Dental, and Imaging. Service lines have a clinical mission and provide a mechanism for integrating personnel and services across disciplines. The position of Chief of Medicine, held by a physician executive in the non-service line hospital organizational model, is effectively

[1] Outpatient Clinics include: Primary Care, Cardiology, Pulmonary/Respiratory Therapy, Nephrology, Hematology/Oncology, Infectious Diseases, Endocrinology/Diabetes, Gastroenterology/Hepatology, Dermatology, Neurology, Pain Management/Acupuncture, Agent Orange/Compensation-Pension/Employee Health, OEF/OIF Transition, Optometry/Ophthalmology, Audiology, ENT, Geriatrics, Urology, Orthopedics, General Surgery, Mental Health, Spinal Cord Injury, Traumatic Brain Injury, and Podiatry.

[2] VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgeries,* May 6, 2010, citing Almenoff, P., Sales, A., Rounds, S., et al. *Intensive Care Services in the Veterans Health Administration*. Chest 2007, 132:1455-62 for an explanation of intensive care levels.

[3] Charns, M, Wray, N., Byrne, M., et al. *Service Line Management Evaluation Project, Final Report,* Management Decision and Research Center, Houston Center for Quality of Care and Utilization Studies, VA Health Services Research and Development Services, April 2001.

incorporated within the title of Service Line Director in medical facilities organized by clinical service lines.

Accreditation Council of Graduate Medical Education (ACGME)

While VHA's primary function is "to provide a complete medical and hospital service for veterans," a second statutory mission is to carry out a program of education and training of health personnel.[4] To accomplish this mission, the facility participates in a teaching program for residents. A residency program is a period of education in a chosen specialty which physicians undergo after graduating from medical school. If successfully completed at a fully accredited institution, the physician is eligible to sit for board examination in the respective specialty.

A private professional organization, ACGME, is responsible for the accreditation of residency programs in 133 specialty and subspecialty areas of medicine. ACGME relies on 26 specialty-specific committees, known as Residency Review Committees (RRC), to develop its accreditation standards and review accredited programs for compliance with the standards.[5]

Adherence to ACGME standards has important implications for a teaching site's achieving and maintaining full accreditation for residency programs. In order for residents to be eligible to take examinations for board certification they must graduate from ACGME-accredited programs. In addition, many states require completion of an ACGME-accredited residency to qualify for physician licensure. Further, training programs must be ACGME-accredited to receive graduate medical education funds from the Federal Centers for Medicare and Medicaid Services.

The facility is subject to ACGME/RRC standards and oversees approximately 56 residents and 80 medical students yearly in the internal medicine department. Typically, five medicine resident physicians and six medical students periodically rotate through the facility's inpatient medicine services; six medical students are assigned to specialty clinics (such as cardiology, pulmonary, hematology-oncology, and neurology); and 15 resident physicians work in the general medicine continuity clinics.[6]

In conjunction with two non-VA institutions, the facility is a member of an education consortium, an umbrella organization with its own Program Director who oversees all teaching operations at member hospital institutions. The AGCME/RRC considers the Program Director to be ultimately responsible for all accredited internal medicine

[4] 38 U.S.C. 7302. "In order to carry out more effectively the primary function of the Veterans Health Administration and in order to assist in providing an adequate supply of health personnel to the Nation, the Secretary to the extent feasible without interfering with the medical care and treatment of veterans, shall develop and carry out a program of education and training of health personnel."

[5] www.acgme.org/acgmeweb. Accessed 11.17.2013.

[6] In a continuity clinic, a trainee, under the supervision of a faculty preceptor, serves as a primary care provider for a specified panel of patients over an extended period of time (up to several years).

residency and fellowship education at a participating institution (in this case, the members of the consortium).[7]

Allegations

It was alleged that a current Service Line Director (Physician A) was not qualified for the position, lacked the necessary leadership skills, and that growing discontent with facility leadership was causing high nursing staff turnover rates and low morale. It was also alleged that facility leadership had not addressed clinicians' concerns of ineffective leadership and its alleged consequences on patient care, personnel retention, staff morale, and the medical education mission. The multiple allegations, summarized, included:

- Physician A was not board certified, had not completed a residency, and had limited experience managing hospital inpatients.
- Physician A had failed to establish respectful and cordial communication with providers under supervision and often ignored staff physicians' recommendations regarding new staff recruitment and hiring.
- Physician A created a hostile work environment that contributed to the relocation of long-serving qualified providers.
- Physician A made no attempts to retain qualified and experienced providers.
- Physician A hired a physician who was deemed unqualified for the position by several physician staff.
- Physician A proposed changing clinical operations to include the implementation of a hospitalist model and telemedicine Intensive Care Unit without appropriate on-site back up, which would have violated ACGME training program requirements and VHA's credentialing and privileging guidelines.
- Physician A contributed to the resignation of physician leaders and then assumed the positions of Acting Director of units within the Service Line.
- Physician A arbitrarily modified a physician's timecard.
- Physician A reprimanded a provider for disclosing another provider's salary.
- Physician A used performance evaluations as a form of retaliation.
- Physician A performed skin biopsies outside the scope of approved privileging.
- Physician A obstructed the cardiology consult process between two Service Lines.

[7] ACGME Program Requirement II. B. 1.

During the course of our inspection, we received various additional allegations related to Cardiology Service equipment damage from a recurrent roof leak, confusion as to how clinical performance was evaluated, and who was authorized to perform out of Operating Room (OR) airway management.

Scope and Methodology

We conducted a site visit June 18–20, 2013, and interviewed the facility Director, Chief of Staff (COS), Associate Director, selected clinical leaders, administrative staff, and providers. We interviewed facility affiliate staff including the Program Director for the Academic Consortium. We also spoke with the Veterans Healthcare Administration (VHA) Deputy Chief Officer for Academic Affiliations and the VHA Director of Credentialing and Privileging. We reviewed applicable facility policies, VA and VHA handbooks and directives, qualification standards, credentialing and privileging information, ACGME's RRC standards and other documents.

Several of the allegations related to issues that were outside the scope of our inspection. We did not review the allegations regarding a hostile work environment, modification of a provider's time card, reprimands, performance evaluations and retaliation issues, hiring practices that were unrelated to patient care or credentialing/privileging issues, and the cardiology equipment damage that was related to a recurrent roof leak.

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

Issue 1: Physician A Lacked Appropriate Qualifications

Service Line Director Qualifications

We did not substantiate that Physician A was not adequately qualified for the position of Service Line Director.

Physician A was appointed as a Service Line Director, a leadership role that confers management responsibilities over many clinical components of the facility. The facility's Bylaws and Rules of the Medical Staff specify that Service Line Directors are appointed by the facility Director based upon the recommendation of the COS.[8] In this instance, the COS recommended, and the facility Director approved Physician A's appointment. When interviewed during our inspection, both expressed support of Physician A's leadership and management decisions.

VA Handbook 5005, Part II, Appendix G2, *Physician Qualification Standard,* details the overall requirements for appointment as a physician in VHA which includes graduation from a recognized school of medicine or osteopathy, licensure, and English proficiency.[9] The Handbook also outlines the requirements for grade. The physician Service Line Director must meet the requirements of the grade immediately below Chief (senior grade) plus attainment of additional professional recognition that may be demonstrated by:

(1) Certification by an American Specialty Board, or

(2) Significant accomplishments in clinical practice, educational activities, research or administration which clearly distinguish the physician as having the highest professional qualifications in the specialty area to which assigned, such as:

   (a) Past or present faculty appointment at the professional level in an approved medical school, or

   (b) Completion of an accredited residency in the primary specialty area or in a related area to which the individual will be assigned and unusual professional accomplishment such as:

      1. Publication of articles in nationally recognized professional journals, or

      2. Officer in a State or National professional medical organization, or

      3. Directorship of a hospital or large clinic.

[8] VACIHCS Bylaws and Rules of the Medical Staff, December 3, 2012.
[9] VA Handbook 5005, *Physician Qualification Standard in VHA*, April 15, 2002.

While Physician A had no residency training, had not published in a peer reviewed professional journal, and had not held office in a State or National medical organization, Physician A previously held a leadership role among providers with similar areas of expertise at a CBOC site and holds board certification from an American Specialty Board. Physician A's certification was granted through a previously available program which permitted board eligibility based on time in clinical practice when a qualifying period in residency training had not been completed.

ACGME Qualifications Requirements

Acting Director. We found that Physician A does not meet ACGME qualifications to serve as Acting Director for a specific unit within the Service Line. To meet RRC standards, the director of this specific unit must hold specialized certification. This standard applies to temporary and permanent directors. Physician A does not hold the required certification.

Medicine Attending Physician.[10] Facility Bylaws state that the Service Line Director is administratively responsible for the operation of the service as well as its clinical services. According to Physician A, the Service Line Director's duties include leadership, supervisory, and oversight responsibilities for several different units and departments. The facility is affiliated with two medical schools and is extensively involved in medical education at both the graduate and undergraduate levels. The training of students and residents is a significant responsibility for many of the physicians who work in Physician A's Service Line.

Physician A does not directly participate in medical training activities at the facility and would be precluded from doing so by ACGME/RRC standards. Physician A has no graduate medical education beyond internship.

Skin Biopsy Procedures Qualifications

We did not substantiate the allegation that Physician A had inappropriately performed skin biopsies. We reviewed Physician A's credentialing and privileging information and noted approval to perform skin biopsies.

Issue 2: Leadership and Management Practices

Selection of Qualified Physicians

We substantiated that Physician A hired a physician deemed unqualified by several physician staff. During the interviewing process, we also found that Physician A did not consistently consult with local medical education leaders when selecting physician staff who would be involved in the training activities of medical students and residents.

[10] A medicine attending physician is a fully licensed physician who has completed a residency and, in an academic facility, is board-certified in a respective field of medicine. When an attending physician has responsibilities for medical learners (such as residents, interns, and medical students), he/she would be referred to as a teaching attending.

Medical education leadership related to us examples of staff physicians hired by Physician A without the knowledge and/or concurrence of leaders with responsibility for the education consortium's mission.

One example involved a family practice physician who was recruited as a nocturnist hospitalist[11] without input from education program directors and other key faculty. The ACGME/RRC policy precludes a family practice physician from functioning as the supervising faculty for internal medicine residents working in a "night medicine" setting.[12] Night medicine shifts must include "faculty member interaction that allows for meaningful evaluation of resident performance, including the opportunity for bedside teaching and observation of direct patient care."[13] When the family practice physician is on duty, internal medicine residents working in a night medicine capacity must telephone an out-of-hospital internal medicine staff member who meets ACGME/RRC faculty requirements for resident supervision.

A second example involved Physician A's selection of a physician to fill a clinician-educator position despite complaints and objections regarding the physician's clinical confidence, teaching skills, knowledge base, and practical experience.

Cardiology Consult Process and Service Line Agreement

We did not substantiate the allegation that Physician A obstructed the cardiology consult process between two Service Lines. VHA supports a clear and efficient consultation process because the process works best where defined work flow rules exist.[14] A service agreement is an agreement or understanding between two or more services that defines the work flow rules after discussion and consensus.

VHA specifies that the facility Director, or designee, is responsible for implementing standardized processes for the management of consults.[15] Staff from both departments reported a lack of consensus between the two services regarding consult management. We found that a service agreement proposed in 2005 has been in revision since 2011. A current, service agreement between the Service Lines outlining the cardiology consult process has not been successfully negotiated.

Issue 3. Practitioner Oversight and Evaluation

During the course of our interviews, clinicians reported being unaware of the specific criteria used to evaluate their clinical performance. We reviewed the facility's evaluation process and found that the Focused Professional Practice Evaluation (FPPE) process was not consistently completed for newly hired Licensed Independent Practitioners (LIP).

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[11] A hospitalist is a physician whose primary professional focus is the general medical care of hospitalized patients; a nocturnist is a physician who is present in the hospital during night time hours.
[12] Night medicine is defined as a rotation of two or more consecutive nights of inpatient clinical duty.
[13] ACGME RRC Program Requirement 1.A.2.
[14] VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008.
[15] VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010.

An FPPE is a VHA oversight process requiring facility staff to evaluate the privilege-specific competence of an LIP requesting initial or additional privileges.[16] Facility policy outlines the requirements and processes of Professional Performance Evaluation, which can include FPPE and Ongoing Professional Practice Evaluations.[17]

FPPEs must be initiated on, or before, the LIP starts to provide patient care and completed within a facility specified time-period during which medical staff leadership evaluate and determine a practitioner's professional performance. Facility policy requires that Service Line Directors complete LIP FPPEs within 3 months of the LIP's initial appointment.

The criteria for the FPPE process must be defined in advance using objective criteria accepted by the LIP, recommended by the Service Line Director and ECMS as part of the privileging process, and approved by the facility Director. The process may include periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients. Results of the FPPE must be documented in the practitioner's provider profile and reported to the ECMS for consideration in making a recommendation on whether or not to grant privileges. ECMS minutes must reflect the documents reviewed and the rationale for the conclusion to grant, or not grant, privileges.

We reviewed the FPPE documentation of select LIPs hired between 2011 and 2013 and found Service Line Directors had not consistently completed FPPEs as required. Of the 47 newly hired LIPs we reviewed, documentation for 16 (34 percent) was not completed as required.

Issue 4: Staff Morale Has Deteriorated

We substantiated that the All Employee Survey (AES)[18] and the VHA Strategic Analytics for Improvement and Learning (SAIL) data[19] reflected a decline in staff morale.

We selected components of the AES that may be related to staff morale and noted that the AES scores have dropped in the following categories since the 2011 AES: Entrepreneurial, Job Control, Senior Management, and Satisfaction-2yrs.

[16] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
[17] VACIHCS Workforce - 6, *Privileging and Professional Performance Evaluation*, March 28, 2013.
[18] VA All Employee Survey is a summarized annual survey that VA uses to measure employee job satisfaction, perceptions of workplace civility, and job aspects.
[19] VHA SAIL is a recently developed health care monitor model that benchmarks the Quality and Efficiency of 128 VA facilities providing acute medical and surgical inpatient services.

Questions on the AES	2011 Response Average Legend High satisfaction rate is 3.11-5.00; Watch zone rate is 3.00-3.10; Low satisfaction rating is 1.0-2.99	2012 Response Average Legend High satisfaction rate is 3.11-5.00; Watch zone rate is 3.00-3.10; Low satisfaction rating is 1.0-2.99
Entrepreneurial- Managers in my facility are warm and caring. They seek to develop employee's full potential and act as their mentors or guides.	3.04	2.86
Job Control- I have a lot to say about what happens on my job.	3.11	2.99
Senior Management-Compared to what you think it should be, how satisfied are you with the quality of senior managers at your facility?	3.25	2.92
Satisfaction-2yrs-Compared to what it was 2 years ago, how is your overall level of satisfaction with your job?	3.02	2.76

VHA SAIL data for the first quarter of Fiscal Year (FY) 2013 reveals that of 128 VA medical centers, the facility ranks 107th in employee satisfaction.[20]

Issue 5: Nursing Staff Turnover

We could not substantiate that the nursing staff turnover rate was high or that the turnover rate was due to discontent with executive leadership.

We requested nursing staff turnover rates for FY 2010 through FY 2013, and the facility provided nursing staff internal turnover information. We noted variations in the internal nursing staff turnover rates from FY 2010 to FY 2013. Nursing leadership commented that the variations in the rates may be related to the facility's practice of primarily hiring internal candidates for vacant positions and not using other recruiting options. In addition, inpatient units were combined which led to nursing staff transferring to other clinical areas within the facility.

In FY 2013, nursing leadership compiled data from exit interviews with staff that had transferred within the facility and those who had left the facility. The most common reason cited by staff was that they did not like the hours of shifts being worked, followed by change in career and relocating from the area.

Issue 6: Out of Operating Room Airway Management

We substantiated the allegation received while on-site that staff were unclear as to who was authorized to perform out of OR airway management (endotracheal intubation)[21] and that facility documentation was incomplete. Facility staff stated that the Medical

[20] This data is extracted from the AES which is conducted at the VA on an annual basis.
[21] During endotracheal intubation, a tube is placed into a patient's airway to assist respiration.

Officer of the Day (MOD) and residents (with proper oversight) are allowed to intubate patients for urgent and emergent airway management.[22]

VHA policy requires that the facility have a process for ensuring the competency of staff performing out of OR airway management and have a sufficient number of providers deemed competent in airway management during all hours when patient care is provided.[23] VHA also requires that the facility includes provisions for out of OR airway management that reflect the specific practice settings and circumstances of that facility, including an assessment of the number and type of clinical staff whose expected duties would include endotracheal intubation and airway management in a non-operating room setting.[24]

Facility Bylaws indicate that MODs will be code team leaders[25] and facility policy allows residents to perform out of OR airway management with proper oversight.[26] Additionally, the facility policy requires that the COS decide the number and type of clinical staff who will intubate patients. The facility supplied a list of providers who were authorized to perform out of OR airway management; however, this list did not include names of the MODs, residents, and other clinical staff. We found two MODs had performed intubations over the past year, but they were not included on the authorized staff list. Furthermore, facility policy states a respiratory therapist privileged to perform out of OR airway management will be present to provide 24-hour in-house coverage and will respond to all codes and situations requiring airway management. Respiratory therapists were not included on the list provided by the facility.

The lack of a comprehensive list has led to staff confusion as to who is authorized to perform out of OR airway management.

Conclusions

We did not substantiate that Physician A was not adequately qualified for the position of Service Line Director. Physician A met basic VA qualifications and grade requirements. However, Physician A did not meet ACGME/RRC standards to serve as the Acting Director of one of the Service Line components. The Chief of Staff appointed Physician A as acting director of a high level unit despite Physician A's limited formal inpatient training and lack of graduate medical education beyond the internship level. The appointment as an acting director of the high level unit, in addition to not meeting ACGME/RRC standards, has placed Physician A in an awkward, unlikely role.

[22] The Medical Officer of the Day is a designated responsible physician who is physically present in an inpatient facility during periods when regular medical staff are not on duty. These periods generally include evenings, nights, weekends, and holidays, but may be required in other circumstances.
[23] VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
[24] VHA Directive 2012-032.
[25] A code team consists of specially trained and equipped medical staff that is available to provide advanced cardiac life support in the case of an emergency.
[26] VACIHCS Patient Care Programs – 42, *Out of Operating Room Air Management*, April 15, 2013.

The overall complexity of inpatient services and the expansive scope of graduate and undergraduate medical education make this facility's medical leadership positions especially challenging. A physician leader's own training credentials and perceived insight in understanding the mosaic of medical practice, inpatient care, and medical education programs serve as critical elements relating to the effectiveness of a leader. While meeting nominal VHA qualifications as a Service Line Director, Physician A's minimal background and experience with inpatient care, particularly, have caused the perception by some Service Line staff that Physician A lacks the proper credentials.

We did not substantiate the allegation that Physician A had inappropriately performed skin biopsies, as there was authorization to perform this procedure.

While not personally having a defined role in the facility's teaching operations, Physician A's decisions as Service Line Director affect the educational experience offered at the facility. We substantiated that Physician A selected a physician who was deemed unqualified for the position by other facility physicians. We agree with the facility physicians who voiced qualitative objections to the physician's hiring. We also substantiated that Physician A did not consistently include medical educators in the selection process of physician staff whose duties would include teaching medical learners. The facility Director and Chief of Staff indicated that they supported Physician A's leadership and management decisions.

We did not substantiate the allegation that Physician A obstructed the cardiology consult process. We found there was no current, signed service agreement between two Service Lines that outlined the consult process due to a lack of consensus among providers.

We found that FPPEs were not consistently completed as required. We substantiated that AES results and the SAIL data reflected a decline in staff morale.

We could not substantiate that the nursing staff turnover rate was high or that the turnover rate was due to discontent with facility leadership. We substantiated that staff were unclear as to who was authorized to perform out of OR airway management and that facility documentation was incomplete.

Recommendations

1. We recommended that the Veterans Integrated System Network Director ensure that the Chief of Staff appoints a director of the specific unit of the subject Service Line, who meets the qualification standards of the Accreditation Council of Graduate Medical Education's Residency Review Committee.

2. We recommended that the Facility Director ensure that selection of physicians who will be participating in medical educational activities is conducted within the standards of the Accreditation Council of Graduate Medical Education's Residency Review Committee and that compliance be monitored.

3. We recommended that the Facility Director ensure the implementation of a standardized process for the management of cardiology consults, consistent with VHA policy.

4. We recommended that the Facility Director ensure processes be strengthened so that Focused Professional Practice Evaluations for licensed independent practitioners are consistently conducted as required, and that compliance is monitored.

5. We recommended that the Facility Director ensure that the Chief of Staff maintain a comprehensive list of staff that is authorized to perform out of Operating Room airway management in compliance with facility policy.

Appendix A

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 22, 2014

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

Subject: **Healthcare Inspection – Administrative Irregularities, Leadership Lapses, and Quality of Care Concerns at the VACIHCS, Des Moines, IA**

To: Director, Kansas City Office of Healthcare Inspections (54KC)

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

Please see the attached VISN 23 and VA Central Iowa Health Care System (VACIHCS) response to the Office of Inspector General's inspection, which was initiated after allegations of administrative irregularities, leadership lapses, and quality of care concerns at VACIHCS were made to the offices of Senators Charles Grassley and Tom Harkin.

(original signed by:)

Steven C. Julius, M. D.

Acting Network Director, VISN 23

Appendix A

Acting VISN Director Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendation

Recommendation 1. We recommended that the Veterans Integrated System Network Director ensure that the Chief of Staff appoints a director of the specific unit of the subject Service Line, who meets the qualification standards of the Accreditation Council of Graduate Medical Education's Residency Review Committee.

Concur

Target date for completion: January 22, 2014

Facility response: VACIHCS has identified and is in the process of appointing a physician who meets the qualification standards of ACGME's Residency Review Committee.

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 17, 2014

From: Director, VACIHCS, Des Moines, IA (636A6)

Subject: **Healthcare Inspection – Administrative Irregularities, Leadership Lapses, and Quality of Care Concerns at the VACIHCS, Des Moines, IA**

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

Please see the attached VA Central Iowa Health Care System (VACIHCS) response to the Office of Inspector General's inspection, which was initiated after allegations of administrative irregularities, leadership lapses, and quality of care concerns were made to the offices of Senators Charles Grassley and Tom Harkin. The VACIHCS Leadership Team and staff are committed to providing the highest level of care and services possible and appreciate the opportunity to address the identified concerns.

(original signed by:)

Judith Johnson-Mekota, FACHE

Director

Appendix B

System Director Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 2. We recommended that the Facility Director ensure that selection of physicians who will be participating in medical educational activities is conducted within the standards of the Accreditation Council of Graduate Medical Education's Residency Review Committee and that compliance be monitored.

Concur

Target date for completion: January 15, 2014

Facility response: Since August 2012 it has been, and will continue to be, our practice to invite the Residency Program Director to all interviews for physicians that provide supervisory oversight or provider education for Residents.

To more accurately ensure and monitor future compliance, the following statements will be added to the privileging form for all providers, including locums, who are privileged at VACIHCS:

"Will this provider be providing any education or supervision to residents? Yes No
If yes, was our affiliate's Residency Program Director or designee consulted in the selection process? Yes No"

Compliance will be reported to the Chief of Staff on a quarterly basis.

Recommendation 3. We recommended that the Facility Director ensure the implementation of a standardized process for the management of cardiology consults, consistent with VHA policy.

Concur

Target date for completion: January 16, 2014

Facility response: A service agreement has been developed to standardize the process utilized at VACIHCS to manage cardiology consults and this agreement is consistent with VHA policy. The service agreement is currently being circulated for approval.

Recommendation 4. We recommended that the Facility Director ensure processes be strengthened so that Focused Professional Practice Evaluations for licensed independent practitioners are consistently conducted as required, and that compliance is monitored.

Concur

Appendix B

Target date for completion: February 14, 2014

Facility response: The VACIHCS Credentialing and Privileging Coordinator has redesigned and implemented the system to track Focused Professional Practice Evaluations for all new providers. Review of data from the tracking system, specifically the status of initial Focused Professional Practice Evaluations, will be added as a standing agenda item for all meetings of the Executive Committee of Medical Staff to monitor compliance.

Recommendation 5. We recommended that the Facility Director ensure that the Chief of Staff maintain a comprehensive list of staff that is authorized to perform out of Operating Room airway management in compliance with facility policy.

Concur

Target date for completion: December 2, 2013

Facility response: A process has been developed utilizing the Talent Management System to track staff who are authorized to perform out of Operating Room airway management. Clinicians are added to the list in the Talent Management System once they've completed the required competencies and the renewal date for competency assessment is tracked.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Thomas Jamieson, MD Dorothy Duncan, RN, MHA Stephanie Hensel, RN James Seitz, RN, MBA Laura Snow, LCSW, MHCL Jennifer Whitehead, Program Support Assistant

Appendix D

Report Distribution

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Director, VA Midwest Health Care Network (10N23)
Director, VA Central Iowa Health Care System (636A6/00)

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House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Charles E. Grassley, Tom Harkin
U.S. House of Representatives: Bruce Braley, Steve King, Tom Latham, Dave Loebsack

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