Troubles Continue for the Phoenix VA

According to the Joint Commission on the Accreditation of Healthcare Organizations (Joint Commission, JCAHO), an independent organization that reviews hospitals, the Phoenix VA does not comply with U.S. standards for safety, patient care and management (1). The hospital was at the epicenter of the national scandal over the quality of care being afforded to the nation's veterans where the now notorious practice of double-booking patient appointments was first exposed. The hospital's indifferent management provoked congressional investigations that uncovered still more system-wide abuses leading to the removal of the hospital director and the resignation of then VA secretary, Eric Shinseki. The hospital maintains its accreditation but with a follow-up survey in 1-6 months where it must show that it has successfully addressed the 13 identified problems (1). Inspectors who conducted the review in July found that VA employees were unable to report concerns "without retaliatory action from the hospital." Other alarming deficiencies were that Phoenix administrators did not maintain a "safe, functional environment" or "a culture of safety and quality." They concluded that the hospital does not have adequate policies and procedures to "guide and support patient care, treatment and services."

Elizabeth Eaken Zhani, a media relations manager at the JCAHO, stressed that noncompliance findings do not typically lead to a loss of accreditation (2). Of more than 4,000 medical facilities evaluated each year, she said, less than 1 percent are denied accreditation. The Phoenix VA has a right to appeal and an opportunity to correct failings so the hospital meets national standards. In a written statement October 20, VA officials said plans have been developed with an expectation that compliance issues will be resolved within 120 days. "We are also working diligently to address the cultural issues identified by The Joint Commission and have implemented a number of items to enable employees to raise concerns about safety or quality without fear of retaliation...".

In 2010, the Phoenix VA was among 20 VA medical centers to earn The JCAHO's "Top Performer" honor. The most recent audit, in 2011, showed Phoenix at or above target values established by the commission for every major category of health care and administration. It is unclear if care quickly deteriorated at the VA over three short years or previous JCAHO evaluations were inadequate. JCAHO inspections usually are conducted by a retired hospital administrator, physician and nurse. They usually review policies and procedures and rarely meet with physicians, nurses, technicians or clerks directly involved in patient care.

In an editorial entitled "After ALL THAT, Phoenix VA still fails review?!" the Arizona Republic (3) stated the "Phoenix VA is the hospital the VA would want to get right. The one at which the troubled agency would throw all its resources to assure that, despite all evidence to the contrary, VA leaders really did know what they were doing. And, yet, the Phoenix VA flunked its review". The editorial goes on to say that, "Perhaps the most fundamental flaw in the VA system is the forbidding culture of the organization, which regularly and ruthlessly punished whistle-blowers. You would think that, above all else, the VA's new administrators would strive to assure that that malignant practice was
banished. Didn't happen. Failure to assure that a VA worker could 'report concerns about safety or the quality of care to (the reviewing agency) without retaliatory action from the hospital' was at the top of the Joint Commission’s list of findings". The Republic goes on to say that "The Joint Commission's audit provides still more evidence of the intransigence [pigheaded] and resistance to change that the VA presents to even the most determined reformers".

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References