



**Department of Veterans Affairs
Office of Inspector General**

Healthcare Inspection

**Management of the Operating Room
and Quality of Care Issues
James A. Haley VA Medical Center
Tampa, Florida**

**To Report Suspected Wrongdoing in VA Programs and Operations
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Executive Summary

The purpose of this inspection was to determine the validity of the multiple allegations made concerning the management of the operating room and quality of care issues at the James A. Haley VA Medical Center, Tampa, Florida. The complaints fell into three categories: patient care issues, administrative and/or fiscal matters, and personnel-related issues. The allegations concerning personnel issues were reviewed separately and are not part of this report.

As a result of our review, we recommended the following actions:

- In addition to the current operating room (OR) expansion, assess all aspects of OR utilization including, staffing, specialty needs, patient flow, and OR scheduling.
- (a) Perform surgeon specific peer reviews, (b) analyze the high mortality and morbidity identified in National Surgical Quality Improvement Program data and take action as needed, and (c) institute a comprehensive quality management program within the Department of Surgery and Anesthesiology Service.
- Review the causes of surgical delays and make appropriate management changes to improve operating room efficiency.
- Delineate the causes and implement remedies to improve the surgery cancellation rates.
- Comply with the requirements of Veterans Health Administration Handbook 1400.1 regarding documentation of resident supervision.
- Ensure that anesthesiologists do not pre-sign Anesthesia Standard Form 517.
- Continue to take all appropriate actions to control pests.
- In conjunction with the Office of Acquisition and Materiel Management, conduct a review of all contracts between the medical center and University South Florida. The review should determine whether the contracts (a) are necessary, (b) are consistent with VA's needs, (c) have prices that are fair and reasonable, and (d) are properly administered to ensure that VA is only paying for the level of services actually provided under the contract.

The Veterans Integrated Service Network and Medical Center Directors concurred with the recommendations and submitted appropriate corrective action plans. We will follow up on planned actions until they are completed.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, Veterans Integrated Service Network 8 (10N8)

SUBJECT: Healthcare Inspection – Management of the Operating Room and Quality of Care Issues, James A. Haley VA Medical Center, Tampa, Florida

Purpose

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections received multiple allegations concerning the James A. Haley VA Medical Center (the medical center). The purpose of this review was to determine the validity of these allegations.

The allegations generally fell into three categories: patient care, administrative, and personnel-related issues. The personnel allegations were reviewed separately and are not discussed further in this report.

We categorized the remaining allegations into patient care allegations and administrative and fiscal allegations, as follows:

Patient Care Allegations:

- Surgeries were cancelled due to lack of patient beds or operating times.
- Cardiothoracic surgery had excessively high morbidity and mortality (M&M) rates.
- Vascular, cardiothoracic, and ophthalmologic surgeries were delayed due to the unavailability of attending surgeons.
- Ophthalmology Service incurred inappropriate overtime costs.
- Surgeries were cancelled because Ophthalmology Service attending surgeons were not available and because two anesthesiologists performed excessive preoperative evaluations.

- Surgical resident supervision was inadequate.
- Surgery for abdominal free air in a patient was delayed.
- A patient died because of employee error.
- Anesthesia Standard Form 517s were inappropriately pre-signed.
- Surgeons performed inappropriate surgical procedures in the Ophthalmology Clinic.
- The operative suite was closed and surgeries cancelled due to flies.
- Several surgeons had excessive operative times.
- Certified registered nurse anesthetist (CRNA) supervision by anesthesiologists was inadequate.

Administrative and Fiscal Allegations:

- Physician time and attendance was recorded incorrectly.
- Anesthesiology Service staff were not compensated equitably.
- Anesthesiology Service was understaffed and recruitment was difficult due to poor working conditions and insufficient pay.
- The medical center did not receive the cardiovascular services from the University of South Florida (USF) for which it had contracted.
- Hurricane emergency funds were misused.

Background

The medical center is a 327-bed facility affiliated with the USF College of Medicine; it provides acute tertiary medical and surgical care to veterans in the Tampa Bay and surrounding Central Florida areas. The medical center has eight operating rooms (ORs) and two genitourinary¹ procedure rooms.

The primary tour of duty in the OR during our review was 6:30 a.m. to 3:00 p.m. Monday through Friday. At the time of our review, the OR was staffed with 28 registered nurses and 8 surgical technicians. There were two vacant positions for nurses. Eight employees worked 10-hour shifts from 6:30 a.m. to 5:00 p.m. to ensure staff availability if cases ran later than scheduled.

¹ Pertaining to the genital and urinary organs.

The medical center had 57 surgeons on its staff; 28 of them were fee-basis physicians (non-VA community practitioners who performed surgery at the medical center on a pre-arranged remuneration basis). There were 4 full-time anesthesiologists and 14 full-time CRNAs on staff. The medical center had 4.6 full-time equivalent (FTE) anesthesiologist positions vacant at the time of our inspection; however, contract and fee-basis anesthesiologists were used to supplement the shortage.

The medical center had experienced significant turnover in its physician leadership. A medical center staff surgeon was assigned as the Chief of Cardiothoracic Surgery in January 2005. The Chief of Anesthesiology Service resigned in December 2005; the Chief and Associate Chief of Staff retired in February 2006.

Scope and Methodology

In order to address the extensive allegations delineated above, we conducted several site visits at the medical center during April and June 2006. We interviewed relevant clinical staff and administrators. We interviewed the Chiefs of the Surgery, Anesthesiology, Vascular Surgery, Ophthalmology, and Cardiothoracic Surgery Services; the OR nurse manager; the Chief of Acquisitions and Materiel Management Service; the Contracting Officer; and two contract cardiothoracic surgeons. We reviewed patient medical records; quality management (QM) documents; administrative and financial records; workload and staffing data; and pertinent medical center policies, procedures, and standards. We reviewed the contract file for each contract for cardiac surgery services awarded since 1996 and the documentation provided by the medical center of the number of cardiac surgeries performed under the contract each year. We also reviewed personnel records, VA Form 10-2543s,² and Practitioner Profiles related to the Credentialing and Privileging process.

We also received several allegations regarding a non-surgical clinical service of the medical center. We found no evidence of inadequate clinical care for patients treated by this service and no evidence that any individual clinician of this service provided substandard care. Therefore, this report focuses on the allegations and issues concerning the medical center's surgery, anesthesiology, and OR programs. A number of complaints could neither be substantiated nor refuted, primarily due to elapsed time and insufficient QM data. These allegations are summarized in Appendix A.

This inspection was performed in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

² VA Form 10-2543, *Board Action*, is a document used by a Professional Standards Board.

Inspection Results

Section I – Patient Care Allegations

Issue 1: Bed Availability and OR Time

We substantiated that the medical center had insufficient patient beds and operating time to meet patient demand.

A medical center Performance Improvement Team reviewed patient flow issues and reported that in calendar year (CY) 2005, the medical center's bed occupancy rate was 94 and 97 percent for acute care and critical care beds, respectively, and that the medical center was on diversion³ 38 percent of the time.

In CY 2005, the total number of patients treated on fee-basis because no beds were available at the medical center and the related fee-basis costs by bed section were as follows:

Bed Section	Patients Treated	Fee-Basis Cost
Surgical	158	\$1,103,940
Medical	896	\$6,255,659
Total	1054	\$7,359, 599

In addition to diversion causing logistical problems, the OR nurse manager reported that scheduling OR times was difficult because scheduling was decentralized, thus impeding his ability to maximize the utilization of OR time.

The medical center also obtained consultative services from another Veterans Integrated System Network (VISN) in an effort to improve the functioning of the OR. The VISN team identified the need for central control of the OR scheduling. The VISN team also noted that the demand for services exceeded the medical center's capacity, signaling a rapidly approaching crisis. Further, a study conducted in 1989 showed that OR utilization at a Veterans Health Administration (VHA) facility improved by about 9 percent when a centralized scheduling system was used.

We concluded that the surgical service was constrained by a staffing model intended for an 8-hour day, an OR suite built to sustain a much lower case load, and bed availability for a much smaller veteran population. Most OR staff worked 6:30 a.m. to 3:00 pm Monday through Friday. The current expanded schedule for eight of the employees, from 3:00 p.m. to 5:00 p.m. to staff two ORs, was introduced with the intent of completing the regular surgery schedule, not to accommodate more surgeries.

³ Cases needing hospital admission to acute or critical care beds were diverted—that is, redirected to other facilities.

Senior managers told us that there were plans to expand the operative suite from 8 to 10 ORs, and a VHA-funded major construction project is presently underway to meet that goal.

Recommendation

We recommend that the VISN Director ensure that the Medical Center Director, in addition to the OR expansion, assess all aspects of OR utilization, including staffing, specialty needs, patient flow, and scheduling.

Issue 2: Surgery Service Quality of Care

We substantiated that the cardiac surgery program has high mortality rates.

We reviewed data from VA Central Office (VACO) and the National Surgery Quality Improvement Program (NSQIP). This data showed high cardiothoracic surgery mortality rates for the first half of fiscal year (FY) 2005 with marginal improvement for the remainder of the year, relative to VA peers. For the purpose of this review, surgeon M&M, including analysis of all necessary variables, such as patient co-morbidity, risk factors, etc., was not performed.

We reviewed the medical center peer reviews and VHA external expert team peer reviews of seven cardiothoracic surgery cases in which poor care was alleged. We noted a significant disparity between the two sets of reviews. The VHA expert committee identified several cases involving technical and judgment errors not identified by the medical center's reviews. This disparity prompted us to review the medical center's Surgery Service quality assurance activities.

We found that, except for participation in the NSQIP program and collection of NSQIP data, Surgery and Anesthesiology Services quality assurance/performance improvement efforts were minimal. While NSQIP is an important national tool, it is not sufficient to address the full spectrum of quality and patient safety concerns in an operative service.

We concluded that the performance of cardiothoracic surgery and QM efforts needed improvement.

Recommendation

We recommend that the VISN Director ensure that the Medical Center Director: (a) perform surgeon specific peer reviews, (b) analyze the high M&M identified in NSQIP data and take action as needed, and (c) institute a comprehensive QM program within Surgery Service and Anesthesiology Service.

Issue 3: Surgical Delays

We substantiated the allegation that there were surgical delays due to lack of timely presence of attending surgeons in the operating room.

The complainant alleged eight specific occurrences of surgical delays in the Vascular, Cardiothoracic, and Ophthalmology Services. The alleged incidences occurred from August 30, 2001, to January 24, 2004. We reviewed and substantiated or partially substantiated delays in three of the eight cases. See Appendix B for details.

As well as reviewing the eight cases cited above which are summarized in Appendix B, we also reviewed aggregate data for an entire CY. There were 5,423 surgical procedures performed in CY 2005. During that time, the facility recorded 1,040 surgical delays totaling 22,918 minutes. There were various reasons for the delays, the most frequent being “Attending Surgeon Not Present” at the time the procedure was scheduled to begin. Three hundred and thirteen delays (30 percent of all delays) totaling 5,362 minutes (23 percent of all delay minutes) were recorded as “Attending Surgeon Not Present.”

We concluded that the number of surgical delays due to an attending surgeon not being present is a significant factor in surgery delays and requires management attention.

Recommendation

We recommend that the VISN Director ensure that the Medical Center Director review the causes of surgical delays and make appropriate management changes to address this issue.

Issue 4: Ophthalmology OR Utilization

We did not substantiate that the Ophthalmology Service’s use of OR time was inefficient.

The complainant alleged that the Ophthalmology Service had 115 hours of unscheduled time in 2004. The complainant also alleged that despite this excess unscheduled time, the Ophthalmology Service was granted an additional 6 hours per week of operative time.

We found that Ophthalmology had 1,579 hours of available OR time during the 2-year period from January 2004 through December 2005. During that period, Ophthalmology used 1,440 hours to perform 814 surgical procedures,⁴ leaving a balance of 139 hours of unused or unscheduled OR time. The Ophthalmology Service’s OR utilization rate was 91 percent of total hours prior to the 6-hour addition, and it dropped to 81 percent with the additional hours added. However, the 2 additional hours of OR time per day did not

⁴ Six hundred fifty-seven of 792 (83 percent) available normal operative hours were used to perform 363 surgeries in CY 2004. Seven hundred eighty-one of 787 (99 percent) available normal operative hours were used to perform 451 surgeries in CY 2005.

result in increased costs because the OR was maintaining a second shift that supported the operations of two to three ORs until 5:00 p.m. The American College of Surgeons considers an 80–85 percent utilization rate to be the optimum level of efficiency for an OR.

The Ophthalmology Service utilized fee-basis physicians to improve efficiency. To assess progress in this area, we reviewed cataract surgery, the most frequent procedure performed by Ophthalmology. We compared wait times and costs for cataract surgeries performed at the medical center with similar services acquired on contract from a private, fee-basis provider. We found no real cost difference between the medical center and the fee-basis cataract surgery provider. However, the utilization of a fee-basis provider for this operation reduced wait times for cataract surgery from approximately 7 months to 4 months.

We concluded that Ophthalmology Service uses its OR time efficiently, a heavy workload presents continual challenges, and the medical center is addressing these issues. Therefore, we make no recommendations.

Issue 5: Surgical Cancellations

We substantiated that attending surgeons were not available for two specific cases cited in the complaint. We did not substantiate that Ophthalmology Surgery and Vascular Surgery had high cancellation rates due to surgeon unavailability or that two anesthesiologists had excessive cancellation rates due to the ordering of unnecessary tests.

The complainant cited two cases where surgery was cancelled because the surgeon was not available, one on January 31, 2003, and the other on February 10, 2004. Our reviews of these two cases are summarized in Appendix C.

To determine if absence of the attending surgeon was the main reason for surgery cancellations in Ophthalmology Surgery and Vascular Surgery, we reviewed the medical center's reasons for cancellations data for Ophthalmology Surgery and Vascular Surgery. The data showed that absence of an attending surgeon was the reason cited less than 1 percent of the time. The most common reasons for surgical cancellations in Ophthalmology Surgery and Vascular Surgery were “unacceptable medical status” (UMS)⁵ and no “ICU beds,”⁶ respectively.

A complaint alleged that two anesthesiologists (Anesthesiologists 1 and 2 in the following graph) ordered preoperative testing for reasons outside the American College of Cardiology guidelines. We determined that an anesthesiologist was most likely to cancel a surgical procedure if the patient had an “inadequate workup” (IW) or UMS. Our

⁵ UMS would be coded when a patient was not medically stable enough to undergo surgery.

⁶ ICU is Intensive Care Unit.

review of all surgical procedures cancelled in CY 2005 for those two reasons revealed that UMS and IW were responsible for the cancellation of 4.4 percent of procedures. Our review did not identify any outliers among the cited anesthesiologists with regard to cancellation rates. These results are summarized below:

Anesthesiologist	Total Procedures	Total Procedures Cancelled	Cancelled Because of UMS & IW	Percent Procedures Cancelled for UMS & IW
1	1204	176	68	5.6%
2	842	119	35	4.2%
3	738	92	21	2.8%
4	771	114	40	5.2%
5	970	120	32	3.3%
6	132	13	7	5.3%
7	665	99	32	4.8%
8	224	29	9	4.0%
TOTAL	5546	762	244	4.4%

We concluded that the lack of an attending surgeon was not a main cause for surgery cancellations for ophthalmologic and vascular surgeries, and we did not find any outliers among anesthesiologists regarding cancellation rates.

Recommendation

We recommend that the VISN Director ensure that the Medical Center Director delineates the causes and implements remedies to improve the cancellation rates.

Issue 6: Resident Supervision

We did not substantiate the allegation that attending physicians did not properly supervise surgical residents, but we did find that documentation of resident supervision was often lacking.

VHA policy⁷ requires that residents treat patients within their scope of practice and with appropriate documentation to demonstrate attending physician involvement. The “Measure Master Report,” which includes external peer review data for FY 2005, indicated that attending physician compliance with documentation standards for resident surgical admission notes ranged from 17 percent to 60 percent. For FY 2006, documentation compliance was rated at 70 percent. These rates are below VHA’s target goal of 85 percent.

⁷ VHA Handbook 1400.1, *Resident Supervision*.

We did not find evidence to support that residents were providing unsupervised care or that any harm directly resulted from resident care. Medical center staff we interviewed did not believe there was a problem with the actual supervision of residents; rather, they believed the problem was that of inadequate documentation of resident supervision.

We concluded that documentation of surgical resident supervision needs improvement.

Recommendation

We recommend that the VISN Director ensure that the Medical Center Director comply with the requirements of VHA Handbook 1400.1 regarding documentation of resident supervision.

Issue 7: Delayed Surgery

We did not substantiate that a named surgeon inappropriately delayed a patient's surgery.

A complainant alleged that a patient who had free air in the abdomen waited days for surgery. When air is visualized on an imaging study of the abdomen, it can suggest perforation of the bowel, which is a condition that would require immediate surgery in a clinically appropriate patient. We found adequate documentation in the medical record that the timing of this patient's surgery resulted from a reasonable exercise of clinical decision-making rather than from inappropriate delay by a surgeon.

Issue 8: Patient Death Due to Employee Error

We substantiated an allegation that a patient died because of an employee error occurring during a surgical procedure in the year 2002. However, the medical center conducted an internal quality review; in addition, they took appropriate actions based on their findings to prevent further occurrence. The medical center also disclosed the event to the family. Therefore, we make no recommendations.

Issue 9: Pre-Signed Anesthesia Reports

We substantiated the allegation that Anesthesia Standard Form 517s⁸ were inappropriately pre-signed.

A complainant alleged that CRNAs were using Form 517s that were signed by an anesthesiologist prior to initiation of operative procedures. Form 517 is a medical record form used to document the administration of anesthesia during an operation. The form should be filled out by the anesthesiologist or CRNA as an operation proceeds.

⁸ Anesthesia Vice Standard Form 517, JAH Veterans Hospital Anesthesia Record, approved by CPRS [Computerized Patient Record System] Committee, 2-2004.

We found one blank Anesthesia Form 517 with an anesthesiologist's signature and a patient's name and another one with just an anesthesiologist's signature. We were not able to ascertain whether CRNAs actually used pre-signed forms.

We concluded that the presence of pre-signed anesthesia forms was inappropriate.

Recommendation

We recommend that the VISN Director ensure that the Medical Center Director ensures that anesthesiologists do not pre-sign Anesthesia Form 517.

Issue 10: Inappropriate Ophthalmologic Surgery

We did not substantiate the allegation that surgeons perform inappropriate ophthalmologic procedures in the Ophthalmology Clinic.

We found that surgery performed in the Ophthalmology Clinic involved minimally invasive procedures that are properly performed in a clinic setting. Surgeons had received approval from the infection control clinicians and management oversight committees to perform the procedures in the clinic. We inspected the Ophthalmology Clinic for environment of care issues and found that the clinic complied with sterility measures, appropriate pathogen monitors, and terminal cleaning measures.

Issue 11: Pest Control

We substantiated the allegation that managers closed the OR suite on two occasions because of the presence of flies. However, we did not substantiate the implication that medical center managers had not taken appropriate actions to prevent further occurrences.

On two occasions, OR staff noticed flies in the OR suite and immediately reported their observations in accordance with medical center published policies.⁹ Timely sanitary and pest control procedures were implemented, including temporarily closing the OR to protect patient safety. The Pest Control Technician also responded immediately. Further, medical center Management Service staff purchased and installed suspended electric flying insect traps.

We concluded that the medical center managers responded appropriately when they observed flies in the OR suite.

Recommendation

We recommend that the VISN Director ensure that the Medical Center Director continues to take all appropriate actions to control pests.

⁹ JAVHVAMC *Operating Room Policy/Procedure – Principles of Aseptic Technique*, July 2001 paragraph 9.

Section II – Administrative and Fiscal Allegations

Issue 1: Time and Attendance of Surgery Service Physicians

We substantiated that one operation was delayed and another was cancelled because the attending surgeons were not present. We did not substantiate that surgeons routinely take leave and cancel cases to perform surgery at a community hospital or that the medical center incurred unnecessary costs because of delays in arrival times by surgeons.

Fourteen specific dates were cited in the complaint. Our review of the surgical logs for these dates found one surgery that was delayed and one that was cancelled because the attending surgeons were not present. However, on both occasions, the attending surgeons were fee-for-service physicians who received a flat-fee for each surgery performed. We found no evidence to indicate that this practice was systemic. The surgeon responsible for the cancellation was not paid for the cancelled surgery.

We conducted a roll call on April 3, 2006, which included 29 physicians in Surgery Service, 4 physicians in Anesthesia Service, and 5 physicians in Ophthalmology. All 38 physicians included in the roll call were present or accounted for. Our review of physician time and attendance records showed that core hours had been established for all 33 part-time physicians in Surgery, Anesthesia, and Ophthalmology, as required by VA policy.

We concluded that the medical center did not incur unnecessary costs because of the delayed surgery, and the surgeon was not paid for the cancelled surgery.

Issue 2: Justification for Overtime in Surgery Service

We did not substantiate that the medical center incurred substantial overtime costs due to attending surgeon lateness which caused surgeries to end after normal OR hours.

To determine whether late finishes because of delays by attending surgeons necessitated overtime pay, we analyzed the justification on 4,775 requests for 11,325 hours of overtime valued at \$528,660 submitted by Anesthesia and OR staff in CYs 2004 and 2005. While 939 requests (20 percent) for 2,300 hours valued at about \$138,000 indicated that overtime was necessary because of late work, we found nothing in the justification on any of the requests to suggest the work was necessary because of delays caused by attending surgeons.

Because overtime justifications were inconclusive, we extracted from the VistA¹⁰ system all surgeries that were completed after normal OR operating hours and were delayed by the late arrival of the attending surgeon. Our review found that, during the period

¹⁰ VistA is the name of VA's electronic records system. VistA is the acronym for Veterans Health Information Systems and Technology Architecture.

January 1, 2003, through March 31, 2006, (3.25 years) there were 1,110 surgical delays because the attending surgeon was not present; however, overtime was paid in only 20 cases.

Issue 3: Anesthesiology Service Staffing

We substantiated that Anesthesiology Service was understaffed because they were unable to recruit anesthesiologists.

A complainant alleged that the Anesthesiology Service has routinely been understaffed and staff have been forced to work regular overtime schedules without compensation.

At the time of our review, Anesthesiology Service was understaffed by 4.5 anesthesiologists. The Acting Chief of Anesthesiology told us that the understaffing occurred because of difficulties in recruiting anesthesiologists due to a nationwide shortage and the fact that VA pay for anesthesiologists is lower than the private sector.

According to an April 2001 article in the American Society of Anesthesiologists (ASA) newsletter, "...a curtailed supply of anesthesiologists and a growing demand for surgical health care have brought about a national anesthesiologist shortage that could continue into the next decade." This data was confirmed in a November 2003 ASA newsletter article. The ASA April 2001 article also documented that the annual salary for an anesthesiologist at that time ranged from \$282,212 to \$453,000. The medical center's physician salaries at the time of our review ranged from \$90,000 to \$255,000.

We concluded that, despite the medical center's active recruitment activities (advertising in medical journals, in local newspapers, and on government websites), the national shortage of anesthesiologists and the VA salary limitations were contributing factors to the medical center's inability to hire.

While we found that anesthesiologists had been called to the OR on weekends without compensation, this was infrequent and in compliance with Title 38 requirements.

Issue 4: Cardiology Contracts with USF

We substantiated the allegation that there was not sufficient medical center workload to justify a \$300,000 cardiovascular services contract with USF.

The medical center has entered into contracts with USF to provide a full cadre of cardiovascular surgery services, including pre- and post-surgical evaluations, treatment, and follow-up, since 1995.¹¹ From FYs 1996 through 1999, contract physicians performed over 80 percent of the cardiac surgeries performed at the medical center.

¹¹ Although the contracts were awarded for a 1-year time period, records show that some were extended to ensure coverage while a new contract was being negotiated.

Since 1999, the medical center has been able to directly hire staff surgeons, and the number of procedures and outpatient care provided by medical center staff surgeons has steadily increased since 1999, with a corresponding decrease in procedures performed by the USF contract surgeons. Although this should have resulted in a decrease in the level of services required under the contract, the contract's requirement for 1.2 FTE cardiac surgeons did not change. We could not determine what level of services were required or were actually provided under the most recent contracts, or any prior contract, because of the manner in which the medical center awarded and administered the contracts.

The contracts described an FTE as a contractor's employee "working eight (8) hours per day, five (5) days a week," and work hours were defined as "8:00 a.m. – 4:30 p.m. Monday through Friday" and for emergencies on National holidays. The contract required USF staff providing the services to "be present at the medical center and actually performing the required services for the period specified in the contract or the contracting costs would be decreased accordingly during each billing cycle." The contracts also stated that failure to perform contract requirements would result in a proportionate decrease in contract payment or termination. We determined that medical center did not institute any measures to monitor performance to ensure that the contract employees were on-site providing the services required under the contract during the periods specified in the contract. Therefore, the medical center did not know, and we could not determine, whether or not the medical center received the services of 1.2 FTE for any of the contracts for cardiac surgery services.

The medical center was unable to provide justification for the most recent contract, which was awarded in June 2004, or for the 1.2 FTE level of services required under the contract. The Chief of Surgery stated that he had questioned the justification for the contract when he initially came on board about 7 years ago but allowed the contract to continue because he believed it fostered relations with USF. Records show that the medical center was aware as early as 1996 that it was not receiving, and may not have needed, the 1.2 FTE level of services paid for under the contract. Nonetheless, the contract requirements remained unchanged.

Operating room records show that contract surgeons were performing the required minimum of 150 surgeries annually up to 1999.¹² Because the medical center was able to hire staff surgeons, the number of procedures performed by the contract surgeons decreased steadily from January 2000 through June 30, 2005, when the contract expired.

A significant event further impacting the requirements under the contract occurred on February 11, 2001, when the contract physician became a 0.625 (a 5/8^{ths}) FTE medical center staff physician. This event should have resulted in a modification to the contract

¹² Records show that beginning in 2000, some surgeries were performed by another surgeon. This did not result in an increase in the number of procedures performed under the contract; rather, it resulted in a decrease in the number of procedures performed by the initial contract surgeon.

to decrease the level of services required from 1.2 FTE to 0.625 FTE and a 52 percent reduction in cost to the medical center. Instead, on April 5, 2001, the medical center issued a modification to the contract adjusting the contract price by deducting this physician's VA salary from the \$351,249 contract price. Documentation shows that this was done to "recoup" the salary that medical center was paying this physician directly. This practice continued on subsequent contracts awarded for services provided in 2002 through 2005. Because this physician's 0.625 FTE VA salary was significantly less than the contract price for 0.625 FTE, the medical center overpaid USF for the services that were provided under the contract. If the proposed contract price of \$351,249 had been properly adjusted, based on a decreased FTE requirement, the savings to the medical center would have been \$201,968. Because the medical center adjusted the proposed price by deducting this physician's VA salary, the adjustment was approximately 41 percent of this amount. The amount offset was limited to this physician salary and did not include any benefits and other expenses that the medical center incurred on his behalf as a VA employee, which resulted in additional overpayments. This methodology also might have resulted in an illegal supplementation of salary if USF did not adjust this physician's USF position and salary from full time to 0.375 FTE, because he would be receiving pay from USF for the same services he was providing as a VA employee.

Our interviews with the Chief of Surgery indicated that the prior contract physician continued to perform surgery and research after he became a medical center staff physician. Because the medical center did not keep track of his contract hours, we could not establish whether this physician provided any services under the contract after he became a VA physician. The Chief of Surgery told us, "we have no idea" how many hours he worked. The staff physician also stated that he did not keep track of his time under the contract. He said that the medical center "called me to come over and do surgery, and I did not keep track of the time."

Similarly, the other contract physician became a 0.25 (2/8^{ths}) time medical center staff physician on September 6, 2002. According to the Chief of Surgery, services provided by the second contract physician after he became a VA staff physician were performed as a medical center employee with no additional services being provided under the contract. We did not find any evidence that the contract in effect at the time or any subsequent contract was modified to reduce the FTE required under the contract and/or adjust the price. At a minimum, the contract requirements and price should have been reduced by another 0.25 FTE, which would have resulted in a contract for 0.325 FTE.

We concluded that the medical center was not receiving the level of services paid for under the contract. We concluded that these contracts were not awarded and administered properly for many years, which resulted in VA paying for services that were not needed and not provided. We also concluded that the manner in which the medical center modified payment under the contract, after the physicians who provided services

under the contract were appointed to part-time medical center staff positions, was an improper supplementation of salary.

Recommendation

We recommend that the VISN Director ensure that the Medical Center Director, in conjunction with the Office of Acquisition and Materiel Management, conduct a review of all contracts between the medical center and USF. The review should determine whether the contracts: (a) are necessary, (b) are consistent with the medical center's needs, (c) have prices that are fair and reasonable, and (d) are properly administered to ensure that the medical center is only paying for the level of services actually provided under the contract.

Issue 5: Use of Hurricane Funds

We did not substantiate an allegation of improper use of hurricane funds.

We found that in FY 2005, pursuant to the "Military Construction Appropriations and Emergency Hurricane Supplemental Appropriations Act, 2005," VISN 8 authorized about \$37.8 million to the medical center to repair or mitigate damages from hurricanes. Our review of project planning documents and purchase orders indicated that the use and planned use of hurricane funds by the medical center were consistent with the intent of the hurricane legislation. VISN 8 authorized the medical center to use hurricane funds for the following:

Description of Hurricane Funds	Amount
Medical Administration (administrative staff and supplies)	\$266,648
Medical Facilities Operations (non-construction facilities costs)	\$2,099,628
Medical Services (clinical staff and supplies)	\$9,770,293
Medical Facilities (repair/mitigate physical plant damages)	\$25,645,880
Total	\$37,782,449

Our review focused on the appropriateness of funding authorized to repair/mitigate damage to medical facilities at the medical center. To determine whether hurricane funds were used appropriately, we reviewed relevant financial, accounting, and construction-planning records; inspected the condition of some damaged structures that were being replaced; and toured the construction site for one project funded with hurricane funds. Our review showed that the approved projects, totaling about \$26 million, were appropriate for the use of hurricane funds. The projects were:

- Modular Building Replacement (\$2,700,000) – Replaces existing modular buildings and trailers with a new code compliant permanent fabricated building. The prior structures are not compliant with the new building codes for Florida hurricane standards and did not meet wind load and water integrity requirements.

- Infrastructure (\$5,806,000) – Repairs/mitigates damages to the spinal cord injury atrium, main hospital complex, and the USF/Veterans Affairs walkway.
- Nursing Home Care Unit (\$13,348,000) – Repairs/mitigates infrastructure problems caused by stress on the building envelope and water infiltration.
- Emergency Potable Water (\$1,100,000) – Repairs an existing 27-year-old, 150,000 gallon elevated water storage tank system and installs an emergency potable well water source-feed system to the water tank for the hospital water distribution system to provide emergency back-up water for the chiller/cooling towers, flushing toilets, cosmetic usage, and the fire protection system.
- Orlando Outpatient Clinic (\$3,145,880) – Replaces approximately 160,000 square feet of roof on Building 500 at the Orlando Outpatient Clinic and the emergency power supply system generator controls. Replaces Building 523 with a modular building that is compliant with new Florida hurricane standards.

Of the projects listed above, the medical center had awarded contracts for the Modular Building Replacement and the Orlando Outpatient Clinic totaling about \$5.8 million. At the time of our review, the Office of General Counsel was reviewing the planned procurement methodologies for the other three projects totaling about \$20 million. Our review showed that the VISN and VA Capital Investment Board in VACO reviewed the justification and description for all five projects. Additionally, our review of project planning documents and purchase orders indicated that the projects were reasonable and appropriate for the use of hurricane funds.

VISN and Medical Center Directors' Comments

The VISN and Medical Center Directors concurred with the results of this inspection and have taken actions to implement the recommendations in this report. See Appendix D (page 23–29) for the Directors' comments.

Assistant Inspector General for Healthcare Inspections Comments

The VISN and Medical Center directors agreed with the findings and recommendations and provide acceptable improvement plans. We will follow up on planned actions until they are completed.

(original signed by:)

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

Allegations Neither Substantiated nor Refuted

Allegation	Findings	Conclusion
CRNAs are not adequately supervised.	CRNAs interviewed revealed conflicting information regarding the specifics of the degree of supervision provided by anesthesiologists. The presence of blank anesthesia forms pre-signed by an anesthesiologist in addition to conflicting accounts of supervision obtained from the CRNAs suggested the possibility of inadequate supervision.	Neither substantiated nor refuted
Frequent re-intubations resulted from inadequate CRNA supervision.	A confidential complainant reported having direct knowledge that in August 2005, airway rescue was a frequent occurrence because of CRNAs not being adequately supervised. However, interviews with Post Anesthesia Care Unit nurses, Surgical Intensive Care Unit nurses, and Anesthesiology Service staff suggested that re-intubation was a rare occurrence. The medical center does not collect quality assurance data concerning the rates of re-intubation.	Neither substantiated nor refuted
Increased anesthesia-related complications due to the lack of any quality assurance data for the Anesthesiology Service.	While a complainant alleged that two anesthesiologists had high complication rates, the medical center informed us that no quality assurance data was available for the Anesthesiology Service. We reviewed the Anesthesiology Service Performance Improvement Plan for 2005. The plan required ongoing monitors of six anesthesia indicators recommended by JCAHO and several other indicators to continuously assess quality and analyze data, but we could not find any evidence that the plan had been implemented. We found no monthly Anesthesiology Service staff meetings or documentation of monitors in the Clinical Executive Board minutes. Thus, the lack of QM data prevented us from either substantiating or refuting this allegation. This issue is further addressed in our recommendations to the medical center.	Neither substantiated nor refuted

Allegation	Findings	Conclusion
<p>Surgeons exceed requested intraoperative time.</p> <p>A vascular surgeon had prolonged intraoperative times.</p>	<p>There is no documentary evidence of how long any surgeon tells the operating room staff a given case will take. Operative times are averages of all surgeons for that particular surgery. The OR nursing staff makes adjustments, taking into consideration the surgeon’s previous history of performing the procedure. Further, the cases involved occurred years ago, eliminating any realistic possibility that current personnel could recall how long they were told that a specific surgeon would take to complete a case.</p> <p>In 2003, one vascular surgeon had prolonged intraoperative times for carotid endarterectomies¹³ and abdominal aortic aneurysm (AAA) repairs¹⁴ compared to his peers. In 2003, four surgeons performed a total of 16 AAA repairs, and 5 surgeons performed a total of 24 carotid endarterectomies. Average intraoperative time by provider for surgeons conducting AAA repairs ranged from 2 hours 22 minutes to 2 hours 53 minutes, with no surgeon’s time significantly different from his peers. For carotid endarterectomies, the average intraoperative time for four of the five surgeons performing these procedures ranged from 1 hour 54 minutes to 2 hours, 37 minutes. Carotid endarterectomies performed by the fifth surgeon, however, averaged 3 hours 24 minutes. During 2004, this same surgeon performed a total of four AAA repairs. This surgeon’s average intraoperative time for these four procedures was greater than 6 hours. He performed no AAA repairs during 2005 or 2006. While he did conduct a total of 20 carotid endarterectomies in 2004 and 2005, his average intraoperative times for those years were 2 hours 39 minutes and 2 hours 32 minutes, respectively. These times did not significantly differ from those of his peers. Therefore, we did substantiate that a vascular surgeon had prolonged intraoperative times for carotid endarterectomies in 2003 and increased operative times for AAA repairs in 2004 when compared to his peers. However, the small numbers of cases performed by any one provider may limit the statistical significance of this finding. Further, we note that the surgeon in question was no longer employed by the medical center at the time of our inspection.</p>	<p>Neither substantiated nor refuted</p>

¹³ A surgical procedure in which a blockage in the carotid artery in the neck is bypassed.

¹⁴ An abdominal aortic aneurysm is a weakening and stretching of the wall of the aorta.

Alleged Surgery Delays

Date	Allegation	Findings	Conclusion
August 30, 2001	A patient was anesthetized for over an hour before the vascular attending surgeon returned from a conference.	The medical record shows that the attending surgeon was in the OR at 8:15 a.m., the CRNA completed the general anesthesia induction (put the patient to sleep) at 8:45 a.m., and the operation began at 9:15 a.m. We could not determine if the attending surgeon left the OR at any point during the surgical procedure.	Not Substantiated
November 6, 2001	A patient was anesthetized for over an hour before the surgical procedure began.	This patient was under general anesthesia for 1 hour and 25 minutes before the surgical procedure began. The patient was put to sleep at 8:05 a.m., and the operation began at 9:30 a.m. The circulating nurse documented that the surgeon was in the OR at 8:50 a.m.	Partially Substantiated
December 1, 2001	A patient was anesthetized without an attending cardiothoracic surgeon present. The Chief of Surgery started the procedure until the attending surgeon arrived.	The patient was in the OR at 7:10 a.m, the CRNA completed the general anesthesia induction at 8:00 a.m., and the surgeon was in the OR at 8:00 a.m. An inpatient progress note shows that the Chief of Surgery assessed and evaluated the patient and documented discussion of the indications for surgery, risks, and expected benefits. The Operative Report shows that the Chief of Surgery performed the procedure. The Chief of Surgery was the scheduled attending surgeon.	Not Substantiated

Date	Allegation	Findings	Conclusion
June 1, 2002	OR and anesthesia staff had a patient on the OR table at 8:45 a.m., and the vascular attending did not arrive until 10:00 a.m.	We found one emergency vascular procedure performed on Saturday, June 1, 2002. An intraoperative note shows that the patient arrived in the OR at 10:05 a.m. We reviewed the surgical intensive care unit (SICU) nurse flow sheet, which shows that the patient was still in SICU at 8:45 a.m. The patient would have been taken directly to the OR from the SICU since this was an emergency case and after hours.	Not Substantiated
July 5, 2002	A vascular attending surgeon (Surgeon 1) scheduled two toe amputations, completed one procedure, then left the facility to conduct surgical procedures at a community hospital. The attending surgeon's departure caused another attending surgeon (Surgeon 2), who was in the middle of an aortobifemoral bypass (ABF) procedure, to leave a fourth-year resident unsupervised.	<p>We did determine that Surgeon 1 performed 3 surgical procedures at a community hospital during his tour of duty at the medical center. The first case started at 8:45 a.m. and ended at 11:48 a.m.; the second case started at 12:45 p.m. and ended at 1:45 p.m.; and the third case started at 2:07 p.m. and ended at 3:32 p.m. Surgeon 1's tour of duty at the medical center for this date was 8:00 a.m. to 4:00 p.m.</p> <p>We could not determine that the resident was left standing in the OR and not qualified to perform the ABF bypass procedure. We interviewed Surgeon 2, who told us that it was not unusual to work between 2 operating rooms and that the resident was supervised during the critical portion of the surgical procedure.</p>	Partially substantiated

Date	Allegation	Findings	Conclusion
January 29, 2003	An ophthalmologist scheduled three cataract procedures, and one procedure was delayed due to the absence of the attending surgeon.	The Schedule of Operations showed that three cataract procedures were scheduled. The first case was to begin at 7:30 a.m. The nurse's intraoperative note shows that the patient was in the OR holding area at 6:45 a.m. The patient did not enter the OR until 9:35 a.m. The operation began at 9:50 a.m. and ended at 10:15 a.m. The 125-minute delay was attributed to "no attending surgeon" present.	Substantiated
January 24, 2004	A vascular attending surgeon arrived for a scheduled 7:30 a.m. surgical procedure at 8:15 a.m.	We determined this that date occurred on a Saturday. We found no documentation of surgical procedures performed on this date.	Not Substantiated

Alleged Surgical Cancellations

Date	Allegation	Findings	Conclusion
January 31, 2003	An ophthalmologist had ocular cases scheduled. When he was not there by 9:30 a.m., they called his office; he stated he would not be in.	An ophthalmologist had two surgical procedures scheduled. Both procedures were cancelled due to the absence of the attending surgeon. We could not ascertain why the surgeon was not available. Both patients' surgeries were rescheduled and performed; the first patient on March 31, 2003, and the second on April 9, 2003.	Substantiated
February 10, 2004	A patient was anesthetized and awaiting the attending vascular surgeon. Allegedly, the attending vascular surgeon was at a community hospital performing emergency surgery.	Schedule of Operations showed that there were four vascular procedures scheduled that day. Surgeon A had two cases, and Surgeons B and C each had one case scheduled. Surgeon A performed his first case and then, according to the Schedule of Operations, left to go to a community hospital. Surgeon B was reassigned Surgeon A's second case. Surgeon B's original case was reassigned to Surgeon C. Surgeon C did his own original case and not the reassigned case that was originally Surgeon B's; Surgeon C left after doing his own originally assigned case. We were not able to determine if the change in attending surgeons was communicated to all parties involved. One of the four cases was aborted due to no attending surgeon available. This case was originally assigned to Surgeon B, who was covering Surgeon A's second case when the patient was brought into the OR. Although we were able to determine that Surgeon C did perform two cases at the community hospital, we were not able to determine if the procedures were elective or emergent in nature.	Substantiated

VISN Director's Comments

**Department of
Veterans Affairs**

Memorandum

Date: Sept 29, 2006

From: Director, Veterans Integrated Service Network (10N08)

Subject: **Management of the Operating Room and Quality of Care Issues, James A. Haley VA Medical Center, Tampa, Florida**

To: Director, Management Review and Administrative Service (10B5)

Thank you for the opportunity to review the draft report of the Healthcare Inspection at the James A. Haley VA Medical Center, Tampa, Florida.

I have reviewed the report and actions submitted by the Medical Center and concur with the recommendations and the actions taken.

Please contact Karen Maudlin (727) 319-1063 if you have any questions.

(original signed by:)

George H. Gray, Jr.

Network Director, VISN 8

Medical Center Director's Comments to Office of Inspector General's Report

The following comments are submitted in response to the recommendations in the Office of Inspector General's Report:

OIG Recommendation(s)

Recommended Improvement Action 1. We recommend that the VISN Director ensures that the Medical Center Director, in addition to the current OR expansion, assess all aspects of OR utilization including, staffing, specialty needs, patient flow, and OR scheduling.

Concur **Target Completion Date:** Initiated:
August 2006. Ongoing

In May of 2006, the facility had an external review of the OR to evaluate and make recommendations on OR utilization, staffing, patient flow, team cohesiveness, and scheduling. The facility received a report with recommendations in August 2006.

In addition, a VACO surgery/anesthesia team performed a review of the OR in July 2006 and provided the facility with a report and recommendations in August 2006.

In response to these reviews, the following actions have been implemented:

An OR scheduler has been hired (start date 9/18/06) and an additional clerk FTEE will be added to assist in administrative duties.

An RN position is being given to the Ambulatory Procedure Unit to staff the Urology BCG clinic, in order to have the OR RN that is currently doing the job be able to return to the operating room.

On September 1, 2006, the Chief Anesthesia, Acting Chief of Surgery, and OR Nurse Manager began morning meetings to discuss the proposed 48-hour schedule. Each day they look for opportunities to consolidate and adjust rooms to maximize workflow.

In July 2006, an OR Committee was established. This committee will monitor cancellations, delays in first case starts, time outs, and OR utilization.

Recommended Improvement Actions 2. We recommend that the VISN Director ensure that the Medical Center Director: (a) performs surgeon specific peer reviews, (b) analyzes the high M&M identified in NSQIP data and take actions as needed, and (c) institutes a comprehensive QM program within the Department of Surgery and Anesthesiology Service.

Concur **Target Completion Date:** November 1, 2006

To get peer review at the provider level, Surgical Service added the morbidity to their current mortality review and Anesthesia Service has resumed M&M discussions. The two services have also started having joint Death Conferences.

One of the NSQIP nurses is being trained to do performance improvement activities, including pulling provider specific data for surgery in order to identify any outliers.

Surgery and Anesthesia are currently developing a QM plan for the upcoming fiscal year.

Surgery has already begun reviewing complication rates, residency supervision data, and mortality data. (e.g. One change already implemented is to have only one surgeon perform esophagectomy procedures with the assistance of two consultant surgeons who have extensive experience with this type of surgery. At this time, residents will serve in an assistance role only.) Plans are also underway to collect provider specific data for OR length of cases.

Quality Management has been restructured and is in the process of hiring four additional QM staff. One will work with Surgery and Anesthesia.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Medical Center Director review the causes of surgical delays and make appropriate management changes to address this issue.

Concur **Target Completion Date:** Initiated August 2006. Ongoing

The Chief of Surgery presented data on cancellations/delays to the Clinical Executive Board in August 2006 and a focus on delays for the “first case of the day” is currently underway using AORN guidelines for definitions.

Preliminary reviews shows that delays are mostly related to placement of lines and additional tests needed before surgery, and not related to attending surgeon not present.

Changes in OR utilization will be made as appropriate to improve OR efficiency.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Medical Center Director delineates the causes and implement remedies to improve the cancellation rates.

Concur **Target Completion Date:** Initiated August 2006. Ongoing

On September 1, 2006, the Chief Anesthesia, Acting Chief of Surgery, and OR Nurse Manager began morning meetings to discuss the proposed 48-hour schedule and to look for consolidation opportunities to make room for additional space for add-ons or to adjust for rooms with too heavy a workload. Since implementation of these meetings, there have been no cancellations due to OR unavailability. In addition, the OR has been able to accommodate all add-on cases.

A review of three weeks in September 06 compared to September 05 showed a decrease of 50% in OR cancellation rates. No cancellations were due to the physician not being available.

We are adding specific cause information in our data collection to improve drill down and analysis of cancellations.

A joint study proposal titled “Rapid Dissemination of Techniques for Reducing Missed Opportunities for Operating Room Function” with the University of South Florida College of Medicine on causes of OR cancellations are to be submitted in October 2006.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the Medical Center Director comply with the requirements of VHA Handbook 1400.1 regarding documentation of resident supervision.

Concur
Ongoing

Target Completion Date: August 2006.

The Hospital Policy Memorandum on Supervision of Postgraduate Residents was updated to meet the new VHA guidelines in November 2005. The Chief Surgery Service has reinforced the residency supervision requirements one on one with Section Chiefs and Program Managers. Surgery Service is conducting daily reviews of surgery admission. Each chart is reviewed the day after admission for compliance with 1400.1. Attending physicians are notified of findings of non-compliance and follow up documentation is expected.

All Services with residency programs are performing service level monitoring that is reported to the Medical Records Review Committee. The Medical Records Review Committee reports quarterly on residency supervision issues to the Clinical Executive Board.

QM staff are performing 100% residency supervision reviews for 'high-risk' areas including Surgery, Cardiology, and Poly Trauma. The facility has approved an FTEE for residency supervision monitoring which will be in the QM department. The position has been posted and applications are being reviewed by HR for potential interview candidates.

Recommended Improvement Action 6. We recommend that the VISN Director ensure that the Medical Center Director ensures that anesthesiologists do not pre-sign Anesthesia Form 517.

Concur **Target Completion Date:** June 2006

The Anesthesia staff are educated on documentation requirements and will not pre-sign forms.

Recommended Improvement Action 7. We recommend that the VISN Director ensure that the Medical Center Director continues to take all appropriate actions to control pests.

Concur **Target Completion Date:** September 2006

A hospital bulletin was published which mandated the elimination of food outside of the canteen area on the second floor. No food is allowed in the OR/ SICU/PACU/cardiac catheterization break rooms, the SICU waiting area, the surgery waiting area, and the administrative areas.

There has been an ongoing extensive evaluation of the drainage pipes. Broken pipes have been repaired. For the past month, the pest issue has not resulted in the need to close down the operating room.

Recommended Improvement Actions 8. We recommend that the VISN Director ensure that the Medical Center Director, in conjunction with the Office of Acquisition and Materiel Management, conduct a review of all contracts between the medical center and USF. The review should determine whether the contracts (a) are necessary, (b) are consistent with the medical center's needs, (c) have prices that are fair and reasonable, and (d) are properly administered to ensure that the medical center is only paying for the level of services actually provided under the contract.

Concur
2006

Target Completion Date: October 15,

The hospital's Compliance Officer is tasked to lead a review of all contracts between JAHVAH and USF. There are currently three (3) active contracts with USF. The review will begin on September 25, 2006 and will address all issues specified in the VA OIG Report. A formal report of findings will be submitted through the Chief of Staff to the Medical Center Director.

OIG Contact and Staff Acknowledgments

OIG Contact	Marisa Casado, Director Bay Pines Regional Office of Healthcare Inspections (727) 395-2416
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Acknowledgments	David Griffith, Team Leader Willie Toomer, Audit Manager George Patton, Audit Team Leader Andrea Buck, M.D., J.D., Medical Consultant Maureen Regan, Counselor to the Inspector General Melissa Colyn Charles Cook Shelia Cooley Alvin Wiggins Harvey Hittner Triscia Weakley Jerome E. Herbers, Jr., M.D. Carol Torczon
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