Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Surgical Service Issues
James A. Haley VA Hospital
Tampa, Florida

Report No. 09-00356-198 **August 17, 2009**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

Telephone: 1-800-488-8244 between 8:30AM and 4PM Eastern Time, Monday through Friday, excluding Federal holidays

E-Mail: vaoighotline@va.gov

Executive Summary

The VA Office of Inspector General, Office of Healthcare Inspections (OHI) received an anonymous complaint related to perfusionist credentialing and a reorganization of the surgery department at the James A. Haley VA Hospital (the hospital) in Tampa, Florida. The purpose of the review was to determine whether the allegations had merit.

We did not substantiate that two perfusionists from a private-sector medical facility worked in the hospital's operating room (OR) without appropriate credentials. We found that each perfusionist met the provisions of the contract. We did not substantiate that a surgery department reorganization favored certain surgeons or that it adversely affected patients. National and local performance measure data reflects that the hospital is performing comparably to similar VA medical facilities; therefore, we concluded that patient care was not being adversely affected by changes in the surgery department or OR scheduling. We also did not substantiate the allegation that reorganizing the surgical department to control the OR schedule was in violation of OHI recommendations made from a previous healthcare inspection report.

Management agreed with our findings. We made no recommendations.

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

TO: Director, VA Sunshine Healthcare Network (10N8)

SUBJECT: Healthcare Inspection – Alleged Surgical Service Issues, James A. Haley VA Hospital, Tampa, Florida

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) received an anonymous complaint related to perfusionist[1] credentialing and a reorganization of the surgery department at the James A. Haley VA Hospital (the hospital) in Tampa, Florida. The purpose of the review was to determine whether the allegations had merit.

Background

The hospital provides medical, surgical, mental health, geriatric, rehabilitation, ambulatory, home-based primary care, and spinal cord injury services. It operates 320 hospital beds and 264 community living center beds at its primary site in Tampa and also provides care at four community based outpatient clinics located in Brooksville, Lakeland, Zephyrhills, and New Port Richey, Florida. The hospital has affiliation agreements with several educational institutions covering numerous areas of study. It is part of Veterans Integrated Service Network (VISN) 8.

On February 23, 2009, an anonymous complainant contacted the OIG Hotline and made multiple allegations related to inappropriate management practices. Those administrative allegations are not being evaluated in this report.

The complainant alleged that two perfusionists from a private-sector medical facility worked in the hospital's operating room (OR) without appropriate credentials; the complainant provided the first name and the dates of alleged employment of one of the perfusionists. In addition, the complainant alleged that the surgery department was reorganized to control the OR schedule, which favored certain surgeons over others and adversely affected patient care. The complainant alleged that this practice was in

[1] A trained health professional who operates the heart-lung machine during cardiac surgery.

violation of OHI recommendations made in an OIG Combined Assessment Program (CAP) inspection report[2] issued about 4 years ago.

Scope and Methodology

We conducted a site visit on June 25–26, 2009. Prior to our visit, we reviewed American Board of Cardiovascular Perfusion (ABCP) certification information, National Surgery Quality Improvement Program (NSQIP) data, Cardiac Surgery Quality Improvement Program data, OR schedules, and OR utilization reports. While onsite, we also reviewed OR committee minutes, perfusionists' competency files, and surgical performance improvement (PI) plans. We interviewed clinical and administrative staff knowledgeable about professional practice requirements for perfusionists and the OR scheduling process.

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

Inspection Results

Issue 1: Perfusionist Credentials

We did not substantiate the allegation that two perfusionists from a private-sector medical facility worked in the hospital's OR without appropriate credentials, nor did we substantiate that a perfusionist (identified by first name) allegedly worked from January 10–January 23, 2009, without the Administrative Officer (AO) granting privileges. We noted that perfusionists are not credentialed and privileged as described by the complainant; rather, they operate under a Statement of Work and must maintain ABCP certification, among other requirements.

Veterans Health Administration (VHA) does not currently have perfusionist qualification standards.[3] Typically, perfusionists are either hired under locally-developed position descriptions or their services are arranged through a nationally negotiated contract. In this case, hospital managers utilized a national contract to secure the services of two perfusionists. The contract requires that perfusionists be certified by the ABCP, be proficient in English, and demonstrate competence to perform perfusion.

On Friday, January 9, 2009, a contract perfusionist resigned without prior notice. On Monday, January 12, the contracting agency sent a replacement perfusionist to provide immediate coverage. On Monday, January 19, the contractor sent an additional perfusionist to ensure adequate coverage. On Monday, January 26, the contractor assigned a full-time perfusionist to replace the perfusionist that resigned. According to

[2] *Combined Assessment Program Review of the James A. Haley VA Medical Center, Tampa, Florida,* Report No. 06-02004-14, October 25, 2006.
[3] Criteria that define education, experience, and competency requirements.

competency folders, all perfusionists (including the one identified by name) met the stated contract requirements.

Issue 2: Surgery's Reorganization

We did not substantiate the allegation that the surgery department was reorganized to control the OR schedule, which favored certain surgeons over others and adversely affected patient care. As the complainant was anonymous, we were unable to clarify the OR scheduling issues or obtain specific examples of adverse patient care events. Without a precise understanding of what the complainant's concerns may have been, we reviewed past and current organizational charts, surgery wait time reports, surgery-specific fee basis data, OR utilization reports, NSQIP data, and other performance measure results in an effort to identify trends or outliers which could reflect increased patient wait times, poor care, or adverse outcomes.

We were unable to identify surgery department or OR scheduling changes that showed favoritism towards certain surgeons. It appeared to us that managers were taking appropriate actions to reduce backlogs and increase access.

We reviewed NSQIP data from October 1, 2007–December 31, 2008, to assess whether the hospital's surgical outcomes were comparable to other medical centers. The VA NSQIP is a nationally validated, risk-adjusted, outcomes-based program to measure and improve the quality of surgical care. Some of the elements measured are mortality (deaths), morbidity (complications), and length of stay. NSQIP's morbidity and mortality data indicated the hospital's rates were comparable to other VA medical centers for the period October 1, 2007–December 31, 2008. The hospital's Surgical Infection Prevention performance measure[4] data indicates the hospital was meeting the benchmarks in those areas related to surgical care except for one measure. Managers have implemented an action plan to address that issue.

We did not identify any obvious outliers or trends that could indicate systemic quality of care issues in the surgery department. Therefore, we concluded that had organizational changes been made in the surgery department or the OR schedule, those changes did not adversely affect patient care.

Issue 3: Previous CAP Report Recommendations

We did not substantiate the allegation that reorganizing the surgical department to control the OR schedule was in violation of OHI recommendations made in a CAP report issued about 4 years ago. That specific CAP report did not make any recommendations relative to the surgery department or the OR. We believe that the complainant was actually referring to another report, *Healthcare Inspection, Management of the Operating Room*

[4] Measures of evidence based surgical infection prevention strategies.

and Quality of Care Issues, James A. Haley VA Medical Center, Tampa, Florida, Report number 06-01361-15, issued October 25, 2006, which recommended that the hospital Director assess all aspects of OR utilization including staffing, surgical specialty needs, patient flow, and OR scheduling. The hospital's actions included hiring an OR scheduler and an additional registered nurse; implementing morning meetings to discuss a proposed 48-hour OR schedule; and establishing an OR committee to monitor cancellations, delays in first case starts, time outs, and OR utilization. We found that the hospital took appropriate actions.

Conclusion

We did not substantiate the allegation that two perfusionists from a private-sector medical facility worked in the hospital's OR without appropriate credentials. We found that each perfusionist met the provisions of the contract, which required certification by the ABCP, English proficiency, and demonstrated competence to perform perfusion.

We did not substantiate the allegation that the surgery department was reorganized to control the OR schedule, which favored certain surgeons, but adversely affected patients. National and local performance measure data reflects that the hospital is performing comparably to similar VA medical facilities. Further, we did not identify any obvious outliers or trends that could indicate systemic quality of care issues in the surgery department. We concluded that patient care was not being adversely affected by changes in the surgery department or OR scheduling.

We also did not substantiate the allegation that reorganizing the surgical department to control the OR schedule was in violation of OHI recommendations made from a previous healthcare inspection report. The VISN and hospital Directors agreed with our findings. We made no recommendations.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

OIG Contact and Staff Acknowledgments

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Acknowledgments	Audrey Collins-Mack

Appendix B

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