



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

Office of Healthcare Inspections

Report No. 12-04061-18

Healthcare Inspection

Alleged Computed Tomography Scan Delays and Timekeeping Abuses

**Dayton VA Medical Center
Dayton, Ohio**

November 20, 2013

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 complainant's allegations that the Dayton VA Medical Center (facility) placed patients with stroke at risk for potential harm because computed tomography (CT) imaging was not staffed 24 hours a day, 7 days a week. The complainant specifically alleged that delays in obtaining CT scans after-hours reduced the patients' chances of getting tissue plasminogen activator (tPA) therapy, often referred to as a "clot buster" drug. Additionally, the complainant alleged that a great deal of overtime money was paid to CT technologists for call coverage after-hours, when the CT section was not staffed.

We did not substantiate the allegation that after-hours on-call staffing resulted in problematic delays in obtaining CT scans or provision of tPA therapy for acute stroke patients. As a supporting stroke facility, the facility promptly transfers or diverts patients acutely presenting with stroke symptoms to the community primary stroke center and does not provide CT scans or tPA therapy in these cases. While emergency clinicians were very clear about this process, some imaging staff were not.

The facility convened a compliance review and, later, an Administrative Investigation Board (AIB) in response to concerns regarding overtime and timekeeping. The AIB found irregularities in the overtime paid for after-hours CT coverage, but did not substantiate that some timekeepers violated policies and procedures related to timekeeping and privacy.

OHI concurred with the findings and recommendations of the facility's compliance review and AIB. We did not make any recommendations.

The Veterans Integrated Service Network and Facility Directors concurred with the report. No further action is required.



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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted an inspection to assess the merit of allegations regarding patient care delays and timekeeping abuses in Therapeutics and Diagnostic Imaging Service (Imaging Service) at the Dayton VA Medical Center (facility), Dayton, OH.

Background

The facility provides a full range of inpatient and outpatient health care through medical, surgical, mental health, home and community health programs, geriatric, physical medicine and therapy services, neurology, oncology, dentistry, and hospice. The facility has 507 beds, including 127 acute care; 265 nursing home; and 115 domiciliary beds. In addition to supporting four community based outpatient clinics, the facility has contracts with Wright Patterson Air Force Base and 11 area hospitals. The facility is part of Veterans Integrated Service Network (VISN) 10.

A stroke results from blocked or altered blood flow to the brain and may result in multiple complications or death. Veterans Health Administration (VHA) complies with the National Institute of Neurological Disorders and Stroke recommendations in that, for patients acutely (newly) presenting with stroke symptoms, a provider promptly orders a computed tomography (CT) scan to diagnose or rule out stroke.¹ If a stroke is confirmed, thrombolytic (clot-busting) therapy, such as tissue plasminogen activator (tPA) should be given within 3 hours of symptom onset.² When facilities provide tPA for acute stroke, specialty staff support, training, and services are needed due to risks of intracranial hemorrhage and other complications.³

VHA designated each VA medical center as one of three levels of stroke-capable facilities; as such, local stroke care, training, and use of community resources (where VA capacity is absent) is based on this designation.⁴ VHA designated the subject facility as a supporting stroke facility (SSF), and defines SSF as follows:

A VHA SSF is a facility with limited capabilities related to staffing, technician coverage, study interpretation, or appropriate numbers and types of beds that does not allow for consistent care of patients presenting with acute stroke. Robust transfer agreements for in-hospital stroke and protocols, including Emergency Medical Services (EMS) diversion, must

¹ US Department of Veterans Affairs, Health Services Research and Development Service, "Acute Ischemic Stroke Care for Veterans," April 26, 2012, <http://www.hsrd.research.va.gov/news/feature/stroke.cfm>, accessed on 8/26/2013.

² National Institute of Neurological Disorders and Stroke, "NINDS: Stroke Proceedings: Acute Care," May 17, 2011, http://www.ninds.nih.gov/news_and_events/proceedings/stroke_proceedings/recs-acute.htm, accessed on 8/26/2013.

³ Bambauer KZ, Johnston SC, Bambauer DE, Zivin JA, 2006, "Reasons Why Few Patients With Acute Stroke Receive Tissue Plasminogen Activator," *Arch Neurol.* 63(5):661-664, <http://archneur.jamanetwork.com/article.aspx?articleid=791315>, accessed on 8/26/2013.

⁴ *Supra*, "Acute Ischemic Stroke Care for Veterans."

be in place to triage or transfer acute stroke patients to facilities offering a higher level of stroke care. Generally, these are either VHA PSCs [primary stroke centers], non-VA Joint Commission (JC), or state designated PSCs. VHA SSFs can, however, provide post-stroke medical care (excluding thrombolytic therapy), rehabilitation, and follow-up care.⁵

The facility's local "Acute Ischemic Stroke" policy further describes their procedures and role as an SSF as follows:

[...] we do not give [tissue] plasminogen activator (tPA) therapy. All tPA-eligible patients will be transferred to Miami Valley Hospital (MVH) for further evaluation and possible tPA therapy or other treatments. MVH is a Primary Stroke Center with neuro-interventional radiologists. Local ambulance services will not transport patients with possible stroke to the Dayton VA Emergency Department (ED) because it is required to transport such patients to a Primary Stroke Center.

On July 29, 2012, an anonymous complainant contacted the OIG hotline and alleged that patients with acute stroke were at risk for delayed intervention because the facility's computed technology (CT) section was not staffed 24 hours a day, 7 days a week (24/7). The complainant specifically alleged that during after-hours, on-call⁶ CT staff had 60 minutes to arrive to the facility causing delays with CT scans and subsequent administration of tPA. Additionally, the complainant alleged that a great deal of overtime money was paid to the CT technologists for after-hours call coverage, and believed that an administrative reorganization would provide for 24/7 CT coverage at significant cost savings to the facility.

Scope and Methodology

We interviewed the complainant by telephone before conducting a site visit April 22–25, 2013.

We conducted interviews with facility managers and staff. We reviewed relevant literature, VHA and facility policies, procedures, committee minutes, technologist and timekeeper training records, and technologist certification documents. We also reviewed other documents pertaining to these allegations, including a compliance review and an AIB completed by the facility. Additionally, we toured the Imaging Service area.

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.

⁵ VHA Directive 2011-038, *Treatment of Acute Ischemic Stroke (AIS)*, November 2, 2011.

⁶ CT staff rotate being "on call," which means that, when a CT scan is ordered during non-business hours, facility staff telephone the CT technologist with instructions to return to the facility to perform a study.

Inspection Results

Issue 1: Stroke Management

We did not substantiate the allegation that on-call staffing resulted in problematic delays in obtaining after-hours CT scans or provision of tPA therapy for acute stroke patients.

The facility has a robust plan in place to divert or quickly transfer suspected acute stroke patients from the facility to the community PSC. Further, the facility did not provide tPA therapy or CT scans for these patients since both interventions are managed at the community PSC.

We found that Emergency Department and Neurology Service clinicians were aware of the facility's classification as an SSF and of policy stating to divert or transfer any patients with symptoms of acute stroke to the community PSC. However, some Imaging Service staff told us they thought the facility was providing stroke management. Following our site visit, facility leaders educated the Imaging Service staff on the local "Acute Ischemic Stroke" policy.

Issue 2: Timekeeping

Overtime

The complainant alleged that reorganization of Imaging Services could eliminate overtime costs associated with after-hours CT scans by cross training the general radiology technologists in basic CT scanning, thereby providing CT imaging around the clock. Additionally, we received reports of overtime irregularities from the Combined Assessment Program's Employee Assessment Review survey. We referred all of these concerns to the facility's leadership who initiated a compliance review. The results of the compliance review prompted an Administrative Investigation Board (AIB),⁷ which concluded July 15, 2013.

The compliance review determined that the CT technologist overtime was not in alignment with the American Federation of Government Employees Union Master Agreement. The AIB noted ambiguity among technologists as to the parameters that constituted a "call back." Additionally, the AIB found that the technologist's initials that appeared on the studies did not always match the technologist who was on call and received overtime compensation for being on call. Although the AIB did not substantiate fraudulent overtime compensation on the part of the CT technologists, the board found irregularities in the overtime paid for after-hours CT coverage.

The AIB recommended creation of specific policies and procedures to address Imaging Service activities, call-back, and accountability; revisions to registration practices and

⁷ VA Handbook 0700, *Administrative Investigations*, July 31, 2002, and VA Directive 0700, *Administrative Investigations*, March 25, 2002.

overtime tracking; and a cost/benefit analysis of alternative staffing during peak overtime hours.

OHI concurred with the findings and recommendations of the facility's compliance review and AIB. We made no recommendations.

Timekeeper Abuses and Irregularities

While not one of the complainant's allegations, in the course of our investigation we heard concerns that some timekeepers may have violated policies and procedures related to timekeeping and privacy. We referred these concerns to the facility's leadership who included these issues in the compliance review and AIB.⁸

The compliance review team was unable to substantiate that timekeepers shared confidential information related to timekeeping with staff or others who did not have a need to know. The compliance review also did not substantiate that staff accessed patient records without cause or a need to know.

The AIB described the timekeeping process as "chaotic and not uniform," and the compliance review included a recommendation for training of all timekeepers on posting, call, call back, and overtime pay.

OHI concurred with the findings and recommendations of the facility's compliance review and AIB. We made no recommendations.

Conclusions

We did not substantiate the allegation that after-hours on-call staffing resulted in problematic delays in obtaining CT scans or provision of tPA therapy for acute stroke patients. As an SSF, the facility promptly transfers or diverts patients acutely presenting with stroke symptoms to the community PSC and does not provide CT scans or tPA therapy in these cases.

The facility convened a compliance review and, later, an AIB in response to concerns regarding overtime and timekeeping. The AIB found irregularities in the overtime paid for after-hours CT coverage, but did not substantiate that some timekeepers violated policies and procedures related to timekeeping and privacy.

In summary, we concurred with the findings and recommendations made by the facility's compliance review and AIB. We made no recommendations.

⁸ VA Handbook 0700, *Administrative Investigations*, July 31, 2002, and VA Directive 0700, *Administrative Investigations*, March 25, 2002.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 4, 2013

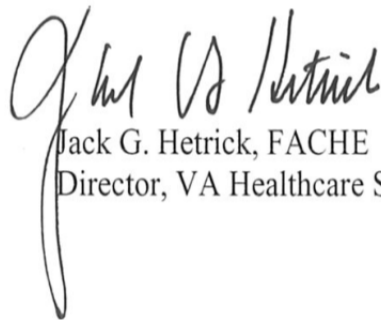
From: VISN Director (10N10)

Subject: Alleged Computed Tomography Scan Delays and Timekeeping Abuses, Dayton VAMC, Dayton, OH

To: Director, Baltimore Office of Healthcare Inspections (54BA)

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

1. Thank you for this review and the opportunity to continue to improve the quality and services of care provided to Veterans.
2. I have reviewed the report and actions taken by the Dayton VAMC to immediately address and resolve any findings.
3. If you have any questions or require additional information, please contact Jane Johnson, VISN 10 Deputy Quality Management Officer at (513) 247-4631.



Jack G. Hetrick, FACHE
Director, VA Healthcare System of Ohio (10N10)

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 3, 2013

From: Director, Dayton VA Medical Center (552/00)

Subject: Alleged Computed Tomography Scan Delays and Timekeeping Abuses, Dayton VAMC, Dayton, OH

To: Director, VISN (10N10)

1. Thank you for the opportunity to review and provide comments to the draft report of the VA Office of Inspector General Healthcare Inspections' review of Alleged Computer Tomography Scan Delays and Timekeeping Abuses at the Dayton VA Medical Center Dayton, Ohio. I concur with the findings.
2. The acknowledgement of the facility's robust plan to divert or quickly transfer suspected acute stroke patients from the facility to a community Primary Stroke Center is appreciated.
3. The corrective action plans initiated quickly to address the administrative issues identified by the facility's Administrative Investigation Board and Compliance Review are in progress. The Dayton VAMC Leadership Team is committed to assuring all actions are completed.
4. If you have any questions or need additional information please contact Lisa Durham, Chief, Quality Management, Dayton VAMC at 937-268-6511 extension 7630.



Glenn Costie, FACHE

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Margie Chapin, RT (R, MR, CT), J.D., Team Leader John D. Daigh, JR., M.D. Nelson Miranda, LCSW Melanie Oppat, MEd, LDN Victor Rhee, MHS Cynthia Gallegos, Program Support Assistant

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