DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Alleged Delay in Surgical Care, Lack of Resident Oversight, and Improper Physician Pay at the Edward Hines, Jr. VA Hospital

Hines, Illinois

HEALTHCARE INSPECTION | REPORT #19-00004-187 | AUGUST 8, 2019

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the validity of allegations regarding a delay in surgical care, lack of resident oversight, and improper physician pay at the Edward Hines, Jr. VA Hospital, Hines, Illinois (facility).

On June 25, 2018, the OIG received allegations from a confidential complainant. The complainant alleged a delay in performing an appendectomy, that the delay in performing this appendectomy was caused in part by inadequate resident oversight, and that surgeons paid by the VA were unavailable because they were also working for other institutions.[1]

The OIG substantiated that a delay of approximately three hours occurred in performing an appendectomy on a patient, but the delay did not result in an adverse event.[2] The OIG team determined the delay was due to another patient requiring surgery more urgently and poor communication.

In spring 2018, the patient presented to the facility's emergency department at 9:00 p.m. (Day 1) with uncomplicated appendicitis, and an operative intervention was planned for the following day as an add-on to the surgical schedule.[3] The OIG determined that the patient received appropriate preoperative monitoring and care and found no evidence of an adverse event.

During the working week, the number of operating rooms (ORs) at the facility decreases from six to two at 3:00 p.m. and from two to one at 5:00 p.m. After 3:00 p.m., the scheduling of surgical cases is determined by the requesting surgeon and anesthesiologists and is based on the patient's condition. Around 3:00 p.m. on Day 2, one of the two ORs was occupied with a scheduled surgery. The other OR was needed for an unscheduled urgent surgery. This resulted in a surgical delay of approximately three hours for the patient with appendicitis. At 6:45 p.m., the patient underwent an appendectomy in the available OR.

From admission to surgery, there were two hand-offs in the patient's care that involved the Chief Resident and three general surgery attendings.[4] The first hand-off was between the on-call surgeon, Chief Resident, and day surgeon. The day surgeon informed the OIG that the Chief

[1] An appendectomy is the surgical removal of an infected appendix. An appendix is a finger-like sac attached to the lower end of the large intestine.

[2] The Joint Commission defines an adverse event as a as "a patient safety event that resulted in harm to a patient."

[3] Appendicitis is infection of the appendix.

[4] The three general surgery attending physicians involved in the patient's care were the on-call surgeon who worked from 6:00 p.m. Day 1 until 6:00 a.m. Day 2; the day surgeon who worked from 6:00 a.m. to approximately 6:00 p.m. Day 2; and the surgeon of record who started work at 6:00 p.m. Day 2. Attending surgeons are senior physicians who provide supervision to physician's trainees. https://www.merriam-webster.com/dictionary/attending. VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.

Resident did not discuss the add-on surgery, and the day surgeon reported being unaware that the surgical case had been added to the schedule.[5] The second hand-off was between the Chief Resident and surgeon of record. The surgeon of record informed the OIG that the Chief Resident initially stated that the urgent surgery would last approximately three hours and to arrive around 8:00 p.m. for the appendectomy. Later, the surgeon of record stated being informed by the Chief Resident that the urgent surgery ended early, but the surgeon of record did not need to come in earlier than planned. Poor communication between the residents and the surgeons contributed to the delay in surgery.

The Joint Commission requires that processes be in place to communicate patient information when transitioning the patient from one clinical area to another clinical area.[6] Although not an allegation and not a Veterans Health Administration requirement, the OIG identified that the facility's practice for scheduling surgeries did not address communication among key staff during the multiple steps between identifying the need for surgery and the time of surgery. The OIG noted that opportunities existed for facility leaders to evaluate the need for, and implement as necessary, communication improvements between residents and surgeons.

The OIG did not substantiate that the patient's appendectomy was delayed because of inadequate resident oversight. Staff interviews and electronic health record documentation confirmed that general surgery attendings were available at all hours to provide resident supervision, discuss patients, and were present in the OR during surgeries.

While most facility surgeons on staff also worked at other institutions, the OIG team was unable to determine the availability of surgeons or if they were working at other institutions while being paid to work at the facility. The facility had a process in place to document physician hours worked; however, a staff member reported there was no verification process to monitor if surgeons' timecards matched actual hours worked. The OIG confirmed that discrepancies existed during a review of the general surgeons' reported hours worked and their timecards for May 2018. When asked, the facility indicated that documentation was not maintained detailing part-time physicians' tours of duty or responsibilities.

The Veterans Integrated Service Network (VISN) Fiscal Quality Assurance Manager also conducted a review of part-time physician hours and written agreements and determined that the facility did not maintain appropriate documentation to verify and validate individual physician work schedules and payments. The VISN Fiscal Quality Assurance Manager made two

[5] The OIG could not confirm this statement as at the time of the site visit. The Chief Resident had completed residency training, was no longer employed by the facility, and was not available for an interview.

[6] The Joint Commission is an independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States. https://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx. (This website was accessed on March 7, 2019.)

recommendations for the facility to address within six months but did not provide a date for VISN follow-up.

The OIG made two recommendations to the Facility Director to evaluate the surgery scheduling practices and processes, and to ensure documentation for part-time physicians' tours of duty and responsibilities for time and attendance.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan. (See appendixes A and B, pages 11–14 for the Directors' comments.) The OIG considers all recommendations open and will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.

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

Contents

Abbreviations

EHR	electronic health record
OIG	Office of Inspector General
OR	operating room
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the validity of allegations regarding a delay in surgical care, lack of resident oversight, and improper physician pay at the Edward Hines, Jr. VA Hospital, Hines, Illinois (facility).

Facility Background

The facility is part of Veterans Integrated Service Network (VISN) 12, and offers inpatient and outpatient primary, specialty, and surgical care services. VA classifies the facility as a Level 1a high complexity, with an assigned operative complexity level of complex.[7] From October 2017 through September 2018, the facility served 58,208 patients and had a total of 483 hospital operating beds, including 248 inpatient beds, 210 community living center beds, and 25 domiciliary beds. The facility operates six VA community based outpatient clinics located in Bourbonnais (Kankakee Clinic), Oak Lawn, Aurora, Hoffman Estates, Peru (LaSalle Clinic), and Joliet, Illinois. The facility is affiliated with Loyola University of Chicago, Stritch School of Medicine (Loyola), and University of Illinois College of Medicine, Chicago.

Appendicitis

Appendicitis refers to infection of the appendix, a finger-like sac attached to the lower end of the large intestine.[8] If left untreated, appendicitis can progress, resulting in perforation of the appendix and spread of infection into the abdomen. This is known as complicated appendicitis. Treatment of uncomplicated (non-perforated) appendicitis is controversial. The current standard approach to appendicitis requires surgery to prevent uncomplicated appendicitis from developing into complicated appendicitis. However, emerging literature suggests that some patients treated with antibiotics may improve without needing an appendectomy.

[7] The VHA Facility Complexity Model categorizes medical facilities based on "patient population, clinical services offered, educational and research missions, and administrative complexity." Complexity Levels include 1a, 1b, 1c, 2, or 3, with Level 1a facilities being the most complex and Level 3 facilities being the least complex. Office of Quality, Safety, and Value. 2012 VHA Facility Quality and Safety Report. https://www.va.gov/health/docs/2012_vha_facility_quality_and_safety_report_final508.pdf. (The website was accessed February 27, 2019.)

[8] National Institute of Health, National Institute of Diabetes and Digestive and Kidney Diseases, NIH Publication No. 13-4547, Appendicitis, September 2013.

The timing of surgery for patients with uncomplicated appendicitis is dependent on the stability of the patient and the availability of a staffed operating room (OR). The literature varies in terms of the optimal timing of surgery for uncomplicated appendicitis.[9]

Allegations

On June 25, 2018, the OIG received allegations from a confidential complainant regarding a delayed surgery at the facility in spring 2018. The complainant made three allegations:

- There was a delay in performing an appendectomy on a patient.
- The delay in the patient's surgery was due in part to inadequate oversight processes for residents.
- Surgeons are paid by the VA while working for other institutions.

[9] Smink, Douglas et al, *Management of Acute Appendicitis in Adults*, UpToDate, December 5, 2018, https://www.uptodate.com/contents/management-of-acute-appendicitis-in-adults. (The website was accessed on February 14, 2019.) Kim, Maru, et al*, Effect of Surgical Timing and Outcomes for Appendicitis Severity*, ASTR, July 21, 2016 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4961891/. (The website was accessed on November 26, 2018.) Drake, Fredrick Thurston et al, *Time to Appendectomy and Risk of Perforation in Acute Appendicitis*, JAMA Surgery, August 2014, Vol. 149, Number 14, https://www.ncbi.nlm.nih.gov/pubmed/24990687. (The website was accessed on November 26, 2018.) Bhangu, Aneel et al, *Safety of Short, In-Hospital Delays Before Surgery for Acute Appendicitis*, Annals of Surgery, Volume 259, Number 5, May 2014, www.annalsofsurgery.com. (The website was accessed on November 26, 2018.) Eko, Frederick et al, *Ideal Timing of Surgery for Acute Uncomplicated* Appendicitis, January 2013, North American Journal of Medical Sciences, volume 5(1), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3560134/. (The website was accessed on November 26, 2018.) Abou-Nukta, Fadi et al, *Effects of Delaying Appendectomy for Acute Appendicitis for 12 to 24 Hours,* May 2006, AMA. https://jamanetwork.com/journals/jamasurgery/fullarticle/398369. (The website was accessed on November 26, 2018.)

Scope and Methodology

The OIG initiated the healthcare inspection on September 28, 2018, and conducted an onsite visit November 13–16, 2018.

The OIG team interviewed the complainant; VISN Fiscal Quality Assurance Manager; Chief of Staff; Associate Director for Patient Care Services; Chiefs of Surgery, Anesthesiology, and emergency department; Director of Academic Affiliations; general surgery attendings and residents; the OR Nurse Supervisor and nurses; and other relevant staff.

The period of data review for this report was May 2018 through March 2019. The OIG team reviewed the patient's electronic health record (EHR), relevant medical literature, relevant Veterans Health Administration (VHA) and facility policies, relevant Joint Commission standards, patient safety reports, physician timecards and schedules, OR schedules, and applicable committee meeting minutes.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Patient Case Summary

The patient, in their 30s, presented to the facility's emergency department at 9:00 p.m. on Day 1, complaining of lower abdominal pain of several hours.[10] The emergency department physician noted the patient had right lower abdominal tenderness on palpation but did not have a fever. A computerized tomography (CT) scan was obtained and showed "early acute appendicitis" without perforation of the appendix.[11]

The patient was admitted to the facility at 12:33 a.m. on Day 2, under the care of the General Surgery Service. A general surgery resident (initial surgical resident) evaluated the patient at 1:55 a.m. and noted an elevated white blood cell count and a CT finding consistent with non-perforated appendicitis. The initial surgical resident documented the surgery was "non-emergent."[12]

The initial surgical resident discussed the risks and benefits for antibiotic therapy versus appendectomy with the patient. The patient opted for appendectomy, which included the administration of preoperative antibiotics.[13] The initial surgical resident reviewed the patient's case with the Chief Resident and the general surgery on-call surgeon (on-call surgeon), with a plan for an "early add-on appendectomy."[14] Overnight, the patient remained without a fever and reported pain scores in the mild to moderate range, requiring only one dose of pain medication.

A second general surgery resident (day surgical resident) completed a preoperative scheduling worksheet at 7:44 a.m. on Day 2. This worksheet noted discussion and approval by the oncoming general surgeon (day surgeon) to add the patient to the day surgeon's OR surgery schedule for that day with the Chief Resident assisting in the surgery.[15]

Throughout the day, the patient remained without fever and did not require pain medication. The patient was transferred to the preoperative surgical area (pre-op) at 2:30 p.m.[16] Concurrently to the patient arriving in the pre-op area, an unscheduled urgent surgery was added to the schedule

[10] The OIG uses the singular form of they (their/them) to protect the patient's privacy.

[11] CT is radiographic imaging using cross sectional images. https://www.merriam-webster.com/dictionary/computerized%20tomography. (The website was accessed on February 26, 2019.)

[12] Non-emergent means not needing immediate attention. https://www.merriam-webster.com/dictionary/emergent#synonyms. (The website was accessed on February 14, 2019.)

[13] Pre-operative or prophylactic antibiotics are important for preventing wound infection and abscesses following an appendectomy. https://journals.sagepub.com/doi/10.1177/1457496913497433. (The website was accessed on March 7, 2019.)

[14] The on-call surgeon was on call from 6:00 p.m. Day 1 to 6:00 a.m. Day 2.

[15] The day surgeon had three scheduled surgeries on the day in question beginning at 7:30 a.m., 9:46 a.m., and 12:45 p.m.

[16] Pre-op is a holding area where patients are prepped for surgery.

at 2:24 p.m. for the available OR. The unscheduled urgent surgery took precedence over the non-emergent appendectomy and was expected to take approximately three hours. At 6:45 p.m., the patient underwent an appendectomy. The surgery was performed by an on-call general surgeon (surgeon of record).[17] No complications were noted. The patient did well post-operatively and was discharged to home on Day 3.

Inspection Results

1. Delay in Performing an Appendectomy on a Patient

The OIG substantiated that a delay occurred in performing an appendectomy on a patient, but the delay did not result in an adverse event.[18] The OIG team determined the delay was due to another patient requiring surgery more urgently and poor communication between residents and attending surgeons. The OIG determined that the patient received appropriate preoperative monitoring and care. However, the OIG found that opportunities existed for facility leaders to evaluate the need for, and implement as necessary, communication improvement between residents and attending surgeons.

Urgent Surgery

Facility staff informed the OIG team that OR availability and staffing changed from accommodating six ORs to two ORs at 3:00 p.m. and from two ORs to one OR at 5:00 p.m. Surgeries starting after 3:00 p.m. are scheduled as determined by the requesting surgeon and anesthesiologists and are scheduled based on the patient's condition.

The OIG confirmed that on Day 2, a scheduled surgery began at 3:09 p.m. and was completed at 4:16 p.m. in one of the two available ORs.[19] Concurrently to the patient with appendicitis arriving in the pre-op area at 2:20 p.m., an unscheduled urgent surgery was added to the schedule at 2:24 p.m. for the other available OR. The unscheduled urgent surgery took precedence over the non-emergent appendectomy and was expected to take approximately three hours. This postponed the start time for the appendectomy until an OR and staff became available.

Communication Concerns

Although the Joint Commission requirements are not specific to the OR, the Joint Commission requires that processes be in place to communicate patient information, and during transitions in

[17] The surgeon of record started work at 6:00 p.m. on Day 2.

[18] The Joint Commission defines an adverse event as "a patient safety event that resulted in harm to a patient."

[19] Although the surgery ended at 4:16 p.m., the OR would have had to be cleaned, reconfigured, and staffed prior to initiating the next surgery.

care, hand-off communication allows for discussions between the giver and the receiver.[20] Communication among healthcare providers is essential to delivering quality care. The OIG team identified poor communication between the residents and attending surgeons.

Communication between Residents and Attending Surgeons

According to the EHR, the initial surgical resident assessed the patient and documented on Day 2, at 1:55 a.m. that the patient's condition was consistent with "early acute appendicitis." The initial surgical resident documented that the on-call surgeon and the Chief Resident agreed to add the patient to the surgery schedule for an appendectomy. At 7:44 a.m., the day surgical resident completed the preoperative scheduling worksheet and documented that the patient's surgery was discussed with and approved by the day surgeon and the Chief Resident, both of whom would be performing the appendectomy. A nurse stated that the preoperative scheduling worksheet was printed to the OR where the charge nurse and anesthesiologist added the appendectomy to the schedule for approximately 2:15 p.m., to follow the day surgeon's scheduled surgeries.

Contrary to both the initial and day surgical residents' documentation in the EHR, the day surgeon reported to the OIG being unaware that the patient's appendectomy had been listed as an add-on surgery. The day surgeon stated that the Chief Resident did not discuss the add-on surgery. The day surgeon reported leaving the OR around 3:30 or 4:00 p.m.[21] The day surgeon told the OIG that another surgery could have been "bumped" [moved to a later time] to accommodate the patient's add-on appendectomy. The OIG found no evidence that the OR staff tried to contact the day surgeon about the add-on appendectomy. Also contrary to the EHR documentation, the OR schedule and interviews with staff indicated that the Chief Resident was performing another surgery and was unavailable to perform the add-on appendectomy. The poor communication between the residents and the attending surgeons about the add-on surgical case, as well as the lack of a closed loop communication in which the day surgeon would have acknowledged the add-on surgical case, contributed to the delay in surgery.[22]

[20] The Joint Commission is an independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States. https://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx. (This website was accessed on March 7, 2019.)

[21] The OIG could not confirm this statement as, at the time of the site visit, the Chief Resident had completed residency training, was no longer employed by the facility, and was not available for an interview.

[22] According to The Joint Commission, closed loop communication is the exchange of information between a sender and a receiver and usually includes acknowledging the receipt of information and verifying with the sender that information received is the same as the intended information. David P. Baker, Ph.D. et al, "The Role of Teamwork in the Professional Education of Physicians: Current Status and Assessment Recommendations," *The Joint Commission Journal on Quality and Patient Safety* 31, no.4 (April 2005): 185-202.

Surgery Scheduling

The OIG team requested a copy of the facility policy for OR scheduling and received an unsigned copy of a document titled *Operating Room Policy and Procedure: Scheduling*. The document provided was not a facility-wide policy but labeled an OR policy and procedure with a signature line for the clinical nurse manager; it was dated/revised in May 2007 and last reviewed in 2009. The document provided guidelines for requesting add-on elective surgeries stating "complete the add-on scheduling worksheet and print to the OR office. The OR scheduler, CN [charge nurse] or clinical director must be contacted by the service…the request will be either denied or accepted. If the case [surgery] is accepted, the add-on will be added to the OR schedule."

The OIG substantiated through interviews that the add-on process was consistent with the above policy guidelines. When scheduling a surgery, surgical residents were responsible for evaluating the patient, discussing the surgery with the Chief Resident and attending surgeon, completing the preoperative scheduling worksheet, and sending it to the OR. The Chief Resident was responsible for identifying and coordinating with an available attending surgeon.[23] The OR charge nurse and anesthesiologist determined the room and staff availability before adding the surgery to the schedule.

The OR scheduling document provided by the facility does not address a closed loop communication to confirm or notify the identified attending surgeon of the acceptance and time of the add-on surgery.

2. Alleged Delay in Patient's Surgery Related to Resident Oversight

The OIG did not substantiate that the patient's appendectomy was delayed because of inadequate resident oversight.

The VHA handbook on resident supervision states "[i]n a health care system where patient care and the training of health care professionals occur together, there must be a clear delineation of responsibilities to ensure that qualified practitioners provide patient care, whether they are trainees or full-time staff. As resident trainees acquire the knowledge and judgment that accrue with experience, they are allowed the privilege of increased authority for patient care."[24]

[23] Attending surgeons are senior physicians who provide supervision to physician's trainees. https://www.merriam-webster.com/dictionary/attending. VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012. This VHA Handbook was scheduled for recertification on or before the last working day of December 2017 but has not been recertified.

[24] VHA Handbook 1400.01.

VHA requires that the patient's EHR contain documentation of resident supervision by the attending physician. This is achieved through a progress note in the patient's EHR written by the attending physician; an addendum to the resident note by the attending physician; the attending physician co-signing a resident's note; or the resident documenting in the progress note the name of the attending physician with whom the resident discussed the patient and that the attending physician is agreeable with the assessment and treatment plan.[25] In addition, VHA requires attending physicians to be physically present in the OR.[26]

The OIG confirmed that the EHR of the patient at issue contained the co-signatures of the attendings to the residents' notes, and the attendings entered an addendum to the residents' notes verifying agreement with the care documented and provided by residents.

3. Surgeons Allegedly Paid by VA while Working for Other Institutions

While most facility surgeons on staff also worked at other institutions, due to discrepancies in timecards and lack of documentation outlining the tour of duty for part-time physicians, the OIG team was unable to determine the availability of surgeons or whether they were paid consistent with the hours reflected on their timecards. The facility did not maintain documents outlining tours of duty.

VHA allows for part-time physicians to work either fixed or adjustable work hours.[27] Part-time physicians on fixed tours have an agreed upon tour of duty that remains constant. Although the facility reported not having any part-time physicians with adjustable work hours in the Surgery Service, the OIG concluded that the general surgery part-time physicians were functioning as if they had adjustable work schedules. The part-time physicians did not consistently work specific days or hours.

Upon review of the Surgical Service May 2018 schedules and timecards, the OIG noted the days worked per the schedules did not match the reported days worked on the timecard for two of the part-time attending physicians. Because of this discrepancy, the OIG was unable to determine if surgeons were available when they were scheduled.

The OIG team discovered that the facility had a process in place to document part-time physician hours worked; however, a staff member reported the facility did not have a verification process

[25] VHA Handbook 1400.01.

[26] VHA Handbook 1400.01.

[27] VHA Directive 1035, *Oversight and Improvement of the Part-Time Physician Program*, November 29, 2013. This directive expired November 30, 2018 and has not been updated. Part-time physicians use adjustable work hours when their duties "routinely make it difficult or inappropriate for them to adhere to a regular tour of duty." An adjustable work hours schedule should be documented and monitored quarterly.

to monitor if surgeons' timecards matched their actual work hours.[28] Because of the lack of monitoring, the OIG could not determine what hours the part-time physicians actually worked or if they had received pay consistent with those hours.

VISN Review

When interviewed, the VISN Fiscal Quality Assurance Manager reported conducting a review of part-time physician hours for all VISN 12 facilities in response to the OIG issued report in March 2018.[29] The Fiscal Quality Assurance Manager stated not being to determine if facility physicians were meeting their assigned tours of duty because the facility did not maintain required documents showing schedules for part-time physicians working a fixed schedule.[30] The VISN completed its review in April 2019 and determined that the facility does not maintain appropriate documentation to verify and validate individual physician work schedules and payment. The VISN made two recommendations for the facility to address within six months, but did not provide a date for VISN follow-up.[31]

Conclusion

The OIG substantiated that the patient's appendectomy was delayed approximately three hours. The delay was due to another patient needing surgery more urgently and poor communication, rather than inadequate resident oversight. The patient received appropriate preoperative monitoring and care. The OIG found no evidence of an adverse event to the patient related to the delay.

The OIG team identified poor communication between the residents and the attending surgeons. The facility lacked an updated, signed OR scheduling policy. The unsigned policy did not address the communication process when a surgery has been accepted and scheduled.

The OIG did not substantiate the patient's surgery was delayed because of inadequate resident oversight. Staff interviews confirmed the availability of general surgery attendings to residents; documentation in the patient's EHR confirmed that attendings were supervising the residents' work and were present in the OR during surgeries.

The OIG team was unable to determine if surgeons were available or paid appropriately due to discrepancies in timecards, lack of documentation of the part-time physicians fixed work

[28] VHA Directive 1035.

[29] VA Office of Inspector General, *Review of Resident and Part-Time Physician Time and Attendance at Oklahoma City VA Health Care System,* Report No. 17-00253-93, March 28, 2018. https://www.va.gov/oig/pubs/VAOIG-17-00253-93.pdf. (The website was last accessed on February 27, 2019.)

[30] The facility reported in February 2019 that they are working to obtain documentation of work schedules for part-time surgeons.

[31] VISN Audit Report of the Hines VAMC, received April 11, 2010.

schedules, and the lack of a verification process to monitor if surgeons' timecards matched their actual work hours. The VISN Fiscal Quality Assurance Manager also conducted a review of part-time physician hours and determined that the facility did not maintain appropriate documentation to verify and validate individual physician work schedules and payments.

Recommendations 1–2

1. The Edward Hines, Jr. VA Hospital Director evaluates the current surgery scheduling practices to determine if changes are required to improve communication processes, and takes action as necessary.
2. The Edward Hines, Jr. VA Hospital Director ensures that documentation is in place that determines part-time physicians' tours of duty and responsibilities for time and attendance and monitors compliance.

Appendix A: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 12, 2019

From: Director, VA Great Lakes Health Care System (VISN 12)

Subj: Healthcare Inspection—Alleged Delay in Surgical Care, Lack of Resident Oversight, and Improper Physician Pay at Edward Hines, Jr. VA Hospital, Hines, Illinois

To: Director, Office of Healthcare Inspections (54HL08)

Director, GAO/OIG Accountability Liaison (GOAL) office (VHA 10EG GOAL Action)

1. I have reviewed and concur with the findings and recommendations in the OIG report entitled Healthcare Inspection—Alleged Delay in Surgical Care, Lack of Resident Oversight, and Improper Physician Pay at Edward Hines, Jr. VA Hospital, Hines, Illinois.
2. Hines concurs with all recommendations. Evidence of the corrective action plan with quality improvements to address the recommendations are provided for review.
3. I would like to thank the OIG inspections team for comprehensive review at Edward Hines, Jr. VA Hospital, Hines, IL.

(Original signed by:)

Victoria P. Brahm, MSN, RN, VHA-CM
Acting Network Director, VISN 12

Appendix B: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 12, 2019

From: Director, Edward Hines, Jr. VA Hospital (578)

Subj: Healthcare Inspection—Alleged Delay in Surgical Care, Lack of Resident Oversight, and Improper Physician Pay at Patient at Edward Hines, Jr. VA Hospital, Hines, Illinois

To: Director, VA Great Lakes Health Care System, (VISN 12)

1. Thank you for the opportunity to review and comment on the draft report, Alleged Delay in Surgical Care, Lack of Resident Oversight, and Improper Physician Pay at Patient at Edward Hines, Jr. VA Hospital, Hines, Illinois.
2. I have reviewed and concur with the status of the actions and recommendations as submitted. Most importantly, the OIG concluded that patient care was appropriate and residents had adequate supervision.

(Original signed by:)

Steve E. Braverman, M.D.
Medical Center Director

Comments to OIG's Report

Recommendation 1

The Edward Hines, Jr. VA Hospital Director evaluates the current surgery scheduling practices to determine if changes are required to improve communication processes, and takes action as necessary.

Concur.

Target date for completion: December 31, 2019

Director Comments

The Chief of Surgery completed an evaluation of the surgery scheduling practice to determine process changes needed to improve communication. Upon completion, it was determined that a new surgery policy will be developed to include key personnel with defined responsibility and accountability for communicating scheduling changes and issues, focused communication with staff during the perioperative time frame and day of surgery, a provision for enhancing communication with the veteran and other support persons designated by the veteran, and a process to enhance effective communication among provider and veteran. Surgical Service Staff will be educated on the new policy through the monthly Surgical Service Staff Meeting. Chief of Staff will monitor and track policy completion and staff education completion through the Medical Executive Board (MEB).

Recommendation 2

The. Edward Hines, Jr. VA Hospital Director ensures that documentation is in place that determines part-time physicians' tours of duty and responsibilities for time and attendance and monitors compliance.

Concur.

Target date for completion: February 29, 2020

Director Comments

The Chief of Surgery conducted an evaluation of the time and attendance compliance for part-time physicians' tours of duty. Upon completion, it was determined that all personnel should have an up to date tour of duty that complies with VA regulation format that is accessible for review and audit. The Surgery Section Chiefs will review and approve each provider's tour of duty. The Chief of Surgery will review and approve the tour documents. The Surgical Service Line Administrative Staff will conduct random internal audits for time and attendance compliance for part-time physicians' tours. Audit results will be reported at the monthly Medical

Executive Board (MEB) meeting until a 90% compliance is achieved for 3 consecutive months and then quarterly thereafter.

OIG Contact and Staff Acknowledgments

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