Administrative Closure, Detroit MI

Time and Attendance Issues

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections reviewed allegations regarding a patient who waited over 6 hours for a surgical procedure because the attending surgeon (surgeon) was unavailable at the John D. Dingell VA Medical Center located in Detroit, Michigan. Allegedly, the surgeon was working at another hospital performing surgery. Further, it was alleged that this surgeon was frequently unavailable during his scheduled tours of duty because he performed surgery at a private hospital during his scheduled VA time.

Background

The complainant made the following allegations:

- On September 23, 2010, a patient was left waiting in the holding area for more than 6 hours because the surgeon was working at a private hospital during the surgeon's VA tour of duty.
- The surgeon's surgical cases are frequently rescheduled or delayed, causing the Government to incur costs, such as overtime for operating room (OR) nurses.
- Patient care is placed at risk because a contract physician, whose tour of duty ends at 5:00 p.m., frequently leaves at noon without providing further care for patients.

Scope and Methodology

We conducted an onsite inspection December 13–16, 2010. We reviewed the patient's electronic medical record (EMR), medical center policies, committee minutes, quality management data, and administrative documentation related to timecards, time and attendance audits, provider credentialing and privileging folders, and other applicable medical center documents. We also reviewed a 2010 Compliance Officer's Part-Time Attendance Audit Report. We interviewed the surgeon, other employees, and managers with knowledge of or the responsibility for administrative controls related to these allegations.

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.

Case Summary

The patient was a 49-year old male veteran with a medical history that included Non-Hodgkin's Lymphoma[1], testicular cancer, chronic pancreatitis[2], and post traumatic stress disorder. On August 31, 2010, a General Surgery Service consult was entered into the EMR for removal of the infusaport. The patient presented at the medical center for removal of the infusaport September 27, not September 23 as indicated in the allegation.

The patient arrived at 7:18 a.m. and was assessed pre-operatively for surgery. The patient was the first case scheduled in OR number 03 at 8:00 a.m. The patient's post-operative assessment nursing note is timed at 3:00 p.m.

Results

We substantiated that the surgeon was not available at the medical center at the scheduled surgery time.

Tours of Duty. According to the medical center's Chief of Human Resources, only fixed tours of duty are available to part-time physicians at their facility. The surgeon's scheduled tour of duty was 7:30 a.m. to 5:00 p.m. on Mondays and 1:00 p.m. to 5:00 p.m. on Tuesdays. The surgeon informed us that on September 27, his expertise was needed in a surgery case at another hospital, and he informed his supervisor of the unavoidable delay for his scheduled VA tour.

We reviewed the surgeon's timecard and found that leave without pay was documented for 7:30 a.m. until 11:00 a.m. on September 27. The surgeon stated that he was available at the medical center at 11:00 a.m., and that other scheduled patients were taken to the assigned room for operative procedures and OR staff were reassigned to support other cases. This further delayed the patient's procedure. When the assigned room and staff were available, the infusaport was removed.

The surgeon also told us that in the past, he would schedule only emergent surgery cases at the private hospital on his VA scheduled days, and on occasion, he would go to the private hospital and perform those cases. However, he explained that after he spoke with the Chief of Surgery and was reminded of the attendance expectations, this practice stopped.

Medical Center Internal Audits. We reviewed the medical center's Compliance and Business Integrity Audit Plan for Fiscal Year (FY) 2010 and found that part-time

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[1] Lymphoma is a cancer of a part of the immune system called the lymphatic system.

[2] Chronic pancreatitis is long-term progressive inflammatory disease of the pancreas that leads to permanent deterioration of the structure and function of the pancreas.

physician auditing was a part of the plan to ensure consistency and prevent fraudulent practices. We interviewed the medical center's Compliance Officer who said that the part-time physician attendance audit is conducted twice a year in March and September.

The September 2010 audit report, identified that some physicians were missing and could not be accounted for. The medical center Director requested that the audit be repeated in October 2010. According to the Compliance Officer, there were variances during that audit as well; however, the surgeon was not among either group. The Medical Center Director took immediate action to address the issues.

We did not substantiate that additional costs were incurred by the Government because of the surgeon's late arrival for his tour of duty.

Interviewees informed us that there were delays because surgeons were not available for surgery cases, but OR start times were adjusted and tardiness has improved. Further, they initiated a performance improvement measure designed to improve surgeon punctuality.

Overtime. We inquired if overtime was tracked and correlated with delays attributed to surgeons' tardiness. Overtime is tracked for OR staff; however, it is extremely difficult to attribute its usage to surgeon delays because other variables that occur during the course of a day that requires the retention of staff. These variables include unforeseen complications during scheduled surgeries, patient delays, and emergent surgery cases that are appended to the OR schedule.

We did not substantiate that patients are placed at risk because of the surgeon. We could not substantiate that the identified surgeon frequently leaves at noon.

Patient Wait Times. We reviewed the Patient Advocate Tracking Data for the Surgery Service to determine if there were any complaints related to wait times or delays for the surgeon. We found one entry in which a patient sent a letter complimenting a staff member's professionalism and the surgeon's performance. There were no patient incident reports or complaints related to the unavailability of the surgeon at the medical center.

Cancellations. We reviewed a list of surgery case cancellations sorted by attending surgeon, type of surgery, and reason for cancellation dating June 1–December 6, 2010. We did not find any cancellations that were assigned to the surgeon.

Surgery Delays. We reviewed surgery delays from June 1–December 8, 2010 and found that there were 10 documented delays related to the surgeon's assigned cases.

Conclusions

We substantiated that on September 27, a patient who was scheduled for surgery at 8:00 a.m. waited over 6 hours. The assigned surgeon, who is a part-time employee of the medical center, was unavailable. The surgeon was not on duty and time and attendance records show leave without pay documented from 7:30 a.m. to 11:00 a.m. The surgeon informed us that on occasion, he would leave the medical center to perform emergent procedures, but that this practice has now ceased.

The medical center has a local policy and internal process to evaluate compliance with part-time physicians' attendance. After a medical center audit of part-time physicians in September 2010, managers identified process weaknesses, which they are addressing.

We did not substantiate that additional overtime costs were incurred because of the surgeon's tardiness. Emergencies, complications, and unforeseen patient issues affect OR schedules and may contribute to retention of staff beyond their scheduled tours of duty. Managers have identified tardiness as a performance improvement area and actively track and report the occurrences to senior leadership.

We did not substantiate that patients are placed at risk. We did not substantiate that the surgeon frequently leaves at noon. We reviewed the surgeon's timecards and did not find any documented occurrences of these absences. Further, interviewees did not voice concerns that the surgeon was unavailable in the afternoon hours. There are also documented entries of unscheduled hours when the surgeon worked at the medical center beyond his assigned tours of duty.

Recommendations

We made no recommendations as medical center management were aware of some of the issues and were in the process of taking action to ensure improve part-time physician attendance accountability issues.

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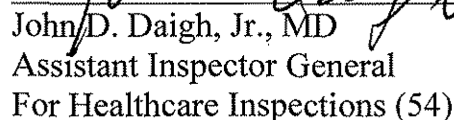
Approved/Disapproved



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