



REDACTED REPORT

OFFICE OF THE MEDICAL INSPECTOR

Revised Final Report to the

Office of Special Counsel

OSC File Number DI-11-3203

Imaging Service

Department of Veterans Affairs

Central Arkansas Veterans Healthcare System

Little Rock, Arkansas



Veterans Health Administration

Washington, DC

Draft Report Date: November 7, 2012

OMI TRIM # 2011-D-1419

Any information in this report that is the subject of the Privacy Act of 1974 and/or the Health Insurance Portability and Accountability Act of 1996 may only be disclosed as authorized by those statutes. Any unauthorized disclosure of confidential information is subject to the criminal penalty provisions of those statutes.

Executive Summary

The Under Secretary for Health requested that the Office of the Medical Inspector (OMI) investigate complaints submitted to the Office of Special Counsel (OSC) by a whistleblower (a radiology technologist) at the Department of Veterans Affairs (VA), Central Arkansas Veterans Healthcare System, John L. McClellan Memorial Veterans Hospital, Little Rock, Arkansas (hereafter, the Medical Center). The whistleblower alleged that the Medical Center is engaging in conduct that may constitute violations of law, rule, or regulation, gross mismanagement, and substantial and specific danger to public health. In brief, the allegations are:

- Poor inventory management in the Imaging Service;
- Inadequate cleaning and infection control practices in the Imaging Service;
- Employees fail to reconcile medications when administering contrast agents to patients; and
- Violations of patients' privacy rights.

The OMI conducted a site visit to the Medical Center from November 29 - December 1, 2011.

Conclusions

Poor inventory management in the Imaging Service

- The OMI substantiated the presence of expired supplies in the computed tomography (CT) and interventional radiology (IR) rooms. However, the OMI did not substantiate the allegation that essential supplies are out of stock in the CT and IR rooms.
- The OMI did not substantiate that expired supplies are used in procedures.
- The Medical Center investigated the circumstances surrounding the care of Veteran #1 and determined that in the CT room used that day, the technician had not replaced, as required, all needed supplies, including suction canisters and tubing.
- The OMI could not substantiate the allegation that a Veteran aspirated due to the lack of available suction equipment, since his preexisting medical condition was a significant factor.
- The OMI did not substantiate the allegation that the CT and IR rooms are not equipped with cardiac monitors or blood pressure (BP) cuffs.

Inadequate cleaning and infection control practices in the Imaging Service

- The OMI substantiated the allegation that cleaning and infection control had been inadequate in the CT and IR rooms, that Environmental Management Services (EMS) employees had only cleaned each room once daily and not until 12:30 p.m., and that the rooms were not cleaned after each procedure. The OMI found that the Medical Center is addressing these issues; however, overflowing trash cans and laundry bins were observed during the OMI site visit.
- The OMI substantiated that EMS failed to provide cleaning services for CT and IR on the weekend of October 14-16, 2011, and that the radiology technologist had to remove trash and laundry, and clean the room before performing a scheduled procedure on a patient. The OMI concludes that the Medical Center took appropriate action in response to the event.

- The OMI did not substantiate that the employees in CT and IR failed to follow infection control (IC) policies established to ensure compliance with The Joint Commission standards. The CT and IR staff consistently described cleaning tables and equipment exposed to secretions or blood with CaviWipes.¹ The OMI observed that the employees conducting a procedure were in compliance with Medical Center policy 114-7, section 3h (6), regarding gowns, caps and masks.
- The Medical Center's Aspire data for significant hospital acquired infections is below VHA national averages for all three infections that are tracked.

Failure to reconcile medications when administering contrast agents to patients

- The OMI did not substantiate the allegation. The Medical Center is providing appropriate guidance to Veterans who are taking metformin and who receive an intravenous contrast agent for the purpose of CT scanning.

Violation of Patients Privacy Rights

- The OMI substantiated that there were information disclosure issues in the Imaging Service that possibly violate the Privacy Act of 1974, 5 U.S.C 552a; and the Health Insurance Portability and Accountability Act (HIPAA).
- At the OMI's request, the Medical Center devised an immediate plan to provide patient privacy.

Recommendations

The Medical Center should:

1. Enforce their policies and procedures for discarding expired supplies in the CT and IR rooms.
2. If not already done, peer review the events of (b)(6) 2011, including the patient's care before he arrived in the CT room, and take appropriate action.
3. Monitor EMS response time for the cleaning of CT and IR rooms on weekdays and weekends, and discuss the findings with leadership in Imaging Service and EMS.
4. Ensure that the rooms are cleaned according to policy before and after use.
5. Maintain the *Temporary Patient Privacy Action Plan* until the long-term privacy action plan is completed.

Summary Statement

The OMI substantiated most of the whistleblower's allegations and agree that these are significant issues that must be corrected. However, the investigation does not find that the Medical Center's actions constitute gross mismanagement, or a substantial and specific danger to public health. In regard to the issue of privacy, the Office of General Counsel found that while the findings do not allow for specific conclusions, they reveal potential risks for improper

¹ CaviWipes® are a cleaner and disinfectant for non-porous surfaces and fixtures.

disclosure. Any disclosure of information protected by statute without either the consent of the individual about whom the information pertains or an applicable exception, may be a violation of law, rule, or regulation.

I. Summary of Allegations

The Under Secretary for Health requested that the Office of the Medical Inspector (OMI) investigate complaints submitted to the Office of Special Counsel (OSC) by a whistleblower (a radiology technologist) at the Department of Veterans Affairs (VA), Central Arkansas Veterans Healthcare System, John L. McClellan Memorial Veterans Hospital, Little Rock, Arkansas (hereafter, the Medical Center). The whistleblower alleged that the Medical Center is engaging in conduct that may constitute violations of law, rule, or regulation, gross mismanagement, and substantial and specific danger to public health. In brief, the allegations are:

- Poor inventory management in the Imaging Service;
- Inadequate cleaning and infection control practices in the Imaging Service;
- Employees fail to reconcile medications when administering contrast agents to patients; and
- Violations of patients' privacy rights.

II. Facility Profile

The Medical Center, part of Veterans Integrated Service Network 16, operates two hospitals, located in Little Rock and North Little Rock. The Medical Center offers a broad spectrum of inpatient and outpatient health care services, ranging from disease prevention through primary care, to complex surgical procedures, and extended rehabilitative care. The 178-bed Medical Center serves as a teaching facility for more than 1,200 students and residents annually. Its principal affiliate is the University of Arkansas for Medical Sciences. The Medical Center reaches Veterans through its Community-Based Outpatient Clinics in Mountain Home, El Dorado, Hot Springs, and Mena, its Home-Based Primary Care Center in Hot Springs, and a drop-in treatment center for homeless Veterans in downtown Little Rock. In June of 2011, the Nuclear Medicine Service and Radiology Service joined to become the Diagnostic and Therapeutic Imaging Service (hereafter, the Imaging Service). This Service is comprised of the following: general radiology, mammography, computed tomography (CT), magnetic resonance imaging (MRI), ultrasound, interventional radiology (IR), and nuclear medicine.

III. Conduct of the Investigation

The OMI team consisted of (b)(6) Medical Inspector, (b)(6), a Medical Investigator, and (b)(6) Clinical Program Manager. The OMI interviewed the whistleblower on several occasions. The whistleblower provided additional information to assist the OMI in identifying a specific patient where quality of care concerns were raised. The OMI conducted a site visit to the Medical Center from November 29 - December 1, 2011, held an entrance briefing with Medical Center leadership, and toured the two IR rooms and two CT rooms during the day and evening shifts. At the conclusion of the site visit, the OMI held an exit briefing with Medical Center leadership. Documents reviewed are shown in Attachment A.

During the site visit, the OMI interviewed the following individuals: (b)(6) Acting Medical Center Director, Chief of Staff; (b)(6), Deputy Medical Center Director; (b)(6) (b)(6) Associate Medical Center Director; (b)(6), RN, Nurse Executive/Associate Director

Patient Care Services; (b)(6), Acting Chief of Staff, Deputy Chief of Staff; (b)(6)
(b)(6) MPH, Chief of Quality Management; (b)(6) Patient Safety
Manager; (b)(6) acting Chief of Radiology; (b)(6)
acting Chief of Imaging; (b)(6), Administrative Officer, Radiology; (b)(6), chief
radiology technologist; (b)(6) radiology technologist, supervisor; (b)(6), day
shift radiology technologist and CT Supervisor; (b)(6) day shift radiology technologist;
(b)(6) day shift radiology technologist; (b)(6) part-time employee in
Diagnostic Radiology; (b)(6), interventional radiology lead technologist; (b)(6)
(b)(6) interventional radiology technologist; (b)(6) radiology technologist; (b)(6)
(b)(6) radiology technologist, CT technologist; (b)(6), Chief Environmental
Management System (EMS); (b)(6), EMS employee; (b)(6), EMS employee;
(b)(6) RN Infection Control; (b)(6), Union Representative-Cath. Lab
Technician; (b)(6) MD, Emergency Department; and (b)(6)
Emergency Department Nurse Manager.

The Office of General Counsel reviewed the findings to determine if there was any violation of law, rule, or regulation.

The OMI *substantiated* allegations when the facts and findings supported that the alleged events or actions took place. The OMI *did not substantiate* allegations when the facts showed that the allegations were unfounded. The OMI *could not substantiate* allegations when there was no conclusive evidence to either sustain or refute the allegations.

IV. Findings, Conclusions, and Recommendations

A. Poor inventory management in the Imaging Service

The whistleblower alleged:

1. The local supply cabinets in the CT and IR rooms are inadequately stocked and the inventory is not rotated effectively by morning staff. As a result, there are expired supplies in the cabinets and essential supplies are out-of-stock.
2. The supplies maintained in the CT and IR room cabinets, are not rotated effectively resulting in usage of expired sutures, catheters, stents, drainage tubes, and wires.
3. On October 14, 2011, a patient in the CT room aspirated due to the lack of a suction canister and tubes.
4. The CT and IR rooms are not equipped with cardiac monitors or blood pressure (BP) cuffs.

Findings

The Medical Center's CT section operates two CT scanners: a 4-slice CT scanner scheduled to be replaced in March 2012; and a 64-slice CT scanner, installed in 2009, which is capable of performing specialized examinations such as the identification of pulmonary emboli. In CT, there is one lead technologist, four CT-trained radiology technologists (RTs), and one scheduling clerk. The RTs work staggered shifts to staff the procedure rooms from 7:00 a.m. until 8:30 p.m.

After hours, there is an on-call RT with a 1-hour response time requirement. The Medical Center completed approximately 16,807 CT studies in fiscal year (FY) 2011.

The IR section operates two procedure rooms. IR is staffed by one lead technologist and four IR-trained RTs. The RTs staff the rooms on weekdays, and provide on-call coverage for evenings and weekends. The Medical Center completed approximately 2,539 IR studies in FY 2011.

In the Medical Center, the CT and IR rooms are located along the same hallway. The CT and IR sections keep BP cuffs and cardiac monitors in the supply cabinets, and share a crash cart with a portable cardiac monitor. In addition, there is one cardiac monitor and one portable vital signs monitor in each of the IR suites.

The Medical Center installed supply cabinets in the CT and IR rooms 1 year ago. The lead RT during the day shift is responsible for reviewing the expiration dates on all supplies a minimum of once per month. They are to remove all expired supplies.

Medical Center leadership indicated that 2 weeks before OMI's arrival they had completed a review of all supplies in the CT and IR rooms to ensure all expired items had been removed. On November 29, 2011, the OMI toured these rooms and checked the expiration dates on several hundred items. In the IR room, the OMI team found two packages of introducer sheaths with expiration dates of September 1, 2011, and two packages of sterile sheets from Supply, Processing, and Distribution (SPD), which had expired November 26, 2011. In the CT scan room there were three bottles of Omnipaque; one had expired on September 1, 2011, and the other two on October 1, 2011.² The OMI also found one package of Visipaque with an expiration date of October 1, 2011, along with a container of Clorox wipes with an expiration date of November 23, 2011.

The Medical Center staff reported that they have never encountered a time when necessary supplies were not available, nor have they ever used expired supplies on patients.

Veteran #1

Veteran #1 was a 59-year-old male admitted to the inpatient medical unit on (b)(6) 2011, with a diagnosis of spontaneous bacterial peritonitis, acute kidney injury, abdominal tenderness, and loculated ascites.^{3, 4, 5} His past medical history included gout, alcoholic cirrhosis of the liver, congestive heart failure, atrial fibrillation, and hypotension. On (b)(6) 2011, his condition deteriorated and he developed increased abdominal distension, dyspnea, and belching with a feculent odor.⁶ After a medical examination, the patient was

² Omnipaque is an intravenous iodinated contrast agent that makes vessels, highly vascular organs, and other structures more conspicuous on radiographic studies.

³ Spontaneous bacterial peritonitis is an infection in the abdominal cavity without an obvious source which may occur in patients with chronic liver disease.

⁴ Acute kidney injury is a reduction in kidney filtration function.

⁵ Ascites is the abnormal accumulation of serous fluid in the abdominal cavity. Loculation describes the formation of pockets between tissues and organs within the accumulated fluid.

⁶ Dyspnea is synonymous with shortness of breath.

transferred to the medical intensive care unit (MICU) and an abdominal CT was ordered to help identify the underlying cause for his change in status, and to rule out a possible bowel obstruction.

At 5:19 p.m. that day, an iodinated contrast injection questionnaire was completed for the Veteran. He was then placed into the CT scanner, where shortly thereafter, he began to vomit. He aspirated and began to have trouble breathing; the ED was called for assistance. The responding ED physician told the OMI that upon his arrival to the CT room, he noticed that the suction equipment was not available. The RT left the room to obtain the equipment. The ED physician suctioned the Veteran while he laid on his side, but he became unresponsive and pulseless. The ED physician initiated cardiopulmonary resuscitation and resuscitated the Veteran successfully. During the resuscitation, the Veteran was intubated; however, the electronic health record (EHR) indicated that he had "feculent material coming out from his mouth and that he surely aspirated." During his interview, the ED physician reported that the Veteran did not have a nasogastric tube in place prior to arrival in CT. The Veteran was transferred to the MICU on a ventilator. Per family consent, a do-not-resuscitate order was entered into the EHR. The Veteran's prognosis was poor secondary to decompensated liver disease and associated infections; he died the following day.

The Chief RT indicated that the RTs are responsible for replacing all necessary equipment at the beginning of their tours of duty, at the beginning of each procedure, and again at the end of the procedure. The Medical Center did an investigation of the availability of suction equipment, and determined that the RT who had staffed the room on the previous case had not replaced all supplies, including suction canisters and tubing, as required. The Medical Center conducted training for appropriate personnel.

Conclusions

- The OMI substantiated the presence of expired supplies in the CT and IR rooms. However, the OMI did not substantiate the allegation that essential supplies are out of stock in the CT and IR rooms.
- The OMI did not substantiate that expired supplies are used in procedures.
- The Medical Center investigated the circumstances surrounding the care of Veteran #1 and determined that in the CT room used that day, the technician had not replaced, as required, all needed supplies, including suction canisters and tubing.
- The OMI could not substantiate the allegation that a Veteran aspirated due to the lack of available suction equipment, since his preexisting medical condition was a significant factor.
- The OMI did not substantiate the allegation that the CT and IR rooms are not equipped with cardiac monitors or BP cuffs.

Recommendations

The Medical Center should:

1. Enforce their policies and procedures for discarding expired supplies in the CT and IR rooms.
2. If not already done, peer review the events of (b)(6) 2011, including the patient's care before he arrived in the CT room, and take appropriate action.

B. Inadequate Cleaning and Infection Control Practices

The whistleblower alleged that:

1. Cleaning and infection control (IC) is inadequate in the CT and IR rooms. EMS employees only clean each room once daily, and not until 12:30 p.m. Rooms should be cleaned after each procedure. Because of infrequent cleaning, there are overflowing trash cans, laundry bins, and blood on the floor.
2. Employees in CT and IR fail to follow IC policies established to ensure compliance with Joint Commission (JC) standards. Equipment exposed to blood or blood products should be cleaned immediately after each sterile procedure. Tables are not cleaned after each use; only the sheet covering the table is changed between patients. This is not in compliance with Medical Center policy 114-7, section 3h (5) and 3i (3).
3. On Sunday, October 16, 2011, EMS had not cleaned the CT and IR rooms since the preceding Friday. Another RT moved trash bags and laundry bins into the hallway and cleaned the room so that it could be used for a scheduled procedure.
4. Not all employees in the room during invasive procedures are wearing caps and masks as required by Medical Center policy 114-7, section 3h (6).

Findings

Prior to the OMI site visit, the tour of duty for the EMS employees assigned to clean the IR and CT rooms began at 12:00 noon and ended at 8:30 p.m. There was no EMS coverage during the morning; therefore, by 12:00 noon the trash and used linens needed to be removed. On November 21, 2011, two EMS shifts were established: 7:00 a.m. until 3:30 p.m., and 3:30 p.m. until 12:00 midnight. Despite these changes, the OMI observed overflowing trash cans and laundry bins in the IR rooms.

When questioned, the CT and IR staff described using CaviWipes[®] on the procedure table and any equipment stained with secretions or blood.⁷ They reported changing the sheet on the procedure tables after every patient. The OMI was told that terminal cleaning, including mopping floors, wiping cabinets, and wiping electronic equipment, was not performed between all CT or IR cases. The OMI observed IR staff wearing caps, masks, gowns, and gloves during procedures being conducted in the IR rooms.

⁰ CaviWipes[®] are a cleaner and disinfectant for non-porous surfaces and fixtures.

On Friday, October 14, 2011, the EMS employee scheduled to clean the CT and IR rooms was on annual leave. The EMS employee assigned to clean the ED had also been assigned to cover the Radiology Service; however, the trash cans and laundry bins were not emptied at the end of the day. On Sunday, October 16, a RT called the EMS employee on-call for CT and IR, but the call was not returned. The RT cleaned the room so that a scheduled procedure could be completed. The acting Chief of Imaging Service stated that this situation was an outlier, and reported it to leadership. Consequently, the Chief of EMS requested that she be contacted via cell phone or pager for any issues related to EMS.

The OMI reviewed the JC survey of the Medical Center conducted October 3-7, 2011, and found no report of IC violations. Prior to the JC survey, the Medical Center's multidisciplinary environmental rounds team monitored the CT and IR rooms in January and August of 2010 and 2011, and documented environmental issues related to the cleaning of the floor and trash removal. The environmental rounds team found no instances of failure to clean non-critical reusable medical equipment (RME) including the procedure table, overhead light(s), instrument tray(s), and BP cuffs.

Data from the VA's ASPIRE database show the following for the Medical Center:⁸

- MRSA (methicillin resistant *Staphylococcus aureus*) infection rate: The VHA average is 0.25, with a goal of 0.00. Central Arkansas' rate is below the VHA average at 0.14.
- VAP (ventilator-associated pneumonia) rate: The VHA average is 1.83, with a goal of 0.00. Central Arkansas' rate is below the VHA average at 0.67.
- CLAB (central line associated blood stream infections) rate: The VHA average is 1.12, with a goal of 0.00. Central Arkansas' rate is below the VHA average at 0.73.

Conclusions

- The OMI substantiated the allegation that cleaning and infection control had been inadequate in the CT and IR rooms, that EMS employees had only cleaned each room once daily and not until 12:30 p.m., and that the rooms were not cleaned after each procedure. The OMI found that the Medical Center is addressing these issues; however, overflowing trash cans and laundry bins were observed during the OMI site visit.
- The OMI substantiated that EMS failed to provide cleaning services for CT and IR on the weekend of October 14-16, 2011, and that the RT had to remove trash and laundry, and clean the room before performing a scheduled procedure on a patient. The OMI concludes that the Medical Center took appropriate action in response to the event.
- The OMI did not substantiate that the employees in CT and IR failed to follow IC policies established to ensure compliance with JC standards. The CT and IR staff consistently described cleaning tables and equipment exposed to secretions or blood with CaviWipes. The OMI observed that the employees conducting a procedure were in compliance with Medical Center policy 114-7, section 3h (6), regarding gowns, caps and masks.

⁸ Aspire is a public web-based dashboard that documents quality and safety goals for all VA Hospitals.

- The Medical Center's ASPIRE data for significant hospital acquired infections is below VHA national averages for all three infections that are tracked.

Recommendations

The Medical Center should:

3. Monitor EMS response time for the cleaning of CT and IR rooms on weekdays and weekends, and discuss the findings with leadership in Imaging Service and EMS.
4. Ensure that the rooms are cleaned according to policy before and after use.

C. Failure to Properly Reconcile Patient Medications

The whistleblower alleged that:

1. Patients taking the oral anti-hyperglycemic medication metformin should be instructed not to take the medication for 48 hours after receiving iodinated intravenous contrast material for a CT study because of risk of contrast-induced renal dysfunction.⁹ According to Medical Center policy 114-2, patients are supposed to receive this information in writing. The RTs do not consistently review patients' medical records to determine whether they take metformin, and therefore, are not properly advising patients about the risk of contrast-induced renal dysfunction. Many of the written forms directing patients to refrain from taking the drug for 48 hours after the administration of contrast agents are thrown away rather than provided to patients. The whistleblower has collected from 4 to 15 written forms per week that had been thrown away.

Findings

During the course of medical care, patients may be required to undergo radiographic imaging. Many of today's diagnostic imaging studies use intravenous iodinated contrast agents to adequately evaluate disease processes. Although these agents are generally safe, their use poses some risks including allergic reactions, drug interactions, and contrast-induced nephropathy.¹⁰ At the time of electronic order entry, clinicians are required to review these risks, take actions to mitigate them, and document the provision of informed consent to proceed with recommended radiographical imaging.

Clinicians advise Veterans about the risks that exist following the administration of intravenous iodinated contrast agents. Due to increased risks for complications, Veterans who are taking the oral anti-hyperglycemic medication metformin are instructed to discontinue its use for 48 hours after receiving intravenous iodinated contrast agents.

On the day of scheduled radiographical imaging, RTs screen Veterans for possible allergic reactions, drug interactions, and contraindications prior to administering the contrast agent. RTs advise all Veterans taking oral metformin to discontinue the medication for 48 hours after

⁹ Metformin is an anti-hyperglycemic medication commonly prescribed for patients with diabetes.

¹⁰ Contrast-induced renal dysfunction is defined as the impairment of renal function within 48-72 hours of intravenous contrast agent administration. The highest risk of contrast-induced nephropathy is in patients with renal insufficiency and diabetes.

receiving contrast agents. RTs counsel Veterans verbally, and then provide documentation of this counseling in the EHR in the pre-contrast progress note in accordance with Medical Center policy, *Administration of Contrast Agents*.¹¹ Additionally, RTs provide Veterans with written documentation of this counseling in the form of a handout. The OMI was told that some Veterans choose to discard these forms prior to leaving the imaging suite.

The OMI reviewed a sample of ten Veterans who were prescribed metformin in FY 2011 and who had received radiologic imaging studies requiring the administration of intravenous iodinated contrast agents, in order to determine compliance with Medical Center policy. All EHRs reviewed contained documentation of counseling regarding the recommendation to discontinue metformin for 48 hours following the radiologic procedure.

Conclusions

- The OMI did not substantiate the allegation. The Medical Center is providing appropriate guidance to Veterans who are taking metformin and who receive an intravenous contrast agent for the purpose of CT scanning.

Recommendations

None

D. Violation of Patients Privacy Rights

The whistleblower alleged:

1. Veterans waiting to have procedures completed in the CT and IR rooms are lined up on stretchers or in wheelchairs in the hallway, and it is common practice for Imaging Service staff to interview them and obtain consent for procedures in this common area, when other patients are present.
2. This constitutes a violation of the Health Insurance Portability and Accountability Act (HIPAA).

Findings

The patient's informed consent is required before most medical procedures. The OMI was told that Medical Center staff obtain informed consent from ambulatory patients either in private rooms or in clinic rooms. However, patients on stretchers or in wheelchairs are consented in an alcove located in the hallway outside the IR and CT procedure rooms. The iMed consent computer is located within this alcove in between two stretchers that are separated by a curtain. The Acting Chief of Imaging Service told OMI that they have been concerned about this as an ongoing issue. The OMI believes that this situation represented a privacy violation, and told the Medical Center it had to be corrected immediately.

¹¹ *Administration of Contrast Agents*, Central Arkansas Veterans Healthcare System, Diagnostic and Therapeutic Imaging Service, Policy/Procedure No. 114-2, November 2011.

During the site visit, the Medical Center provided the OMI with the *Temporary Patient Privacy Action Plan* (Attachment B). This plan identifies room 1D-177, adjacent to CT and IR, as a closed area that will accommodate a stretcher or a wheelchair and will provide complete privacy for obtaining informed consent. The Medical Center began using this room to obtain informed consent during the OMI's visit. The Medical Center will consent patients from the ED in the ED prior to arriving in the Imaging Service. Physicians will consent inpatients in a private room on the ward prior to their arrival in imaging for their procedure. All iMed consents will be obtained using a laptop computer when access to a desktop computer is not feasible. The OMI reviewed the long-term privacy action plan, which involves changes to the physical plant.

Conclusions

- The OMI substantiated that there were information disclosure issues in the Imaging Service that possibly violate the Privacy Act of 1974, 5 U.S.C 552a; and the Health Insurance Portability and Accountability Act (HIPAA).
- At the OMI's request, the Medical Center devised an immediate plan to provide patient privacy.

Recommendations

The Medical Center should:

5. Maintain the *Temporary Patient Privacy Action Plan* until the long-term privacy action plan is completed.

Summary Statement

The OMI substantiated most of the whistleblower's allegations and agree that these are significant issues that must be corrected. However, we do not find that the Medical Center's actions constitute gross mismanagement, or a substantial and specific danger to public health. In regard to the issue of privacy, the Office of General Counsel found that while the findings do not allow for specific conclusions, they reveal potential risks for improper disclosure. Information maintained by VA is protected by several privacy statutes and their implementing regulations. Generally, these privacy statutes only allow VA to release information when there is either the consent of the individual about whom the record pertains or an applicable exception.

The Privacy Act of 1974, 5 U.S.C. 552a, is one such statute. Under the Privacy Act, no federal agency may release information from a system of records without the consent of the individual about whom the record pertains. A system of records is defined as any record maintained about an individual by a federal agency, which is retrievable by the individual's name, social security number or other personal identifier. Similarly, the regulations implemented pursuant to the HIPAA Privacy Rule, 45 C.F.R. Parts 160, 162 and 164, prohibit covered entities such as VA from releasing protected health information (PHI) in the absence of consent or an applicable exception. VA's privacy statute, 38 U.S.C. 5701, prohibits the release of the names and addresses of VA beneficiaries and their dependents; and, 38 U.S.C. 7332, prevents the disclosure of information related to HIV, sickle cell anemia, and the treatment of alcohol or drug dependency. Any disclosure of information protected by the statutes outlined above without

either the consent of the individual about whom the information pertains or an applicable exception, may be a violation of law, rule, or regulation.

Attachment A

The following documents were reviewed in preparation of the report:

1. *Supply, Processing, and Distribution (SPD) Operational Requirements*: VA Handbook 7176, August 16, 2002.
2. *VHA Inventory Management*: VHA Handbook 1761.02, October 20, 2009.
3. *Ensuring Sterility of Non-Biological Implantable Devices*: VHA Directive 2007-001, January 4, 2007.
4. *Reusable Medical Equipment (RME): Use, Reprocessing, Safety and Quality Assurance*: Memorandum No. 130-, CAVHCS, February 25, 2011.
5. *CT and IR inventory supply list*.
6. *Infection Prevention and Control*: Diagnostic and Therapeutic Imaging Service Policy/Procedure No. 114-7, September 2011.
7. *Administration of Contrast Agents*: Diagnostic and Therapeutic Imaging Service Policy/Procedure No. 114-2, November 2011.
8. *Immediate Temporary Patient Privacy Action Plan*: November 29, 2011.
9. *Long Term Patient Privacy Action Plan*, Executive Decision Memo, October 13, 2011.
10. *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*: VHA Directive 2010-018, May 6, 2010.
11. *Coverage Schedule for Imaging Service*: Chief of Imaging Service, December 2, 2011
12. *Joint Commission Survey*, October 3-7, 2011
13. *Combined Assessment Program Review of the Central Arkansas Veterans Healthcare System Little Rock, Arkansas*, August 2, 2011.
14. *Interventional Radiology Central Line Infection Rates*: FY 2010 and 2011

Attachment B

Diagnostic and Therapeutic Imaging Service
Central Arkansas Veterans Healthcare System (CAVHS)
Little Rock, Arkansas

Immediate Temporary Patient Privacy Action Plan:

November 29, 2011

1D177 will be used to obtain consent for patients that need to be consented in the Imaging area. 1D177 is a closed area that will accommodate a stretcher or a wheelchair patient and has total privacy. This room is adjacent to the interventional/CT area of the department and is easily accessible.

Patients needing procedures from the Emergency Department (ED) will be consented in the private cubicles in the ED by Radiology physicians who will go to the area prior to the procedure.

Radiology physicians will consent in-patients on the floor who are in a private room prior to the patient coming to the Imaging Department for their procedure. This consent will be obtained by a portable laptop utilizing the IMED consent. Inpatients that do not have a private room will be consented in 1D177 prior to the procedure.

Obtaining consent in the ED and obtaining in-patient consent on the floors will decrease the amount of patients needing to be consented in 1D177.

This new process to safeguard patient privacy will be communicated to all physicians in the department and to the APN's that support the MDs. Immediate notification to utilize this process has been made to accommodate the patients scheduled for procedures in the AM and for emergency procedures that may occur this pm.

This temporary patient privacy action plan will stay in effect until the long term patient privacy plan is activated.

Long Term Patient Privacy Action Plan:

CAVHS has been working on a plan to create a pre-procedure holding area for our IR/CT patients or any Imaging patients that require preparation prior to a procedure. This would include offices to interview patients in privacy, areas to hold stretcher patients, and an area for wheelchair or ambulatory patients to wait prior to a Radiology or Nuclear Medicine procedure. The Executive Memo Decision (EDM) has been presented to management and has been reviewed by all services that will be affected by this project. The facility planner has worked closely with the Imaging Service to assure that the needs of the service are met. The EDM and the floor plan of the site are attached.

Central Arkansas Veterans Healthcare System
EXECUTIVE DECISION MEMO

TO: Medical Center Director
THROUGH: Joint Leadership Council/Board/Committee
FROM: Board/Committee/Subcommittee Name
SUBJECT: Space constraints in Radiology Service

For Further Information Contact:

Action Requested: X Request for approval
 Request for discussion or further review
 For your information
 Other (specify)

STATEMENT OF ISSUE: Radiology and Nuclear Medicine both are in need of patient care holding space, IR staff space, and equipment storage space. Ideally a 6-bed patient holding area is needed and one room about 200sf for equipment and 2 offices spaces for IR staff. Both Radiology and Nuclear Medicine have inadequate space to meet the privacy mandates when discussing patient care issues or consenting the patient for procedures or exams. In addition due to inadequate administrative space the Fire and Safety regulations are in violation as the hallways are always obstructed with patient stretchers, and hindered egress. The Services have been cited in several inspections regarding patients on stretchers in the hallway which is a safety violation, lack of privacy when preparing patients, and inadequate area to process pre and post patients.

Specifically the need is for a minimum of 1400 sf for pre and post procedure space and patient holding space. Currently there is enough staff to operate a 4-bed holding area but considering future needs a 6-bed area is supportable and additional staffing would be necessary. Radiology and nuclear medicine services are completely landlocked with no space for easy expansion within their existing areas. The options contained herein involve the use of Voluntary and DAV space and the North Atrium.

In addition, with the purchase of additional high cost equipment, (e.g. an additional 32 slice CT scanner, a C-arm for pain management and upgrading the 4 slice CT scanner for the second 64 slice CT scanner) and the desire to expand the Pain Management program, the existing problem has become an even more critical issue. Without further expansion, Radiology cannot grow or develop any new programs, and is in fact not providing the privacy and dignity that our veterans deserve.

RECOMMENDATION (of the requestor): There are two options and either of the two options suggested would be acceptable to fulfill the needs of Radiology Service Nuclear Medicine and assure that we meet the Patient Safety requirements and the Patient Privacy/HIPPA mandates. Option 1, with only 4 bed holding area, may be faster but is considered a short term dressing. Option 2, with an area designed for 6 bed holding, and is believed to be the solution for the long term. Both options affect other services by requiring Voluntary and DAV to be relocated to the 1F unfinished area. Both are somewhat expensive but Option 2 would be the best alternative for future growth, therefore, it is recommended. Additional recurring costs could be delayed to 2012 or 2013 to fully implement the 6 bed area.

IDENTIFY THE VHA/VISN/CAVHS GOAL OBJECTIVE AND STRATEGY BEING ADVANCED BY THE REQUESTED BOARD/COMMITTEE/SUBCOMMITTEE:

BOARD DISCUSSION:

BOARD RECOMMENDATION:

JLC Recommendation: Approve Disapprove Deferred

Comment: _____

SIGNATURE

Medical Center Director: Approve Disapprove Deferred

Comment: _____

I. **STATEMENT OF ISSUE:** Radiology and Nuclear Medicine both are in need of patient care holding space, IR staff space, and equipment storage space. Ideally a 6-bed patient holding area is needed and one room about 200sf for equipment and 2 offices spaces for IR staff. Both Radiology and Nuclear Medicine have inadequate space to meet the privacy mandates when discussing patient care issues or consenting the patient for procedures or exams. In addition due to inadequate administrative space the Fire and Safety regulations are in violation as the hallways are always obstructed with patient stretchers, and hindered egress. The Services have been cited in several inspections regarding patients on stretchers in the hallway which is a safety violation, lack of privacy when preparing patients, and inadequate area to process pre and post patients.

Specifically the need is for a minimum of 1400 sf for pre and post procedure space and patient holding space. Currently there is enough staff to operate a 4-bed holding area but considering future needs a 6-bed area is supportable and additional staffing would be necessary. Radiology and nuclear medicine services are completely landlocked with no space for easy expansion within their existing areas. The options contained herein involve the use of Voluntary and DAV space and the North Atrium.

In addition, with the purchase of additional high cost equipment, (e.g. an additional 32 slice CT scanner, a C-arm for pain management and upgrading the 4 slice CT scanner for the second 64 slice CT scanner) and the desire to expand the Pain Management program, the existing problem has become an even more critical issue. Without further expansion, Radiology cannot grow or develop any new programs, and is in fact not providing the privacy and dignity that our veterans deserve.

II. **SUMMARY OF FACTS AND/OR BACKGROUND:** Radiology has made several minor changes in the area in order to relieve some of the issues with patients waiting on stretchers in the hallway. A small holding area was established off the Orange Atrium that has the capability for 3 stretchers and has 3 chairs for ambulatory patients. This area is often over capacity due to the high volume of stretcher patients and the number of wheelchair inpatients in gowns that are brought to the area. We do not allow patients in gowns to wait in the public waiting room due to privacy issues. This area is so congested that it has become a safety issue for staff administering to the patients, the ability to access the area in an emergency and to move a patient from the holding area to a procedure room without "juggling" patients in and out of the area to remove a stretcher. There is a stretcher bay outside Interventional Radiology that will

hold 2 stretchers, however is in a hallway that is a main thru-fare for patient checking in for CT. The CT check-in area can accommodate 2 stretchers or 3-4 patients in wheelchairs that are receiving oral contrast and/or waiting for their CT scan or inpatients waiting for an ultrasound. None of these areas have adequate privacy for discussions with the patient, to consent the patient, or are designed to administer pre and post evaluations and preparation of patients. We are in the process of obtaining a 32 slice CT scanner that will be used primarily for Interventional Radiology cases such as biopsies and drains and will increase the volume to 4-6 cases per day (we currently have to limit these procedures to 2 per day and any emergent or urgent cases must be sent out Fee basis).

Radiology has agreed to assist Neurology and PM&RS with Pain Management to try to alleviate the backlog of patient requesting this service; in order to expand this program additional space is necessary. We have recently added the MILD procedure; which has been very successful but again we are limited in the number of cases we can accommodate due to space issue for pre and post procedure. Radiology's involvement both in the Pain Management program and the MILD procedure play a large role in reducing OR time, opiate use in our veterans and quality of care for our patients. MILD procedure requires 4 hours in the Ambulatory Care recovery area, biopsies, drains and vertebroplasty's take 4 hours recovery time, and epidurals take 10 minutes monitoring time. It is anticipated that the epidural procedures will more than double what is currently being done in the OR when the program is moved to the Radiology area and has Radiology physician, Neurology physicians and PM&RS physician working on reducing the backlog in the pain management program. In FY11 Radiology alone completed 916 epidurals which averaged about 10 per day and 4 days per week. The installation of the new C-arm for pain management and minor interventional procedures will increase capacity in the existing two interventional rooms which would decrease the need to outsource patients for pain management or urgent Interventional Procedures, and reduce bed days of care for inpatients. If either plan is initiated it will have an impact on freeing up OR time. Currently Neurology is doing approximately 16 epidural cases each of the two days that they have OR time. These patients are processed by Ambulatory Surgery for pre-op and go to recovery for 5-15 minutes post op if there are no complications. They are normally in the OR from 0800 to 1430 two days per week which takes the support of 1 OR nurse, 1 Rad tech and a Pre-Op Screening Nurse. If this function was moved to Radiology it would free up two days in an OR room and over two hours of monitoring time per day. In addition, the Neurology physician feels that he could do up to 24 cases per day in Radiology which would help reduce the backlog in the Pain Management program. If this were to occur, Radiology will experience 2.5 times more epidural workload 2 days per week than they currently schedule. Radiology and PMRS and Neurology have worked out a plan to increase their production per day by Radiology using the holding area and equipment rooms 3 days per week and PMRS and neurology use the areas 2 days per week.

Generally, there has been a significant shift from inpatient to outpatient services (about 20% of the patients were outpatients 5 years ago and now 80% of our patients are outpatient) in Interventional Radiology. This has created an increase in the number of patients that must be sent to monitoring areas. This is increasing even more with the introduction of new procedures and new equipment.

This workload increase will also impact the recovery areas that are used by Radiology.

III. SYNOPSIS OF SIGNIFICANT RELATED ISSUES: We have recently received funding for a 32 slice CT scanner which will be used to support Interventional Radiology procedures. This will have a significant impact on workload and will involve having more patients brought to the area on stretchers. In addition we have received a new C-arm. We have culled out a space in our existing area for the C-arm and plan to use it in conjunction with Neurology Service and PM&RS in enhancing the pain management program and in reducing that backlog. It will also mean that Neurology and PM&RS will be able to reduce their OR time and decrease their impact on Ambulatory Surgery recovery areas. However in order to initiate these programs we will need additional space for pre and post-procedural care of the patients.

IV. CRITERIA FOR DECISION MAKING: The primary issues rest with improving our position to meet the increasing health care diagnostic demands we experience and for the future projections as indicated in the HCPM. Resolving privacy and patient safety issues as well as improving the environment for staff, patients, and visitors. The additional space provided by both options will benefit and satisfy most areas mentioned but only Option 2 will resolve all of our issues. The lack of adequate space to prepare patients both pre and post procedures has a significant impact on the Service and this facility. We are not compliant with patient privacy issue by interviewing and preparing patients in an open area with other patient and family members able to overhear discussions, we are non compliant with patient safety issues by having patients held outside procedure rooms and blocking the hallways, and we are compromising employee and patient safety by having staff work in areas that are overcrowded and risk being bumped while starting an IV or administering oral contrast. In order to be compliant with VA privacy, HIPAA and Patient safety we would have to significantly reduce the number of patient being seen in CT, Ultrasound, General Radiology and Interventional Radiology which would mean outsourcing procedures and /or creating a backlog and not meet the wait-time measures for seeing patients within 30 days of desired date, or expediting inpatient care to reduce bed days of care. It is anticipated that in the near future the wait time will be reduced to requiring that patients be seen within 14 days of the desired date; the additional equipment and additional space will make this a realistic goal to meet. However without the equipment and space this will not be possible.

V. CROSSCUTTING ISSUES: N/A

VI. STAKEHOLDER INVOLVEMENT: In review of the immediate area the only space that seems plausible to accommodate the needs of Radiology and Nuclear Medicine are to expand into the area adjacent to Radiology in the Orange Atrium. This would impact CBO. The current CBO operation has recently been expanded to support the heavy volume from the green atrium and is expected to continue until Primary Care is relocated to NLR. This requires that we ensure we can continue to keep CBO on the first floor without negatively impacting their operation. We have determined that CBO space need requires the use of Voluntary space for CBO until Primary Care is relocated to NLR. Regardless, the two options will thus require the use of Voluntary and DAV spaces whether we expand and create a 4bed or 6 bed holding area. There are few first floor or any other floor to consider for Voluntary and DAV. The unfinished space of 1F (i.e. adjacent to the new MICU area) is ideal for both activities and is considered to be a good semi-permanent solution considering the length of time it will take to obtain necessary funds to expand 1F MICU. Both options propose relocating Voluntary and DAV to the 1F area that is unfinished space. There are no other options to relocate these services at this time and it is questionable if there will be adequate space after Primary Care is relocated. Voluntary Service may be able to move back to their original space but DAV would more than likely have to move to another area.

Also, the 2011 approved pain management services' equipment acquisition and relocation to Radiology will offer improvements in coordination of care and throughput of care for Surgery, Neurology, and PM&RS. Both Neurology Service and PM&RS are very interested in the expansion and further development of a pain management program that would be located in Radiology. The three services have developed plans to share equipment; staffing and have each brought this project up in our Business Plans. VISN 16 / CAVHS Management has already purchased equipment to be placed within Radiology's area for this pain program. This

program move to Radiology would have a positive impact on Surgery Service as it would free up OR time that is currently being used by Neurology and PM&RS for pain management and, thus, increase the throughput within the Ambulatory Surgery and recovery areas.

VII. OPTIONS AND ARGUMENTS:

Option 1:

Develop a 4-bed Radiology & Nuclear Medicine Patient Holding area into the space now occupied by Voluntary Service and DAV Travel office. This will require construction to modify that area to adapt it to a pre and post procedure area that would accommodate the expansion of existing programs in Interventional Radiology. Other modifications are shown to add office space for the IR APN. See drawing attached here:


Existing First
Floor-North Atrium-Vt

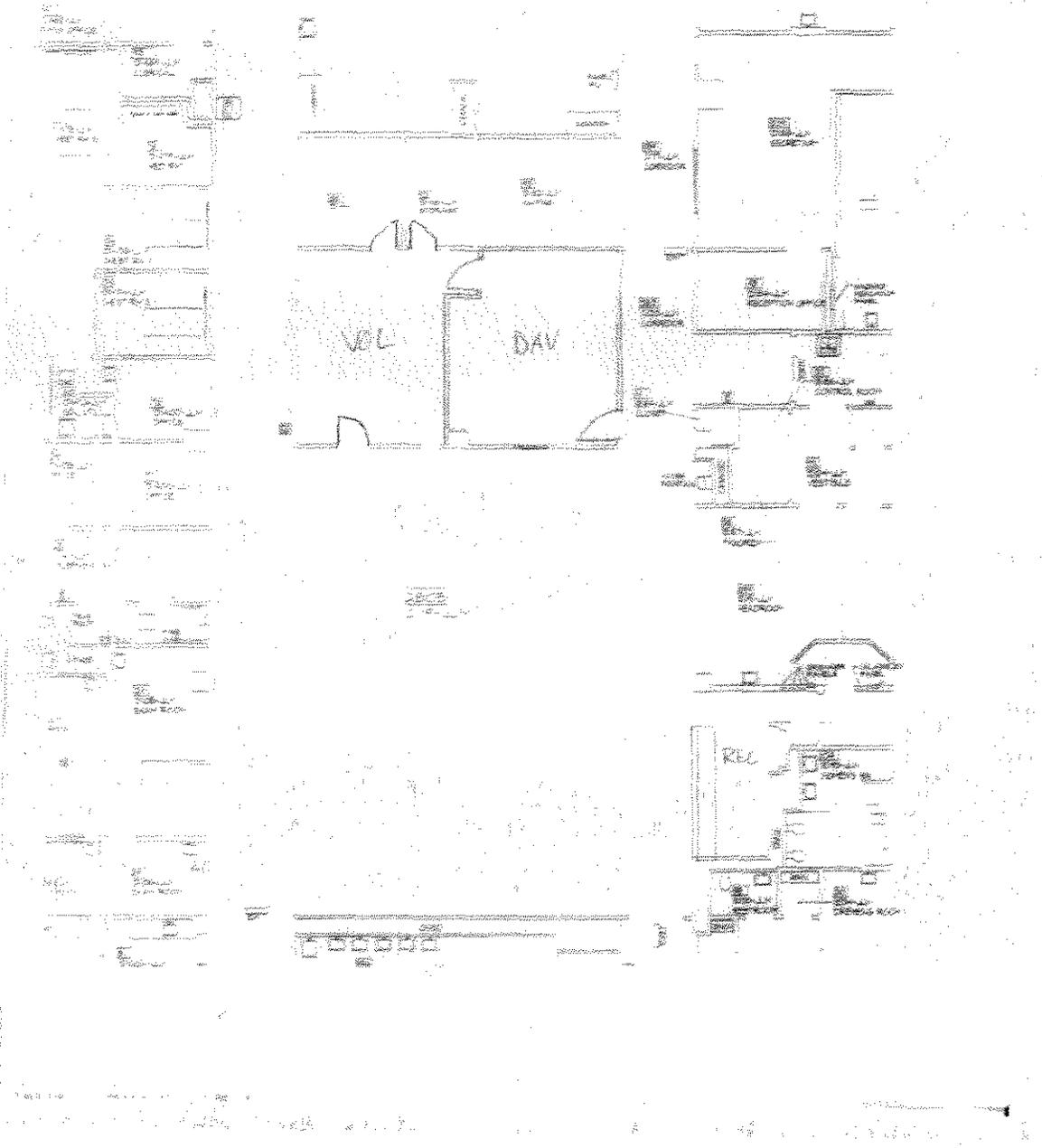

Option1-4bed Pt
holding area. pdf


Option1&2 relocate
Vol-DAV to 1F unfinis

Arguments Pro: Immediate patient holding will be satisfied and we have adequate staffing and funds to activate a 4-bed holding unit but future growth will not be possible within this area. Expand the Radiology /Nuclear Medicine area into the space now occupied by Volunteer Service and DAV Travel office. This will require construction to modify that area to adapt it to a pre and post procedure area that would accommodate the expansion of existing programs in Interventional Radiology and the introduction of new programs in the area that will greatly improve patient care, and reduce backlogs and wait times for our veterans. This will allow for both Radiology and Nuclear Medicine to meet the requirements for HIPAA/Patient Privacy, Fire and Safety regulations and would improve patient safety. Both options 1 and 2 include a small modification near Nuclear Medicine's entry that will gain greatly needed Interventional Radiology (IR) APN office space.

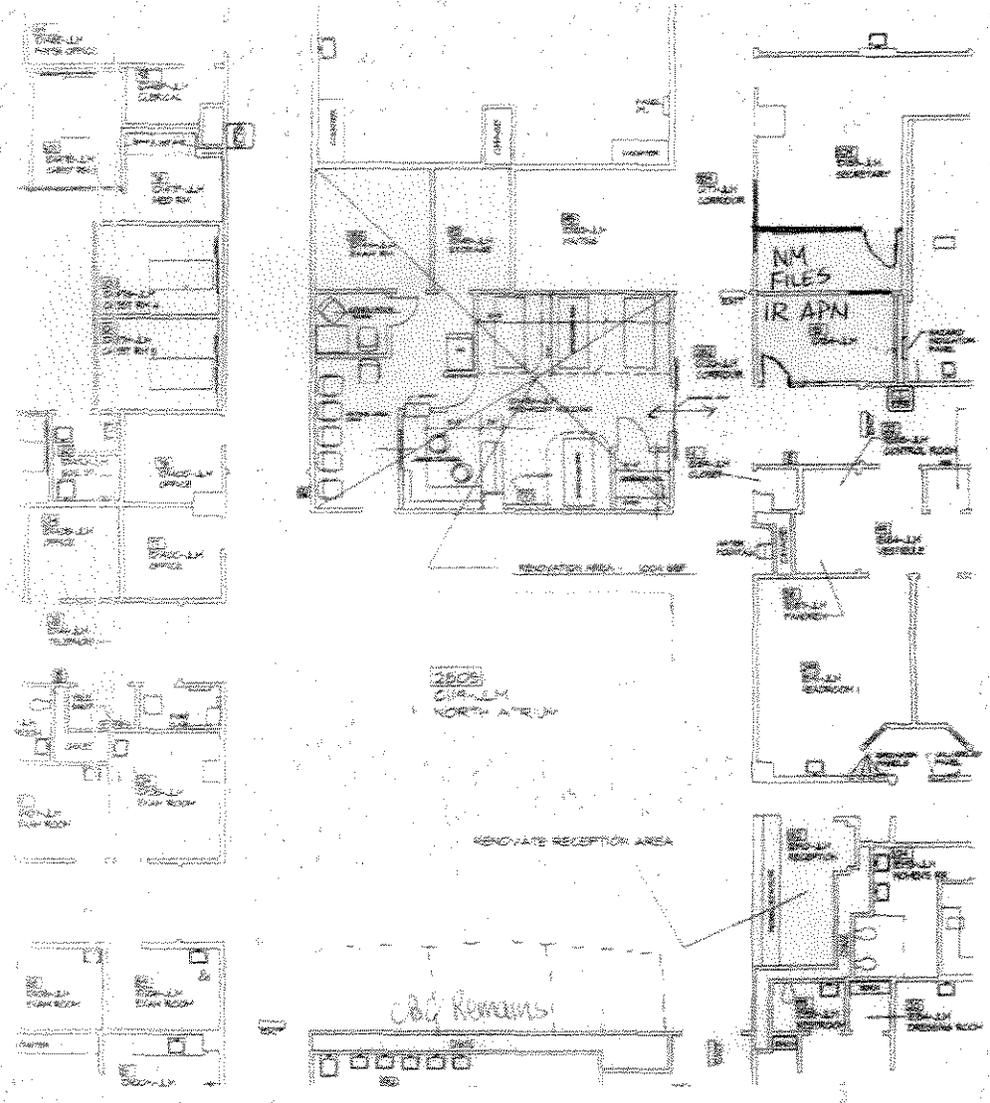
Arguments Con: The current daily demand for patient holding oftentimes equates to at least 3-4 patients throughout the day. The current staffing levels can support a 4-bed area but no more than that level. The problem with this option is that the HCPM indicates a continual increase in Radiology and Nuclear Medicine workload to 2030 and considering current trends, we feel a 6-bed area minimally is needed. Developing a 4-bed area now will require more expansion later and may be more expensive to expand or modify the area after it has been in operation and would have to be closed while under construction. The configuration would require expanding into the atrium or completely relocating the unit to the atrium as shown in option 2. One thing is certain, without expansion, Radiology cannot grow or develop any new programs. One other need that will not be met with option 1 is equipment storage room. Option 1 Does provide a very small storage room for Interventional Radiology but is not ideal. Adequate storage cannot be resolved unless some space is developed in the atrium area but that was not addressed. The planned installation of the additional 32 slice CT scanner and the installation of the C-Arm that is intended to develop a pain management program in Radiology (in collaboration with Neurology and PM&R) will quickly push our need for more than 4 bed holding unit. If we do nothing or proceed with option 1, we could indeed see more and more cases having to be outsourced.

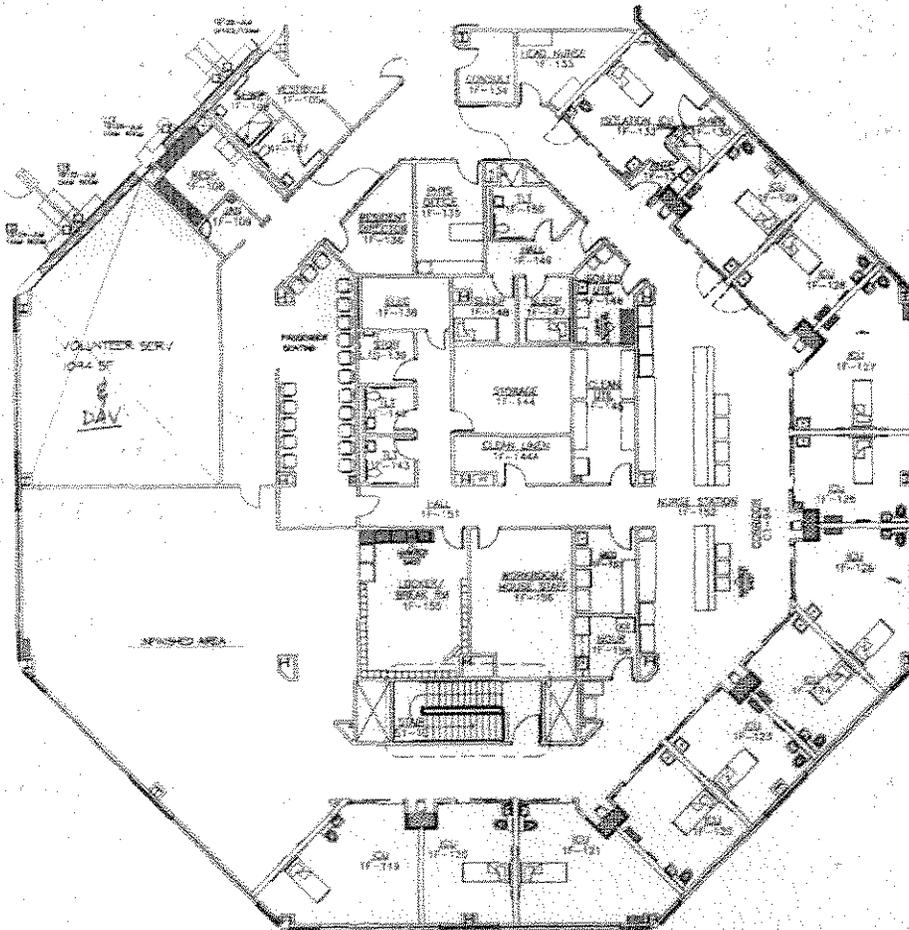
EXISTING



CONCEPT OPTION 1 (4 Bed)

Vol/DAY to IF
CBO Remains as is





MODIFIED 1ST FL LAYOUT - IF AREA/ VOL SERV.
 SCALE: 1/8" = 1'-0"

Option 2:

Develop a 6-bed Radiology & Nuclear Medicine Patient Holding area in the North Atrium. Remove the 3 kiosks (modular offices) from the orange atrium that are currently held by CBO and develop the orange area into a pre and post procedure area for Radiology and Nuclear Medicine. This option will require the use of Voluntary and DAV space. The unfinished space adjacent to the new MICU area would need to be developed to house Volunteer/Escort functions and then CBO could be placed in the current Volunteer/Escort space to continue to divert long waiting lines for travel pay from the Green Atrium. Other modifications are shown to add office space for the IR APN and space would be created to resolve equipment storage needs. See drawings attached here:



Existing First
Floor-North Atrium-Vt



Option2-6bed Pt
Holding.pdf

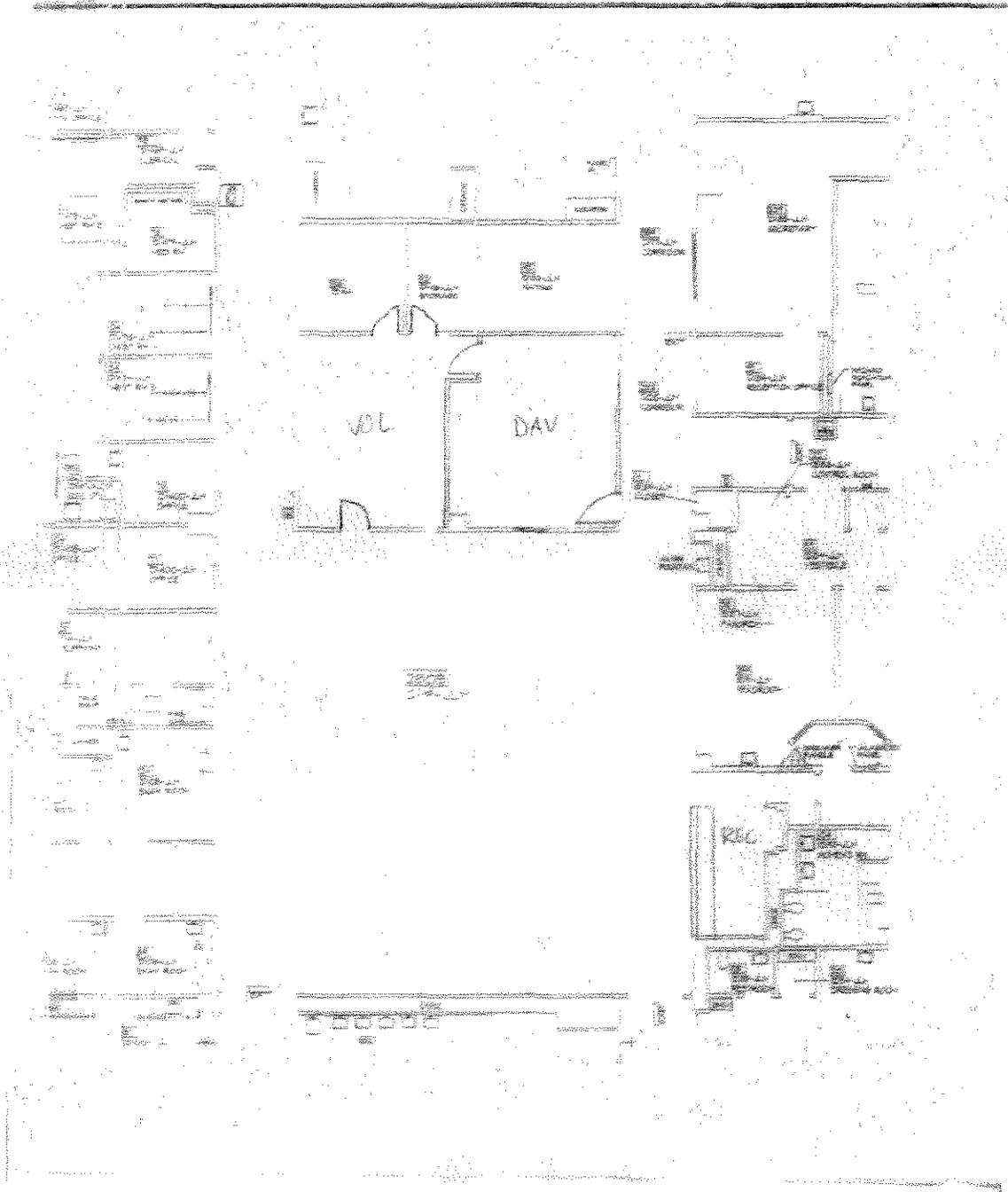


Option1&2 relocate
Vol-DAV to 1F unfinist

Arguments Pro: The Option 2 changes would accommodate the expansion of existing programs in Interventional Radiology and the introduction of new programs in the area that will greatly improve patient care, and reduce backlogs and wait times for our veterans. The 6-bed holding unit would be adequate for the number of rooms and equipment we will have in place and only if we approve and significantly expand with even more high cost equipment will we see a need for more than the 6-bed unit. Such future expansion will dictate a significant outlay of construction and site prep funds and would not be expected to be feasible. The new 6-bed holding area, equipment storage area and APN staff spaces will allow compliance for both Radiology and Nuclear Medicine for Patient privacy and would improve patient safety. Without these additional spaces, our ability to provide quality pre and post care would demand a decision be made immediately to continue to install approved and funded new equipment and /or if the existing case load should be reduced so that we are in compliance with Privacy Issues/HIPPA and Patient Safety. The Option 2 areas will eliminate these concerns and place us in position to be prepared for our inevitable growth. Both options 1 and 2 include a small modification near Nuclear Medicine's entry that will gain greatly needed Interventional Radiology (IR) APN office space. Option 2 only offers the potential for Voluntary Service or DAV to remain on the first floor once CBO can be accommodated as Primary Care relocates to NLR. This option will relocate but maintain CBO in good position to continue its efforts to divert patients from the Green atrium. Voluntary Service would also be placed near the MICU and have adequate space to provide good coverage and services to families and those having the greatest need for their services.

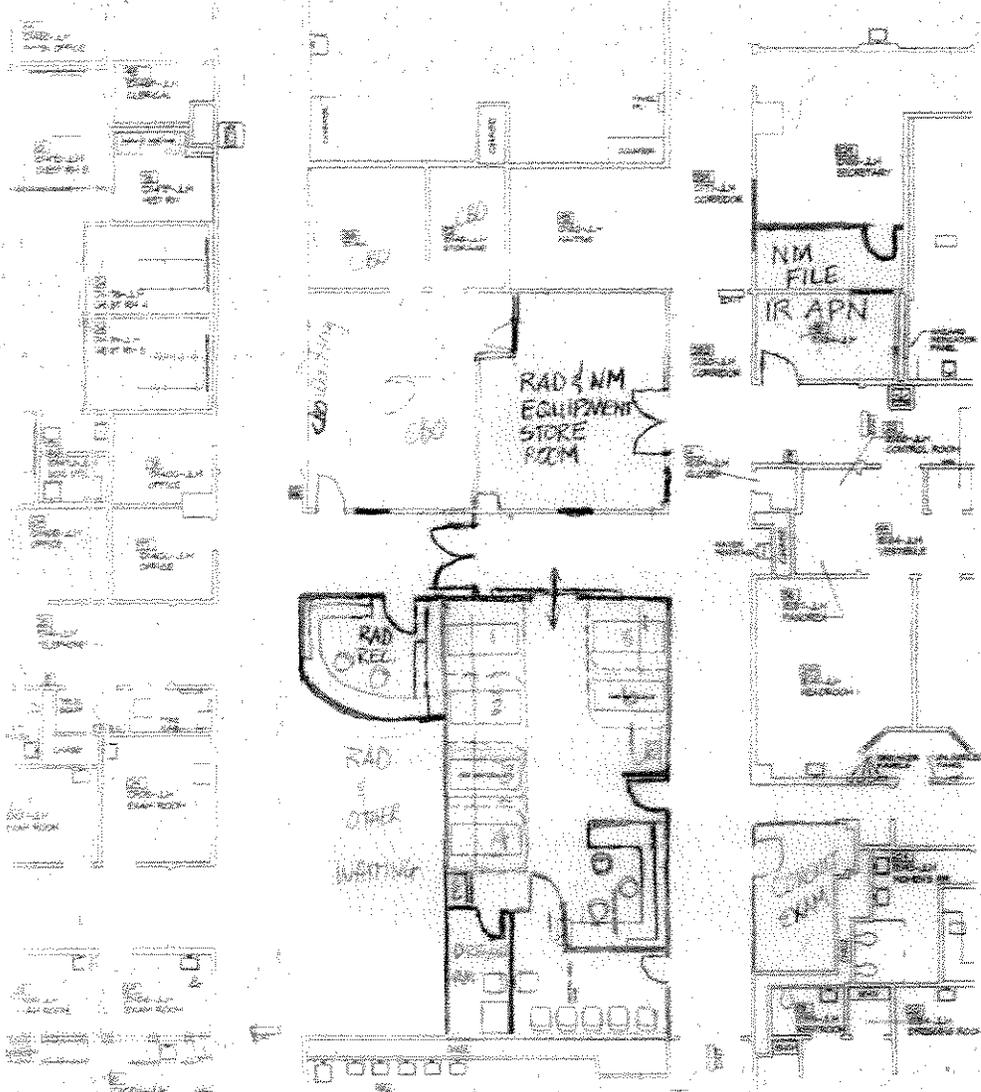
Arguments Con: Option 2 is more expensive in terms of the initial construction costs and may take a few more months to complete but is more logical and feasible to develop now rather than having to expand in the future as is projected if we choose Option 1. This option also will demand more recurring resources eventually. As growth dictates it, we envision activating 4 beds initially and we would have space to quickly add more staff

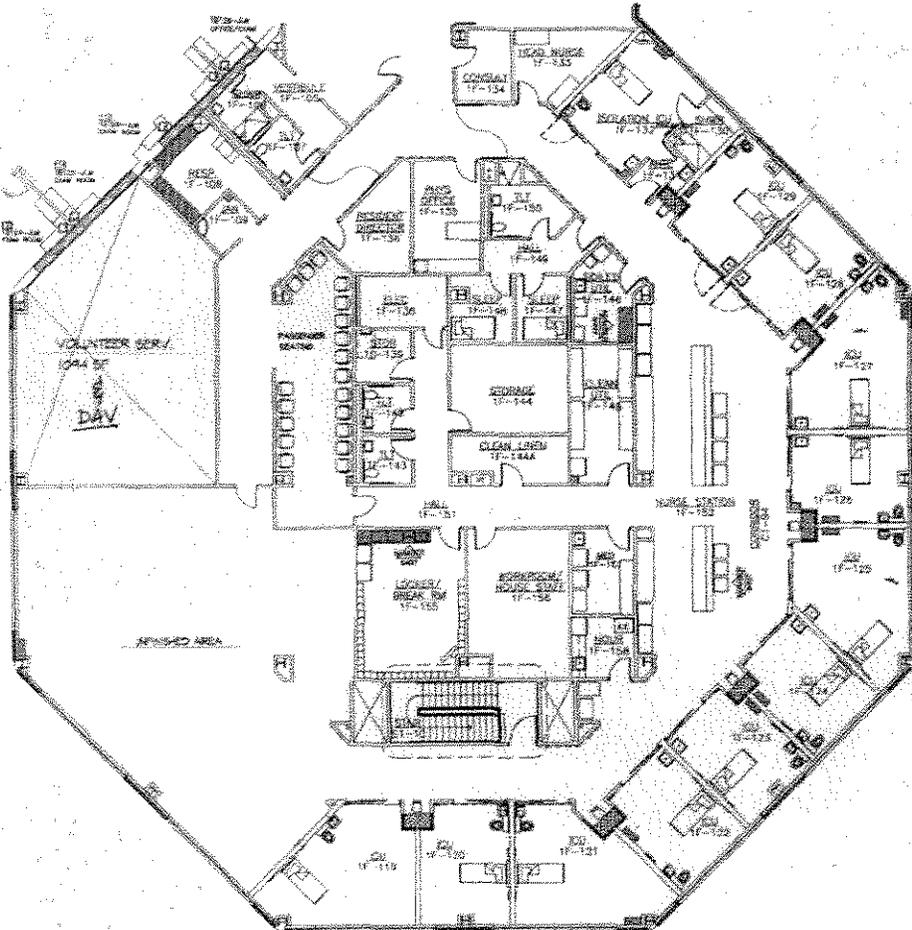
EXISTING



CONCEPT OPTICALZ (6 Bed)

- Vol/DAY to IF
- CBD moves to Vol Space





MODIFIED 1ST FL LAYOUT - IF AREA/ VOL SERV.
 SCALE 1/8" = 1'-0"

later. This will impact our budget and demand shifting of resources but is a much better position to be in that having to outsource much workload while the area is relocated or expanded as would be the case with Option 1. Without this expansion, Radiology cannot grow or develop any new programs.

VIII. RECOMMENDED OPTION: Either option would be acceptable and would meet the immediate patient holding needs of the Service for existing workload. Both options have merit however considering the projected increase in workload as depicted within the HCPM and trends in our known workload, our current lack of adequate equipment storage and staff spaces, we feel Option 2 is the best alternative. Both require almost equal disruption to other services and the need to use equal amount of space in the 1F undeveloped area. Both options attempt to devise a plan to minimize disruption to existing services during construction and it is understood that Option 2 will demand more time and greater care during construction. Option 2 offers the greatest long term benefit from all perspectives. Considering the pros and cons of both options, we further contend that we cannot do anything to negatively impact current efforts to expand the PACT now nor future growth of Specialty Clinics on the first floor at LR, and it is believed that option 2 will be the best overall direction to proceed as it will enhance our ability to meet Specialty space needs.

IX. DISSENTING OPINIONS REGARDING RECOMMENDED OPTION: The most significant impact would entail impacting DAV and Voluntary service spaces and it is understood that they would have to move to 1F or to another floor of the building or there would be numerous domino moves to clear first floor space possibly within the blue atrium. Regardless, both DAV and Voluntary services and even CBO have mentioned adverse impacts to their programs if they cannot remain on the first floor. Both options have reflected what is required to keep them activate and on the first floor and all services have expressed agreement.

X. EFFECT OF RECOMMENDED OPTION ON EXISTING PROGRAMS AND/OR FACILITIES: Without this expansion Radiology cannot grow or develop any new programs. It is even questionable at this point if we should continue to move forward with the installation of the 32 slice CT scanner for IR procedures and the Pain Management C-Arm that is intended to develop a pain management program in Radiology with the collaboration of Neurology and PM&RS if there is not adequate space to provide the appropriate pre and post care that are required. Radiology's involvement in Pain Management is very important to patient care; reducing the use of opiates in our veteran population, improving quality of life, and reducing OR time that is currently being used by Neurology and PM&RS for Pain Management. With the installation of the 32 slice CT scanner, in this area we will be able to increase the number of Interventional Radiology procedures that need to be accomplished under CT; this will also allow us to increase the number of patients seen in for routine CT scans as we will not be required to block time for Interventional Radiology procedures. This will allow us to reduce our wait time for CT exams and reduce our current outsourcing of urgent IR Procedures.

In discussing Option 2's impact with CBO, it is believed that CBO will be placed in good position to continue its efforts to divert patients from the Green atrium. Volunteer /Escort would also be placed near the MICU and have adequate space to provide good coverage and services to families and those having the greatest need for their services.

XI. LEGAL OR LEGISLATIVE CONSIDERATIONS OF THE RECOMMENDED OPTION

None. Staff areas and privacy for Veterans will be enhanced in both options but more definitively within Option 2. There are no general staff areas being negatively impacted so AFGE concerns should be minimal.

XII. BUDGET OR FINANCIAL CONSIDERATIONS OF THE RECOMMENDED OPTION:

Both options will require construction dollars to make the necessary modifications to the area. The estimate cost of these options is as follows:

Option 1:

Construction Costs:

Relocate Voi & DAV to vacant MICU 1F area: \$90,000
Renovate space for 4-bed Pt Holding and create IR APN Office space: \$108,000
Total Construction: \$198,000

Activation Costs:

Furnishings: \$15,000
Equipment/Expendables: \$12,000
Start-up supplies: \$5,000
Total Nonrecurring: \$32,000

Recurring Costs:

Recurring FCP: \$8,000
Staffing: \$ 90,000 (1 RN needed for 4-bed unit)
\$70,000 (1 Rad Tech needed for Pain program)
Total Recurring: \$168,000

Option 2:

Construction Costs:

Relocate Voi & DAV to vacant MICU 1F area: \$90,000
Renovate Atrium space for 6-bed unit Rad/NM Recept, IR APN office, and Equip
Storage space: \$ 216,000
Relocate CBO: \$14,000
Total Construction: \$320,000

Activation Costs:

Furnishings: \$25,000
Equipment/Expendables: \$16,000
Start-up supplies: \$5,000
Total Nonrecurring: \$46,000

Recurring Costs:

Recurring FCP: \$8,000 (4beds) or \$10,000 (6-beds)
Staffing: \$90,000 (1 RN for 4 or 6 bed unit)
\$74,000 (1 LPN when expand from 4 to 6 bed unit)
\$70,000 (1 Rad Tech needed for pain program)

Total Recurring - Initially - \$168,000
Total Recurring - 6bed unit - \$ 244,000 (within 10-18 months or nit FY2014)

NOTE:

An additional RN would be required for either a 4 bed or 6 bed holding unit. An additional LPN would be required for Radiology Service/Nuclear Medicine to effectively operate a 6-bed area. An additional Radiology Technologist would also be needed to operate the pain procedure room but that would be required even if we do not expand. Neurology has agreed to provide nursing support for pain patients to do all pre-assessment on their patients; Radiology would assume the post procedure monitoring of epidural patients.

XIII. PUBLIC RELATIONS OR MEDIA CONSIDERATIONS OF THE RECOMMENDED OPTION:

None

XIV. CONGRESSIONAL OR OTHER PUBLIC OFFICIAL OR AGENCY CONSIDERATIONS OF THE RECOMMENDED OPTION:

None

XV. CONGRESSIONAL OR OTHER PUBLIC OFFICIAL OR AGENCY CONSIDERATIONS OF THE RECOMMENDED OPTION:

IMPLEMENTATION: There are several construction projects in Radiology that should be initiated in the next few months: developing an ultrasound suite to make room for the installation of the 32 slice CT scanner, and the removal, either renovation and installation of the new wide bore MRI. In addition with the purchase of the Claim, there will have to be some modification and moving of existing equipment to make room for its installation. Several of these projects will be turn-key but some may be done internally. The development of this area is critical to Radiology, not only for the pain management initiative but for the increased volume that will be the result of the 32 slice CT scanner that will be used by Interventional Radiology. Lead for this project will be deferred Engineering Service, although Radiology would like to be part of discussions and decision that are made regarding this initiative. Option 2 can be implemented while other work is progressing and even while FACT primary care remains at LR and while we initiate other FACT changes at LR. The North Astoria work could proceed also with only having to work around our reception and waiting areas for patients and for those waiting occasionally for the Chest pain unit and urgent care but there are very few. All other business waiting would relocate to other areas for CEO, Voluntary, and DAV.

XVI. CONCURRENCE FROM AFFECTED SERVICES:

Engineering Service:

[Redacted Signature]

Department of Service Chief

4/17/10
Date

Operational Services:

[Redacted Signature]

Department of Service Chief

[Signature]

DAV Contract:

[Redacted Signature]

Department of Service Chief

[Signature]

Contract Administration:

[Redacted Signature]

Department of Service Chief

[Signature]

Note: This document is a copy of the original copy of a contract and should not be used as a substitute for any original documents. [Redacted]