Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Washington, DC, VA Medical Center

Report No. 06-00627-232 **September 29, 2006**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) conducted a program review of the Washington, DC, Veterans Affairs Medical Center (VAMC or the medical center) during the week of May 22–26, 2006. The purpose of the review was to evaluate selected operations focusing on patient care administration, quality management (QM), and administrative management controls. During the review, the Office of Investigations provided 4 fraud and integrity awareness briefings to 491 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 5.

Results of Review

This review focused on seven areas. The medical center complied with selected standards in the following areas:

- All Employee Survey (AES)
- Diabetes and Atypical Antipsychotic Medications
- Environment of Care (EOC)
- Survey of Healthcare Experiences of Patients (SHEP)

We identified three areas that needed additional management attention. To improve operations we made the following recommendations:

- Improve internal administrative controls over the Contract Nursing Home (CNH) program.
- Strengthen the peer review program, mortality analysis, and adverse event disclosure.
- Ensure documentation of patient notification of mammography results in the medical center's Veterans Health Information Systems and Technology Architecture (VistA).

This report was prepared under the direction of Mr. Randall Snow, JD, Associate Director, and Ms. Gail Bozzelli, RN, Health Systems Specialist, Washington, DC, Office of Healthcare Inspections.

VISN and Medical Center Director Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendices A and B, pages 12–20, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Introduction

Medical Center Profile

Organization. The medical center is a tertiary care hospital that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at community based clinics located in Greenbelt and Charlotte Hall, MD; Alexandria, VA; and southeast Washington, DC. The medical center is part of Veterans Integrated Service Network (VISN) 5 and serves a population of about 48,395 enrolled veterans in a primary service area that includes metropolitan Washington, DC, and selected counties in Maryland and Virginia.

Specialized Programs. The medical center's programs include the following:

- Cardio-Thoracic Surgery
- Eastern Pacemaker Surveillance Center
- Geriatric Rehabilitation
- Home Based Primary Care
- Hospice and Palliative Care
- Information Management Field Office
- Institute for Clinical Research
- National Media Development Center
- Office of Special Projects
- War Related Illness and Injury Study Center

Affiliations and Research. The medical center is affiliated with Howard University School of Medicine, Georgetown University School of Medicine, and George Washington University Medical School.

Resources. In fiscal year (FY) 2005, medical care expenditures totaled $238 million (exclusive of Medical Care Collection Fund collections, alternative revenues, and specific purpose dollars). FY 2005 staffing was 721 full-time equivalent employees (FTE), including 152 physician, 555 nurse, and 14 nurse practitioner FTE.

Workload. In FY 2005, the medical center treated 48,395 unique patients. The inpatient care workload totaled 28,658 admissions, and the average daily census was 188, including long term care patients. The outpatient care workload was 419,269 visits.

Objectives and Scope of the CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations focusing on patient care, quality management, and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration, QM, and management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following seven activities:

All Employee Survey
Breast Cancer Management
Contract Nursing Home Program
Diabetes and Patients on Atypical Antipsychotic Medications
Environment of Care
Quality Management
Survey of Healthcare Experiences of Patients

During this review, we also presented 4 fraud and integrity awareness briefings for 491 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

The review covered facility operations for FY 2005 through May 8, 2006, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Washington, DC VA Medical Center*, Report No. 02-02172-129, July 14, 2003). In this report we summarize selected Focused Inspections and state opportunities for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the section titled "Other Observations" have no reportable conditions.

Results of Review

Opportunities for Improvement

Contract Nursing Home Program

Conditions Needing Improvement. CNH Program Managers needed to improve monitoring and oversight of CNH activities and amend local policies to ensure that veterans receive quality care in safe environments.

Review Team. Veterans Health Administration (VHA) Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, requires that a CNH Review Team be established for evaluation of nursing homes that care for veterans. The CNH Review Team must include a registered nurse, a social worker, and other disciplines as appropriate to evaluate areas of non-compliance. A designated social worker was not available to perform monthly visits to CNHs. The CNH social worker became the CNH Review Team Coordinator and for several months there were no CNH visits by a social worker. Temporary coverage was arranged, but that staff consistently failed to make required visits and /or phone contact with patients in CNHs. Also, initial and annual reviews of CNH for contract award were not properly documented (findings, recommendations, ongoing monitoring, and follow-up services).

Oversight Committee. A CNH Oversight Committee with upper-management level representation was established in May 2006. VHA policy requires oversight of the CNH Review Team to ensure that veterans receive quality care. Facilities with CNH programs must establish a CNH multidisciplinary oversight committee with upper management representation from social work, nursing, quality management, acquisition, and medical staff to effectively administer and monitor the program. The committee is established by the Medical Center Director and is responsible for completing and monitoring mandated CNH reviews.

Policy. The local policy did not reflect the establishment of the Oversight Committee.

Recommended Improvement Action 1: We recommend that the VISN Director ensure that the Medical Center Director requires: (a) social worker and nursing visits are conducted per VHA Handbook 1143.2, (b) continuation of a CNH Oversight Committee activity with multidisciplinary upper-management level representation, (c) amendment of local policy to meet VHA requirements for a CNH Oversight Committee, and (d) use of VA Nursing Home evaluation tools to report adverse events and improve communication between nursing homes and CNH program managers.

Quality Management

Conditions Needing Improvement. The QM program was generally effective, with appropriate review structures in place for 11 of the 14 program activities reviewed. However the peer review process, disclosure of adverse events to patients, and the mortality analysis needed improvement.

Peer Review Process. Peer review is the ongoing evaluation of a provider's professional performance by their colleagues. The Veterans Health Administration (VHA) peer review directive required medical centers to develop a peer review policy by March 4, 2005. The medical center established a peer review program in November 2005. However, the program was not fully implemented at the time of our visit. Prior to that time, there was no coordinated effort to review practice patterns, collect and trend data, and identify areas to improve patient care. The VHA policy also requires completion of all peer reviews within 45 days of discovery of an event. In a random sample of 38 reviews, 7 were not completed within this time frame.

Adverse Event Disclosure. When serious adverse events occur as a result of patient care, VHA policy requires staff to discuss the events with patients, inform them of their right to file tort or benefit claims, and document the notification in the patient's medical record. In a sample of 21 patients who experienced adverse events from January 2005 through May 2006 we found 20 patient medical records with documentation of patient notification; of these 20, only 3 documented advisement of the right to file tort or benefit claims.

Mortality Trending. Although the facility trended deaths in considerable detail including the time and location of the death, it did not trend deaths by individual provider as required by VHA policy.

Recommended Improvement Action 2: We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) the formal peer review program is strengthened, (b) providers complete peer reviews within the 45-day requirement, (c) clinicians fully inform patients who experience adverse events of tort and benefit remedies, and (d) QM Staff trend deaths by individual provider.

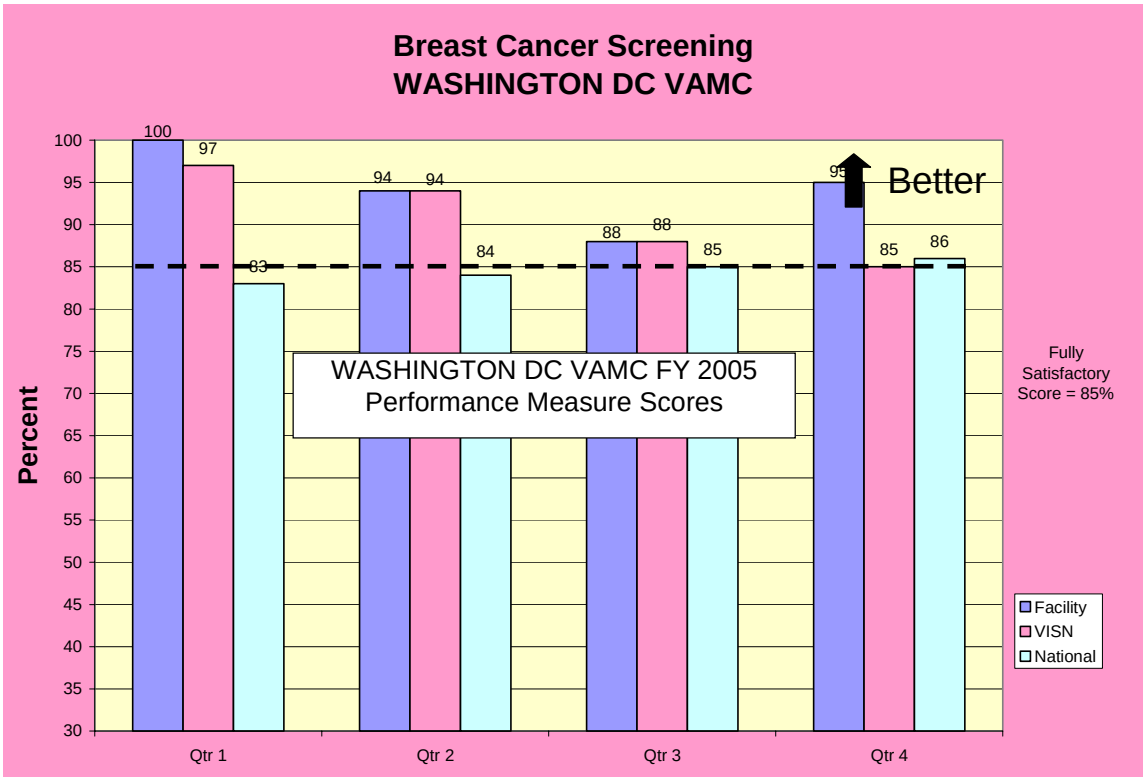
Breast Cancer Management

Condition Needing Improvement. VHA breast cancer screening performance measures assess the percent of patients screened according to prescribed timeframes. Timely screening, diagnosis, communication, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. We assessed these items in a sample of 10 patients who were newly diagnosed with breast cancer. To determine compliance, we used standards outlined in VHA and local

policies. The medical center needed to ensure that patient notification of normal and abnormal mammography results were documented in VistA.

Screening and Referral. The system exceeded the VHA performance measure for breast cancer screening in 2 of the 4 quarters for FY 2005, and exceeded the national standard in all 4 quarters, as indicated in the graph below. Nine of the 10 cases we reviewed received appropriate screening, with 1 case not receiving appropriate screening due to patient issues such as no shows for scheduled appointments.

All 10 patients received mammography results within 30 days, timely biopsy procedures, and timely consultations for general surgery; while 9 of the patients received timely hematology/oncology, and radiation therapy consults. Nine of the patients requiring multiple treatment modalities had documentation of interdisciplinary treatment plans in the medical record. The tenth patient did not require any further treatment after the completion of the biopsy.



Patients appropriately screened	Mammography results reported to patient within 30 days	Patients appropriately notified of their diagnoses	Patients received timely consultations	Patients received timely biopsy procedure	Documentation of interdisciplinary treatment plan
9/10	**10/10**	**10/10**	**10/10**	**9/10**	**9/10**

Documentation of Results Notification. Documentation of patient notification of normal and abnormal results was not recorded in the medical center's VistA. The medical center refers patients to an outside facility to perform mammography. VHA regulation requires entry of all mammography reports, regardless of where they are performed, into VistA. The off-site mammography facility is expected to also provide a written summary of the report to the patient. To ensure continuity of care and compliance with prescribed documentation practices, the notification must be documented in the patient's off-site medical record, as well as in the referring medical center's VistA.

Recommended Improvement Action 3: We recommend that the VISN Director ensure that the Medical Center Director requires documentation of patient notification of mammography results in VistA.

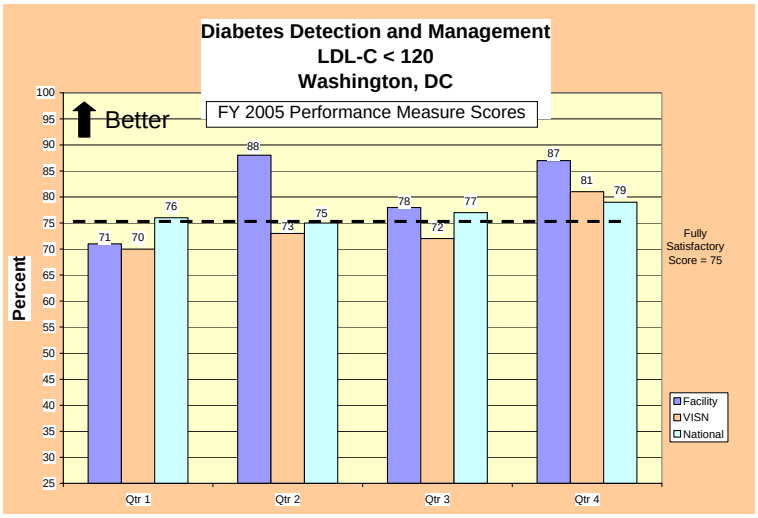
Other Observations

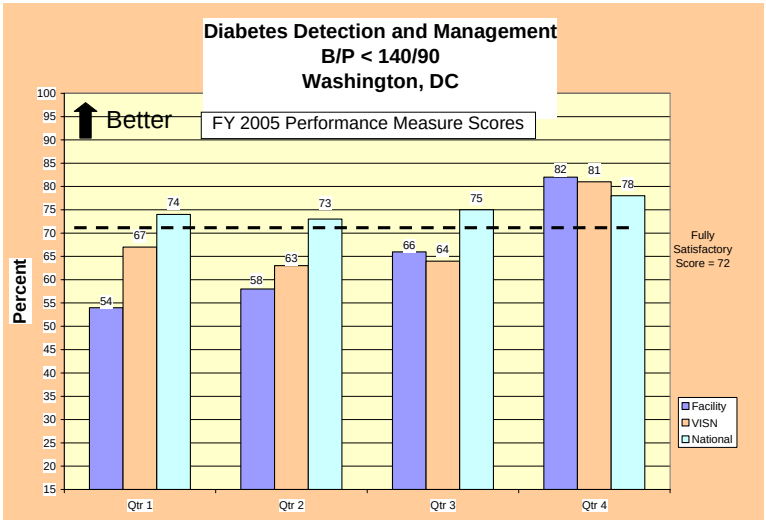
Diabetes and Atypical Antipsychotic Medications

Mental health patients receiving atypical antipsychotic medications (medications that cause fewer neurological side effects but increase the patient's risk for the development of diabetes) require effective diabetes screening, monitoring, and treatment.

VHA clinical practice guidelines suggest that diabetic patients' blood glucose levels be at a therapeutically acceptable level (Hemoglobin A1c (HbA1c) below 9 percent) to avoid symptoms of hyperglycemia; blood pressure should be less than or equal to 140/90 millimeters of mercury (mmHg); and low density lipoprotein cholesterol (LDL-C) should be less than 120 milligrams per deciliter (mg/dl). The system must meet these standards to receive fully satisfactory ratings for these performance measures.

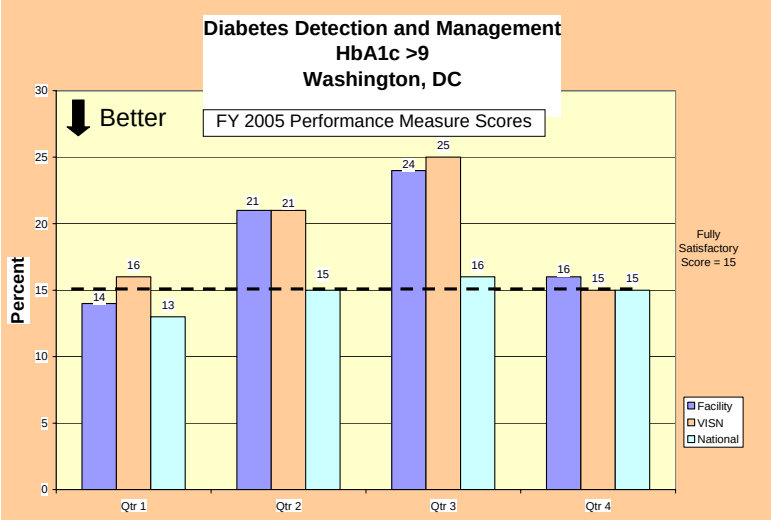
The medical center met or exceeded VHA performance measures for LDL-C of less than 120 mg/dl for the last 5 reporting quarters. Blood pressure management scores consistently improved in FY 2005 and were fully satisfactory for 2 quarters of FY 2006, as demonstrated in the following charts.





The medical center had less than satisfactory scores for FY 2005 for HbA1c, but has taken the following action to improve:

- Measuring HbA1c at the point of care.
- Initiation of a health improvement program for the seriously mentally ill.
- Diabetes monitoring education for patients.
- Addition of a full-time pharmacist in the Diabetes clinic.
- Telehealth program for patients to monitor their blood sugars at home and transmit the data to their medical record electronically.



We reviewed a sample of 13 patients who were on one or more atypical antipsychotic medications for at least 90 days. Two of the 13 had diabetes, which developed after the initiation of atypical antipsychotic medications in both patients. See table for a summary of results.

Diabetic patients with HbA1c more than 9 percent	Diabetic patients with B/P less than 140/90 mm/Hg	Diabetic patients with LDL-C less than 120mg/dl	Non-diabetic patients appropriately screened
1/2	2/2	2/2	11/11

Environment of Care

The purpose of the evaluation is to determine if the medical center maintains a safe and clean healthcare environment. The medical center must establish a comprehensive EOC program that fully meets all VHA, Occupational Safety and Health Administration, and Joint Commission on Accreditation of Healthcare Organizations standards. To evaluate EOC, clinical and non-clinical areas are inspected for cleanliness, safety, infection control, and general maintenance. The medical center maintained a clean and safe environment with no reportable findings.

All Employee Survey

The Executive Career Field (ECF) Performance Plan for FY 2005 directs VISNs to widely disseminate results from the 2004 AES by, at a minimum, conducting a town hall meeting open to all employees at each facility during the rating period. VISNs were

directed to analyze the survey results and formulate plans to address action items for improvements by September 30, 2004. Such plans must demonstrate milestones that include time lines and measures that assess achievement.

The medical center met all requirements of Performance Measure 22 in the ECF performance plan for FY 2005. Facility analysis of the survey results targeted Conflict Resolution, Job Control, and Work and Family Balance as opportunities for improvement. An action plan, which had measurable objectives with identified timelines and milestones, was developed by the September 2004 deadline. Actions taken to improve the work environment are well documented, with an emphasis on communications and customer service. The medical center established a Veterans Service Advocacy Council, which directly deals with employee satisfaction issues. Mandatory customer service training was started in November 2005 for all employees. Survey results and the action plan were disseminated to the employees by e-mail, staff meetings, town hall meetings, newsletters called "Sandygrams" from the Director, and the "Irving Street Journal," an internal medical center publication.

Administration of the 2006 All Employee Survey was completed just prior to the CAP review, and the employee participation rate dramatically increased to 89 percent from 33 percent in 2004.

Survey of Healthcare Experiences of Patients

Veteran patient satisfaction surveying is designed to promote health care quality assessment and improvement strategies that address patients' needs and concerns, as defined by patients. In 1995, VHA began surveying its patients using a standardized instrument modeled from the Picker Institute, a non-profit health care surveying group. The Performance Analysis Center for Excellence of the Office of Quality & Performance is the analytical, methodological, and reporting staff for SHEP. To meet Measure 21 of the VHA Executive Career Field Performance Plan for FY 2006 the medical center must achieve patient satisfaction scores of very good or excellent in 77 percent of outpatients and 76 percent of inpatients surveyed. The following graphs show the medical center's SHEP results for inpatients and outpatients.

Dates of Survey Reporting period:
Q3, Q4 FY 2005

Washington, DC

INPATIENT SHEP RESULTS

Facility Name	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
National	80.73	78.27	89.40	67.36	65.08	75.37	83.35	73.98	69.52
VISN	75.8-	74.5-	85.1-	63.2-	60.1-	74.40	79.6-	69-	66.9-
Medical Center	78.80	76.50	84.2-	66.20	60.9-	74.00	80.1-	67.3-	64.1-

* Less than 30
"+" "-" Indicate Results that are Significantly Better "+" or
Worse "-" than the National

Dates of survey reporting period:
Q1 FY 2006

Washington, DC

OUTPATIENT SHEP RESULTS

	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	81.5	78	95.3	73.1	83.7	76.2	82.6	66.5	82.2	80.7	85.2
VISN	81.2	76.4	95.1	71.5	82.6	76.6	76.5	63.7	81.3	77.9	85.1
Outpatient Clinics - Overall	81.7	83.2	93.5	72.1	85.7	75.7	77.1	61.5	82	80.2	82.9
WASHINGTON OUTPATIENT CLINIC	80.8	84.5	93.2	70.5	85	74.7	*	*	81.2	79.8	82
ALEXANDRIA OUTPATIENT CLINIC	85.3	67.5	93.7	80.4	89.7	76.2	74.3	*	83.4	*	83.5
SOUTHEAST WASHINGTON CBOC	85.6 +	80.9 +	96.8 +	77.9 +	84.9 +	83.2 +	*	*	84.4 +	*	89.5 +
PRINCE GEORGES COUNTY	85.5	71.4	95.8	78.9	89.6	81.5	69.1	*	84.4	*	86.3
CHARLOTTE HALL OUTPATIENT CLINIC	93.3 +	72.1	97	91.5 +	94.7 +	90.3 +	74.7	*	93.1 +	*	94.6 +

* Less than 30 Respondents
"+" "-" Indicate Results that are Significantly Better "+" or
Worse "-" than the National Average

The medical center has an organized, systematic approach to analysis and improvement of SHEP data scores. Data is analyzed daily, and trend lines and appropriate statistics are applied monthly. Actions taken to improve scores include the addition of nursing staff, scripting exercises, and changes in departmental structure to improve pharmacy access. The medical center was awarded the Customer Service Award from the Veterans Affairs Undersecretary for Health for outstanding work in improving emotional support to inpatients. To improve emotional support for patients, the medical center analyzed SHEP and patient compliments/complaints data; the analysis showed a direct correlation to overall satisfaction scores reported by veterans.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 15, 2006

From: Network Director (10N5)

Subject: **Combined Assessment Program Review Washington DC VA**MC

To: Combined Assessment Program Review, Washington DC VAMC

1. Attached please find the action plan for the recommendations from the Office of the Inspector General Combined Assessment Program Review conducted May 22, 2006 - May 26, 2006.

2. We appreciate the professionalism demonstrated by your team during this review process.

3. If you have any questions regarding this report, please contact Mr. Sanford Garfunkel, Director of the Washington DC VAMC at 202-745-8100.

(original signed by:)

JAMES J. NOCKS, M.D., M.S.H.A.

VISN Director's Comments to Office of Inspector General's Report

The following VISN Director's comments are submitted in response to the recommendations in the Office of Inspector General Report:

OIG Recommendations

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) social worker and nursing visits are conducted per VHA Handbook 1143.2, (b) the continuation of a CNH Oversight Committee with multidisciplinary upper-management level representation, (c) local policy is amended to meet VHA requirements for a CNH Oversight Committee, and (d) the use of VA Nursing Home evaluation tools to report adverse events and improve communication between nursing homes and CNH program managers.

Concur **Target Completion Date:** 9/06

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) the formal peer review program is strengthened, (b) providers complete peer review within the 45-day requirement, (c) responsible clinicians fully inform patients, who experience adverse events, of tort and benefit remedies, and (d) QM Staff trend deaths by individual provider.

Concur **Target Completion Date:** 9/06

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Medical Center Director requires documentation of patient notification of mammography results VistA.

Concur **Target Completion Date:** 9/06

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 14, 2006

From: Medical Center Director, Washington, DC VA Medical Center

Subject: **Combined Assessment Program Review of the Washington, DC VA Medical Center**

To: VISN Director, Capitol Health Network, VISN 5 (10N5)

A Combined Assessment Program Review by the Office of the Inspector General was conducted at the Washington VA Medical Center from May 22, 2006 - May 26, 2006. Attached, please find the draft report of the findings and corrective actions. Implementation of the corrective actions is well underway.

If you have any questions or need additional information, please contact Ms. Deborah Amdur at (202) 745-8212.

(original signed by:)

SANFORD M. GARFUNKEL

Medical Center Director

Medical Center Director's Comments to Office of Inspector General's Report

The following Medical Center Director's comments are submitted in response to the recommendations in the Office of Inspector General Report:

OIG Recommendations

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Medical Center Director requires (a) Social worker and nursing visits are conducted per VHA Handbook 1143.2, (b) continuation of a CNH Oversight Committee with multidisciplinary upper-management level representation, (c) amend local policy to meet VHA requirements for a CNH Oversight Committee, and (d) use VA Nursing Home evaluation tools to report adverse events and improve communication between nursing homes and CNH program managers.

Concur: Yes **Target Completion Date:** 9/06

Social Work and Nursing Visits:

In compliance with the VHA Handbook 1143.2, all veterans in Community Nursing Homes under VA Contract are being visited on a monthly basis with nursing and social work visiting on alternating months. Permanent staff is being hired to fulfill these roles; in the interim, existing staff have taken on this additional responsibility.

CNH Oversight Committee:

The CNH Oversight Committee continues to meet quarterly to discuss community nursing home-related issues. Committee representation consists of representatives from social work, nursing, quality management, contracting, and medical staff.

Amendment of Local CNH Policy:

Washington VA Medical Center Community Services Policy Memorandum No. 4 May, 2006, establishes requirements for a CNH Oversight Committee.

Use of VA Nursing Home Evaluation Tools

VA Community Nursing Home Website has been incorporated as the evaluation tool to report adverse events and to improve communication between nursing homes and CNH program managers. The Community Nursing Home Exclusion Review form is being used to document the annual review process for community nursing homes. The monthly visit form is in a template format and is being utilized to provide information that must be evaluated and documented on each community nursing home monthly visit. The Adverse and/or Sentinel Event Reporting form is used to report adverse and/or sentinel events involving contract patients in Community Nursing Homes. The Centers for Medicaid and Medicare (CMS) Website that lists deficiencies, staffing and performance on quality measures for all certified nursing homes is being used by the CNH Review Team. The Annual Certification Report via the CNH Website has been initiated.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director requires (a) strengthening the formal peer review program, (b) providers complete peer review within the 45-day requirement, (c) responsible clinicians fully inform patient's who experience adverse events of tort and benefit remedies, and (d) QM Staff trend deaths by individual provider.

Concur: Yes **Target Completion Date:** 9/06

Peer Review Program: A formal process for peer review is now in place. The Peer Review Committee has met monthly since 5/06. When a case is identified, the records are reviewed by another provider with expertise in the field of the provider(s) in question. Once the records have been reviewed by the provider; the Peer Review Committee then reviews the record as well as the recommendations from the individual

peer review. The Committee decides, based on the review, what action, if any should be taken.

Completion of Peer Reviews: Since 5/06, 9 cases have been peer reviewed. Only one of these cases was not completed in the 45 day time period. During the CAP Review, 38 records were reviewed and 7 were not completed within the 45 day time period. The organization has gone from an 18% delinquent rate to a 10% delinquent rate. This reflects the improvement that has occurred since 5/06. This Medical Center will continue to monitor the timeliness of reviews and expects to be at 100% by 9/06.

Disclosure: A full disclosure process is in place including a templated note that includes all required elements of disclosure. All providers have been educated about the disclosure requirements and the use of the disclosure template. Since 5/06, there has been 1 case of a patient with a serious adverse event. Full disclosure occurred including informing the patient of their right to file a benefit or tort claim. The disclosure was documented in the medical record. The Quality Management Department will continue to monitor all cases for appropriate disclosure and documentation.

Trending of Deaths by Individual Provider: the review of deaths by individual provider was initiated 7/06. QM will begin reporting death trends by individual provider at the Medical Executive Committee in 9/06. This will be done on a quarterly basis.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Medical Center Director requires documentation of patient notification of mammography results VistA.

Concur: Yes **Target Completion Date:** 9/06

Documentation of Patient Notification of Mammography Results:

The following plan is being implemented by the Women's Health Clinic:

The Breast Clinic Surgeon will review all mammogram reports.

For negative reports:

The patient will be informed of their results and the recommended time frame for their next visit telephonically or by mail. Method of notification will be documented in CPRS using an established template.

For all positive reports:

The patient will be notified either telephonically or by mail that there is an abnormal finding on their mammogram report. They will be immediately scheduled for an appointment in the Breast Clinic. The Breast Clinic Surgeon will discuss the results and plan of care with the patient and document this discussion and plan of care in CPRS.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Randall Snow, J.D. Associate Director Regional Office of Healthcare Inspections Washington, DC 202-565-8451
Acknowledgments	Tom Bennett Gail Bozzelli Donna Giroux Nelson Miranda Carol Torczon

Appendix D

Report Distribution

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U.S. House of Representatives: Eleanor Holmes Norton

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