



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

Office of Healthcare Inspections

Report No. 07-03184-77

Combined Assessment Program Review of the John D. Dingell VA Medical Center Detroit, Michigan



February 19, 2008

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is 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.
- 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

During the week of October 22–26, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the John D. Dingell VA Medical Center (the medical center), Detroit, MI. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). We also provided fraud and integrity awareness training to 78 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 11.

Results of the Review

The CAP review covered seven operational activities. We identified the following organizational strength and reported accomplishment:

- The medical center earned the Energy Star for 2 years.

We made recommendations in six of the activities reviewed; five were repeat recommendations from the prior CAP review. For these activities, the medical center needed to:

- Meet Veterans Health Administration (VHA) requirements for peer reviews (PRs).
- Ensure that the Patient Advocate critically analyzes and reports patient complaint data.
- Conduct an independent review of the 11 patients who were cited in this review as having adverse outcomes to ensure that VHA policy is followed.
- Inform the patients identified by our review and/or their representatives of their rights to file a claim and ensure that these discussions are documented.
- Initiate patient incident reports, as required.
- Establish a collaborative disclosure process.
- Ensure that managers and staff are educated on adverse event disclosure processes.
- Take action to ensure that QM, the Risk Manager (RM), and other key staff members establish a process to review and monitor the adverse event disclosure process so that improvements can be made.
- Ensure that root cause analysis (RCA) reviews are implemented and completed in accordance with VHA policy.

- Require that data on medication reconciliation be tracked and trended to identify opportunities for improvement and that results be presented to the Healthcare Leadership Committee (HLC) for action.
- Ensure that utilization management (UM) data is tracked and trended to identify opportunities for improvement.
- Ensure that a physician is assigned to UM as an advisor and receives training.
- Conduct inter-rater reliability reviews in accordance with VHA policy.
- Ensure that moderate sedation data is trended and presented to the appropriate committee for review.
- Analyze and refer resuscitation data to the HLC for review.
- Update computerized patient record system (CPRS) business rules to ensure full compliance with VHA policy.
- Develop an action plan to improve patient satisfaction and overall scores and identify specific staff responsibilities.
- Include nurse managers in environment of care (EOC) rounds.
- Address identified housekeeping issues.
- Ensure that appropriate position risk and sensitivity designations are made for community based outpatient clinic (CBOC) employees.
- Complete the appropriate level of background screening for CBOC employees.
- Ensure that patient notification of abnormal mammography results is documented in the medical record.
- Ensure that mammography services are completed by the contract provider within 30 days.

The medical center complied with selected standards in the following activity:

- Surgical Care Improvement Project (SCIP).

This report was prepared under the direction of Verena Briley-Hudson, Director, Chicago Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with all findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 22–32 for the full text of the Directors’ comments.) We will follow up on all planned actions until they are completed.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
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Introduction

Profile

Organization. The medical center is a tertiary facility located in Detroit, MI, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at two CBOCs in Pontiac and Yale, MI. The medical center is part of VISN 11 and serves a veteran population of about 331,000 throughout Wayne, Oakland, Macomb, and St. Clair counties.

Programs. The medical center provides acute medical, surgical, psychiatric, neurological, and dermatological inpatient care. Primary care services, medical services, and surgical specialties are also provided, including mental health clinics, substance abuse treatment, a day activity center, and a community based psychiatric program. The medical center has 109 hospital beds, 108 nursing home beds, and 50 domiciliary beds.

Affiliations and Research. The medical center is affiliated with Wayne State University's School of Medicine and provides training for approximately 75 medical residents, as well as other disciplines, including audiology and speech pathology, dentistry, dietetics, nursing, optometry, podiatry, psychology, rehabilitation medicine, social work, and surgical auxiliaries. In fiscal year (FY) 2007, the medical center's research program had 29 projects and a budget of \$3.6 million in VA grant funding.

Resources. In FY 2007, medical care expenditures totaled \$228.6 million. FY 2007 staffing was approximately 1,479 full-time employee equivalents (FTE), including approximately 95 physician and 237 registered nurse FTE.

Workload. In FY 2007, the medical center treated 37,612 unique patients and provided 25,385 inpatient days in the Nursing Home Care Unit (NHCU). The inpatient care workload totaled 3,737 discharges, and the average daily census, including nursing home patients, was 128. Outpatient workload totaled 358,215 visits.

Objectives and Scope

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 administration and QM.
- 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 and QM. 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.

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:

- Breast Cancer Management.
- CBOCs.
- CPRS Business Rules.
- EOC.
- QM.
- SCIP.
- Survey of the Healthcare Experiences of Patients (SHEP).

The review covered medical center operations for FY 2007 and FY 2008 through October 26, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the John D. Dingell VA Medical Center, Detroit, Michigan*, Report No. 06-03480-54, January 5, 2007).

We also presented three fraud and integrity awareness briefings for 78 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.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the “Review Activities Without Recommendations” section have no reportable findings.

Organizational Strength

Medical Center’s Efforts Earn the Energy Star

In 2006, as a part of the VA’s in-house automated benchmarking system,¹ medical center managers started tracking energy performance through the Environmental Protection Agency’s energy performance rating system. These efforts earned the medical center the Energy Star² in 2006 and 2007. Highlights from this energy efficiency project are communicated to employees through bi-weekly publications. Employees are also encouraged to be more energy efficient at home by setting their thermostats at 68 degrees in winter and 75 degrees in summer.

Energy management activities included:

- Establishing setback times on air handling units.
- Ensuring preventive maintenance of boilers and heating, ventilation, and air-conditioning systems.
- Reducing peak-hour energy usage by installing a million gallon storage system.
- Initiating the replacement of all large lamps with smaller, more efficient lamps.
- Updating 95 percent of all fans with efficient motors.
- Utilizing outside air for heating and cooling.

Medical center managers are continually geared towards implementing the most economical and environmentally friendly projects to ensure maximum returns.

¹ Tool for tracking utility usage and costs.

² Government program that helps businesses and individuals save money and protect the environment through superior energy efficiency.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the medical center's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the medical center Director, Chief of Staff (COS), and key employees. Senior managers were supportive of performance improvement (PI) activities and were actively recruiting to fill the QM Manager position. The Associate Director currently serves as the Acting QM Manager. We identified eight program areas that required further management attention.

Peer Review Process. The PR process needed to be improved to ensure effective communication, timely completion of reviews, and identification of trends that would lead to process improvement. This was a recommendation from our prior CAP review.

Minutes from the PR Committee were not submitted to the HLC, as required by VHA policy.³ The PR Committee meets monthly; however, the last recorded minutes were for June 2007. No formal minutes were generated or submitted to the HLC for July, August, and September 2007. The HLC did not meet in August. Staff informed us that PR data was presented to the committee during July and September, but no formal minutes were generated. Our review of HLC minutes showed that for July and September, PR data was deferred with no further discussions.

Once the need for a PR is determined, VHA and medical center policies require initial reviews to be completed within 45 days and PR Committee evaluations to be completed within 120 days. A review of the PR data showed that of the 43 PRs performed during FY 2007, 6 took more than 45 days for completion of the initial review, and 15 took more than 120 days for final evaluation by the committee.

Individual PRs were tracked and trended by rating levels⁴ and by changes from one rating level to another.

³ VHA Directive 2004-054, *Peer Review for Quality Management*, September 29, 2004.

⁴ Peer reviews are assigned an individual rating: Level 1 – Most practitioners would have managed the case similarly; Level 2 – Most practitioners might have managed the case differently; Level 3 – Most practitioners would have managed the case differently.

Documentation shows that out of 21 PRs rated as Level 3, 1 PR rating was changed to a Level 2, and 1 PR rating was changed to a Level 1. However, follow-up actions were not identified, and processes were not improved.

Patient Complaints. Patient complaints were collected and aggregated in reports that were presented to the HLC during FY 2006; however, this was not done for FY 2007 until September. This was a recommendation from our prior CAP review. In September, the Patient Advocate began collecting patient complaint data to identify problems. Patient complaint data was graphed for the 1st, 2nd, and 3rd quarters of FY 2007. We were informed that this information was shared with the Chief of Primary Care and with primary care staff; however, it was not presented in any clinical forum, such as the HLC. Therefore, no action was taken to improve the identified areas.

Adverse Event Disclosure. An adverse event is any untoward incident, therapeutic misadventure, iatrogenic⁵ injury, or other undesirable occurrence directly associated with care or services provided within the jurisdiction of a medical center, outpatient clinic, or other VHA facility. The phrase “disclosure of adverse events” refers to the forthright and empathetic discussion of clinically significant facts between providers and/or other VHA personnel and patients or their representatives about the occurrence of an adverse event that resulted in patient harm or could result in harm in the foreseeable future. VHA recognizes two types of adverse event disclosure:

(a) Clinical Disclosure of Adverse Events. This is an informal process to inform patients or their representatives of harmful adverse events related to the patient’s care. In a clinical disclosure, one member (or more) of the clinical team provides factual information to the extent it is known, expresses concern for the patient’s welfare, and reassures the patient or representative that steps are being taken to investigate the situation, remedy any injury, and prevent further harm. Clinical disclosure needs to be considered a routine part of clinical care and needs to be made by the attending or senior practitioner or designee.

⁵ Induced in a patient by a physician’s activity, manner, or therapy (for example, an infection or other complication of treatment).

(b) Institutional Disclosure of Adverse Events. In cases involving potential legal liability or resulting in serious injury or death, the more formal process of institutional disclosure is needed. In an institutional disclosure, the patient or representative and any family members designated by the patient or representative are invited to meet with institutional leaders and others, as appropriate. An apology is made, and when appropriate, information about and procedures available to request compensation is provided.

When adverse events occur as a result of patient care, VHA policy⁶ requires staff to discuss the events with the patients or their representatives. The medical center Director is responsible for:

- Ensuring that staff members involved in adverse events and subsequent disclosure processes are provided with adequate support systems.
- Ensuring that as part of the disclosure process, patients or their representatives are offered appropriate options, such as arrangements for a second opinion, additional monitoring, expedited clinical consultations, or bereavement support.
- Ensuring that patients or their representatives are made aware of their rights under 38 U.S.C. Section 1151, informed about the tort claim process, and provided with information concerning where to obtain assistance in filling out the necessary forms.

We reviewed 11 surgical physician disclosure template notes documented in CPRS. All documentation was within VHA policy; however, there was no documentation in the progress notes about the complications or adverse events and no documentation to show that the patients were advised of their rights to file a claim.

Further, there was no evidence of a collaborative approach between the COS, the RM, Regional Counsel, and the treatment team for appropriate adverse event disclosure. There were no processes in place to ensure that clinical providers notified the RM of adverse events; therefore, there was no coordination for disclosure as outlined in VHA and medical center⁷ policy.

⁶ VHA Directive 2005-049, *Disclosure of Adverse Events to Patients*, October 27, 2005.

⁷ Medical Center Memorandum 11-61, *Disclosure of Adverse Events*, May 10, 2006.

Additionally, we found that 11 patient incident reports were required, but 3 were never initiated. If proper procedures had been followed, incidents could have been referred to the appropriate clinical managers and administrative leaders for further review and action.

Root Cause Analysis. Timely and complete RCAs are a critical component of an effective and efficient patient safety program. One aggregated RCA that was due in September 2007 was incomplete at the time of our visit. We were informed that this review was still pending due to a late start. Four individual RCAs were completed during the past 12 months; however, not all were completed within the 45-day requirement. An action plan was presented to senior managers with target dates for completion.

Medication Reconciliation. National Patient Safety Goal 8 requires that facilities accurately reconcile all medications across the continuum of care and compile a complete list of each patient's medications upon admission, transfer, and discharge. We were informed that opportunities for improvement were identified but had not been presented to the HLC for action.

Utilization Management Program. UM data was not tracked and trended to identify system problems. We were informed that unanalyzed data is presented and discussed in UM Committee meetings; however, the committee did not notate any system problems or identify any opportunities for improvement.

Medical center managers did not comply with VHA⁸ or medical center policy⁹ in regards to assigning a physician advisor to serve as a third party reviewer for all cases not meeting standardized criteria. We were informed that patients with third party insurance coverage were referred to a physician advisor; however, non-insured patients were not referred.

Inter-rater reliability¹⁰ reviews were being conducted only for non-insured patients. Monthly reports showed that the UM nurse and the Medical Care Cost Recovery Program review nurse conducted reliability reviews on 10 random non-insured patient cases. Reports were submitted to the

⁸ VHA Directive 2005-009, *Utilization Management Policy*, March 7, 2005.

⁹ Medical Center Memorandum 11-62, *Utilization Management Policy*, October 26, 2006.

¹⁰ Inter-rater reliability is the extent to which two or more individuals agree.

UM Committee; however, the reports showed no trending analysis.

Moderate Sedation. Outcomes of moderate sedation administration are monitored monthly throughout the medical center. Data from these monitors were not trended for analysis. We were informed that trending started in July 2007. However, our document review did not reveal that the trended data was presented to the HLC for action.

Review of Resuscitation Episodes. Medical center managers collect data that measures the outcomes of all patient resuscitation episodes (referred to as codes¹¹). We reviewed Cardiopulmonary Resuscitation (CPR) Committee minutes from October 2006–January 2007 and for April 2007. There were no minutes for February and March 2007. Discussion about code data was deferred during October, November, and December 2006 CPR Committee meetings. During the January 2007 CPR Committee meeting, there was a brief discussion regarding action plans, but no data analysis was presented. The April 2007 CPR Committee meeting noted that code sheets would be reviewed. However, there was no presentation of trended data analysis and no evidence that code data was presented to the HLC.

Recommendation 1

We recommended that the VISN Director ensure that the Medical Center Director takes action to meet VHA requirements for PRs.

The VISN and Medical Center Directors agreed with the finding and recommendation. Effective December 2007, the minutes of the PR Committee will be submitted on a monthly basis to the HLC on Clinical Care for review. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 2

We recommended that the VISN Director ensure that the Medical Center Director requires the Patient Advocate to conduct critical analyses of patient complaint data and present results to the HLC for action.

The VISN and Medical Center Directors agreed with the finding and recommendation. A review of patient complaint data was conducted, and primary care managers will

¹¹ A medical emergency in which a team of medical personnel work to revive an individual in cardiac arrest.

develop a PI plan. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 3

We recommended that the VISN Director ensure that the Medical Center Director conducts an independent review of the 11 patients who were cited in this review as having adverse outcomes to ensure that VHA policy is followed.

The VISN and Medical Center Directors agreed with the finding and recommendation. Each of the cases will have a thorough review with the findings documented and appropriate actions taken. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 4

We recommended that the VISN Director ensure that the Medical Center Director requires staff to inform the patients identified by our review and/or their representatives of their rights to file a claim and ensures that these discussions are documented in accordance with VHA policy.

The VISN and Medical Center Directors agreed with the finding and recommendation. The RM will conduct training and work in conjunction with the COS or designee to notify all 11 patients or their representatives regarding VA and Veterans Benefits Administration benefits. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 5

We recommended that the VISN Director ensure that the Medical Center Director requires that the three patient incident reports that were never initiated be immediately initiated and completed, as required.

The VISN and Medical Center Directors agreed with the finding and recommendation. The three patient incident reports were completed December 7, 2007. The corrective action is acceptable, and we consider this recommendation closed.

Recommendation 6

We recommended that the VISN Director ensure that the Medical Center Director takes action to establish a collaborative disclosure process to ensure that patients are appropriately informed.

The VISN and Medical Center Directors agreed with the finding and recommendation. Staff will be provided with

training. Presentations to patients and their families will be accomplished by the attending physicians. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 7

We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that managers and staff are educated on the adverse event disclosure requirements and responsibilities outlined in VHA and medical center policy.

The VISN and Medical Center Directors agreed with the finding and recommendation. Training will be provided to appropriate staff, and an electronic link to the adverse event disclosure policy will be sent to all licensed practitioners by the RM. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 8

We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that QM, the RM, and other key staff members establish a process to review and monitor the adverse event disclosure process so that improvements can be made.

The VISN and Medical Center Directors agreed with the finding and recommendation. A data collection tool will be developed, and the RM will review all reported adverse events. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 9

We recommended that the VISN Director ensure that the Medical Center Director requires that RCAs are completed in accordance with VHA policy.

The VISN and Medical Center Directors agreed with the finding and recommendation. An action plan was developed to address issues related to timely completion of the RCA process and team responsibilities. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 10

We recommended that the VISN Director ensure that the Medical Center Director requires that data on medication reconciliation be tracked and trended to identify opportunities for improvement and that results be presented to the HLC for action.

The VISN and Medical Center Directors agreed with the finding and recommendation. The Patient Safety Manager will develop a template to review medical records for medication discrepancies and medication reconciliation. Aggregated data will be presented to the HLC for action. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 11

We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that UM data is tracked and trended to identify opportunities for improvement and that UM data is presented to the HLC for action.

The VISN and Medical Center Directors agreed with the finding and recommendation. On December 5, 2007, UM data were graphed. Data will be presented at the HLC for Organizational Performance meeting. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 12

We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that a physician advisor is assigned to the UM program and receives appropriate training.

The VISN and Medical Center Directors agreed with the finding and recommendation. On October 30, 2007, a trained physician advisor was assigned to the utilization review process. The corrective action is acceptable, and we consider this recommendation closed.

Recommendation 13

We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that inter-rater reliability reviews are conducted in accordance with VHA policy.

The VISN and Medical Center Directors agreed with the finding and recommendation. There will be an increase of inter-rater reliability reviews. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 14

We recommended that the VISN Director ensure that the Medical Center Director requires that moderate sedation data be tracked and trended to identify opportunities for

improvement and that trended data be presented to the HLC for action.

The VISN and Medical Center Directors agreed with the finding and recommendation. The Conscious Sedation Committee will ensure that all providers utilize the conscious sedation monitor to input data on every patient. All identified opportunities for improvement will be presented to the HLC. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 15

We recommended that the VISN Director ensure that the Medical Center Director requires that code data be tracked and trended to identify opportunities for improvement and that code data be presented to the HLC for action.

The VISN and Medical Center Directors agreed with the finding and recommendation. FY 2008 data is being trended and will be presented to the HLC for Organizational Performance at the January 2008 meeting. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

**Computerized
Patient Record
System Business
Rules**

The purpose of this review was to determine whether business rules complied with VHA policy.¹² VHA Handbook 1907.01 specifically states that “no edit, reassignment, deletion, or alteration of any documentation after the manual or electronic signature has been completed can occur without the approval of the Health Information Management professional or the Privacy Officer (PO).” CPRS business rules are facility-specific and define the functions certain groups or individuals may perform in the medical records within that facility.

A communication (software informational patch¹³ USR*1*26) was sent from the VHA Office of Information (OI) on October 20, 2004, to all medical centers, providing guidance on a number of issues related to the editing of electronically signed documents in the electronic medical records system. The OI cautioned that “the practice of editing a document that was signed by the author might have a patient safety implication and should not be allowed.” On June 7, 2006, VHA issued a memorandum to all VISN Directors instructing

¹² VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

¹³ A patch is a piece of software that can be an upgrade, fix, or update to address new issues, such as security problems.

all VA medical centers to comply with the informational patch sent in October 2004.

We reviewed VHA and medical center policies and interviewed the Chief of Health Information Management Service (HIMS), the PO, and clinical coordinators. One business rule did not limit retraction, amendment, or deletion of signed medical record notes to the PO or the Chief of HIMS. Medical center staff took immediate action to remove this business rule while we were onsite.

Recommendation 16

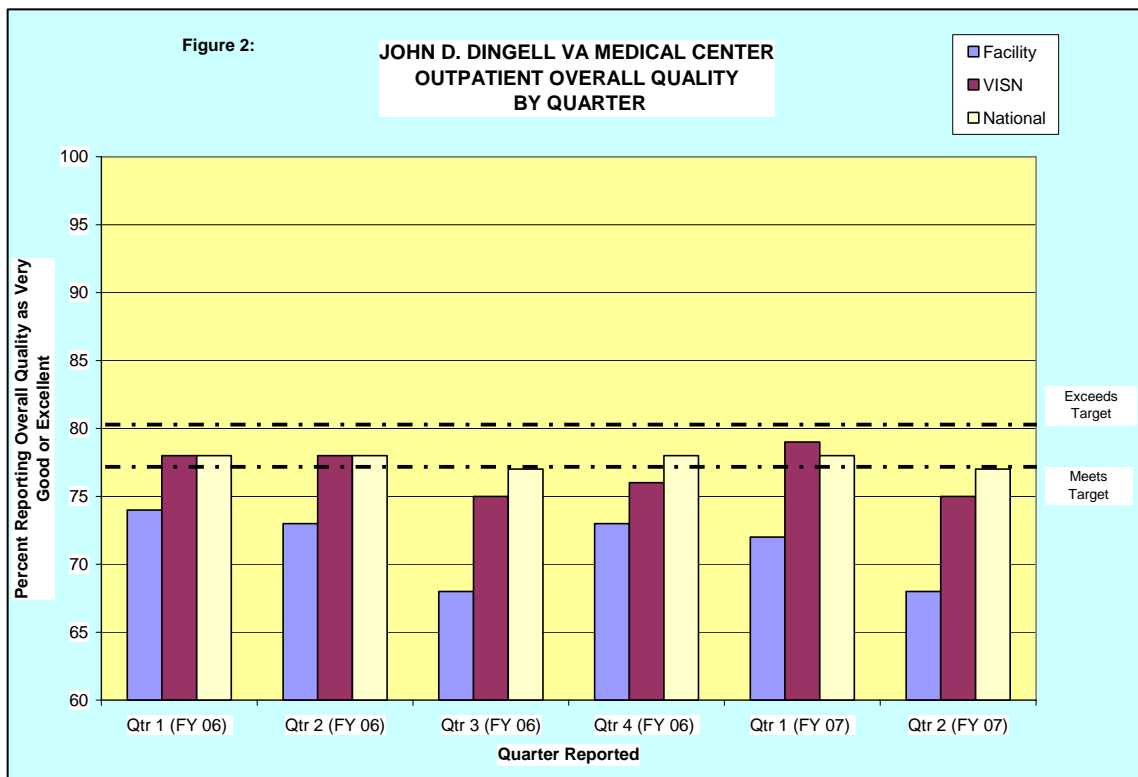
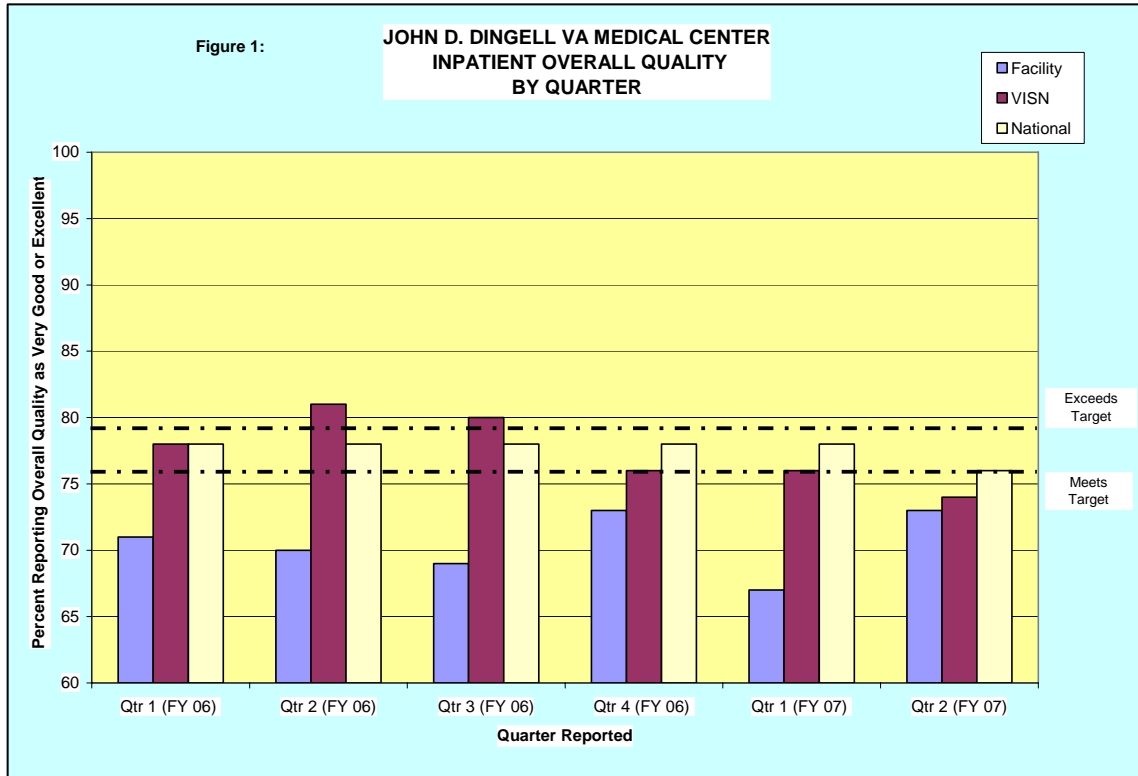
We recommended that the VISN Director ensure that the Medical Center Director requires that CPRS business rules comply with VHA policy and OI guidance related to altering signed medical record notes.

The VISN and Medical Center Directors agreed with the finding and recommendation. All business rules related to the documentation of patient care will be assessed on a monthly basis. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

**Survey of
Healthcare
Experiences of
Patients**

The purpose of this review was to assess the extent that VHA medical centers use the quarterly/semi-annual survey report results of patients' health care experiences with the VHA system to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical, methodological, and reporting staff for SHEP. VHA set performance measure (PM) target results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients.

Figure 1 on the next page shows the SHEP PM results for inpatients. Figure 2 on the next page shows the SHEP PM results for outpatients.



The medical center's SHEP PM scores have been under the established targets for the last 6 quarters of available data. Medical center managers have identified opportunities for improvement based on the SHEP survey scores and have developed an action plan that has measurable and achievable goals. There is one full-time employee dedicated to patient advocacy. Medical center managers are currently recruiting for an additional Patient Advocate. During our review, medical center managers received data from VISN 11 reflecting improved outpatient satisfaction scores.

We reported findings in this area during the prior CAP review. At that time, we were informed that patient complaint data would be collated monthly and evaluated to identify patient concerns that required prompt attention in an effort to improve suboptimal patient satisfaction scores. We could not validate that this process had been established.

Recommendation 17

We recommended that the VISN Director ensure that the Medical Center Director develops an action plan to improve patient satisfaction and overall scores and identifies specific staff responsibilities.

The VISN and Medical Center Directors agreed with the finding and recommendation. Patient care concerns are documented and submitted to the patient representative for action. A focus group will meet with outpatients on a weekly basis to discuss SHEP questions. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Environment of Care

The purpose of this review was to determine if the medical center had established a comprehensive EOC program that contributed to a safe and clean environment, complied with safety standards and guidelines, maintained an effective infection control program, and identified hazards that might pose a safety threat to patients and staff in locked acute mental health units.

We inspected four patient care units (the NHCU, the surgical unit, surgical intensive care, and locked mental health) and followed up on findings and recommendations from our prior CAP review. Managers were responsive to environmental concerns identified while we were onsite. The infection control program monitored, trended, analyzed, and reported data to clinicians for implementation of quality improvements. The Multidisciplinary Safety Inspection Team conducted a

risk assessment of the locked mental health unit, and staff initiated corrective actions. The following deficiencies required further management attention.

Environment of Care Rounds. The EOC rounds team conducts unannounced inspections of every clinical and administrative area twice yearly. However, we found that nurse managers of patient care areas have generally not been included in these inspections. Because nurse managers are aware of housekeeping practices, work order response times, and other environmental issues, they should be included in the inspections of their areas.

Housekeeping Issues. Nurse managers expressed concern over limited housekeeping availability on weekends that resulted in overflowing trash receptacles and dirty linen containers. Staff also expressed concerns that housekeepers might need additional training on the proper cleaning of rooms for patients diagnosed with multi-drug resistant organisms.

During the prior CAP review, we identified opportunities for staff to improve general cleaning practices in preparation for new patient admissions. In response to our recommendation, managers developed a checklist for use by Environmental Management Service (EMS) supervisors and provided training for EMS staff. The Chief of EMS reported that supervisors complete two or more checklist forms per month to evaluate cleaning of made-ready rooms. Our inspection revealed that further interventions were warranted. For example, staff needed to ensure that all items, including sterile supplies, are removed from bedside stands; air system covers are cleaned; and all patient care equipment is sanitized.

Recommendation 18

We recommended that the VISN Director ensure that the Medical Center Director requires that nurse managers are included in EOC rounds in their respective areas.

The VISN and Medical Center Directors agreed with the finding and recommendation. Nursing leadership will rotate participation in weekly environmental rounds. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 19 We recommended that the VISN Director ensure that the Medical Center Director requires that identified housekeeping issues are addressed.

The VISN and Medical Center Directors agreed with the finding and recommendation. All EMS supervisors will be required to do 10 made-ready room inspections weekly to ensure compliance with medical center policies. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Community Based Outpatient Clinics The purpose of this review was to follow up on our prior CAP review recommendations by determining whether CBOCs are in compliance with selected standards of operations. Our prior review found that the medical center needed to improve the process for completing background screenings of individuals who provide care to patients and to verify information on the criminal background of appointees.

We reviewed background screenings for 19 Yale and 12 Pontiac CBOC personnel and found that 2 of the Yale CBOC personnel, a pharmacist and a transcriptionist, did not have the required security clearances. Additionally, medical center managers did not track or monitor background screening documentation and were unaware of this deficiency. Both contracted personnel had been employed at the CBOC for several years, and both have access to VA computer systems and patient and other sensitive information.

Recommendation 20 We recommended that the VISN Director ensure that the Medical Center Director requires the Contracting Officer to ensure that appropriate position risk and sensitivity designations are made.

The VISN and Medical Center Directors agreed with the finding and recommendation. The Contracting Officer will receive a completed VA Form 2280, "Position Risk and Sensitivity Level Designation," from the Contracting Officer Technical Representative/Program Official and will initiate the National Agency Check and Inquiries (NACI) background security check for contractor employees within 10 workdays after contract award. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 21

We recommended that the VISN Director ensure that the Medical Center Director requires the Contracting Officer to ensure that appropriate levels of background screening are monitored and tracked to completion.

The VISN and Medical Center Directors agreed with the finding and recommendation. A quarterly monitor will be implemented requiring all Contracting Officers to review their contracts. The supervisory Contracting Officer will update the Network Contract Manager of any pending or incomplete background security checks. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Breast Cancer Management

The purpose of this review was to follow up on our prior CAP review recommendations and to validate implementation of the action plan submitted in response to those recommendations. During our prior review, we found that providers needed to document patient notification of abnormal mammography results in the medical record. Additionally, we found that mammography services needed to be completed by the contractor within 30 days.

An action plan was submitted in response to the recommendations. The plan stated that performance monitors would be implemented to ensure that providers documented patient notification of results. We were also informed that a performance monitor would be initiated to ensure that examinations were appropriately scheduled. We were unable to validate the implementation of the performance monitors. We found that staff were tracking timeliness of treatment; however, trending and analysis of the data had not been initiated.

Recommendation 22

We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that providers document patient notification of abnormal mammogram results in the medical record.

The VISN and Medical Center Directors agreed with the finding and recommendation. A performance monitor was created and implemented in October 2007. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 23

We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that mammography services are completed by the contract provider within 30 days.

The VISN and Medical Center Directors agreed with the finding and recommendation. Training on scheduling appointments within 30 days has been completed for supervisors and the Director of the affiliate mammography center. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Review Activities Without Recommendations

Surgical Care Improvement Project

The purpose of this review was to determine if clinical managers implemented strategies to prevent or reduce incidences of surgical infections for patients having major surgical procedures. Surgical infections present significant patient safety risks and contribute to increased post-operative complications, mortality rates, and health care costs.

We evaluated the following VHA PM indicators:

- Timely administration of prophylactic antibiotics to achieve therapeutic serum and tissue antimicrobial drug levels throughout the operation. Clinicians should administer antibiotics within 1–2 hours prior to the first surgical incision. The time of administration depends on the antibiotics given.
- Timely discontinuation of prophylactic antibiotics to reduce risk of the development of antimicrobial resistant organisms. Clinicians should discontinue antibiotics within 24–48 hours after surgery. The time depends on the surgical procedure performed.
- Controlled core body temperature for colorectal surgery, which should be maintained at greater than or equal to 36 degrees Celsius or 96.8 degrees Fahrenheit immediately post-operative. Decreased core body temperature is associated with impaired wound healing.

VHA set target PM scores for each of the above indicators. The medical center did not meet the fully satisfactory rating of 70 percent for body temperature monitoring following colorectal surgery during the last 3 reported quarters. To improve this PM, managers had developed appropriate

action plans, monitored the efficacy of the actions, and communicated the results to staff. Actions included closer operating room temperature monitoring and use of electronic warming devices, warm blankets, and fluids. Nursing staff were also encouraged to record patients' temperatures on flow sheets after surgery and at regular intervals thereafter to ensure that actions were effective.

We reviewed 30 surgical patients' medical records from quarter 3 of FY 2007. The review included medical records for each of the following surgical categories: (1) colorectal, (2) vascular, (3) orthopedic (knee or hip replacement), and (4) hysterectomy.

Our review showed that medical center employees timely started and discontinued antibiotics or documented clinical reasons for continued antibiotic use. Clinicians controlled immediate post-operative body temperature for the patients who had colorectal surgery. We made no recommendations.

VISN Director Comments

Department of
Veterans Affairs

Memorandum

Date: December 7, 2007

From: VISN Director (10N11)

Subject: **Combined Assessment Program Review of the
John D. Dingell VA Medical Center, Detroit, Michigan**

To: Director, Chicago Healthcare Inspections Division (54CH)
Director, Management Review Service (10B5)

Per your request, attached is the response from Detroit VAMC. If you have any questions, please contact Jim Rice, VISN 11 QMO, at (734) 222-4314.



Linda W. Belton, FACHE

Attachments

Medical Center Director Comments

Department of
Veterans Affairs

Memorandum

Date: December 5, 2007

From: Medical Center Director (553/00)

Subject: **Combined Assessment Program Review of the
John D. Dingell VA Medical Center, Detroit, Michigan**

To: Director, Chicago Healthcare Inspections Division (54CH)
Director, Management Review Service (10B5)

1. I would like to take this opportunity to express my gratitude for the helpful insight provided by this OIG team during the CAP review. The opportunities for improvement have been embraced by all of us and will serve as the way forward for continuous improvement as we strive to meet the needs of our veterans.
2. We have reviewed each recommendation and developed a plan of action that will meet the intent of the associated recommendation. Each plan will be implemented expeditiously and thoroughly monitored to satisfactory completion.
3. Thank you again for your assistance during this visit.



Michael K. Wheeler

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to meet VHA requirements for PRs.

Concur

Target Date: December 31, 2007

Effective December 2007, the minutes of the Peer Review committee will be submitted on a monthly basis to the HLC on Clinical Care for review. The aggregation of peer review data will be resolved using the newly developed tracking form, which separates both the 45-day as well as the 120-day requirement as outlined in VHA Directive 2004-054. The tracking form was implemented in October 2007 and was shared with the OIG inspection team during the CAP review.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires the Patient Advocate to conduct critical analyses of patient complaint data and present results to the HLC for action.

Concur

Target Date: January 15, 2008

A review of all Patient Advocate data was conducted for all medical center services. Of the 87 complaints reviewed for FY 2007, 38 of the records were related to a lack of confidence or trust in the caregiver, and 39 records revealed that the patient/family disagreed with the decisions of care. Both areas peaked during the 2nd and 3rd quarters but declined by greater than 50 percent during the 4th quarter of FY 2007. These results were provided to the ACOS for Primary Care on December 6, 2007, for review of the trends and follow-up improvement actions. The patient complaint data is now being presented to the HLC for Organizational Performance, and this became effective on December 6, 2007. Lastly, action plans will be developed by the Primary Care Service and will be shared with appropriate staff as well as the Customer Service Council and the HLC for Organizational Performance.

Recommendation 3. We recommended that the VISN Director conducts an independent review of the 11 patients who were cited in this review as having adverse outcomes to ensure that VHA policy is followed.

Concur

Target Date: December 15, 2007

The Disclosure of Adverse Events template, taken from the VHA Directive 2005-049, *Disclosure of Adverse Events to Patients*, October 27, 2005, was implemented in May 2006. After reviewing the 11 cases selected, we identified some opportunity to retrain the providers on the proper use of the template. Each of the cases will have a thorough review with the findings documented and appropriate action taken. All ACOS will be required to discuss the appropriate use of the template at future staff meetings and the required addendum to the progress notes. The RM will monitor the use of the template for completeness and address concerns related to use of the template with appropriate service chiefs in a timely manner.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires staff to inform the patients identified by our review and/or their representatives, of their rights to file a claim and ensures that these discussions are documented in accordance with VHA policy.

Concur

Target Date: December 28, 2007

The RM will conduct training and will work in conjunction with the COS or designee to notify all of the 11 patients or their representatives. The training and notification process will be in place by December 28, 2007. In addition to this training, the RM will routinely send electronic reminders to ACOS to ensure that the template is used and that the "Claim for Damage, Injury, or Death" (SF 95) form, tort claim benefits, or information about VBA benefits are offered to the patient/family.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that the three patient incident reports that were never initiated be immediately initiated and completed, as required.

Concur

Target Date: December 7, 2007

These three incident reports have been completed as of December 7, 2007.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director takes action to establish a collaborative disclosure process to ensure that patients are appropriately informed.

Concur

Target Date: December 5, 2007

In addition to training of provider staff noted above, the COS will require all involved clinical staff to participate. Effective December 5, 2007,

presentations to patient and family will be accomplished by the attending physician from the responsible service and the RM.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that managers and staff are educated on the adverse event disclosure requirements and responsibilities outlined in VHA and medical center policy.

Concur

Target Date: Ongoing

An electronic message with a link to the Adverse Event Disclosure policy will be sent to all licensed practitioners by the RM by December 27, 2007. The RM will also provide training to appropriate staff related to Adverse Event Disclosure beginning in January 2008.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that QM, the RM, and other key staff members establish a process to review and monitor the adverse event disclosure process so that improvements can be made.

Concur

Target Date: Ongoing

The RM will review all adverse events that are reported on the disclosure template. Appropriateness of use, timeliness of disclosure, participation of involved clinical staff, and thoroughness of documentation will be reviewed. A data collection tool will be developed with the assistance of the ACOS of PI by December 21, 2007, and will be utilized for future reports.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires that RCAs are completed in accordance with VHA policy.

Concur

Target Date: Ongoing

An action plan was developed on October 1, 2007, to address issues related to timely completion of the RCA process and team responsibilities. Part of this action plan included closer monitoring of the progress towards completion and keeping leadership informed of challenges that may occur along the way. We have also conferred with the Battle Creek VAMC's Patient Safety Manager whose process for completing RCAs has been identified as a strong practice within VISN 11. (The action plan is on file with the OIG).

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires that data on medication

reconciliation be tracked and trended to identify opportunities for improvement and that results be presented to the HLC for action.

Concur

Target Date: Ongoing

The Patient Safety Manager will work with Medical Records, Quality Management, Primary Care ACOS and the Assistant Chief of Medicine to develop a template to review medical records for medication discrepancies and the reconciliation of medications. The draft template was shared with the OIG team during the CAP Review. Once identified, corrections to medications will be made. Monthly aggregation of data from the medication reconciliation monitors will be presented to the appropriate clinical services and to the HLC for Organizational Performance for follow-up action and resolution. This template was implemented November 30, 2007. (The action plan is on file with the OIG.)

Recommendation 11. We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that UM data is tracked and trended to identify opportunities for improvement and that UM data is presented to the HLC for action.

Concur

Target Date: Ongoing

UM data will now be tracked and trended. On December 5, 2007, UM data on appropriateness of admissions (InterQual® criteria) and length of stay were graphed. In FY 2008, data will be aggregated/graphed to identify trends which will be presented at the next UM Committee and the next HLC for Organizational Performance meeting (The action plan is on file with the OIG.)

Recommendation 12. We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that a physician advisor is assigned to the UM program and receives appropriate training.

Concur

Target Date: October 30, 2007

On October 30, 2007, a physician advisor was assigned to the utilization review process. Training for physician advisors was held on November 1 via live net meeting national training.

Documentation was lacking regarding second and third level reviews. Currently, the second and third level reviews (when necessary) are recorded in MEDORA (computer program), the VISN data collection application.

Recommendation 13. We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that inter-rater reliability reviews are conducted in accordance with VHA policy.

Concur

Target Date: Ongoing

InterRater Reliability reviews are conducted on a random sample of admission and continued stay reviews. Because of the random selection process in use, these reviews may or may not include those patients admitted who have third party insurance. In order to capture more patients, we will increase our sample size during these reviews. At this time, InterRater reliability is not required to be reported per VHA Directive 2005-040 or our Medical Center Policy 11-62. The national UM committee is looking at a tool to be used by all facilities in all VISNs. After reviewing the statistics at the December UM Committee meeting, the UM Committee may decide to discontinue this review until the national tool is selected.

Recommendation 14. We recommended that the VISN Director ensure that the Medical Center Director requires that moderate sedation data be tracked and trended to identify opportunities for improvement and that trended data be presented to the HLC for action.

Concur

Target Date: Ongoing

As recommended, the monitor is available to all providers to input moderate sedation data on every patient. Providers have been trained on the reasons why data is being tracked and trended. This means of recording information was implemented in October of 2007. Utilization of the Conscious Sedation monitor has been made a part of our medical center Moderation Sedation policy. (The action plan is on file with the OIG.)

Data Trending: The Conscious Sedation Committee will ensure that all necessary employees can properly utilize the conscious sedation monitor. They will meet monthly to conduct an evaluation of the collected data, appreciate any trends, and make recommendations that may lead to any opportunities for improvement. As recognized by the Conscious Sedation Committee, all identified opportunities for improvement will be presented to the HLC for Organizational Performance during the December 2007 meeting.

Recommendation 15. We recommended that the VISN Director ensure that the Medical Center Director requires that code data be tracked and trended to identify opportunities for improvement and that code data be presented to the HLC for action.

Concur

Target Date: Ongoing

Code Blue data tracking for FY 2002 through FY 2007 is on file with the OIG. FY 2008 data is currently being trended. All data analysis and

trends will be presented at the HLC for Organizational Performance beginning with the January 2008 meeting.

Recommendation 16. We recommended that the VISN Director ensure that the Medical Center Director requires that CPRS business rules comply with VHA policy and OI guidance related to altering signed medical record notes.

Concur

Target Date: October 30, 2007

The deficiencies identified during the OIG CAP review were corrected while the OIG team was on site in October 2007.

All Text Integration Utilities (TIU) business rules related to the documentation of patient care will be assessed on a monthly basis to ensure compliance with VHA policy. VHA Handbook 1907.01, *Health Information Management and Health Records*.

Individual(s) responsible for the continued maintenance and updating of the TIU business rules will be the Chief of HIMS and selected designees, CPRS Clinical Application Coordinators, and the Hospital Privacy Officer.

The current status of TIU business rules and/or any modifications in them will be reported each month to the Medical Records Committee.

Any modification or changes to TIU business rules will first be submitted for review and authorization/confirmation by the Chief of HIMS.

Recommendation 17. We recommended that the VISN Director ensure that the Medical Center Director develops an action plan to improve patient satisfaction and overall scores and identifies specific staff responsibilities.

Concur

Target Date: Ongoing

An action plan to improve the overall inpatient and outpatient scores has been put into place. The medical center has implemented a bottled water distribution program; twice a day, Voluntary Service hands out bottles of water to veterans waiting for appointments. Patient concerns regarding their care will be documented at this time and submitted to the patient representative for review and action. The medical center has also started the Post-Discharge Call Program; nurses call patients within 72 hours of discharge to check on their clinical status and answer any questions patients might have. A focus group is in the process of forming that will meet with a group of outpatients on a weekly basis to discuss SHEP questions and get a better understanding of how veterans are answering the questions. The ACOS for Organizational Performance will oversee the Customer Service Council as part of his new position. The vacant Patient

Advocate position is in the process of being filled; the announcement has generated significant interest within the medical center. Patient Advocate Liaisons have and will receive on-going training. The supervisory staff will be receiving mandatory customer service training; supervisors will be expected to disseminate the information to their employees and develop PI programs within their respective services to address patient satisfaction issues.

Recommendation 18. We recommended that the VISN Director ensure that the Medical Center Director requires that nurse managers are included in EOC rounds in their respective areas.

Concur

Target Date: December 1, 2007

Historically, when the Environment of Care Rounds Team arrives on a unit to perform their semi-annual inspection, the Clinical Nurse Manager (CNM), or Charge Nurse if the CNM is not available, has been invited to accompany the team. Many times, due to patient care needs or other concerns, the CNM was not able to join the team. The rounds schedule is published by means of a Medical Center Policy Memorandum; however, to improve nursing availability during these inspections, we began providing reminders to nursing staff of upcoming rounds in their areas as of December 1, 2007. Additionally, nursing leadership will rotate participation with weekly environmental rounds.

Recommendation 19. We recommended that the VISN Director ensure that the Medical Center Director requires that identified housekeeping issues are addressed.

Concur

Target Date: December 14, 2007

Housekeeping had a large turnover of staff and had four vacant supervisory positions. The supervisory positions have been filled, and additional housekeeping staff have been requested and approved to supplement current staff on weekends and off tours in inpatient areas.

Staff received initial Methicillin-resistant Staphylococcus aureus (MRSA) training in March and April of FY 2007. Infection Control held inservices for EMS personnel on November 30, 2007, on isolation procedures, with a special emphasis on MRSA and Clostridium difficile. Training materials were provided to housekeeping supervisors to discuss with employees who were unable to attend the inservices.

Inservices will be conducted by Housekeeping supervisors by December 21, 2007 to further educate EMS front-line staff on terminal room cleaning to ensure that all EMS issues are addressed from a sanitation standpoint when a new patient is admitted in an inpatient area. All EMS supervisors working on days and afternoons will be required to do

10 made-ready bed/room inspections on a weekly basis to ensure compliance with all EMS and medical center policies. These inspections will be tracked and trended using the attached checklist. (The action plan is on file with the OIG.)

An EMS Assistant Chief hired in November 2007 will be responsible for capturing, monitoring, and aggregation of data on a monthly basis. This will ensure accountability of quality control and also identify negative trends so they are addressed in a timely manner.

Recommendation 20. We recommended that the VISN Director ensure that the Medical Center Director requires the Contracting Officer to ensure that appropriate position risk and sensitivity designations are made.

Concur

Target Date: December 18, 2007

The appropriate position risk and sensitivity designation is made using the VA Form 2280. The VA Form 2280 requires the review and signatures of the Information Security Officer (ISO) and Contracting Officer Technical Representative (COTR)/Program Official. This form will be completed by the ISO and COTR and submitted to the Contracting Officer for all contractor employees within 5 workdays after the award of the contract.

The Contracting Officer will receive a completed VA Form 2280 from the COTR/Program Official and the name, e-mail address, place of birth (city and state), date of birth, and social security number for each contractor employee and a point of contact from the company before initiating the NACI background security check for contractor employees within 10 workdays after contract award.

Recommendation 21. We recommended that the VISN Director ensure that the Medical Center Director requires the Contracting Officer to ensure that appropriate levels of background screening are monitored and tracked to completion.

Concur

Target Date: December 17, 2007

The Contracting officers will receive training on the background security checks using VA Handbook and Directive 0710 and Notice 6-06 as the guide for the training.

A quarterly monitor will be implemented for all contracting officers to review their contracts for the accuracy and completion of all NACI background security checks for contractor employees. Implementation date, January 1, 2008; first report will be due March 30, 2008.

The Contracting supervisor will update the Network Contract Manager of any pending or incomplete background security checks based on the

quarterly monitor. The due date will be 5 work days after the end of each quarter.

Recommendation 22. We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that providers document patient notification of abnormal mammogram results in the medical record.

Concur

Target Date: Ongoing

A performance monitor regarding providers notifying patients of results in a timely manner was created and implemented in October 2007. Performance for timely notification (there was notification and that notification was timely) is currently at approximately 51 percent. The ACOS for Primary Care was notified of these results and will require providers to correct fall-outs that very day. All providers whose records were reviewed were provided with memorandums detailing their personal performance and listing the patients that fell out (were not notified). All providers were notified relative to the requirement to inform patients of their results the week of the IG visit. Screen captures of the mammogram review result reminder were prepared, and all providers were trained by the Women Veteran's Program Manager (WVPM) as follows: FIRM D, November 29, 2007, and FIRM A, December 4, 2007. The WVPM has been working with individual providers having problems completing the reminders. (The information is on file with the OIG.)

Recommendation 23. We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that mammography services are completed by the contract provider within 30 days.

Concur

Target Date: December 7, 2007

Radiology provided training to the contractor in May 2007 to clarify the timeframe (within 30 days) for appointments. Recurring training was completed on December 7, 2007, for supervisory staff and the Director of the affiliate mammography center regarding scheduling appointments within 30 days. A program assistant will be hired soon dedicated to the mammography program.

OIG Contact and Staff Acknowledgments

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