



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

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**Combined Assessment Program  
Review of the  
VA San Diego Healthcare System  
San Diego, California**

## Quality Management

**Conditions Needing Improvement.** The QM program was generally effective. Appropriate review structures were in place for 12 of the 14 program activities reviewed. However, the disclosure process for patients who experienced adverse events and patient complaint analyses needed improvement.

Disclosure Process. When serious adverse events occur as a result of patient care, VHA

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policy requires staff to discuss the events with the patients and, with input from Regional Counsel, inform them of their right to file torts or benefits claims. In a sample of 16 patients who experienced adverse events during inpatient care from January 2005 through January 2006, we found that clinicians had documented the adverse events discussions in the progress notes for 13 patients. However, staff had not documented that they had advised any of the patients about their right to file torts or claims.

Patient Complaint Analyses. For FY 2005, patient complaint reports were limited to broad topic areas, such as access to and timeliness of care. VHA policy requires that patient advocates aggregate complaints, analyze the data, and present trended reports to senior managers and patient care providers. The Patient Advocate needed to expand data analyses in the patient complaint program to identify trends and opportunities for improvement.

**Recommendation 3.** We recommended that the VISN Director ensure that the Healthcare System Director requires that: (a) responsible clinicians fully inform patients who experience adverse events and document the discussions and (b) the Patient Advocate perform more detailed patient complaint analyses and present trended reports to senior managers.

The VISN and Healthcare System Directors agreed with the findings and recommendations and reported that they will address the disclosure issue through revised templates, training, and ongoing audits. Patient complaints will be analyzed and reported to designated committees quarterly. The improvement plan is acceptable, and we will follow up on the completion of the planned actions,

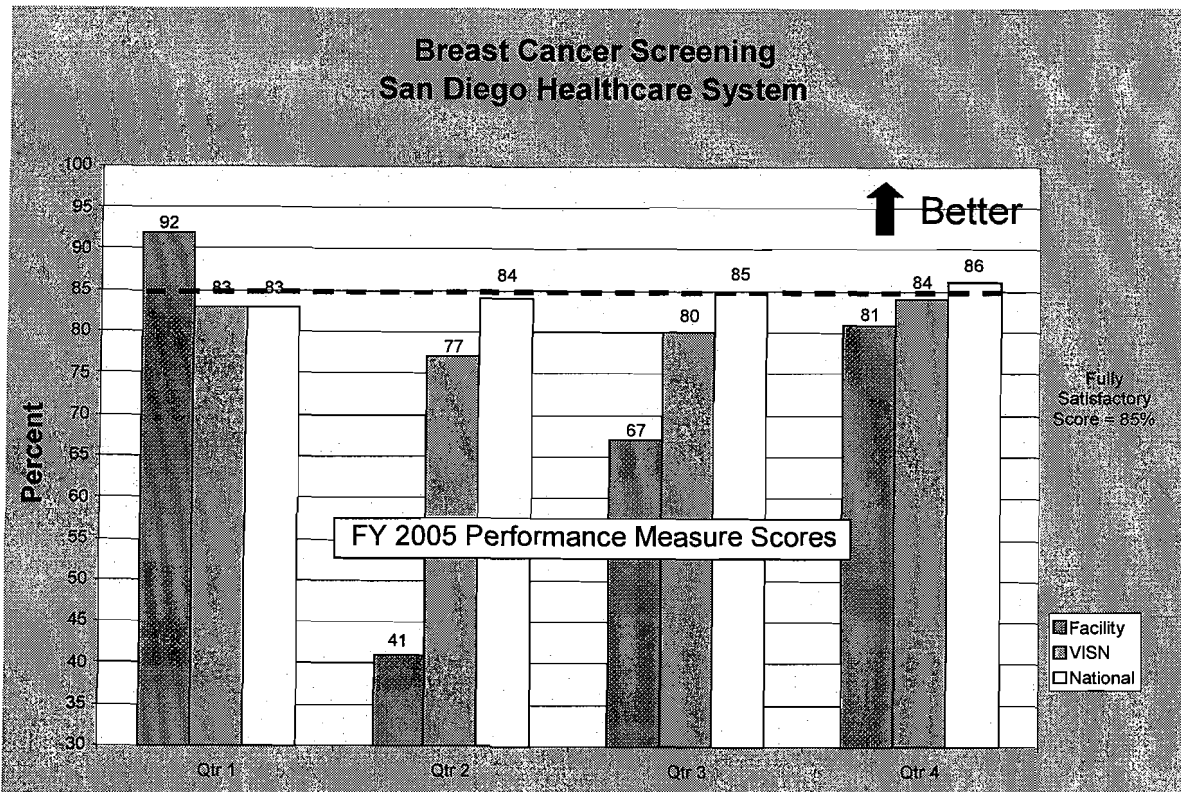
## Breast Cancer Management

**Conditions Needing Improvement.** Clinicians needed to ensure that the number of women receiving breast cancer screening (mammography) services meets or exceeds VHA's established performance target of 85 percent. In addition, staff needed to ensure

that mammography reports are readily available to all clinicians by scanning results into the computer system within a reasonable timeframe.

The VHA breast cancer screening performance measure assesses 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 either newly diagnosed with breast cancer or had abnormal mammograms during FY 2005. To determine compliance, we used the standards outlined in VHA and local policies. There are no published timeliness standards regarding report scanning.

**Screening and Referral.** The system did not meet the VHA performance measure for breast cancer screening in three of the four quarters for FY 2005, as indicated in the graph below. However, the 10 cases we reviewed received appropriate screening.



All 10 patients appeared to be aware of their diagnoses, as indicated in the table on the next page. Clinicians referred patients who had abnormal or highly suspicious mammograms to the surgery clinic for follow-up evaluation. Eight of the 10 patients

who were diagnosed with malignant cancer were referred to the appropriate clinic for timely surgery and/or hematology/oncology consultative services. The remaining two patients had either benign results or pending diagnoses at the time of our review.

**Timeliness.** The time between mammogram and biopsy procedure appeared excessive in 5 of the 10 cases. However, further review revealed that the delays appeared to be due to various patient issues, such as no shows, cancellation of scheduled appointments, and incorrect contact information. We also found that the length of time for scanning mammogram reports was excessive in five cases; the range was 47 to 170 days. Program managers agreed that mammography reports should be available in the medical records more quickly to facilitate interdisciplinary planning and coordination of care.

<b>Patients appropriately screened</b>	<b>Mammography results reported to patient within 30 days</b>	<b>Patients appropriately notified of their diagnoses</b>	<b>Patients received timely consultations</b>	<b>Patients received timely biopsy procedures</b>
<b>10/10</b>	<b>10/10</b>	<b>10/10</b>	<b>10/10</b>	<b>5/10</b>

Since 2002, patients have had the option to obtain their mammograms at any one of 12 contract facilities. Program managers acknowledged that it was difficult to track compliance with the breast cancer screening measure because they had to rely upon notification by the facilities or patients. In March 2005, managers signed a sharing agreement for patients to have their mammograms done only at the Naval Medical Center in San Diego or one of its affiliates. Although the agreement has been in place less than a year, clinicians are optimistic that compliance with the breast screening measure will improve because mammography services are centralized.

**Recommendation 4.** We recommended that the VISN Director ensure that the Healthcare System Director takes action to: (a) improve compliance with VHA’s breast cancer screening performance measure and (b) ensure that mammogram reports are scanned within a reasonable timeframe.

The VISN and Healthcare System Directors agreed with the findings and recommendations and reported that they will ensure tracking of patients through the mammogram process from consult to completion, audit charts of veterans meeting criteria for required mammograms, and ensure these veterans receive telephonic and written notification. Fee Basis staff began scanning mammogram reports into medical records upon receipt and monitoring the timeliness of scanning these reports weekly. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

## Patient Medical Information

**Condition Needing Improvement.** During our inspection of patient care areas, we found patient-specific medical records and test results in two unattended offices and on a cart in a patient care hallway. Federal law and VHA policy require that confidential patient information be secured. Managers took immediate steps to correct the deficiencies. However, the need to safeguard patient information should be emphasized to all system employees.

**Recommendation 5.** We recommended that the VISN Director ensure that the Healthcare System Director requires that all confidential patient information is secured.

The VISN and Healthcare System Directors agreed with the findings and recommendation and reported that they will re-emphasize the importance of securing confidential information, modify the screen saver on all computer workstations to include a warning about securing confidential patient information, and implement ongoing inspections for unsecured information. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

## Equipment Accountability

**Conditions Needing Improvement.** The Acquisition and Materiel Management Service (A&MMS) Chief needed to improve controls to properly account for nonexpendable equipment (items costing more than \$5,000 with an expected useful life of 2 years or more) or equipment sensitive in nature. VA policy requires the completion of physical inventory counts to ensure equipment is properly accounted for and recorded on EILs. As of November 30, 2005, the system had 206 EILs containing 24,431 items, valued at \$89 million. We identified two areas that needed improvement.

**EIL Inventory Counts.** VA policy requires staff to complete EIL inventory counts within 10 days of notification (20 days if the EIL contains 100 items or more). A&NIMS staff is required to send delinquency notices to responsible officials and to the Healthcare System Director. Under VA policy, the Healthcare System Director is the only official authorized to grant extensions for delinquent inventory counts. We found that 13 (8 percent) of 162 EIL inventory counts due in FYs 2004–2005 were not completed. The A&MMS Chief told us that she had notified all responsible officials of the scheduled inventory counts, and she had notified the responsible officials and the Healthcare System Director about those that were delinquent. However, there was no evidence that the Healthcare System Director granted extensions or held the responsible officials accountable for the deficiencies. Without current and accurate reviews, the status of these 13 EILs (containing 951 items valued at about \$5 million) is unknown, and they are vulnerable to theft, vandalism, and misuse.