Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Pacific Islands Health Care System Honolulu, Hawaii

Report No. 06-02003-225 **September 26, 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 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.
- 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

During the week of June 19–23, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Pacific Islands Health Care System (the health care system). The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 143 health care system employees. The health care system is part of Veterans Integrated Service Network (VISN) 21.

Results of Review

The CAP review covered six operational activities. We identified the following organizational strengths and reported accomplishments:

- New consolidated medication list improved continuity of care.
- New communication approach addressed vulnerable care transitions.

We made recommendations in two of the activities reviewed plus one repeat recommendation from the prior CAP report. For these activities, the health care system needed to:

- Ensure that patient information attached to or visible on computer screens is protected.
- Ensure that clinicians develop and follow individualized plans for follow-up visits for patients placed in community nursing homes (CNHs) and that the CNH oversight committee has appropriate membership.
- Determine the mechanisms for communication about and oversight of veteran patients treated at Tripler Army Medical Center through the joint venture, formalize the mechanisms, and ensure compliance.

The health care system complied with selected standards in the following four activities:

- QM.
- Breast cancer management.
- Patient satisfaction survey results action plans.
- Monitoring patients on atypical antipsychotic medications.

This report was prepared under the direction of Ms. Julie Watrous, Director, Los Angeles Healthcare Inspections Division.

VISN and Health Care System Directors' Comments

The VISN and Health Care System Directors agreed with the CAP review findings and provided acceptable improvement plans. (See Appendixes A and B, pages 11-15, 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

Health Care System Profile

Organization. Based in Honolulu, Hawaii, the VA Pacific Islands Health Care System (the health care system) provides a broad range of medical care services. The health care system provides outpatient medical and mental health care through an ambulatory care clinic in Honolulu and five community based outpatient clinics on Hawaii (Hilo and Kona), Maui, Kauai, and Guam. Traveling clinicians also provide episodic care on Molokai, Lanai, and American Samoa. The health care system is part of VISN 21 and serves a veteran population of about 127,600 veterans throughout Hawaii and the Pacific Islands.

Programs. The health care system provides outpatient primary medical, mental health, dental, and long-term care. Inpatient psychiatric care is provided in a 20-bed VA operated ward in Tripler Army Medical Center (TAMC). Acute medical-surgical inpatient care is provided at TAMC through a VA/Department of Defense (DoD) sharing agreement, or through non-VA providers in the community. Long-term care services are provided in a 60-bed Center for Aging.

Affiliations and Research. The health care system is affiliated with the University of Hawaii School of Medicine and provides training for 39 residents, as well as other disciplines, including nursing, dental, and pharmacy. In fiscal year (FY) 2005, the health care system research program had 20 projects and a budget of $4.5 million. Important areas of research include post-traumatic stress, dementia, and hepatitis C.

Resources. In FY 2005, medical care expenditures totaled $119.4 million. The FY 2006 medical care budget is $123.5 million. FY 2005 staffing was 552 full-time equivalent employees (FTE), including 48 physician and 71 nursing FTE.

Workload. In FY 2005, the health care system treated 20,976 unique patients. The inpatient care workload totaled 545 discharges from TAMC, and the average daily census, including long-term care patients, was 74. The outpatient care workload was 187,550 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 administration and quality management (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, employees, and patients; and reviewed clinical and administrative records. The review covered the following six activities:

Breast Cancer Management	Monitoring of Patients on Atypical Antipsychotic Medications
Contract Community Nursing Homes (CNH)	QM
Environment of Care	Patient Satisfaction Survey Scores

The review covered facility operations for FY 2005 and FY 2006 through June 16, 2006, and was done in accordance with OIG standard operating procedures for CAP reviews.

In this report, we make consultative suggestions and recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Results of Review

Organizational Strengths and Reported Accomplishments

New Consolidated Medication List Improved Continuity of Care

The health care system's managers chartered an interdisciplinary team to create a consolidated list of each patient's medications, which could be printed, reviewed during clinic visits, and updated as necessary. The team created a health summary document that included adverse medication reactions, allergies, and outpatient medications. The new process starts with the clinic clerk printing the document prior to the patient's appointment, then the provider reviews the list with the patient during the visit. The provider enters any changes into the computerized medical record and provides a copy of the list to the patient for use at other healthcare venues, including non-Veterans Health Administration (VHA) and emergency care. This innovative process was shared with TAMC managers, who duplicated the process in their outpatient programs. This initiative was also presented at Hawaii's Annual Patient Safety Conference in March 2006.

New Communication Approach Addresses Vulnerable Care Transitions

To improve communications at key care transitions, such as transfers from one level of care to another, the health care system's managers chartered an interdisciplinary team in FY 2005. The team recommended a technique based on the following framework: (1) situation, (2) background, (3) assessment, and (4) recommendation (SBAR). The team identified 11 vulnerable care transitions and created SBAR computerized medical record templates for each one to remind providers to address all important issues. Prior to implementation of the SBAR communication technique, dental service reported an adverse event in which communication failure was cited as a factor. Dental service has reported that the SBAR communication technique has improved and streamlined the communication process within dental service and between the health care system and community providers. Also, there have been no adverse events related to poor communication since the technique was implemented.

Opportunities for Improvement

Environment of Care

The purpose of the evaluation was to determine if the health care system maintained a safe and clean patient care environment. We inspected clinical and non-clinical areas for cleanliness, safety, infection control, and general maintenance. The health care system generally maintained a clean and safe environment, with the exception of safeguarding patient information.

In an unattended nurses' station, patient information was taped to two computer monitors. Also, visible computer screens in a clinic and a nursing unit hallway displayed patient information. Federal law and VHA policy require that patient information be secured. Managers took immediate steps to correct the deficiencies. However, the need to safeguard patient information should be emphasized to all health care system employees.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Health Care System Director requires that patient information attached to or visible on computer screens be secured.

The VISN and Health Care System Directors agreed with the findings and recommendation and reported that they have taken appropriate actions by informing employees to secure sensitive information and by implementing monthly inspection exercises targeting protection of confidential information. The improvement plan was acceptable, and we consider the issues resolved.

Contract Community Nursing Home Program

The purpose of this review was to assess if the health care system complied with requirements regarding the selection, placement, and monitoring of patients in CNHs. The VHA CNH Program has two important tenets: (1) patient choice in selecting a nursing home and (2) local VHA facility oversight of CNHs. Oversight consists of monthly patient visits and annual reviews. To assess the health care system's CNH Program oversight, we reviewed medical records of 10 randomly selected patients; conducted a site visit at one CNH that housed over 90 percent of the patients in the program; reviewed relevant documents; and interviewed program officials, patients, family members, and contract CNH administrators.

Overall, we found that the CNH Coordinator appropriately provided the required monitoring of patients in the program by involving patients and family members in the placement process, conducting monthly site visits, performing annual evaluations of CNHs before contract renewals, and establishing effective working relationships with the

appropriate veteran's benefits office and the local ombudsman's office staff. However, we identified improvement opportunities in three areas.

Follow-Up Visits Plans. Medical records did not contain individualized follow-up plans prior to placement of the patients in nursing homes. VHA policy requires that a plan be developed that addresses each patient's needs, as well as follow-up visits that will be provided by the health care system. The CNH Coordinator acknowledged that individualized plans were not developed and stated that this requirement would be incorporated in the authorization notes in all future placements.

Nursing Visits. Medical records contained excellent documentation of monthly visits by the CNH Coordinator (social worker). However, we did not find consistent visits from a registered nurse (RN). The health care system is required to provide oversight visits by both a social worker and RN to every patient in a CNH as indicated by the patients' follow-up plans. The Associate Chief of Staff for Geriatrics and Extended Care (ACOS/GEC) told us that it was not always possible for a RN to participate in all the visits because of nursing staff limitations. The CNH Coordinator stated that a RN had accompanied her on several visits but acknowledged that services provided by the RN were not always documented in the medical records. The ACOS/GEC agreed to develop a plan to comply with the required RN visits and document services provided in the medical records.

Oversight Committee Membership. The Oversight Committee meeting minutes from meetings held in 2006 did not show representatives from QM or VISN 21 Consolidated Contracting Authority (CCA), as required. While this requirement has been a VHA policy since 2004, the Oversight Committee did not include QM and acquisition/contracting representatives until March 2006.

Recommended Improvement Action 2: We recommended that the VISN Director ensure that the Health Care System Director takes action to make certain that: (a) the CNH Coordinator develops individualized plans for follow-up visits prior to placement of patients in CNHs, (b) a RN provides and documents the required visits, and (c) the Oversight Committee membership includes QM and CCA.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that they will take actions, which will include developing standardized notes for documenting follow-up visits plans and implementing a tracking log for nursing documentation. The target date for completion is September 15, 2006. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Oversight of Veteran Patients' Care at TAMC

As part of this review, we followed up on the recommendations resulting from a prior CAP review of the health care system. In the *Combined Assessment Program Review of the Spark M. Matsunaga VA Medical and Regional Office Center* (Report No. 01-01254-10, October 9, 2001), we made a recommendation to improve the monitoring of veteran patients who receive care at TAMC through the sharing agreement. During this CAP review, we determined that the corrective action plan was only partially implemented.

The health care system had improved the communication about and oversight of veteran patient care at TAMC through utilization review and inclusion at selected TAMC monitoring committees. However, health care system personnel who were designated to attend the committees did not always attend or send a delegate. For example, the designated health care system employee did not attend the Risk Management Committee for several months prior to her resignation in March 2006, and no one was designated to take her place. Also, the action plan called for revisions to the sharing agreement document, but the document still did not specify all the mechanisms for communication and oversight of veteran patients receiving care at TAMC (such as health care system staff attendance at the Monday morning meetings, notification of adverse events, and sharing of performance data for use in reprivileging those providers who are privileged at both facilities). Without these mechanisms formalized in the sharing agreement, the informal processes are vulnerable to failure when staff are deployed or reassigned.

Recommended Improvement Action 3: We recommended that the VISN Director ensure that the Health Care System Director should: (a) determine all the mechanisms that will provide essential communication and information sharing between the health care system and TAMC, (b) ensure that these mechanisms are formalized in either the sharing agreement or in standard operating procedures, and (c) ensure that the health care system representative or a delegate attend all monitoring committees.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that they have taken actions, which will include the creation of a new VA/DoD Joint Venture Committee to address clinical care and quality improvement issues between the two organizations. Health care system staff will participate in key TAMC committees. These mechanisms will be formalized in the revised Master Sharing Agreement. The target date for completion is January 2007. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Other Review Topics

Quality Management

The purpose of this review was to evaluate whether the health care system's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the health care system director, chief of staff, chief nurse executive, and QM personnel, and we evaluated plans, policies, and other relevant documents. For the purpose of this review, we defined a comprehensive QM program as including the following program areas:

- QM and performance improvement committees, activities, and teams.
- Patient safety functions (including healthcare failure mode and effects analyses, root cause analyses, aggregated reviews, and patient safety goals).
- Risk management (including disclosure of adverse events and administrative investigations related to patient care).
- Utilization management (including admission and continued stay appropriateness reviews).
- Patient complaints management.
- Medical record documentation reviews.
- Medication management.
- Restraint and seclusion usage reviews.
- Staffing effectiveness analyses.

To evaluate monitoring and improvement efforts in each of the above program areas, we reviewed the health care system's performance of a series of data management process steps. These steps were consistent with Joint Commission on the Accreditation of Healthcare Organizations standards and included:

- Identifying problems or potential improvements.
- Gathering and critically analyzing the data.
- Comparing the data analysis results with established goals or benchmarks.
- Identifying specific corrective actions when results do not meet goals.
- Implementing and evaluating actions until the problems are resolved or the improvements are achieved.

We also evaluated whether clinical managers appropriately used the results of quality monitoring in the medical staff reprivileging process. Also, we reviewed mortality analyses to determine the level of facility compliance with VHA guidance.

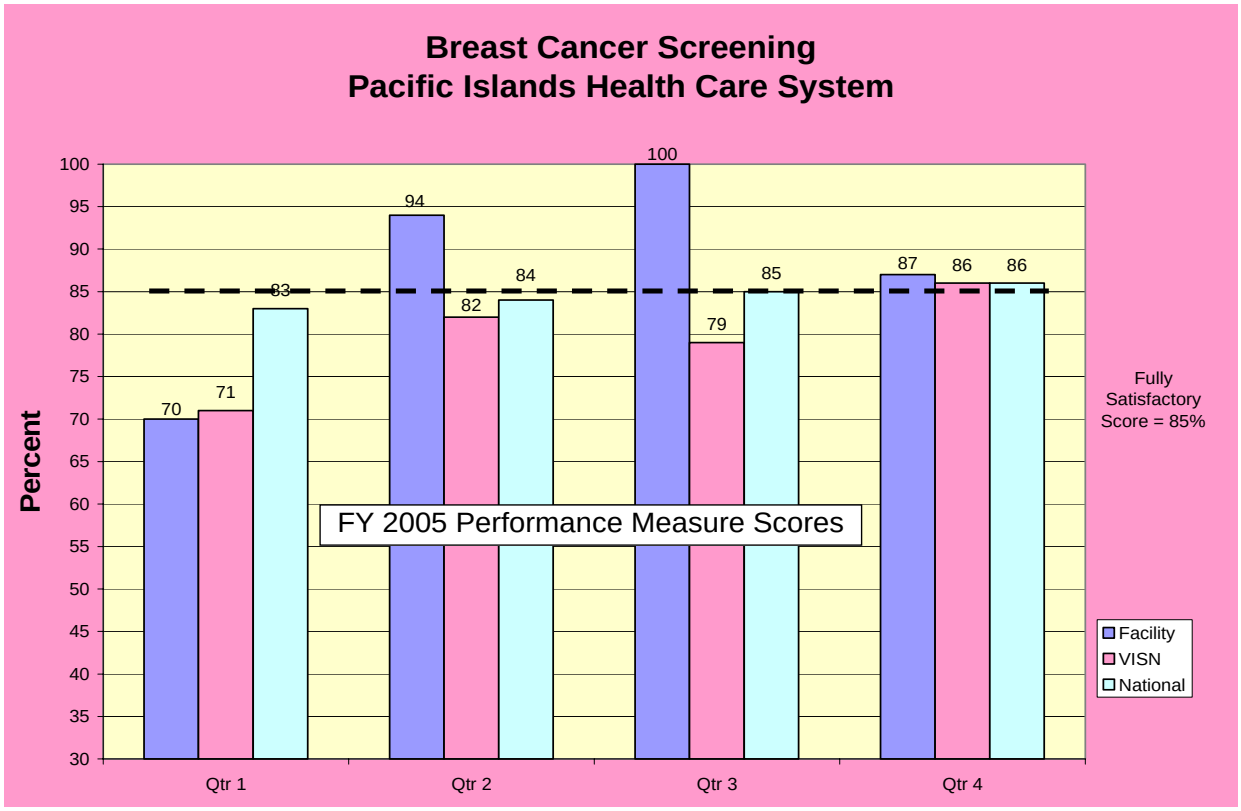
We found that the QM program provided comprehensive oversight of the quality of care. Generally, when problems were identified, actions were taken and adequately evaluated. We found good senior management support and clinician participation. We are not making any recommendations.

Breast Cancer Management

The purpose of this review was to assess the effectiveness of breast cancer screening and management. We evaluated the health care system's scores for the breast cancer screening performance measure in FY 2005, interviewed program officials, reviewed medical records, and analyzed relevant documents. The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes.

Timely diagnosis and treatment are essential to early detection, appropriate management, and optimal patient outcomes. We reviewed these items in all 10 patients who had abnormal mammography findings during FY 2005. All screening and diagnostic mammograms, as well as follow-up interventions, were provided at community facilities on a fee-for-service basis.

The health care system achieved the fully satisfactory level on the VHA performance measure for breast cancer screening by the end of FY 2005 and provided the required radiology, surgery, and oncology consultative services and follow-up care (see chart below and table on the next page).



Patients appropriately screened	Mammography results reported to patient within 30 days	Timely biopsy procedures, appropriate notification of diagnoses, and timely consultations to diagnostic and treatment services, when indicated.
10/10	10/10	10/10

Overall, we found that clinicians provided breast cancer screening appropriately and ensured that follow-up services and/or interventions occurred within reasonable timeframes. We are not making any recommendations.

Patient Satisfaction Survey Scores

The purpose of this review was to assess the extent to which the health care system used the results of VHA's patient satisfaction survey to improve care, treatment, and services. In 1995, VHA began surveying its patients using a standardized instrument modeled from the Picker Institute, a non-profit health care surveying group. VHA set 77 percent as the FY 2006 target for the results of its Survey of the Health Experiences of Patients (SHEP). The table below shows the national, VISN 21, and health care system's survey results.

Second Quarter FY 2006	VA Pacific Islands HCS 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	80.7	78.1	94.8	72.6	83.3	75.8	81.5	65.5	81.7	80.8	84.7
VISN	81.9	78.7	94.7	74.2	84.1	76.6	83.2	69.4	82.7	80.5	84.1
VA Pacific Islands HCS overall	80.6	75.4	94.5	73.6	86.3	78.1	82.9	57.4	80.7	83.5	87.1

The health care system's managers shared the results with employees, as expected. Managers acknowledged their continuing efforts to manage the increased demand for services and to provide health care across a large geographic area of islands. They had formulated plans to reduce waiting times, provide more patient education materials, and address staffing issues. We found the action plans acceptable and are not making any recommendations.

Monitoring of Patients on Atypical Antipsychotic Medications

The purpose of this review was to determine whether clinicians appropriately monitored and managed patients receiving a specific class of medications used to treat psychosis. While these medications cause fewer neurological side effects (such as involuntary tremors) than other classes of antipsychotic medications, they increase the risk of developing diabetes.

VHA clinical practice guidelines for screening patients who are at risk for the development of diabetes suggest that fasting blood glucose (FBG) is the preferred screening test and should be performed every 1–3 years. A normal FBG is less than 110 milligrams/deciliter (mg/dL). In patients with slightly higher FBG values (110–126 mg/dL), clinicians should provide counseling about such prevention strategies as calorie-restricted diets, weight control, and exercise. In patients with high FBG values (greater than 126 mg/dL) on at least two occasions, clinicians should diagnose diabetes.

In 2004, a VISN 21 study assessed whether clinicians performed baseline monitoring, including weight and FBG, for patients beginning therapy with atypical antipsychotic medications. Results showed that few of these patients had baseline monitoring documented in their medical records. Recommendations included educating clinicians about the monitoring guidelines and creating a template progress note that would include the monitoring parameters.

The health care system implemented the above recommendations and also developed an automated message that reminded clinicians to address all the guidelines. We reviewed the medical records of 13 randomly selected patients who were receiving one or more atypical antipsychotic medications for at least 90 days. None of the 13 patients had diabetes. We found that all of the 13 patients were screened for diabetes and appropriately counseled about prevention strategies. One patient, whose FBG was within the slightly high range, received appropriate counseling about prevention strategies. We are not making any recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 15, 2006

From: VISN Director

Subject: **Combined Assessment Program Review of the VA Pacific Islands Health Care System, Honolulu, Hawaii**

To: Director Los Angeles Healthcare Inspections Division (54LA)
Director, Management Review Office (10B5)

1. I appreciate the opportunity to provide comments to the draft report of the Combined Assessment Program (CAP) review of the VA Pacific Islands Health Care System (VAPIHCS), during the week of June 19-24, 2006. I have discussed the findings and recommendations with the senior leadership at VAPIHCS.

2. In brief, I concur with all of the recommendations in the report. The staff at VAPIHCS has already begun to implement improvement actions. The implementation plan in Appendix B provides both initiated and planned corrective actions specific to each recommendation.

3. Thank you for the opportunity to review the draft report.

Robert Wiebe MD

Robert L. Wiebe, M.D.

Appendix B

Health Care System Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 14, 2006

From: Health Care System Director

Subject: **Combined Assessment Program Review of the VA Pacific Islands Healthcare System, Honolulu, Hawaii**

To: Robert L. Wiebe, M.D., Network Director Sierra Pacific Health Care System

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

Health Care System Director's 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

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Health Care System Director requires that patient information attached to, or visible on, computer screens be secured.

Concur

Protection of sensitive/confidential patient information was reviewed with NHCU staff during a Town Hall staff meeting, as well as during their nursing meeting in July 2006. Tracer exercises targeting protection of sensitive/confidential information are to be conducted monthly. Quarterly reports will be presented during NHCU Performance Improvement Committee meetings. Mandatory VA-wide Privacy and Cyber Security Training was completed by staff by due date of **June 30, 2006**. The "Statement of Commitment and Understanding" confirming their understanding of the training, the consequences for non-compliance, and their commitment to protecting sensitive and confidential information has also been completed. Surveillance of employee areas is presently accomplished during facility environment of care administrative rounds using a checklist which inspects for improper display of sensitive patient information and data. ***Closed June 30, 2006***.

Recommended Improvement Action 2: We recommended that the VISN Director ensure that the Health Care System Director takes action to make certain that: (a) the CNH Coordinator develops individualized plans for follow-up visits prior to placement of patients in CNHs, (b) a RN provides and documents the required visits, and (c) the Oversight Committee membership includes QM and CCA.

Concur

a. ***Follow up visit plan*** – Effective August 1, 2006, an individualized follow-up will be incorporated in the authorization notes in all future CNH placements. We will explore development of a templated CPRS authorization note which includes identification of a follow-up visit, to be completed by **September 15, 2006**.

b. ***Nursing visit documentation*** – VHA Handbook 1143.2 dated June 4, 2004. Review of on-going monitoring follow-up visits in NH was reviewed with the Social Work Executive and Geriatrics and Extended Care Head Nurse. We will develop a templated CNH RN note in CPRS, or have the RN complete an addendum to the current CNH SW templated note in the frequency as required by this Handbook. A tracking log will be implemented by **August 31, 2006**, to include documentation deadlines that will be reported in the CNH Oversight Committee.

c. ***Oversight Committee membership*** – QM and CCA representatives will participate in future CNH Oversight Committee meetings. ***Closed August 1, 2006***.

Recommended Improvement Action 3: We recommended that the VISN Director ensure that the Health Care System Director should: (a) determine all the mechanisms that will provide essential communication and information sharing between the health care system and TAMC, (b) ensure that these mechanisms are formalized in either the sharing agreement or in standard operating procedures, and (c) ensure that the health care system representative or a delegate attend all monitoring committees.

Concur

a. On July 31, 2006, the TAMC and VAPIHCS leadership held a Strategic Planning Conference in which this topic was discussed. TAMC and VA both agreed that participation of VA members on key TAMC patient care oversight committees will occur. This action will occur no later than October 1, 2006. The leadership approved the creation of a new VA/DoD Joint Venture Committee specifically to address clinical care and quality improvement issues and opportunities between the two organizations. The newly chartered Clinical Quality Committee is in the process of being formed and is tasked with the review of existing TAMC committees and recommendations for VA membership participation. The on-going oversight of the newly formed Clinical Quality Committee and VA participation on TAMC committees will be the responsibility of the Joint Venture Steering Group (JVSG). This action will be accomplished by **October 1, 2006**.

b. The current 2002-2007 Master Sharing Agreement is being renewed effective December 2007. The rewrite will include the overall oversight mechanism of joint venture committee structure. Standard operating procedures will be created to reflect the day-to-day operational elements of how the committees will function. The charter for the Clinical Quality Committee is due by October 1, 2006. The suspense for the rewrite of the Master Sharing Agreement is due by January 30, 2007 and will be submitted at that time for approval up both chains of command. These actions were formally agreed to with TAMC counterparts at the July 31, 2006, Strategic Planning Conference.
Projected Action Completion Date(s):

October 1, 2006 – Clinical Quality Committee Charter
January 30, 2007 – Revision of the Master Sharing Agreement.

c. Results of the committees and attendance at the committees will be reported to the Joint Venture Steering Group meeting on a quarterly basis. This will be effective **December 31, 2006.**

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Julie Watrous, Director Los Angeles Office of Healthcare Inspections (213) 253-5134
Acknowledgments	Daisy Arugay Carole Lehman Michelle Porter

Appendix D

Report Distribution

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