VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Pacific Islands Health Care System

Honolulu, Hawaii

Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:

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Figure 1. *VA Pacific Islands Health Care System, Honolulu, Hawaii (Source: https://vaww.va.gov/directory/guide/, accessed on July 23, 2019)*

Abbreviations

ADPCS	associate director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
FPPE	focused professional practice evaluation
FY	fiscal year
LIP	licensed independent practitioner
MST	military sexual trauma
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UCC	urgent care center
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Pacific Islands Health Care System (the facility). The inspection covers key clinical and administrative processes that are associated with promoting quality care.

CHIP inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The inspections are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus each year.

The OIG team looks at leadership and organizational risks as well as areas affecting quality patient care. At the time of the inspection, the clinical areas of focus were

1. Quality, safety, and value;

2. Medical staff privileging;

3. Environment of care;

4. Medication management (specifically the controlled substances inspection program);

5. Mental health (focusing on military sexual trauma follow-up and staff training);

6. Geriatric care (spotlighting antidepressant use for elderly veterans);

7. Women's health (particularly abnormal cervical pathology result notification and follow-up); and

8. High-risk processes[1] (specifically the emergency department and urgent care center operations and management).

This unannounced visit was conducted during the week of April 8, 2019. The OIG held interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a broad spectrum of clinical and administrative processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this facility's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this facility and

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[1] The OIG's review of the emergency department and urgent care center (UCC) operations and management focused on the clinical risks of the emergency department/UCC areas. This review was not performed at the VA Pacific Islands Health Care System because the facility did not have an emergency department or UCC.

other Veterans Health Administration (VHA) facilities to identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Inspection Impact

Leadership and Organizational Risks

At the time of the OIG's visit, the facility leadership team consisted of the director, chief of staff, associate director for Patient Care Services (ADPCS), and associate director (primarily nonclinical). Organizational communications and accountability were managed through a committee reporting structure with the Leadership Governance Council having oversight for several working groups. The director served as the chairperson of the Leadership Governance Council, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The leaders were also engaged in monitoring patient safety and care through the Quality, Safety and Value Executive Board, which was responsible for tracking, identifying trends, and monitoring quality of care and patient outcomes and reports to the Leadership Governance Council.

The facility's leadership team had been working together for approximately 10 months, although the chief of staff and ADPCS had served in their position for several years.

The OIG noted that selected employee satisfaction survey results indicated that facility leaders were generally engaged and promoted a culture of safety where employees feel safe bringing forward issues and concerns. However, opportunities exist for the ADPCS to improve nursing staff satisfaction and attitudes in the workplace. The selected patient experience survey scores applicable to facility leaders demonstrated that patients seem generally satisfied with the leadership and care provided, and facility leaders had implemented processes and plans to maintain positive patient experiences.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[2] and disclosures of adverse patient events, and did not identify any substantial organizational risk factors.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities

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[2] The definition of sentinel event can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life."

and differences between the top and bottom performers" within VHA.[3] Although the leadership team members were generally knowledgeable within their areas of responsibility about selected SAIL metrics and SAIL community living center (CLC) measures, the leaders should continue to take actions to sustain and improve performance of the quality of care metrics and measures likely contributing to the facility's SAIL "2-star" and CLC "2-star" quality ratings.[4]

The OIG noted deficiencies in six of the seven clinical areas reviewed and issued 12 recommendations that are attributable to the director, chief of staff, ADPCS, and associate director. These are briefly described below.

Quality, Safety, and Value

The OIG found there was general compliance with requirements for protected peer review, patient safety, and resuscitation episodes review. However, the OIG identified noncompliance with interdisciplinary reviews of utilization management data.[5]

Medical Staff Privileging

The facility generally complied with requirements for privileging. However, the OIG had concerns with the facility's process for professional practice evaluations.[6]

Environment of Care

The facility generally met requirements for emergency management and had medical equipment and supplies available for patient care. However, the OIG identified parent facility

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[3] VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a "star rating" system to designate a facility's performance in individual measures, domains, and overall quality.
http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938.
(The website was accessed on March 6, 2019, but is not accessible by the public.)

[4] Based on fiscal year 2018, quarter 3 ratings at the time of the site visit.

[5] According to VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019), UM reviews include evaluating the "appropriateness, medical need, and efficiency of health care services according to evidence-based criteria." This directive expired July 31, 2019.

[6] The definitions of ongoing professional practice evaluation and focused professional practice evaluations can be found within Office of Safety and Risk Awareness, Office of Quality and Performance, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, July 2016 (Revision 2). An ongoing professional practice evaluation is "the ongoing monitoring of privileged providers to confirm the quality of care delivered and ensures patient safety." A focused professional practice evaluation is "a time-limited process whereby the clinical leadership evaluates the privilege-specific competence of a provider who does not yet have documented evidence of competently performing the requested privilege(s) at the facility." A focused professional practice evaluation for cause is "a time-limited period during which the medical staff leadership assesses the provider's professional performance to determine if any action should be taken on the provider's privileges."

noncompliance with environmental and medication safety, infection prevention, and patient privacy requirements. In addition, the OIG team noted environmental cleanliness and patient privacy concerns at the Leeward Oahu VA Clinic.

Medication Management

Overall, the facility complied with requirements for most of the performance indicators evaluated for medication management, including the controlled substances coordinator reports, pharmacy operations, and pharmacy inspections. However, the OIG identified noncompliance with the requirement for controlled substances area inspections.

Mental Health

The OIG team also found the facility complied with many of the mental health performance indicators, including the designation of a Military Sexual Trauma (MST) coordinator, tracking of MST-related data, and provision of clinical care. The OIG noted a concern, however, with staff completion of MST mandatory training.

Women's Health

The facility performed adequately on many of the indicators related to women's health, including requirements for a designated women veterans program manager and follow-up care for cervical cancer screening, when indicated. However, the OIG identified concerns with the Women Veterans Health Committee core membership, tracking of data related to cervical cancer screenings, and communicating test results to patients within the required time frame.

Summary

In reviewing key healthcare processes, the OIG issued 12 recommendations for improvement directed to the facility director, chief of staff, ADPCS, and associate director. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this facility. The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network director and facility director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 63–64, and the responses within the body of the report for the full text of the directors' comments.) The OIG considers recommendation 6 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Assistant Inspector General
for Healthcare Inspections

Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to provide oversight of healthcare services to veterans. This focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Pacific Islands Health Care System (the facility) is accomplished by examining a broad overview of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and facility leaders so that informed decisions can be made on improving care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a culture to sustain positive change.[7] Investments in a culture of safety and quality improvement with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations.[8] Figure 2 shows the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

To examine risks to patients and the organization when core processes are not performed well, the OIG focused on the following nine areas of clinical and administrative operations that support quality care at the facility: [9]

1. Leadership and organizational risks

2. Quality, safety, and value (QSV)

3. Medical staff privileging

4. Environment of care

5. Medication management (specifically the controlled substances inspection program)

6. Mental health (focusing on military sexual trauma follow-up and staff training)

7. Geriatric care (spotlighting antidepressant use for elderly veterans)

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[7] Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/. (The website was accessed on January 24, 2019.)

[8] Institute for Healthcare Improvement, "How risk management and patient safety intersect: Strategies to help make it happen," March 24, 2015. http://www.npsf.org/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen. (The website was accessed on January 24, 2019.)

[9] See Figure 2. CHIP inspections address these processes during FY 2019 (October 1, 2018, through September 30, 2019); they may differ from prior years' focus areas.

8. Women's health (particularly abnormal cervical pathology results notification and follow-up)

9. High-risk processes (specifically the emergency department and urgent care center operations and management).[10]
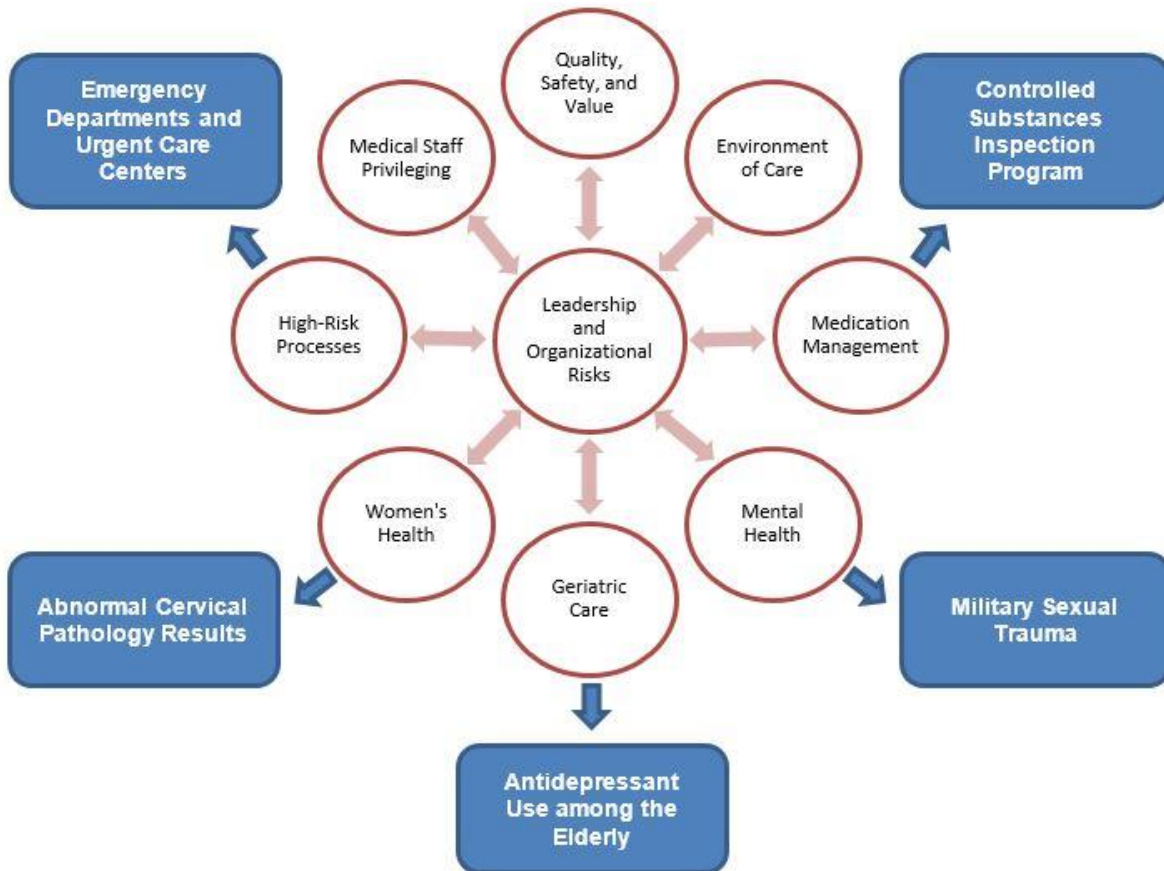
Figure 2. *Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

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[10] The OIG's review of the emergency department and urgent care center (UCC) operations and management focused on the clinical risks of the emergency department/UCC areas. This review was not performed at the VA Pacific Islands Health Care System because the facility did not have an emergency department or UCC.

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports;[11] physically inspected OIG-selected areas; and discussed processes and validated findings with managers and employees. The OIG also interviewed members of the executive leadership team.

The inspection period examined operations from August 29, 2015, through April 12, 2019, the last day of the unannounced week-long site visit.[12] While on site, the OIG did not receive any complaints beyond the scope of the CHIP inspection.

This report's recommendations for improvement target problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the facility completes corrective actions. The facility director's comments submitted in response to the report recommendations appear within each topic area.

The OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reports and Quality Standards for Inspection and Evaluation published by the Council of the Inspectors General on Integrity and Efficiency.

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[11] The OIG did not review VHA's internal survey results, instead focusing on OIG inspections and external surveys that affect facility accreditation status.

[12] The range represents the time period from the last Combined Assessment Program review, which was performed prior to the comprehensive healthcare inspection, to the completion of the unannounced week-long CHIP site visit.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare facility. Leadership and organizational risks can impact the facility's ability to provide care in all of the selected clinical areas of focus.[13] To assess the facility's risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement

2. Employee satisfaction

3. Patient experience

4. Accreditation and/or for-cause surveys and oversight inspections

5. Factors related to possible lapses in care

6. VHA performance data

Executive Leadership Position Stability and Engagement

Because each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities. Figure 3 illustrates this facility's reported organizational structure. The facility has a leadership team consisting of the director, chief of staff, associate director for Patient Care Services (ADPCS), and associate director (primarily nonclinical). The chief of staff and ADPCS oversee patient care, which requires managing service directors and chiefs of programs and practices.

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[13] L. Botwinick, M. Bisognano, and C. Haraden, "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006. www.IHI.org. (The website was accessed on February 2, 2017.)

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│Chief of   │   │  ADPCS    │   │   Associate    │
│Staff      │   │           │   │   Director     │
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Chief of Staff
- Clinical Information Service
- Dental Service
- Geriatrics, Rehabilitation and Extended Care Service
- Laboratory Service
- Medical Education Service
- Medical Staff Office
- Mental Health Service
- Pharmacy Service
- Primary Care Service
- Radiology Service
- Research and Development Service
- Specialty Care Service
- Transition and Care Management Program

ADPCS
- Care in the Community
- Caregiver Support Service
- Connected Care Service
- Education Service
- Infection Control Service
- Geriatrics and Extended Care
- Primary Care Nursing Service
- Telephone Advice Service
- Transition and Care Management Program

Associate Director
- Compensation and Pension Service
- Facilities Maintenance and Engineering Service
- Health Administration Service
- Joint Venture Operations
- Logistics Management Service
- Office of Financial Services
- Privacy Office
- Prosthetics Service
- Safety and Security Service
- Voluntary Service

(Director)
- Compliance Officer
- Equal Employment Opportunity Officer
- Group Practice Management
- Public Affairs Service
- Research Compliance Officer
- Rural Health Service
- Strategic Planner
- Quality, Safety, and Values Service

Figure 3. Facility Organizational Chart[14]
Source: VA Pacific Islands Health Care System (received April 8, 2019)

At the time of the OIG site visit, the executive team had been working together for approximately 10 months, although the chief of staff and ADPCS have been in their position for several years (see Table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	May 14, 2017
Chief of staff	September 16, 2007
Associate director for Patient Care Services	August 10, 2014
Associate director	May 27, 2018

Source: VA Pacific Islands Health Care System human resources officer (received April 8, 2019)

To help assess facility executive leaders' engagement, the OIG interviewed the director, chief of staff, ADPCS, and associate director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

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[14] At this facility, the director is responsible for the Compliance Officer; Equal Employment Opportunity Officer; Group Practice Management; Public Affairs Service; Research Compliance Officer; Rural Health Service; Strategic Planner; and Quality, Safety, and Values Service.

In individual interviews, these executive leadership team members generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, as well as employee and patient survey results. In addition, the executive leaders were generally knowledgeable within their scope of responsibilities about selected Strategic Analytics for Improvement and Learning (SAIL) metrics and SAIL community living center (CLC) measures. These are discussed in greater detail below.

The director serves as the chairperson of the Leadership Governance Council, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Leadership Governance Council oversees various working groups, such as the Quality, Safety and Value Executive; Clinical Executive; and Resource Executive Boards.

These leaders are also engaged in monitoring patient safety and care through the Quality, Safety and Value Executive Board, for which the director and chief of Quality Management are co-chairs. The Quality, Safety and Value Board is responsible for tracking and identifying trends and monitoring quality of care and patient outcomes. See Figure 4.[15]

Leadership Governance Council

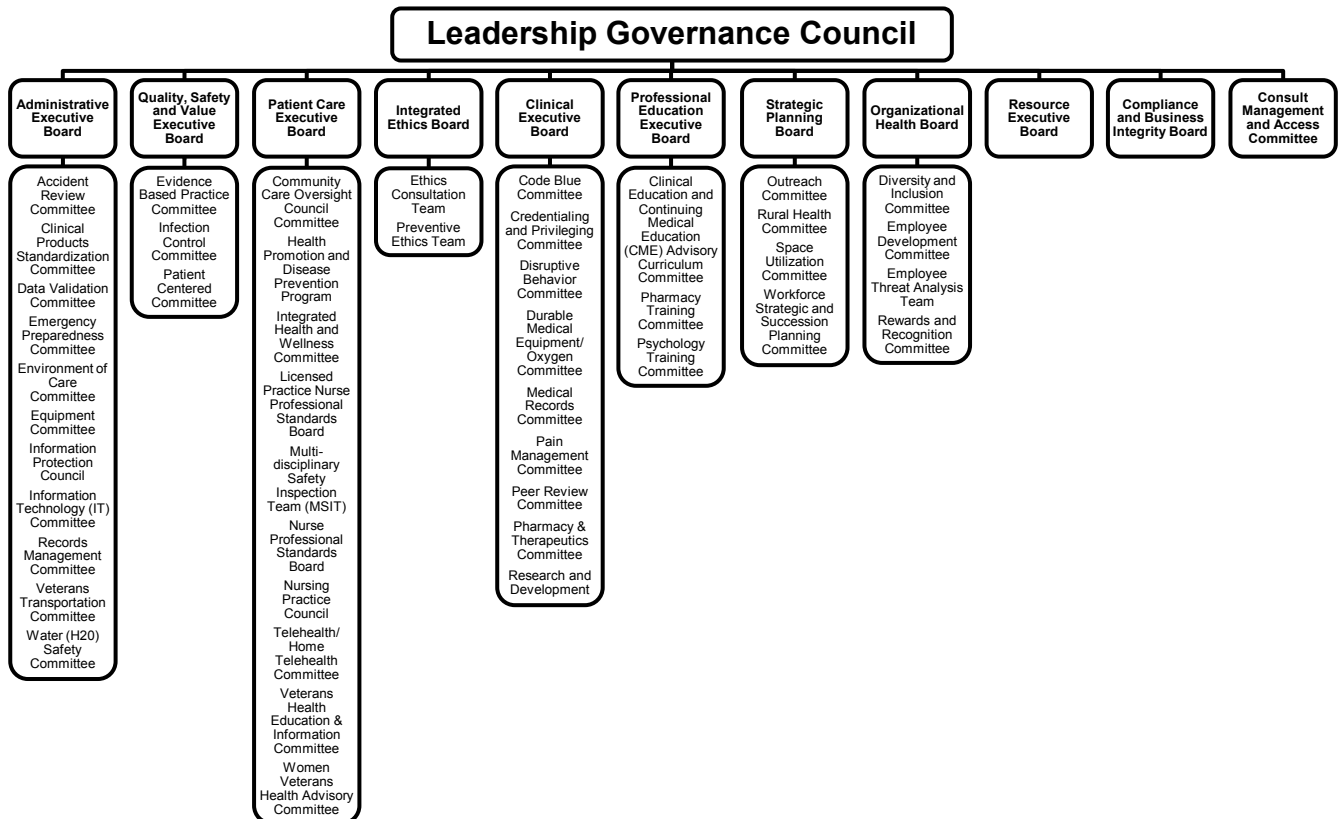| Administrative Executive Board	Quality, Safety and Value Executive Board	Patient Care Executive Board	Integrated Ethics Board	Clinical Executive Board	Professional Education Executive Board	Strategic Planning Board	Organizational Health Board	Resource Executive Board	Compliance and Business Integrity Board	Consult Management and Access Committee
Accident Review Committee; Clinical Products Standardization Committee; Data Validation Committee; Emergency Preparedness Committee; Environment of Care Committee; Equipment Committee; Information Protection Council; Information Technology (IT) Committee; Records Management Committee; Veterans Transportation Committee; Water (H20) Safety Committee	Evidence Based Practice Committee; Infection Control Committee; Patient Centered Committee	Community Care Oversight Council Committee; Health Promotion and Disease Prevention Program; Integrated Health and Wellness Committee; Licensed Practice Nurse Professional Standards Board; Multi-disciplinary Safety Inspection Team (MSIT); Nurse Professional Standards Board; Nursing Practice Council; Telehealth/Home Telehealth Committee; Veterans Health Education & Information Committee; Women Veterans Health Advisory Committee	Ethics Consultation Team; Preventive Ethics Team	Code Blue Committee; Credentialing and Privileging Committee; Disruptive Behavior Committee; Durable Medical Equipment/Oxygen Committee; Medical Records Committee; Pain Management Committee; Peer Review Committee; Pharmacy & Therapeutics Committee; Research and Development	Clinical Education and Continuing Medical Education (CME) Advisory Curriculum Committee; Pharmacy Training Committee; Psychology Training Committee	Outreach Committee; Rural Health Committee; Space Utilization Committee; Workforce Strategic and Succession Planning Committee	Diversity and Inclusion Committee; Employee Development Committee; Employee Threat Analysis Team; Rewards and Recognition Committee			

Figure 4. Facility Committee Reporting Structure
Source: VA Pacific Islands Health Care System (received April 8, 2019)

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[15] The OIG received a supplemental committee reporting structure on November 7, 2019. See Appendix F.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health. Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on facility leadership.

To assess employee attitudes toward facility leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey that relate to the period of October 1, 2017, through September 30, 2018.[16] Table 2 provides relevant survey results for VHA, the facility, and selected facility executive leaders. It summarizes employee attitudes toward these selected facility leaders as expressed in VHA's All Employee Survey. The OIG found the facility average for the selected survey leadership questions was similar to the VHA average.[17] The scores for the members of the executive leadership team, with the exception of the ADPCS, were better than the facility and VHA averages. The ADPCS attributed the scores to low nursing salaries and the inability to offer compensatory time to nurses. In all, employees appear generally satisfied with facility leaders.

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[16] Ratings are based on responses by employees who report to or are aligned under the director, chief of staff, ADPCS, and associate director.

[17] The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

**Table 2. Survey Results on Employee Attitudes toward Facility Leadership
(October 1, 2017, through September 30, 2018)**

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite[18]*	0–100 where HIGHER scores are more favorable	71.7	67.8	72.5	84	51.3	83.3
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.3	3.3	3.7	4.0	2.8	3.8
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.5	4.3	4.3	3.0	4.3
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.5	4.1	4.2	3.3	4.0

Source: VA All Employee Survey (accessed March 8, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. Apart from the ADPCS, the facility and executive leadership team averages for the selected survey questions were generally similar to or better than the VHA average. As with employee satisfaction survey results, the ADPCS maintained that the low scores were

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[18] According to the 2018 VA All Employee Survey Questions by Organizational Health Framework, Servant Leader Index "is a summary measure of the work environment being a place where organizational goals are achieved by empowering others. This includes focusing on collective goals, encouraging contribution from others, and then positively reinforcing others' contributions. Servant Leadership occurs at all levels of the organization, where individuals (supervisors, staff) put others' needs before their own."

primarily due to nursing staff frustration with low pay and compensatory time restrictions. Although facility leaders appear to be maintaining an environment where employees feel safe bringing forth issues and concerns, the ADPCS has an opportunity to improve nursing staff satisfaction and attitudes toward the workplace.

Table 3. Survey Results on Employee Attitudes toward the Workplace (October 1, 2017, through September 30, 2018)

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.6	4.7	4.3	3.7	4.5
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.6	3.9	3.7	3.1	4.2
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.5	1.8	0.8	0.9	2.5	1.0

Source: VA All Employee Survey (accessed March 8, 2019)

Patient Experience

To assess patient attitudes toward facility leaders, the OIG reviewed patient experience survey results that relate to the period of October 1, 2017, through September 30, 2018. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for facility leadership and compares the results to the overall VHA averages.[19]

VHA also collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. The OIG reviewed responses for two of the four survey questions applicable to this facility that reflect patients' attitudes toward facility leaders (see Table 4). Of the two survey questions, the outpatient patient-centered medical home average was higher than VHA average, and the outpatient specialty care rating was lower. Patients seem generally satisfied with the leadership and care provided. Facility leaders appeared to be actively engaged with patients, for example, by implementing a "red coat" program for addressing patients' problems in real time and conducting leadership rounds for more personalized interactions with patients.

Table 4. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2017, through September 30, 2018)

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*[20]	The response average is the percent of "Definitely Yes" responses.	66.9	n/a
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.2	n/a

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[19] Ratings are based on responses by patients who received care at this facility.

[20] The facility does not provide acute inpatient care, therefore, the facility average for two inpatient survey questions is not applicable (n/a).

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.3	79.3
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.5	73.3

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 28, 2018)

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys, including those conducted for cause, by oversight and accrediting agencies to gauge how well leaders respond to identified problems.[21] Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).[22] Indicative of effective leadership, the facility has closed all recommendations for improvement.[23]

At the time of the site visit, the OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities.[24] Additional results included the Long

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[21] The Joint Commission (TJC) conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or other reported complaints. The outcomes of these types of activities may affect the accreditation status of an organization.

[22] According to VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017, TJC provides an "internationally accepted external validation that an organization has systems and processes in place to provide safe and quality-oriented health care." TJC "has been accrediting VA medical facilities for over 35 years." Compliance with TJC standards "facilitates risk reduction and performance improvement."

[23] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by the accreditation organization or inspecting agency.

[24] According to VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs,* May 9, 2017, the Commission on Accreditation of Rehabilitation Facilities "provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies." VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.

Term Care Institute's inspection of the facility's CLC[25] and the Paralyzed Veterans of America's inspection of the facility's spinal cord injury and disorder program and related services.[26]

Table 5. Office of Inspector General Inspections/The Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Combined Assessment Program Review of the VA Pacific Islands Health Care System, Honolulu, Hawaii, Report No. 15-00626-28, November 10, 2015*)	August 2015	18	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Pacific Islands Health Care System, Honolulu, Hawaii, Report No. 15-00180-538, September 30, 2015*)	July 2015	14	0
OIG (*Healthcare Inspection – Summarization of Select Aspects of the VA Pacific Islands Health Care System, Honolulu, Hawaii, Report No. 15-04655-347, September 22, 2016*)	August 2015	1	0
TJC Ambulatory Health Care Accreditation	July 2016	11	0
TJC Nursing Care Center Accreditation		4	0
TJC Behavioral Health Care Accreditation		5	0
TJC Home Care Accreditation		3	0
TJC Laboratory Accreditation	March 2018	5	0
TJC Laboratory Accreditation	January 2016	1	0

Sources: OIG and TJC (inspection/survey results verified with the chief of Quality Management on April 9, 2019)

Factors Related to Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be

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[25] The Long Term Care Institute states that it has been to over 4,000 healthcare facilities conducting quality reviews and over 1,145 external regulatory surveys since 1999. The Long Term Care Institute is "focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings." Long Term Care Institute. http://www.ltciorg.org/about-us/. (The website was accessed on March 6, 2019.)

[26] The Paralyzed Veterans of America inspection took place July 13–14, 2016. This veterans service organization review does not result in accreditation status.

able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 6 lists the reported patient safety events from August 29, 2015 (the prior comprehensive OIG inspection), through April 12, 2019.[27]

Table 6. Summary of Selected Organizational Risk Factors (August 29, 2015, through April 12, 2019)

Factor	Number of Occurrences
Sentinel Events[28]	0
Institutional Disclosures[29]	2
Large-Scale Disclosures[30]	0

Source: VA Pacific Islands Health Care System's chief of Quality Management (received April 8, 2019)

Patient safety indicators, developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services, provide information on potential in-hospital complications and adverse events following surgeries and procedures.[31] This data is not applicable since acute inpatient care is not provided at the facility.

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes "measures on healthcare

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[27] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the VA Pacific Islands Health Care System is a medium complexity (2) affiliated facility as described in Appendix B.)

[28] The definition of sentinel event can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life."

[29] According to VHA Directive 1004.08, *Disclosure of Adverse Events To Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") as "a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or [his or her] personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."

[30] According to VHA Directive 1004.08, VHA defines large-scale disclosures of adverse events (sometimes referred to as "notifications") as "a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue."

[31] Agency for Healthcare Research and Quality. https://www.qualityindicators.ahrq.gov/. (The website was accessed on December 11, 2017.)

quality, employee satisfaction, access to care, and efficiency." It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[32]

VA also uses a star-rating system where facilities with a "5-star" rating are performing within the top 10 percent of facilities and "1-star" facilities are performing within the bottom 10 percent of facilities. Figure 6 describes the distribution of facilities by star rating.[33] As of June 30, 2018, the facility was rated as "2-star" for overall quality.
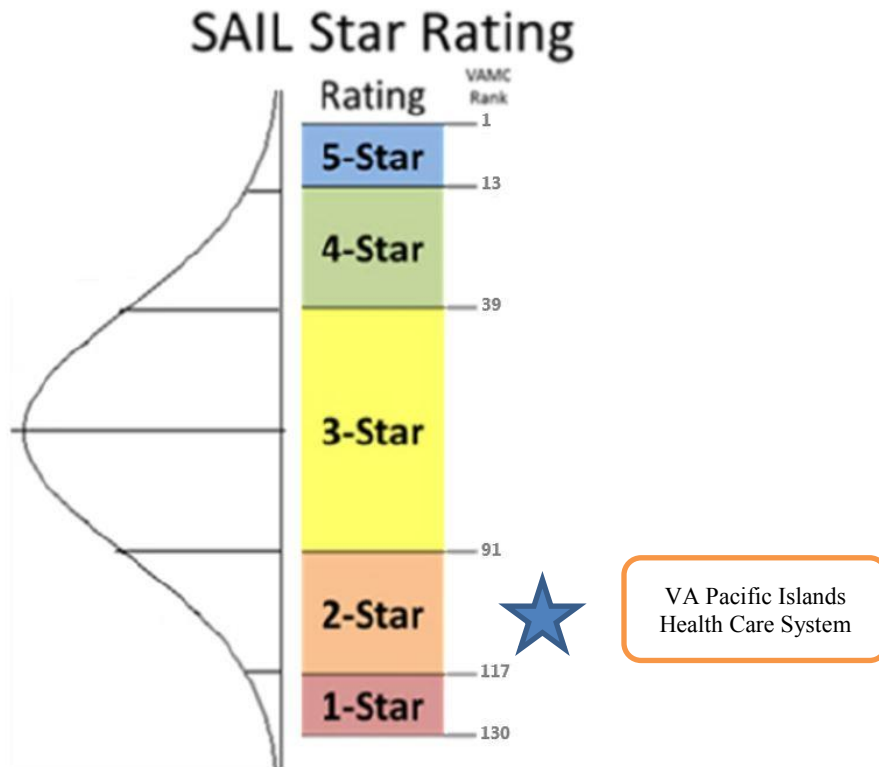

Figure 5. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed March 8, 2019)

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[32] VHA Support Service Center (VSSC), The Strategic Analytics for Improvement and Learning (SAIL) Value Model,
http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938.
(The website was accessed on March 7, 2019, but is not accessible by the public.)

[33] According to the methods established by the SAIL Model, this is based on normal distribution ranking of the quality domain for 130 VA Medical Centers.

Figure 6 illustrates the facility's quality of care and efficiency metric rankings and performance compared with other VA facilities as of September 30, 2018. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of call responsiveness and registered nurse (RN) turnover). Metrics that need improvement are denoted in orange and red (for example, patient-centered medical home (PCMH) care coordination, mental health continuity (of) care, best place to work, and ambulatory care sensitive condition (ACSC) hospitalization).[34]
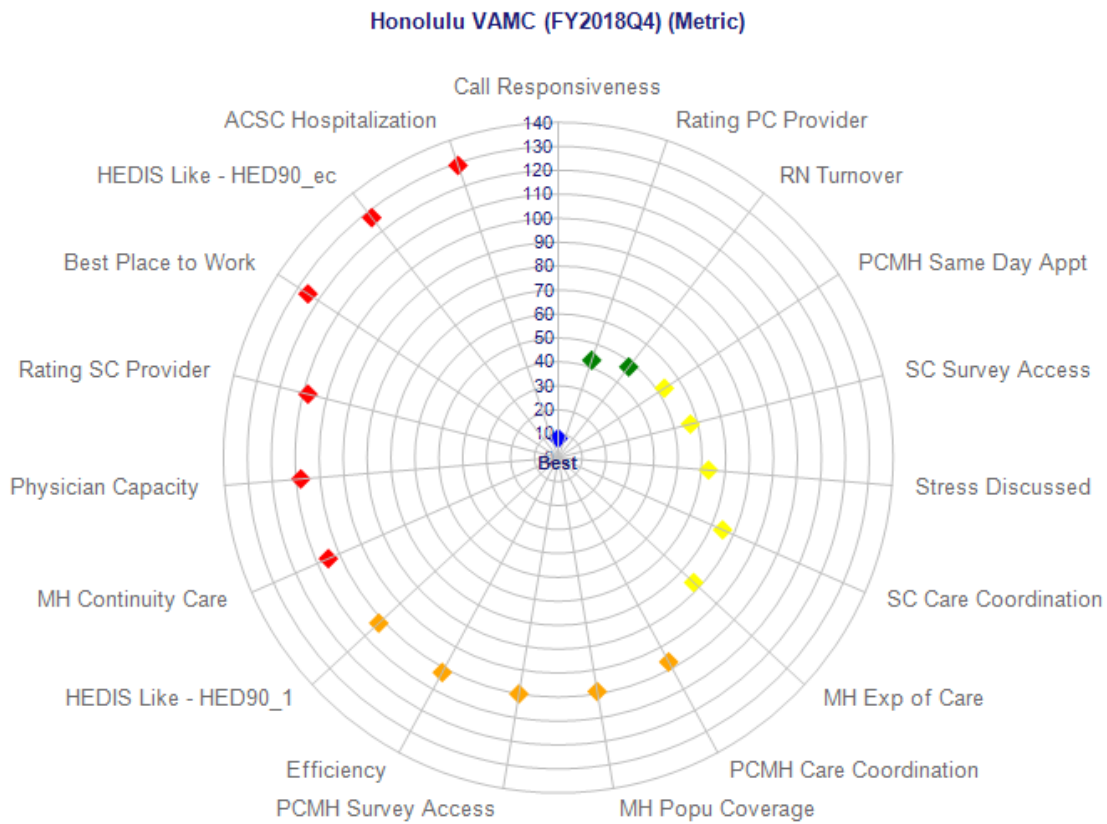
Figure 6. Facility Quality of Care and Efficiency Metric Rankings (as of September 30, 2018)
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). Data definitions are provided in Appendix D.

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[34] For information on the acronyms in the SAIL metrics, please see Appendix D.

The SAIL Value Model also includes "SAIL CLC," which is a tool to summarize and compare the performance of CLCs in the VA. The SAIL model leverages much of the same data used in The Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare*.[35] The SAIL CLC provides a single resource to review quality measures and health inspection results. It includes star ratings for an unannounced survey, staffing, quality, and overall results.[36] Table 7 summarizes the rating results for the facility's CLC as of December 31, 2018. Although the facility has an overall "3-star" rating, its rating for quality is only a "2-star."

**Table 7. Facility CLC Star Ratings
(as of December 31, 2018)**

Domain	Star Rating
Unannounced Survey	2
Staffing	5
Quality	2
Overall	3

Source: VHA Support Service Center

In exploring the reasons for the "2-star" quality rating, the OIG considered the radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 7 illustrates the facility's CLC quality rankings and performance compared with other VA CLCs as of December 31, 2018. The figure uses blue and green data points to indicate high performance (for example, in the areas of physical restraints–long stay (LS) and newly received antipsychotic (Antipsych) medications–short stay (SS)). Metrics that need improvement and were likely the reasons why the facility had a "2-star" for quality are denoted in orange and red (for example, urinary tract infection (UTI) (LS), catheter in bladder (LS), and moderate-severe pain (LS)).[37]

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[35] According to the Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, August 22, 2019, "In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several "star" ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes."

[36] *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated August 22, 2019). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410. (The website was accessed on September 3, 2019, but is not accessible by the public.)

[37] For data definitions of acronyms in the SAIL CLC measures, please see Appendix E.
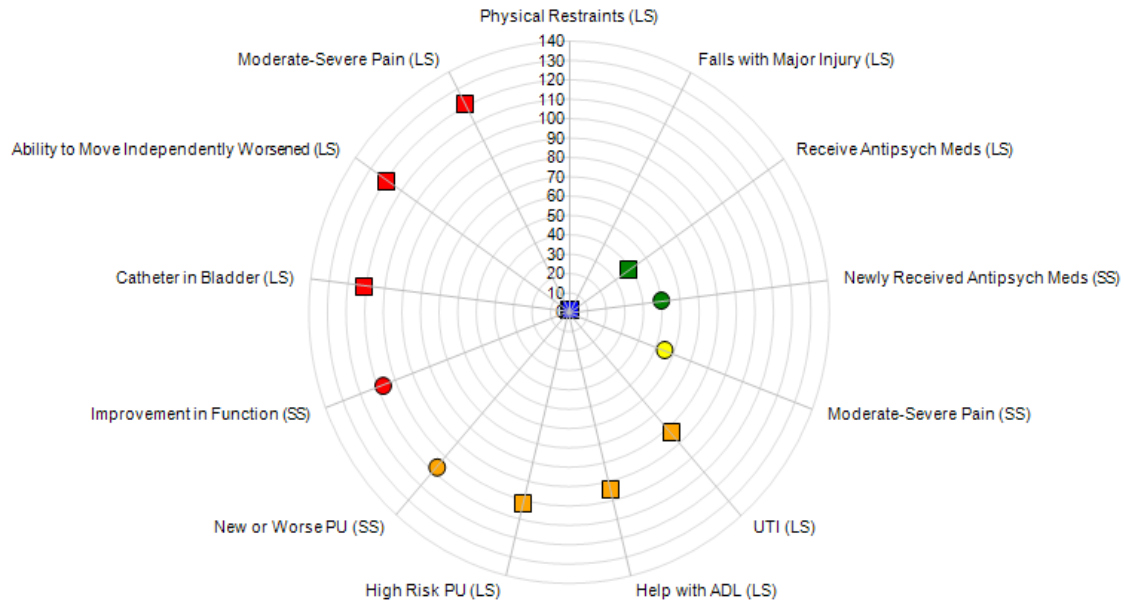
Figure 7. *Facility CLC Quality Measure Rankings (as of December 31, 2018)*
LS = Long-Stay Measure   *SS = Short-Stay Measure*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix E.

Leadership and Organizational Risks Conclusion

The facility's executive leadership team appeared relatively stable, with all four positions permanently filled at the time of the OIG's site visit. As for the selected survey scores related to employees' satisfaction, the facility averages were generally similar to the VHA averages. However, opportunities exist for the ADPCS to improve nursing staff satisfaction and attitudes in the workplace. The two applicable patient experience survey questions for this facility showed one survey score above and one below VHA averages. The facility leaders appeared actively engaged with employees and patients and were working to improve employee and patient engagement and satisfaction. The leaders also seemed to support efforts to improve and maintain patient safety, quality care, and other positive outcomes (such as initiating plans to maintain positive perceptions of the facility through active stakeholder engagement). The OIG's review of the facility's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. The leadership team was knowledgeable within their scope of responsibility about selected SAIL and CLC metrics but should continue to take actions to improve performance of measures contributing to the facility's SAIL and CLC "2-star" quality ratings.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care that involves coordinating care among members of the healthcare team. To meet this goal, VHA must foster a culture of integrity and accountability in which personnel are vigilant and mindful, proactively risk-aware, and committed to consistently providing quality care, while seeking continuous improvement.[38] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[39] VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.[40]

In determining whether the facility implemented and incorporated several OIG-selected key functions of VHA's enterprise framework for QSV into local activities, the inspection team evaluated protected peer reviews of clinical care,[41] utilization management (UM) reviews,[42] patient safety incident reporting with related root cause analyses,[43] and cardiopulmonary resuscitation (CPR) episode reviews.[44]

When conducted systematically and credibly, protected peer reviews reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[45]

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[38] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013. (This VHA directive was scheduled for recertification on or before the last working day of August 2018 but was rescinded October 24, 2019.)

[39] Department of Veterans Affairs, Veterans Health Administration Blueprint for Excellence, September 2014.

[40] VHA Directive 1026.

[41] The definition of a peer review can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a critical review of care, performed by a peer, to evaluate care provided by a clinician for a specific episode of care, to identify learning opportunities for improvement, to provide confidential communication of the results back to the clinician, and to identify potential system or process improvements.

[42] According to VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019), UM reviews include evaluating the "appropriateness, medical need, and efficiency of health care services according to evidence-based criteria." This directive expired July 31, 2019.

[43] The definition of a root cause analysis can be found within VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (This VHA Handbook was scheduled for recertification on or before the last working date of March 2016 and has not been recertified.) A root cause analysis is "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."

[44] VHA Directive 1177, *Cardiopulmonary Resuscitation*, August 28, 2018.

[45] VHA Directive 1190.

The UM program, a key component of VHA's framework for quality, safety, and value, provides vital tools for managing the quality and the efficient use of resources. It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.[46]

Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the facility.[47]

VHA has also issued guidance to support its strategic priority of providing personalized, proactive, patient-driven care and to ensure that the provision of life-sustaining treatments, including CPR, is aligned with patients' values, goals, and preferences. VHA requires that each facility establishes a CPR Committee or equivalent that fully reviews each episode of care in which resuscitation was attempted. The ongoing review and analysis of high-risk healthcare processes is essential for ensuring patient safety and the provision of high-quality care. VHA also has established requirements for basic life support and advanced cardiac life support training and certification for clinicians responsible for administering life-sustaining treatments.[48]

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:[49]

- Protected peer reviews

  o Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)

  o Implementation of improvement actions recommended by the Peer Review Committee

  o Completion of final reviews within 120 calendar days

  o Quarterly review of Peer Review Committee's summary analysis by the Medical Executive Committee

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[46] VHA Directive 1117(2).

[47] VHA Handbook 1050.01.

[48] VHA Directive 1177, VHA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences, January 11, 2017.

[49] For CHIP inspections, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

- o Peer review of all applicable deaths within 24 hours of admission to the hospital
- o Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[50]

- UM[51]
  - o Completion of at least 75 percent of all required inpatient reviews
  - o Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database
  - o Interdisciplinary review of UM data

- Patient safety
  - o Annual completion of a minimum of eight root cause analyses[52]
  - o Inclusion of required content in root cause analyses (generally)
  - o Submission of completed root cause analyses to the National Center for Patient Safety within 45 days
  - o Provision of feedback about root cause analysis actions to reporting employees
  - o Submission of annual patient safety report to facility leaders

- Resuscitation episode review
  - o Evidence of a committee responsible for reviewing resuscitation episodes
  - o Confirmation of actions taken during resuscitative events being consistent with patients' wishes
  - o Evidence of basic or advanced cardiac life support certification for code team responders
  - o Evaluation of each resuscitation episode by the CPR Committee or equivalent

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[50] VHA Directive 1190.

[51] The facility does not provide inpatient care.

[52] According to VHA Handbook 1050.01, "the requirement for a total of eight [root cause analyses] and Aggregated Reviews is a minimum number, as the total number of [root cause analyses] is driven by the events that occur and the [Safety Assessment Code] SAC score assigned to them. At least four analysis per fiscal year must be individual [root cause analyses], with the balance being Aggregated Reviews or additional individual [root cause analyses]."

Quality, Safety, Value Conclusion

The OIG found general compliance with requirements for protected peer review, patient safety, and resuscitation episodes review. However, the OIG identified noncompliance with interdisciplinary reviews of UM data.

VHA requires an interdisciplinary group review of UM data. This process must include, but is not limited to participation by representatives from UM, medicine, nursing, social work, case management, mental health, and chief business office revenue-utilization review.[53] From March 2018 through March 2019, the Clinical Executive Board reviewed UM data; however, the chief business office revenue-utilization review was not represented. As a result, the Clinical Executive Board performed reviews and analyses of UM data without the perspective of key utilization review colleagues. Facility managers were unaware of the requirement to ensure specific interdisciplinary team members participated in UM data review.

Recommendation 1

1. The chief of staff makes certain that all required representatives consistently participate in interdisciplinary reviews of utilization management data and monitors representatives' compliance.

Facility concurred.

Target date for completion: June 2020

Facility response: Utilization Management reports quarterly at the Clinical Practice Council[54] meetings, which has a representative from the Care in the Community Office (also known as the chief business office revenue-utilization review–CBO R UR) that oversees utilization reviews from community and the financial aspect. Review of the report provided by Utilization Management shows comprehensive information including admission and continued stay reviews, Physician Utilization Management Advisor (PUMA) reviews of non-acute days, and revenue loss related to length of stay outliers. Information from the Clinical Practice Council is presented quarterly to the Leadership Governance Council. Quality, Safety, and Values (QSV) Service will monitor compliance to ensure participation and attendance by Care in the Community Office representative (CBO R-UR) for a minimum of two consecutive quarters to ensure compliance at 90 percent or greater.

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[53] VHA Directive 1117(2).

[54] Please see Appendix F for more detail on the Clinical Practice Council.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all healthcare professionals who are permitted by law and the facility to practice independently"—"without supervision or direction, within the scope of the individual's license, and in accordance with individually granted clinical privileges." These healthcare professionals are also referred to as licensed independent practitioners (LIPs).[55]

Clinical privileges need to be specific, based on the individual's clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical Staff and approved by the director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to their expiration.[56]

VHA defines the focused professional practice evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's' professional performance. The FPPE typically occurs at the time of initial appointment to the medical staff or the granting of new, additional privileges." "The on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation (OPPE), is essential to confirm the quality of care delivered."[57]

According to TJC, the "FPPE for Cause" should be used when a question arises regarding a privileged provider's ability to deliver safe, high-quality patient care. The "FPPE for Cause" is limited to a particular time frame and customized to the specific provider and related clinical concerns.[58] Federal law requires VA facilities to report to the National Practitioner Data Bank when facilities take adverse clinical privileging actions, accept the surrender of clinical privileges, or restrict clinical privileges when the action is related to professional competence or professional conduct of LIPs.[59]

To determine whether the facility complied with requirements for privileging, the OIG interviewed key managers and selected and reviewed the privileging folders of several medical staff members:

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[55] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (This VHA Handbook was scheduled for recertification on or before the last working date of October 2017 and has not been recertified.)

[56] VHA Handbook 1100.19.

[57] VHA Handbook 1100.19.

[58] Office of Safety and Risk Awareness, Office of Quality and Performance, Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance, July 2016 (Revision 2).

[59] VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports*, December 28, 2009. (This VHA Handbook was scheduled for recertification on or before the last working date of December 2014 and has not been recertified.)

- Seven solo or few (less than two in a specialty) practitioners hired within 18 months before the site visit or were privileged within the prior 12 months.[60]

- Nine LIPs hired within 18 months before the site visit

- Eighteen LIPs re-privileged within 12 months before the visit

- No providers underwent a FPPE for cause within 12 months prior to the visit

The OIG evaluated the following performance indicators:

- Privileging

  o Privileges requested by the provider

    - Facility-specific

    - Service-specific

    - Provider-specific[61]

  o Approval of privileges for a period of less than, or equal to, two years

- Focused professional practice evaluations

  o Criteria defined in advance

  o Use of required criteria in FPPEs for selected specialty LIPs

  o Results and time frames clearly documented

  o Evaluation by another provider with similar training and privileges

  o Executive Committee of the Medical Staff's consideration of FPPE results in its decision to recommend continuing the initially granted privileges

- Ongoing professional practice evaluations

  o Criteria specific to the service or section

  o Use of required criteria in OPPEs for selected specialty LIPs

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[60] The 18-month period was from October 9, 2017, 2017, through April 8, 2019. The 12-month review period covered April 9, 2018, through April 8, 2019; VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016, refers to a solo practitioner as being one provider in the facility that is privileged in a particular specialty. The OIG considers "few practitioners" as being fewer than three providers in the facility that are privileged in a particular specialty.

[61] According to VHA Handbook 1100.19, facility-specific means that privileges are granted only for procedures and types of services performed at the facility; service-specific refers to privileges being granted in a specific clinical service, such as neurology; and provider-specific means that the privileges should be granted to the individual provider based on their clinical competence and capabilities.

- o Service chief's determination to recommend continuation of current privileges was based in part on the results of OPPE activities

- o Evaluation by another provider with similar training and privileges

- o Executive Committee of the Medical Staff's decision to recommend continuing privileges based on OPPE results

- Focused professional practice evaluations for cause

  - o Clearly defined expectations/outcomes

  - o Time-limited

  - o Provider's ability to practice independently not limited for more than 30 days

  - o Shared with the provider in advance

- Reporting of privileging actions to National Practitioner Data Bank

Medical Staff Privileging Conclusion

The OIG found general compliance with requirements for privileging. However, the OIG identified concerns with the requirements for professional practice evaluations.

VHA requires that FPPEs and OPPEs must be completed and that another provider with similar training and privileges evaluate the privilege-specific competence of the practitioner and document evidence of competently performing requested privileges.[62] For one solo provider's FPPE, five solo providers' OPPEs, and one general provider's OPPE, similarly trained and privileged providers did not complete the evaluations. This resulted in insufficient evidence to confirm the quality of care delivered by the providers. Managers believed that the requirement only applied to the four specialties included in the memorandum and reported that VISN 21 intends to develop a plan to correct the issue with respect to the solo providers.

Recommendation 2

2. The chief of staff confirms that clinical managers ensure that focused and ongoing professional practice evaluations are completed by providers with similar training and privileges and monitors managers' compliance.

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[62] VHA Memorandum, Requirements for Peer Review of Solo Practitioners, August 29, 2016.

Facility concurred.

Target date for completion: June 2020

Facility response: The VISN Quality Management Office has assigned facilities to conduct specialty specific chart reviews for the Ongoing Professional Practice Evaluations (OPPE) and Focused Professional Practice Evaluation (FPPE) process where facilities have two or less providers in that specialty. This is to ensure that focused and ongoing professional practice evaluations are completed by providers with similar training and privileges. The Chief of Staff Office will facilitate the coordination and communication between our facility and the facility assigned to conduct the reviews. Chief of Staff Office will conduct review of all OPPE and FPPE for solo providers on a monthly basis to ensure that these are conducted by similarly trained and privileged providers. This monthly review is to capture the data from the evaluations and will continue until 90 percent or greater compliance is achieved for a minimum of six (6) months. This monitoring will be reported at the Executive Committee of the Medical Staff and a copy will be provided to Quality, Safety, and Values (QSV) Service Accreditation for inclusion in the QSV Council meetings.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct environment of care inspection rounds and resolve issues in a timely manner. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional, but should also promote healing.[63]

The purpose of this facet of the OIG inspection was to determine whether the facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, such as in the locked inpatient mental health unit. The inspection team also looked at facility compliance with emergency management processes.[64]

VHA requires its facilities to have the "capacity for [providing] mental health services for veterans with acute and severe emotional and/or behavioral symptoms causing a safety risk to self or others, and/or resulting in severely compromised functional status. This level of care is typically provided in an inpatient setting;" however, for facilities that do not have inpatient mental health services, that "capacity" could mean facilitating care at a nearby VA or non-VA facility.[65]

VHA requires managers to establish a comprehensive emergency management program to ensure the continuity of patient care and hospital operations in the event of a natural disaster or other emergency. This includes conducting a hazard vulnerability analysis and developing an emergency operations plan. These requirements are meant to support facilities' efforts to identify and minimize harm from potential hazards, threats, incidents, and events related to healthcare and other essential services.[66] Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,[67]

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[63] VHA Directive 1608, Comprehensive Environment of Care (CEOC Program), February 1, 2016.

[64] Applicable requirements for high-risk areas and emergency management include those detailed in or by various VHA Directives, Joint Commission hospital accreditation standards, Occupational Safety and Health Administration, American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), and National Fire Protection Association (NFPA).

[65] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (This VHA handbook was scheduled for recertification on or before the last working date of September 2018 and has not been recertified.)

[66] VHA Directive 0320.01, Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures, April 6, 2017.

[67] VHA Directive 1028, *Electrical Power Distribution Systems*, July 25, 2014. (This VHA directive was scheduled for recertification on or before the last working date of July 2019 and has not been recertified.)

Occupational Safety and Health Administration,[68] and National Fire Protection Association standards.[69] The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.[70]

In all, the OIG team inspected seven areas—two inpatient units (VA-staffed locked inpatient mental health unit at Tripler Army Medical Center and the center for aging or CLC), women's health clinic, specialty clinic, posttraumatic stress disorder recovery rehabilitation program unit, dialysis clinic, and primary care clinic. The team also inspected the Leeward Oahu VA Clinic. The inspection team reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent facility
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies

- Community based outpatient clinic
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies

- Locked inpatient mental health unit
  - Mental health environment of care rounds
  - Nursing station security
  - Public area and general unit safety

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[68] The Occupational Safety and Health Administration (OSHA) is part of the US Department of Labor. OSHA's mission is to assure safe and healthy working conditions "by setting and enforcing standards and by providing training, outreach, education, and assistance." https://www.osha.gov/about.html. (This website was accessed on June 28, 2018.)

[69] The National Fire Protection Association (NFPA) is a global nonprofit organization "devoted to eliminating death, injury, property, and economic loss due to fire, electrical, and related hazards." https://www.nfpa.org/About-NFPA. (This website was accessed on June 28, 2018.)

[70] TJC. Environment of Care standard EC.02.05.07.

- o Patient room safety

- o Infection prevention

- o Availability of medical equipment and supplies

- Emergency management

  - o Hazard vulnerability analysis (HVA)

  - o Emergency operations plan (EOP)

  - o Emergency power testing and availability

Environment of Care Conclusion

Generally, the facility met requirements for emergency management. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified noncompliance with medication safety, infection prevention, and patient privacy at the parent facility. In addition, the OIG team noted environmental cleanliness and privacy concerns at the Leeward Oahu VA Clinic.

TJC requires that "[t]he hospital removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration."[71] In the specialty clinic, the OIG team found an open and expired purified protein derivative multi-dose vial in the medication refrigerator. This resulted in the lack of assurance of safe medication administration. Facility managers stated that staff were aware of proper medication storage requirements; however, nursing staff were only checking expiration dates just prior to use and relying on weekly pharmacy inspections to remove expired medications from those available for use. Facility managers cited that inattention to detail resulted in the expired vial being missed during the weekly pharmacy inspections.

Recommendation 3

3. The associate director for Patient Care Services ensures staff remove expired medications from service and monitors staff compliance.

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[71] TJC. Medication Management standard MM.03.01.01.

Facility concurred.

Target date for completion: June 2020

Facility Response: Clinic Nurse Managers in the Community Based Outpatient Clinics and pharmacy technicians in the main facility will conduct medication inventory rounds to ensure any expired medications in Pyxis (automated dispensing unit) and medication refrigerators are removed or returned to pharmacy as required. The inventory report is presented at the Pharmacy and Therapeutics Committee. A copy of this report will be provided to Quality, Safety, and Values (QSV) Service for inclusion in the QSV Council meeting minutes. The Associate Director for Patient Care Services will ensure compliance at 90 percent for a minimum of six (6) months.

TJC also requires hospitals to minimize the possibility of transmitting infections by ensuring that dirty and used equipment are stored separately from clean equipment.[72] In a vacant patient room at the CLC, the OIG found dirty and clean equipment stored together with ladders being used by a contractor.[73] This resulted in a lack of assurance of a clean and safe patient care environment that minimizes the spread of infection. The associate director attributed a shortage of storage areas throughout the unit as the reason for noncompliance.

Recommendation 4

4. The associate director for Patient Care Services makes certain that managers store clean and dirty medical equipment separately and monitors managers' compliance.

Facility concurred.

Target date for completion: June 2020

Facility response: The room in the Community Living Center (CLC) has been returned for use as a resident's room. CLC staff have been re-educated on the appropriate storage of clean and dirty medical equipment. The Nurse Manager for the CLC will monitor compliance with the segregation of clean and dirty equipment. The monitoring report will be provided to Quality, Safety, and Values (QSV) Service for inclusion in the QSV Council meeting notes. The Associate Director for Patient Care Services will ensure compliance at 90 percent for a minimum of six (6) months.

In addition, TJC requires the protection of patient information against unauthorized access, use, and disclosure.[74] The OIG team noted that computer monitors in the three sections inspected in

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[72] TJC. Environment of Care standard EC.02.02.01.

[73] Facility CLC; Center for Aging unit.

[74] TJC. Information Management standard IM.02.01.03, EP 5.

the primary care clinic did not have privacy screens to protect patient identification and health information.[75] This may result in unauthorized access to protected patient information. The nurse managers and clinical staff were aware of the requirements and cited an insufficient number of privacy screens for all computer monitors as the reason for noncompliance.

Recommendation 5

5. The associate director makes certain staff use privacy screens on all computer monitors located in public areas and monitors staff compliance.

Facility concurred.

Target date for completion: June 2020

Facility response: The clinic nurse managers took inventory of all computer monitors in the modules identifying monitors without the required privacy screens. Orders were placed, privacy screens received and placed. All computer monitors are now in compliance. The Privacy Officer and Information System Security Officer (ISSO) are integral members of the Environment of Care (EOC) team and participate in facility Environment of Care Rounds held weekly. Findings noted from the EOC rounds are used to capture data during these rounds. The use of privacy screens is one of the items on the checklist in the Information Security module. In addition to reporting via the program, the Privacy Officer and/or the ISSO will focus on this area, reinforce the reason for using privacy screens with staff, and report violations to the nurse manager for immediate action. The report from the Performance Logic program will be reviewed during the monthly Environment of Care meetings. A copy of the report will be provided to Quality, Safety, and Values (QSV) Service Accreditation for inclusion in the QSV Council meeting minutes. The Associate Director will ensure compliance at 90 percent or greater for a minimum of six (6) months.

Furthermore, VHA and TJC require hospitals to identify environmental deficiencies, hazards, unsafe practices, and to keep "furnishings and equipment safe and in good repair."[76] The OIG found that the Leeward Oahu VA Clinic waiting room carpet was soiled and unsalvageable. These conditions resulted in a lack of assurance of a clean and safe patient care environment. Facility managers were aware of the flooring condition, initiated a work order for repairs, and cited the delay in completion of the work order was due to the uncertainty of whether it was the landlord's or VA's responsibility to replace the carpeting.

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[75] Primary care clinic pods 2, 3, and 4.
[76] TJC. Environment of Care standard EC.02.06.01; VHA Directive 1608.

Recommendation 6

6. The associate director ensures that the Leeward Oahu VA Clinic waiting room carpet is replaced.[77]

Facility concurred.

Target date for completion: October 2019

Facility Response: Facilities Management and Engineering Services met with the Queen's West Facilities Engineer (landlord for the Leeward Oahu VA Clinic) regarding the waiting room carpet. The recommendation was made to replace the carpet with vinyl tiles. The replacement was completed on October 28, 2019. We request closure of this recommendation based on the evidence provided.

TJC also requires the protection of patient information "against unauthorized access, use, and disclosure of health information."[78] The OIG team found that the Leeward Oahu VA Clinic staff did not secure the transport box containing specimens with personally identifiable information during transfer to the parent facility. This may result in unauthorized access to personally identifiable information. Facility managers believed that securing the transport box with tape provided sufficient protection and made the box tamper proof.

Recommendation 7

7. The chief of staff ensures that Leeward Oahu VA Clinic staff secure laboratory transport boxes containing personally identifiable information and monitors staff compliance.

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[77] The OIG reviewed evidence sufficient to demonstrate that the facility had completed improvement actions and therefore closed the recommendation before the report's release.

[78] TJC. Information Management standard IM.02.01.03, EP 5.

Facility concurred.

Target date for completion: June 2020

Facility Response: Leadership reviewed this finding along with the current process for securing the lab specimen and transport of lab specimens from the Leeward Clinic to the main laboratory. The current process is to secure the personally identifiable information within shipping coolers which are sealed with tamper evident tape. Changes have been made to this process through the addition of opaque bags to contain all lab samples. This additional step provides another layer of security. Monitoring will be done to ensure that the tamper evident tape on the shipping coolers and the opaque bags are intact when they are received in the main lab. Monitoring will be reported at Clinical Practice Council and a copy of this report will be provided to Quality, Safety, and Values (QSV) Service for inclusion in the QSV Council meeting minutes. The Chief of Staff will ensure that no tampering has been done to either the tape on the shipping box or the opaque security bags for a minimum of six (6) months with 90 percent compliance.

Medication Management: Controlled Substances Inspections

The Controlled Substances Act divides controlled drugs into five categories based on whether they have an accepted medical treatment use in the United States, their relative potential for abuse, and the likelihood of causing dependence if abused.[79] Diversion of controlled substances by healthcare workers—the transfer of legally prescribed controlled substances from the prescribed individual to others for illicit use—remains a serious problem that can increase patient safety issues and elevate the liability risk to healthcare facilities.[80]

VHA requires that facility managers implement and maintain a controlled substances inspection program to minimize the risk for loss and diversion and to enhance patient safety. Requirements include the appointment of controlled substances coordinator(s) and controlled substances inspectors, implementation of procedures for inventory control, and inspections of the pharmacy and clinical areas with controlled substances.[81]

To determine whether the facility complied with requirements related to controlled substances security and inspections, the OIG team interviewed key managers and reviewed inspection reports; monthly summaries of findings, including discrepancies, provided to the facility director; inspection quarterly trend reports for the prior two completed quarters;[82] and other relevant documents. The OIG evaluated the following performance indicators:

- Controlled substances coordinator reports
  - Monthly summary of findings to the director
  - Quarterly trend reports to the director
  - Quality Management Committee's review of monthly and quarterly trend reports
  - Actions taken to resolve identified problems
- Pharmacy operations
  - Staff restrictions for monthly review of balance adjustments[83]
- Requirements for controlled substances inspectors

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[79] Drug Enforcement Agency Controlled Substance Schedules. https://www.deadiversion.usdoj.gov/schedules/. (The website was accessed on March 7, 2019.)

[80] American Society of Health-System Pharmacists, "ASHP Guidelines on Preventing Diversion of Controlled Substances," *American Journal of Health-System Pharmacists,* 74, no. 5 (March 1, 2017): 325-348.

[81] VHA Directive 1108.02(1), *Inspection of Controlled Substances*, November 28, 2016 (amended March 6, 2017).

[82] The two quarters were from October 1, 2018, through March 31, 2019.

[83] Controlled substances balance adjustment reports list transactions in which the pharmacy vault inventory balance was manually adjusted.

- o No conflicts of interest

- o Appointed in writing by the director for a term not to exceed three years

- o Hiatus of one year between any reappointment

- o Completion of required annual competency assessment

- Controlled substances area inspections

  - o Completion of monthly inspections

  - o Rotations of controlled substances inspectors

  - o Patterns of inspections

  - o Completion of inspections on day initiated

  - o Reconciliation of dispensing between pharmacy and each dispensing area

  - o Verification of controlled substances orders

  - o Performance of routine controlled substances inspections

- Pharmacy inspections

  - o Monthly physical counts of the controlled substances in the pharmacy

  - o Completion of inspections on day initiated

  - o Security and verification of drugs held for destruction[84]

  - o Accountability for all prescription pads in pharmacy

  - o Verification of hard copy controlled substances prescriptions

  - o Verification of 72-hour inventories of the main vault[85]

  - o Quarterly inspections of emergency drugs

  - o Monthly checks of locks and verification of lock numbers

- Facility review of override reports[86]

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[84] According to VHA Directive 1108.02(1), the Destructions File Holding Report "lists all drugs awaiting local destruction or turn-over to a reverse distributor." Controlled substances inspectors "must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report."

[85] VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010. (This handbook was in effect at the time of the site visit but was rescinded on May 1, 2019, and replaced by VHA Directive 1108.01, *Controlled Substances Management*.)

[86] When automated dispensing cabinets are used, nursing staff can override and remove medications prior to the pharmacists' review of medications ordered by the providers.

Medication Management Conclusion

The OIG found general compliance with requirements for most of the performance indicators evaluated, including the controlled substances coordinator reports, pharmacy operations, and pharmacy inspections. However, the OIG identified noncompliance with requirements for controlled substances area inspections.

VHA requires that controlled substances inspectors verify during controlled substances inspections that there is evidence of a hard copy order (electronic or written) in the patient's medical record for five random dispensing activities.[87] The OIG reviewed monthly inspections from October 2018 through March 2019 and found that controlled substance inspectors did not consistently verify that a hard copy or electronic order was present for five of the six areas selected for review. This may result in increased opportunities for medication errors and drug diversions. The controlled substances coordinator cited misunderstanding of the requirement as the reason for noncompliance.

Recommendation 8

8. The facility director ensures that controlled substances inspectors verify controlled substances orders for five random dispensing activities during monthly area inspections and monitors inspectors' compliance.

Facility concurred.

Target date for completion: January 2020

Facility response: The Controlled Substance Coordinator (CSC) retrained the CS inspectors on 04/19/2019 on verification of five (5) random Controlled Substance activities stressing that waste activity does not count as a separate activity in the random verification process. The surveyor explained to the CSC that the waste is not considered a transaction. The CSC or alternate CSC will review monthly inspection reports within 72 business hours of receipt from inspectors. The CSC will ensure five random controlled substance orders are completed and will monitor compliance at 90 percent or greater for a minimum of six (6) months. The compliance monitoring report will be provided to Quality, Safety, and Values (QSV) Service for inclusion in the QSV Council minutes. Monthly reports for June 2019 through September 2019 (four months) showed compliance rate of 90% or better.

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[87] VHA Directive 1108.02(1).

Mental Health: Military Sexual Trauma Follow-Up and Staff Training

The Department of Veterans Affairs uses the term "military sexual trauma" (MST) to refer to a "psychological trauma, which in the judgment of a mental health professional employed by the Department [of Veterans Affairs], resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training."[88] MST is an experience, not a diagnosis or a mental health condition. Although posttraumatic stress disorder is commonly associated with MST, other frequently associated diagnoses include depression and substance use disorders.[89]

VHA requires that the facility director designates an MST coordinator to support national and VISN-level policies related to MST-related care and serve as a source of information; establish and monitor MST-related staff training and informational outreach; and communicate MST-related issues, services, and initiatives with leadership.[90] Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.[91]

VHA requires that all veterans and potentially eligible individuals seen in VHA facilities be screened for experiences of MST with the required MST clinical reminder in the computerized patient record system.[92] Those who screen positive must have access to appropriate MST-related care.[93] VHA also requires that evidence-based mental health care be available to all veterans with mental health conditions related to MST. Patients requesting or referred for mental health services must receive an initial evaluation within 24 hours of the referral to identify urgent care needs and a more comprehensive diagnostic evaluation within 30 days.[94]

The MST coordinator may provide clinical care to individuals experiencing MST and is thus subject to the same mandatory training requirements as mental health and primary care providers.[95] All mental health and primary care providers must complete MST mandatory

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[88] VHA Directive 1115, *Military Sexual Trauma (MST) Program*, May 8, 2018.

[89] Military Sexual Trauma. https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf. (The website was accessed on November 17, 2017.)

[90] VHA Directive 1115.

[91] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008 (amended November 16, 2015). (This VHA handbook was scheduled for recertification on or before the last working date of September 2013 and has not been recertified.)

[92] VHA Directive 1115 states that "MST-related care is not subject to the minimum active duty service requirement set forth in 38 U.S.C. 5303A; Veterans may therefore be able to receive MST-related care even if they are not eligible for VA health care under other treatment authorities."

[93] VHA Directive 1115.

[94] VHA Handbook 1160.01.

[95] VHA Directive 1115.

training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.[96]

To determine whether the facility complied with the requirements related to MST follow-up and training, the OIG inspection team reviewed relevant documents and staff training records and interviewed key employees. The team also reviewed the electronic health records of 46 outpatients who had a positive MST screen from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

- Designated facility MST coordinator

    o Establishes and monitors MST-related staff training

    o Establishes and monitors informational outreach

    o Communicates MST-related issues, services, and initiatives with local leaders

- Evidence of tracking MST-related data

- Provision of clinical care

    o Referral for MST-related care to patients with positive MST screens

    o Initial evaluation within 24 hours of referral for mental health services

    o Comprehensive diagnostic and treatment planning evaluation within 30 days of referral for mental health services

- Completion of MST mandatory training requirement for mental health and primary care providers

Mental Health Conclusion

Generally, the OIG found compliance with many of the performance indicators, including the designation of an MST coordinator, tracking of MST-related data, and provision of clinical care. The OIG noted a concern with staff completion of MST mandatory training.

VHA requires that all mental health and primary care providers complete the MST mandatory training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.[97] The OIG found 3 of 13 providers hired after July 1, 2012, did not complete the required MST mandatory training within 90 days after entering their position. This

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[96] VHA Directive 1115.01, *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017; Acting Deputy Under Secretary for Health for Operations and Management, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers*, February 2, 2016.

[97] VHA Directive 1115.01; Acting Deputy Under Secretary for Health for Operations and Management, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers*, February 2, 2016.

could potentially prevent clinicians from providing appropriate counseling, care, and service to veterans who experienced MST. The MST coordinator believed the facility was in full compliance for monitoring completed training but acknowledged that the training report did not track whether training was completed within 90 days. For two of the three providers that did not complete MST mandatory training timely, the MST coordinator stated that the providers were unaware of the requirement to complete training within 90 days and cited a coding error in the facility's human resources system for the remaining noncompliant provider.

Recommendation 9

9. The chief of staff confirms that mental health and primary care providers complete military sexual trauma mandatory training within the required time frame and monitors providers' compliance.

Facility concurred.

Target date for completion: June 2020

Facility response: The Military Sexual Trauma (MST) Coordinator met with the Talent Management System (TMS) Coordinator in May 2019 and reviewed reports for tracking completion of MST mandatory training. The coordinators set a local deadline for the mandatory training at sixty (60) days to allow the MST Coordinator time for follow up with staff to meet the ninety (90) day completion requirement. Monthly monitoring of completion reports from TMS will be reviewed by the MST Coordinator, reported to the Associate Chief of Staff for Mental Health and Primary Care, and submitted to the Quality, Safety, and Values (QSV) Service for inclusion in the QSV Council meeting minutes. The Chief of Staff will ensure compliance at 90 percent or greater for a minimum of six (6) months.

Geriatric Care: Antidepressant Use among the Elderly

VA's National Registry for Depression reported that "11 [percent] of veterans aged 65 years and older have a diagnosis of major depressive disorder."[98] The VA/DoD Clinical Practice Guideline (CPG) describes depression as "a common mental disorder that presents with depressed mood, loss of interest or pleasure in regular activities, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration." This can lead to poor quality of life, decreased productivity, and increased mortality from suicide.[99]

According to the Centers for Disease Control and Prevention, older adults are at increased risk for experiencing depression because "80 [percent] of older adults have at least one chronic health condition and 50 [percent] have two or more." Further, "most older adults see an improvement in [their] symptoms when treated with antidepressant drugs, psychotherapy, or a combination of both."[100]

The American Geriatrics Society revised the Beers Criteria in 2015 to include lists of potentially inappropriate medications to be avoided. Potentially inappropriate medication use in older adults continues to be associated with confusion, falls, and mortality.[101] The criteria provide guidelines that help to improve the safety of prescribing certain medications including antidepressants for older adults.

TJC requires clinicians to educate patients and families about the "safe and effective use of medications."[102] In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.[103] Further, TJC requires clinicians to perform medication reconciliation by comparing the medication a patient is actually taking to the new medications that are ordered for the patient and resolving any discrepancies.[104] The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

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[98] Hans Peterson, "Late Life Depression," *U.S. Department of Veterans Affairs*, Mental Health Featured Article, March 1, 2011. https://www.mentalhealth.va.gov/featureArticle_Mar11LateLife.asp. (The website was accessed on March 8, 2019.)

[99] *VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder*, April 2016. https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf. (The website was accessed November 20, 2018.)

[100] Centers for Disease Control and Prevention, "Depression is Not a Normal Part of Growing Older," January 31, 2017. https://www.cdc.gov/aging/mentalhealth/depression.htm. (The website was accessed on March 8, 2019.)

[101] American Geriatrics Society 2015 Beers Criteria Update Expert Panel, "American Geriatrics Society 2015 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults." http://www.sigot.org/allegato_docs/1057_Beers-Criteria.pdf. (The website was accessed on March 22, 2018.)

[102] TJC. Provision of Care, Treatment, and Services standard PC.02.03.01.

[103] VHA Directive 1164, Essential Medication Information Standards, June 26, 2015.

[104] TJC. National Patient Safety Goal standard NPSG.03.06.01.

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remission. Monitoring includes assessment of symptoms, adherence to medication and psychotherapy, and any adverse effects. The CPG also recommends that treatment planning includes patient education about treatment options, including risks and benefits.[105]

To determine whether the facility complied with requirements concerning use of antidepressants among the elderly, the OIG inspection team interviewed key employees and managers. The team also reviewed the electronic health records of 38 randomly selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.[106] The OIG evaluated the following performance indicators:

- Justification for medication initiation

- Evidence of patient and/or caregiver education specific to the medication prescribed

- Clinician evaluation of patient and/or caregiver understanding of the education provided

- Medication reconciliation

Geriatric Care Conclusion

Generally, the facility met requirements as reflected by the performance indicators above. The OIG made no recommendations.

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[105] VA/DoD Clinical Practice Guidelines for the Management of Major Depressive Disorder.

[106] The seven selected antidepressant medications are amitriptyline, clomipramine, desipramine, doxepin (>6mg/day), imipramine, nortriptyline, and paroxetine.

Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up

Each year, about 12,000 women in the United States are diagnosed with cervical cancer.[107] Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.[108] In addition to HPV infection, other risk factors for cervical cancer include smoking, human immunodeficiency virus (HIV) infection, use of oral contraceptives for five or more years, and having given birth to three or more children.[109] Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.[110]

VA is authorized to provide "gender-specific services, such as Papanicolaou tests (Pap smears)," to eligible women veterans. Further, VHA requires that all eligible and enrolled women veterans have access to appropriate services and preventative care. That care would include age-appropriate screening for cervical cancer.[111]

VHA requires that each facility have a "full-time Women Veterans Program Manager (WVPM) to execute comprehensive planning for women's health care." VHA also requires a medical director or clinical champion to be responsible for the clinical oversight of the women's health program. Each facility must also have a "Women Veterans Health Committee (WVHC) comprised of appropriate facility leadership and program directors, which develops and implements a Women's Health Program strategic plan." The Women Veterans Health Committee must meet at least quarterly and report to the executive leaders. The facility must also have a process to ensure the collecting and tracking of data related to cervical cancer screenings.[112]

VHA has established time frames for notifying patients of abnormal cervical pathology results. Abnormal cervical pathology results must be communicated to patients within seven calendar days from the date the results are available to the ordering provider. Communication of the

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[107] Centers for Disease Control and Prevention. "Cervical Cancer" *Inside Knowledge* fact sheet, December 2016. https://www.cdc.gov/cancer/cervical/pdf/cervical_facts.pdf. (The website was accessed on February 28, 2018.)

[108] Centers for Disease Control and Prevention. *Basic Information About Cervical Cancer*, February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)

[109] Centers for Disease Control and Prevention. *What Are the Risk Factors for Cervical Cancer?* February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/risk_factors.htm. (The website was accessed on March 8, 2019.)

[110] Centers for Disease Control and Prevention. *Basic Information About Cervical Cancer*, February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)

[111] VHA Directive 1330.01(2), *Health Care Services for Women Veterans,* February 15, 2017 (amended July 24, 2018).

[112] VHA Directive 1330.01(2).

results to patients must be documented. The facility must ensure that appropriate follow-up care is provided to patients with abnormal results.[113]

To determine whether the facility complied with selected VHA requirements for the notification and follow-up care of abnormal cervical pathology results, the OIG inspection team reviewed relevant documents and interviewed selected employees and managers. The team also reviewed the electronic health records of 12 women veteran patients, between ages 21 and 65, who had an abnormal pap smear or test from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

- Appointment of a women veterans program manager

- Appointment of a women's health medical director or clinical champion

- Facility Women Veterans Health Committee

  o Core membership

  o Quarterly meetings

  o Reports to clinical executive leaders

- Collection and tracking of cervical cancer screening data

  o Notification of patients due for screening

  o Completed screenings

  o Results reporting

  o Follow-up care

- Communication of abnormal results to patients within required time frame

- Provision of follow-up care for abnormal cervical pathology results, if indicated

Women's Health Conclusion

Generally, the OIG found compliance with many of the performance indicators, including requirements for a designated women veterans program manager and follow-up care for cervical cancer screening, when indicated. The OIG noted noncompliance with the Women Veterans Health Committee core membership, tracking of data related to cervical cancer screenings, and communicating test results to patients within the required time frame that warranted recommendations for improvement.

VHA requires that the core membership of the Women Veterans Health Committee includes a women veterans program manager; a women's health medical director; "representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy,

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[113] VHA Directive 1330.01(2).

social work and care management, nursing, ED [emergency department], radiology, laboratory, quality management, business office/Non-VA Medical Care[;] and a member from executive leadership."[114] From July 2018 to March 2019, the Women Veterans Health Committee lacked representation from gynecology, quality management, business office, and executive leadership. This resulted in a lack of expertise in the review and analysis of data as the committee planned and carried out improvements for quality and equitable care for women veterans. The program manager cited time and staff constraints as the reasons for noncompliance but believed they were meeting requirements by selectively including staff they felt provided the most useful input to the committee.

Recommendation 10

10. The chief of staff confirms that the Women Veterans Health Committee is comprised of required members and monitors the committee's compliance.

Facility concurred.

Target date for completion: June 2020

Facility Response: The charter for the Women Veterans Health Committee has been updated to include representatives from the Gynecology Service (Registered Nurse (RN) or Licensed Practical Nurse), Chief of Staff or designee, and Quality (the Clinical Practice Guidelines RN Coordinator). The Women Veterans Health Committee meets quarterly and presents reports to the Clinical Practice Council. A copy of the attendance roster for the Women Veterans Health Committee meetings will also be reported to Quality, Safety, and Values (QSV) Service for inclusion in the QSV Council minutes. Monitoring will be for a minimum of six (6) months (or two quarters) to ensure 90 percent or greater compliance.

VHA requires that each facility has a process to track data, "including notification of patients who are due for screening, tracking of completion of screening, results reporting, and follow-up care" related to cervical cancer screenings.[115] The OIG found that the facility did not have a systematic process for tracking notification of patients due for screening, results reporting, and follow-up care data. Lack of a systematic process may cause delays in addressing abnormal cervical screening results and implementing appropriate action plans. The program manager cited the lack of quality assurance data analysis tools for the women veterans program as the reason for noncompliance.

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[114] VHA Directive 1330.01(2).
[115] VHA Directive 1330.01(2).

Recommendation 11

11. The chief of staff makes certain that program managers collect and track cervical cancer screening notification, results reporting, and follow-up care data and monitors program managers' compliance.

Facility concurred.

Target date for completion: June 2020

Facility Response: VHA Directive 1330.01(2) (Health Care Services for Women Veterans) was reviewed for adherence to Data Collection and Quality Assurance. A spreadsheet created in March 2019 is monitored by the Women Veteran Health Program Manager and is utilized to track the following: pap smears including the diagnostic test order, receipt of reports, reporting of results, and follow up requirements with each Woman Veteran. Aggregate information and trends are provided to Quality, Safety, and Values (QSV) Service for inclusion in the QSV Council meeting minutes. The Women Veteran Health Program Manager will monitor compliance at 90 percent or greater for a minimum of six (6) consecutive months.

VHA also requires that providers notify patients of abnormal cervical pathology results within seven calendar days from the date the results are available.[116] The OIG determined that providers communicated abnormal results to patients within the required time frame in 83 percent of the electronic health records reviewed.[117] This resulted in delayed patient notification and initiation of follow-up care. Facility and program managers cited technical problems with the view alert system and an international dateline time issue between the facility and the clinic in Guam as the reasons for noncompliance.

Recommendation 12

12. The chief of staff ensures that ordering providers communicate abnormal results to patients within the required time frame and monitors providers' compliance.

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[116] VHA Directive 1330.01(2).

[117] Confidence intervals are not included because the data represents every patient in the study population.

Facility concurred.

Target date for completion: June 2020

Facility Response: The *Cervical Cancer Screening Women's Health Clinic Follow Up Guidelines* were revised in June of 2019 by the Women Veterans Health Program Manager. This update states that Women Veterans with abnormal Pap smears must be contacted by the ordering provider within five (5) business days of notification from the cytopathology lab. Review was conducted to gain an understanding of the timing of the communication of abnormal test results to Women Veterans. Monitoring and tracking of compliance of the timeliness of communicating abnormal test results will be completed for a minimum of six (6) months with a compliance rate of greater than or equal to 90 percent. This will be reported at the Women Veterans Health Committee. A copy of this report will be provided to Quality, Safety, and Values (QSV) Service for inclusion in the QSV Council meeting minutes.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Accreditation and/or for-cause surveys and oversight inspections • Factors related to possible lapses in care • VHA performance data	Twelve OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the director, chief of staff, ADPCS, and associate director. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer reviews • UM reviews • Patient safety • Resuscitation episode review	• None	• All required representatives participate in the interdisciplinary review of UM data.
Medical Staff Privileging	• Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank	• Professional practice evaluations are completed by providers with similar training and privileges.	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Parent facility
	  ○ General safety
	  ○ Environmental cleanliness and infection prevention
	  ○ General privacy
	  ○ Women veterans program
	  ○ Availability of medical equipment and supplies
	
	• Community based outpatient clinic
	  ○ General safety
	  ○ Environmental cleanliness and infection prevention
	  ○ General privacy
	  ○ Women veterans program
	  ○ Availability of medical equipment and supplies
	
	• Locked inpatient mental health unit
	  ○ Mental health environment of care rounds
	  ○ Nursing station security
	  ○ Public area and general unit safety
	  ○ Patient room safety
	  ○ Infection prevention
	  ○ Availability of medical equipment and supplies
	
	• Emergency management
	  ○ Hazard vulnerability analysis (HVA)
	  ○ Emergency operations plan (EOP)
	  ○ Emergency power testing and availability
		• Staff remove expired medications from service.
		• Managers store clean and dirty medical equipment separately.
			• Staff use privacy screens on all computer monitors.
			• The Leeward Oahu VA Clinic waiting room carpet is replaced.
			• The Leeward Oahu VA Clinic staff secure laboratory transport boxes containing personally identifiable information.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Controlled Substances Inspections	• Controlled substances coordinator reports • Pharmacy operations • Controlled substances inspector requirements • Controlled substances area inspections • Pharmacy inspections • Facility review of override reports	• None	• Controlled substances inspectors verify orders for five random dispensing activities during monthly area inspections.
Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training	• Designated facility MST coordinator • Evidence of tracking MST-related data • Provision of clinical care • Completion of MST mandatory training requirement for mental health and primary care providers	• None	• Providers complete MST mandatory training within the required time frame.
Geriatric Care: Antidepressant Use among the Elderly	• Justification for medication initiation • Evidence of patient and/or caregiver education specific to the medication prescribed • Clinician evaluation of patient and/or caregiver understanding of the education provided • Medication reconciliation	• None	• None
Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up	• Appointment of a women veterans program manager • Appointment of a women's health medical director or clinical champion • Facility Women Veterans Health Committee • Collection and tracking of cervical cancer screening data	• Ordering providers communicate abnormal results to patients within the required time frame.	• Women Veterans Health Committee is comprised of required members. • Program managers collect and track all required data for cervical cancer screenings.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	• Communication of abnormal results to patients within required time frame • Provision of follow-up care for abnormal cervical pathology results, if indicated		

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this medium complexity (2) affiliated[118] facility reporting to VISN 21.[119]

Table B.1. Facility Profile for VA Pacific Islands Health Care System (459)
(October 1, 2015, through September 30, 2018)

Profile Element	Facility Data FY 2016[120]	Facility Data FY 2017[121]	Facility Data FY 2018[122]
Total medical care budget in dollars	$299,173,233	$305,311,581	$334,252,702
Number of:			
• Unique patients	35,100	33,959	34,995
• Outpatient visits	304,872	295,315	309,008
• Unique employees[123]	929	920	1,036
Type and number of operating beds:			
• Community living center	60	60	60
• Domiciliary	12	12	12
• Mental health	16	16	16
Average Daily Census:			
• Community living center	50	47	46
• Domiciliary	10	10	7
• Mental health	7	4	4

Source: VHA Support Service Center and VA Corporate Data Warehouse
Note: The OIG did not assess VA's data for accuracy or completeness.

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[118] Associated with a medical residency program.

[119] The VHA medical centers are classified according to a facility complexity model; a designation of "2" indicates a facility with "medium volume, low-risk patients, few complex clinical programs, and small or no research and teaching programs."

[120] October 1, 2015, through September 30, 2016.

[121] October 1, 2016, through September 30, 2017.

[122] October 1, 2017, through September 30, 2018.

[123] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[124]

The VA outpatient clinics in communities within the catchment area of the facility provide primary care integrated with women's health, mental health, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table B.2. provides information relative to each of the clinics.

**Table B.2. VA Outpatient Clinic Workload/Encounters and
Specialty Care, Diagnostic, and Ancillary Services Provided
(October 1, 2017, through September 30, 2018)[125]**

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[126] Provided	Diagnostic Services[127] Provided	Ancillary Services[128] Provided
Kahului, HI	459GA	5,641	3,705	Cardiology Dermatology Endocrinology Gastroenterology Neurology Rheumatology Poly-Trauma Spinal cord injury Anesthesia Orthopedics	Laboratory & Pathology	Pharmacy Social work Weight management Nutrition

[124] Includes all outpatient clinics in the community that were in operation as of February 8, 2019.

[125] The definition of an "encounter" can be found in VHA Directive 2010-049, *Encounter and Workload Capture for Therapeutic and Supported Employment Services Vocational Programs*, October 14, 2010. (This directive expired on October 31, 2015, and has not been updated.) An encounter is a "professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition."

[126] Specialty care services refer to non-primary care and non-mental health services provided by a physician.

[127] Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

[128] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[126] Provided	Diagnostic Services[127] Provided	Ancillary Services[128] Provided
Hilo, HI	459GB	5,968	3,449	Cardiology Dermatology Endocrinology Gastroenterology Neurology Rheumatology Poly-Trauma Spinal cord injury Anesthesia Orthopedics	Laboratory & Pathology	Pharmacy Social work Nutrition
Kailua-Kona, HI	459GC	4,761	3,007	Cardiology Dermatology Endocrinology Gastroenterology Nephrology Neurology Rheumatology Poly-Trauma Spinal cord injury General surgery Orthopedics	Laboratory & Pathology	Pharmacy Social work Nutrition

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[126] Provided	Diagnostic Services[127] Provided	Ancillary Services[128] Provided
Lihue, HI	459GD	4,038	2,043	Cardiology Dermatology Endocrinology Gastroenterology Nephrology Neurology Rheumatology Poly-Trauma Spinal cord injury Anesthesia Orthopedics	n/a	Pharmacy Social work Weight management Nutrition
Agana Heights, GU	459GE	7,160	3,505	Dermatology Endocrinology Gastroenterology Rheumatology Poly-Trauma Spinal cord injury Orthopedics Podiatry	n/a	Pharmacy Social work Weight management Nutrition
Pago Pago, AS	459GF	4,136	2,086	Dermatology Endocrinology Gastroenterology Nephrology Poly-Trauma Eye Orthopedics Podiatry	Laboratory & Pathology	Pharmacy Prosthetics Weight management Nutrition

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[126] Provided	Diagnostic Services[127] Provided	Ancillary Services[128] Provided
Ewa Beach, HI	459GG	6,994	2,637	Dermatology	n/a	Pharmacy Nutrition
Saipan, MP	459GH	850	294	Endocrinology Neurology Rheumatology Orthopedics Podiatry	n/a	n/a
Lanai City, HI	459QA	47	14	n/a	n/a	n/a
Kaunakakai, HI	459QB	795	185	Endocrinology Nephrology Rheumatology	n/a	Social work Weight management

Source: VHA Support Service Center and VA Corporate Data Warehouse
Note: The OIG did not assess VA's data for accuracy or completeness.
n/a = not applicable

Appendix C: Patient Aligned Care Team Compass Metrics[129]

Quarterly New Primary Care Patient Average Wait Time in Days

	VHA Total	(459) Honolulu, HI (Spark M. Matsunaga)	(459GA) Maui, HI	(459GB) Hilo, HI	(459GC) Kailua-Kona, HI	(459GD) Lihue, HI	(459GE) Guam, GU	(459GF) American Samoa, AS	(459GG) Leeward Oahu, HI	(459GH) Saipan, MP	(459QB) Molokai, HI
APR-FY18	7.9	14.2	4.5	7.5	2.2	0.1	9.5	1.6	12.3	0.0	n/a
MAY-FY18	7.7	17.1	6.6	3.0	3.3	5.1	3.8	1.3	0.8	0.0	0.0
JUN-FY18	7.6	24.2	10.5	6.1	3.1	3.7	2.4	1.7	8.0	0.0	6.0
JUL-FY18	7.5	21.0	11.7	3.9	6.5	5.6	3.0	1.0	12.7	0.0	0.0
AUG-FY18	7.7	27.9	5.3	3.8	5.8	4.6	2.3	2.7	7.0	0.0	0.0
SEP-FY18	8.5	21.8	4.8	5.4	4.7	5.6	0.6	2.7	27.2	0.0	0.0
OCT-FY19	8.0	30.2	16.4	7.1	14.7	6.8	3.2	1.8	12.3	0.0	0.0
NOV-FY19	8.5	25.1	10.0	4.3	25.8	7.1	1.8	0.1	23.3	0.0	n/a
DEC-FY19	8.6	33.1	4.4	6.6	19.3	4.6	0.0	0.3	17.5	0.0	3.0
JAN-FY19	9.0	30.3	11.4	6.1	5.1	2.0	2.5	0.5	52.6	0.0	0.0
FEB-FY19	8.5	34.1	9.9	4.2	16.7	0.7	2.5	1.4	2.0	0.0	0.0
MAR-FY19	8.1	29.8	12.4	7.9	33.8	9.1	5.5	0.3	8.9	0.0	0.0

Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the facility's explanation for the increased wait times for the Leeward Oahu VA Clinic (459GG). The OIG omitted Lanai, HI (459QA), as no data were reported.

Data Definition: "The average number of calendar days between a New Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date." Note that prior to FY15, this metric was calculated using the earliest possible create date. The absence of reported data are indicated by "n/a."

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[129] Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 13, 2018.

Quarterly Established Primary Care Patient Average Wait Time in Days

	VHA Total	(459) Honolulu, HI (Spark M. Matsunaga)	(459GA) Maui, HI	(459GB) Hilo, HI	(459GC) Kailua-Kona, HI	(459GD) Lihue, HI	(459GE) Guam, GU	(459GF) American Samoa, AS	(459GG) Leeward Oahu, HI	(459GH) Saipan, MP	(459QB) Molokai, HI
APR-FY18	4.3	4.2	2.7	4.9	1.3	2.1	4.1	3.9	5.0	0.0	0.3
MAY-FY18	4.3	5.0	2.1	6.1	0.8	3.4	3.5	3.1	3.0	0.0	0.3
JUN-FY18	4.4	6.0	2.3	5.0	1.9	2.8	2.6	2.7	7.1	0.0	1.0
JUL-FY18	4.7	5.7	1.9	5.3	2.6	5.3	5.2	1.7	4.0	0.0	0.4
AUG-FY18	4.6	9.5	3.3	4.2	3.3	12.7	3.2	3.7	3.7	0.0	0.6
SEP-FY18	4.4	8.5	5.0	5.0	3.0	6.6	4.7	4.4	4.6	0.0	0.5
OCT-FY19	4.0	10.8	5.2	4.0	4.3	5.4	3.5	3.1	3.1	0.1	1.0
NOV-FY19	4.4	10.5	4.7	2.9	6.4	7.7	5.9	3.2	6.0	0.1	4.3
DEC-FY19	4.4	9.2	3.7	3.6	6.4	7.7	3.5	2.8	4.6	0.0	0.7
JAN-FY19	5.0	12.9	3.8	5.9	5.1	10.9	3.9	1.4	6.1	0.0	1.8
FEB-FY19	4.6	11.5	4.7	6.1	8.6	7.0	4.0	2.0	3.8	0.0	3.9
MAR-FY19	4.6	14.2	3.4	3.4	10.3	6.5	4.8	2.4	5.0	0.0	1.6

Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Lanai, HI (459QA), as no data were reported.

Data Definition: "The average number of calendar days between an Established Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date."

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[130]

Measure	Definition	Desired Direction
ACSC hospitalization	Ambulatory care sensitive conditions hospitalizations	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit reviews met	Percent acute admission reviews that meet interqual criteria	A higher value is better than a lower value
APP capacity	Advanced practice provider capacity	A lower value is better than a higher value
Best place to work	All employee survey best places to work score	A higher value is better than a lower value
Call responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Care transition	Care transition (Inpatient)	A higher value is better than a lower value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Comprehensiveness	Comprehensiveness (PCMH)	A higher value is better than a lower value
Cont stay reviews met	Percent acute continued stay reviews that meet interqual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Efficiency/capacity	Efficiency and physician capacity	A higher value is better than a lower value
Employee satisfaction	Overall satisfaction with job	A higher value is better than a lower value

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[130] VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL)* (last updated December 26, 2018). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 7, 2019, but is not accessible by the public.)

Measure	Definition	Desired Direction
HC assoc infections	Health care associated infections	A lower value is better than a higher value
HEDIS like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
HEDIS like – HED90_1	HEDIS-EPRP based PRV TOB BHS	A higher value is better than a lower value
HEDIS like – HED90_ec	HEDIS-eOM based DM IHD	A higher value is better than a lower value
MH wait time	Mental health care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH continuity care	Mental health continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH exp of care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH popu coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	ORYX	A higher value is better than a lower value
PC routine care appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC urgent care appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PCMH care coordination	PCMH care coordination	A higher value is better than a lower value
PCMH same day appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH survey access	Timely appointment, care and information (PCMH)	A higher value is better than a lower value
Physician capacity	Physician capacity	A lower value is better than a higher value
PC wait time	PC wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value

Measure	Definition	Desired Direction
Rating hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RN turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-COPD	30-day risk standardized mortality rate for COPD	A lower value is better than a higher value
RSMR-pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-COPD	30-day risk standardized readmission rate for COPD	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value

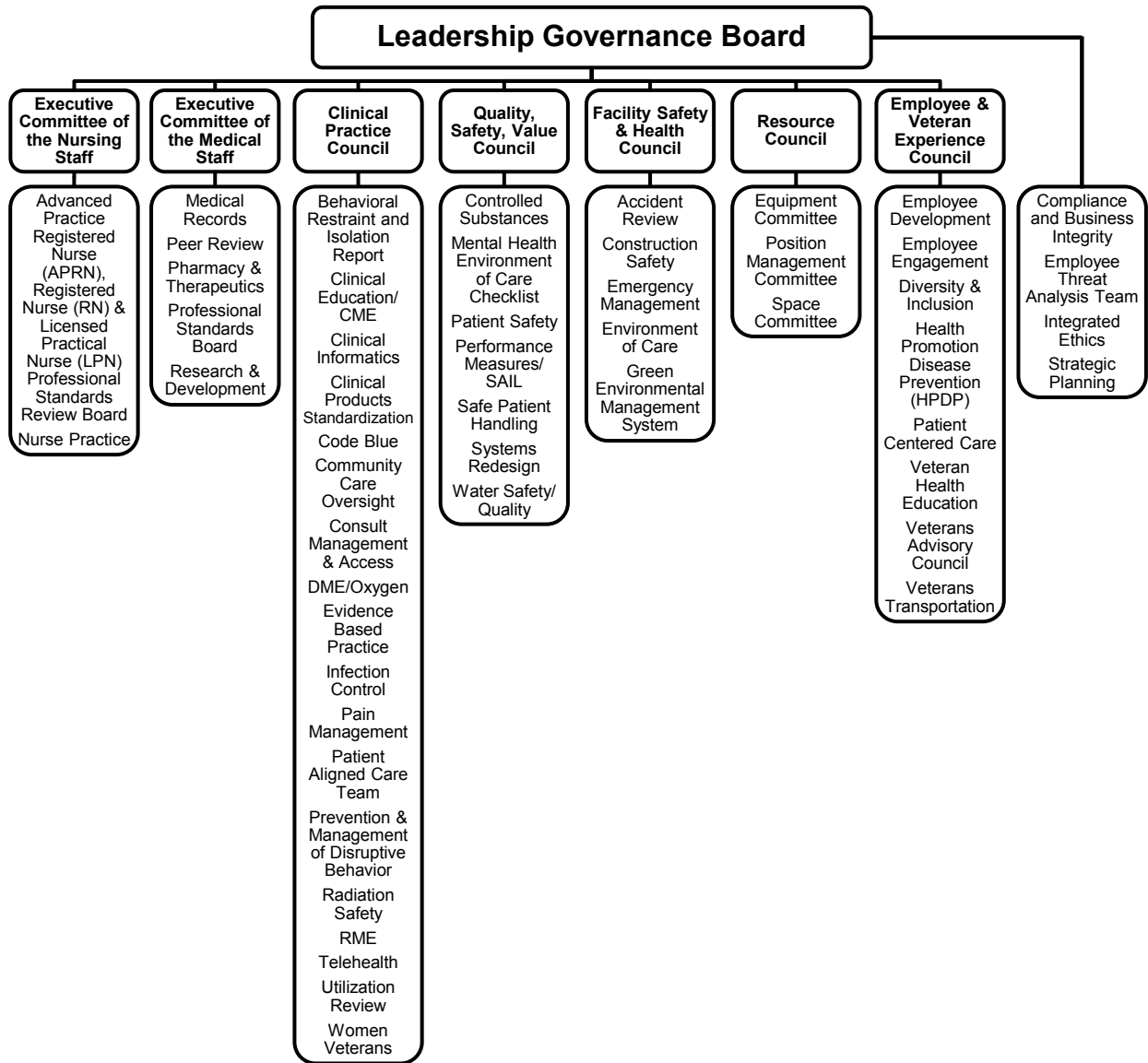| Measure	Definition	Desired Direction
SC care coordination	SC (specialty care) care coordination	A higher value is better than a lower value
SC routine care appt	Timeliness in getting a SC routine care appointment (specialty care)	A higher value is better than a lower value
SC survey access	Timely appointment, care and information (specialty care)	A higher value is better than a lower value
SC urgent care appt	Timeliness in getting a SC urgent care appointment (specialty care)	A higher value is better than a lower value
Seconds pick up calls	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty care wait time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value
Telephone abandonment rate	Telephone abandonment rate	A lower value is better than a higher value

Source: VHA Support Service Center

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) Measure Definitions[131]

Measure	Definition
Ability to move independently worsened (LS)	Long-stay measure: percentage of residents whose ability to move independently worsened.
Catheter in bladder (LS)	Long-stay measure: percent of residents who have/had a catheter inserted and left in their bladder.
Falls with major injury (LS)	Long-stay measure: percent of residents experiencing one or more falls with major injury.
Help with ADL (LS)	Long-stay measure: percent of residents whose need for help with activities of daily living has increased.
High risk PU (LS)	Long-stay measure: percent of high-risk residents with pressure ulcers.
Improvement in function (SS)	Short-stay measure: percentage of residents whose physical function improves from admission to discharge.
Moderate-severe pain (LS)	Long-stay measure: percent of residents who self-report moderate to severe pain.
Moderate-severe pain (SS)	Short-stay measure: percent of residents who self-report moderate to severe pain.
New or worse PU (SS)	Short-stay measure: percent of residents with pressure ulcers that are new or worsened.
Newly received antipsych meds (SS)	Short-stay measure: percent of residents who newly received an antipsychotic medication.
Physical restraints (LS)	Long-stay measure: percent of residents who were physically restrained.
Receive antipsych meds (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.
UTI (LS)	Long-stay measure: percent of residents with a urinary tract infection.

[131] *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated August 22, 2019). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410. (The website was accessed on September 3, 2019, but is not accessible by the public.)

Appendix F: Facility Committee Structure

Leadership Governance Board

Executive Committee of the Nursing Staff	Executive Committee of the Medical Staff	Clinical Practice Council	Quality, Safety, Value Council	Facility Safety & Health Council	Resource Council	Employee & Veteran Experience Council	Compliance and Business Integrity
Advanced Practice Registered Nurse (APRN), Registered Nurse (RN) & Licensed Practical Nurse (LPN) Professional Standards Review Board Nurse Practice	Medical Records Peer Review Pharmacy & Therapeutics Professional Standards Board Research & Development	Behavioral Restraint and Isolation Report Clinical Education/CME Clinical Informatics Clinical Products Standardization Code Blue Community Care Oversight Consult Management & Access DME/Oxygen Evidence Based Practice Infection Control Pain Management Patient Aligned Care Team Prevention & Management of Disruptive Behavior Radiation Safety RME Telehealth Utilization Review Women Veterans	Controlled Substances Mental Health Environment of Care Checklist Patient Safety Performance Measures/ SAIL Safe Patient Handling Systems Redesign Water Safety/ Quality	Accident Review Construction Safety Emergency Management Environment of Care Green Environmental Management System	Equipment Committee Position Management Committee Space Committee	Employee Development Employee Engagement Diversity & Inclusion Health Promotion Disease Prevention (HPDP) Patient Centered Care Veteran Health Education Veterans Advisory Council Veterans Transportation	Employee Threat Analysis Team Integrated Ethics Strategic Planning

Source: Received from the VISN 21 Deputy Quality Management Officer on November 7, 2019.

CME = Continuing Medical Education

DME = Durable Medical Equipment

RME = Reusable Medical Equipment

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: November 5, 2019

From: Director, Sierra Pacific Network (10N21)

Subj: Comprehensive Healthcare Inspection of the VA Pacific Islands Health Care System, Honolulu, HI

To: Director, Los Angeles Office of Healthcare Inspections (54CH01)

Director, GAO/OIG Accountability Liaison (VHA 10EG GOAL Action)

1. Thank you for the opportunity to review the draft report. I concur with the findings and the action plan from the facility in response to those findings.

2. Should you have any questions please contact my Deputy Quality Manager.

(Original signed by:)

John C. Brandecker

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

Appendix H: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: November 1, 2019

From: Director, VA Pacific Islands Health Care System (459/00)

Subj: Comprehensive Healthcare Inspection of the VA Pacific Islands Health Care System, Honolulu, HI

To: Director, Sierra Pacific Network (10N21)

Although the OIG CHIP report received is tentative in nature, we thank you for the opportunity to review and respond. We offer the implementation plans for the survey conducted in April 2019. The facility's points of contact were utilized in the development of the actions and sustainment plans.

(Original signed by:)

Jennifer S. Gutowski, MHA, FACHE

> *For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.*

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