



US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Pacific Islands Health Care System in Honolulu, Hawaii

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Figure 1. Spark M. Matsunaga VA Medical Center of the VA Pacific Islands Health Care System in Honolulu, Hawaii.

Source: <https://www.va.gov/pacific-islands-health-care/locations/>.

Abbreviations

ADPCS/NE	Associate Director Patient Care Services/Nurse Executive
CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Pacific Islands Health Care System, which includes the Spark M. Matsunaga VA Medical Center in Honolulu and outpatient clinics in Hawaii, Lanai, Maui, Molokai, American Samoa, Guam, and Saipan (Commonwealth of the Northern Mariana Islands). The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following areas of clinical and administrative operations:

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on emergency department and urgent care center suicide prevention initiatives)¹

The OIG conducted an unannounced inspection of the VA Pacific Islands Health Care System during the week of May 2, 2022. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of 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 the healthcare system's performance within the identified focus areas at the time of the OIG inspection. Although it is difficult to quantify the risk of patient harm, the findings may help leaders at this healthcare system and other Veterans Health Administration facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

¹ The OIG did not perform the mental health review at the VA Pacific Islands Health Care System because it did not have an emergency department or urgent care center.

Inspection Results

The OIG noted opportunities for improvement and issued four recommendations to the Chief of Staff and Assistant Director for Efficiency and Improvement in the Medical Staff Privileging and Environment of Care areas of review. These results are detailed throughout the report, and the recommendations are summarized in appendix A on page 20.

Conclusion

The number of recommendations should not be used as a gauge for the overall quality of care provided at this system. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the delivery of quality health care.

VA Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 22-23, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendation 1 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.



JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report’s evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Pacific Islands Health Care System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so they can make informed decisions to improve care.¹

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.² Effective leadership has been cited as “among the most critical components that lead an organization to effective and successful outcomes.”³

To examine risks to patients and the organization, the OIG focused on core processes in the following areas of clinical and administrative operations:⁴

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on emergency department and urgent care center suicide prevention initiatives)⁵

¹ VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

² Anam Parand et al., “The Role of Hospital Managers in Quality and Patient Safety: A Systematic Review,” *British Medical Journal* 4, no. 9 (September 5, 2014), <https://doi.org/10.1136/bmjopen-2014-005055>.

³ Danae F. Sfantou et al., “Importance of Leadership Style towards Quality of Care Measures in Healthcare Settings: A Systematic Review,” *Healthcare (Basel)* 5, no. 4 (October 14, 2017): 73, <https://doi.org/10.3390/healthcare5040073>.

⁴ CHIP site visits addressed these processes during fiscal year 2022 (October 1, 2021, through September 30, 2022); they may differ from prior years’ focus areas.

⁵ The OIG did not perform the mental health review at the VA Pacific Islands Health Care System because it did not have an emergency department or urgent care center.

Methodology

The VA Pacific Islands Health Care System includes the Spark M. Matsunaga VA Medical Center in Honolulu and associated outpatient clinics in Hawaii, Lanai, Maui, Molokai, American Samoa, Guam, and Saipan (Commonwealth of the Northern Mariana Islands). General information about the healthcare system can be found in appendix B.

The inspection team examined operations from April 13, 2019, through May 6, 2022, the last day of the unannounced multiday evaluation.⁶ During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.⁷ The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until healthcare system leaders complete corrective actions. The Medical Center Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that system leaders developed based on the reasons for noncompliance.

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

⁶ The OIG's last comprehensive healthcare inspection of the VA Pacific Islands Health Care System occurred in April 2019. The Joint Commission performed ambulatory care, behavioral health care, and home care accreditation reviews in July 2019, and a laboratory accreditation review in April 2022.

⁷ Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Results and Recommendations

Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.⁸ High-impact leaders should be person-centered and transparent, engage front-line staff members, have a “relentless focus” on their vision and strategy, and “practice systems thinking and collaboration across boundaries.”⁹ When leaders fully engage and inspire employees, create psychological safety, develop trust, and apply organizational values to all decisions, they lay the foundation for a culture and system focused on clinical and patient safety.¹⁰

To assess this healthcare system’s leadership and risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Employee satisfaction
4. Patient experience
5. Identified factors related to possible lapses in care and healthcare system leaders’ responses

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The healthcare system had a leadership team consisting of the Medical Center Director (Director), Chief of Staff, Associate Director Patient Care Services/Nurse Executive (ADPCS/NE), Associate Director for Operations (Associate Director), and Assistant Director for Efficiency and Improvement (Assistant Director). The Chief of Staff and ADPCS/NE oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG’s inspection, the healthcare system’s permanently assigned leaders had worked together for less than one month, since the ADPCS/NE’s appointment in April 2022. The ADPCS/NE and Associate Director served in acting roles for approximately six months before being permanently assigned. The Director and Assistant Director were appointed in August 2020 and February 2021, respectively. To help assess leaders’ engagement, the OIG interviewed the

⁸ Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

⁹ Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

¹⁰ Allan Frankel et al., *A Framework for Safe, Reliable, and Effective Care*, Institute for Healthcare Improvement White Paper, 2017.

Director, Chief of Staff, ADPCS/NE, and Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2021 annual medical care budget of \$510,028,321 had increased by approximately 12 percent compared to the previous year's budget of \$456,231,019.¹¹ The Director stated the budget increase did not have much effect due to inflation, but the extra funds helped leaders recruit new physicians. The Associate Director said the current FY's budget was inadequate due to the cost of shipping supplies from the mainland.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."¹² 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 healthcare system leaders.

The OIG reviewed results from VA's All Employee Survey from FYs 2019 through 2021 regarding employees' perceived ability to disclose a suspected violation without fear of reprisal.¹³

¹¹ Veterans Health Administration (VHA) Support Service Center.

¹² "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center.

¹³ The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only. The OIG suspended presentation of individual leaders' All Employee Survey scores due to potential staffing updates (e.g., newly or recently established positions and historical position vacancies) and variations in survey mapping across fiscal years (process of assigning members to workgroups for reporting purposes).

Ability to Disclose a Suspected Violation

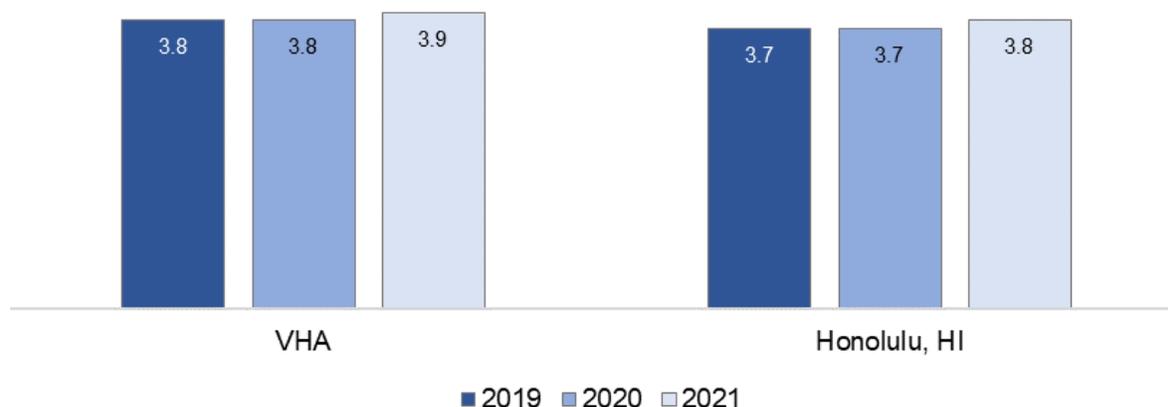


Figure 2. All Employee Survey Results: I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.

Source: VA All Employee Survey (accessed April 4, 2022).

Note: Respondents scored this survey item from 1 (Strongly disagree) through 6 (Do not know).

Patient Experience

Veterans Health Administration (VHA) uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients’ experiences with their health care and benchmark performance against the private sector. VHA’s Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program.¹⁴

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.¹⁵ The OIG reviewed responses to relevant survey questions that reflect patient experiences with the healthcare system from FYs 2018 through 2021. Figures 3 and 4 provide survey results for VHA and the healthcare system over time.¹⁶

¹⁴ “Patient Experiences Survey Results,” VHA Support Service Center.

¹⁵ “Patient Experiences Survey Results,” VHA Support Service Center.

¹⁶ Scores are based on responses by patients who received care at this healthcare system. The OIG omitted inpatient survey results due to the small number of respondents.

Outpatient Patient-Centered Medical Home Satisfaction

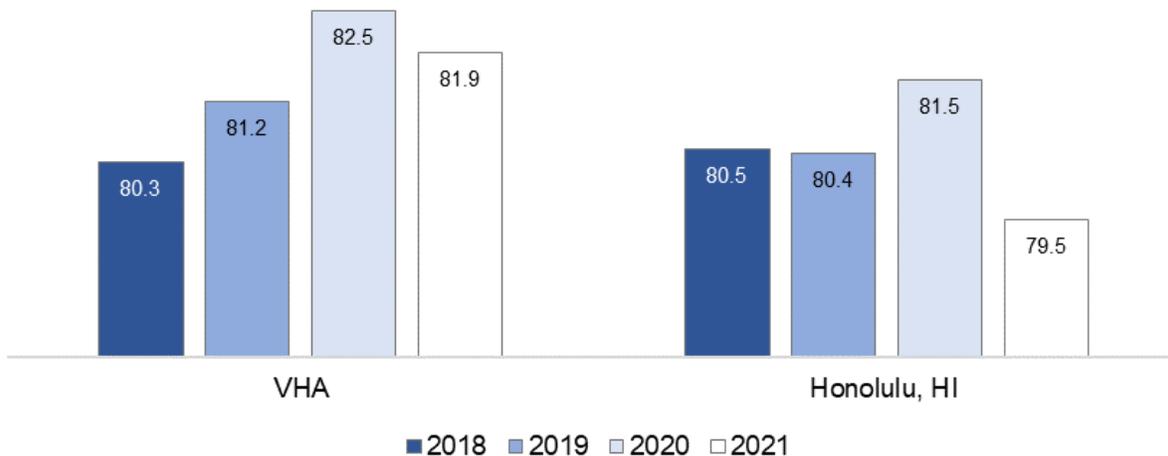


Figure 3. Survey of Healthcare Experiences of Patients Results (Outpatient Patient-Centered Medical Home): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2021).

Note: The score is the percent of “Very satisfied” and “Satisfied” responses.

Outpatient Specialty Care Satisfaction

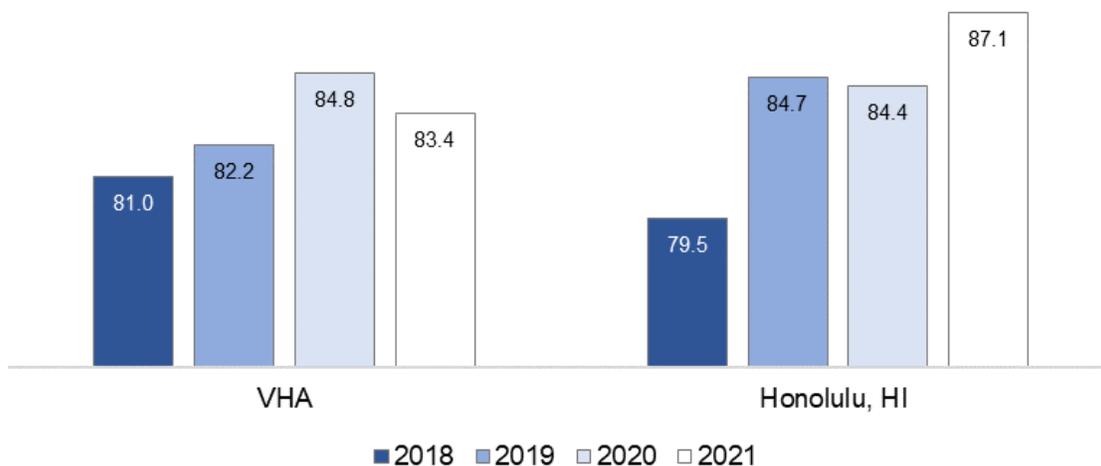


Figure 4. Survey of Healthcare Experiences of Patients Results (Outpatient Specialty Care): Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 21, 2021).

Note: The score is the percent of “Very satisfied” and “Satisfied” responses.

Identified Factors Related to Possible Lapses in Care and Healthcare System Leaders’ Responses

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.¹⁷ “A sentinel event is a patient safety event (not primarily related to the natural course of a patient’s illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm).”¹⁸ Additionally, an institutional disclosure is “a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient’s 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

¹⁷ Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; “Quality and Patient Safety (QPS),” Department of Veterans Affairs, accessed October 13, 2021, <https://www.va.gov/QUALITYANDPATIENTSAFETY/>.

¹⁸ The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, Sentinel Event Policy (SE), July 2023. VHA incorporates The Joint Commission’s definition of a sentinel event in VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

recourse.”¹⁹ Lastly, a large-scale disclosure is “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.”²⁰ To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.

The provision of safe, quality care is the responsibility of facility leaders. According to The Joint Commission’s standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.²¹ A VA medical facility’s culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond when adverse events occur, they may miss opportunities to learn and improve from those events as well as lose trust from patients and staff.²²

The Director reported discussing patient safety events during morning reports and stated that all healthcare system staff were able to voice concerns, adding that they could use an anonymous communication system which was monitored daily. The Director also stated that patients deserved to know what happened following adverse events.

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred from April 13, 2019, through May 2, 2022, and reviewed the information staff reported. The Patient Safety Manager and Risk Manager reported that two sentinel events, one institutional disclosure, and no large-scale disclosures had occurred since the last CHIP visit in 2019. Healthcare system staff performed a clinical and institutional disclosure for one sentinel event and only a clinical disclosure for the second one.²³ Staff explained they did not conduct an institutional disclosure for the latter event because the patient was cognitively impaired and the next of kin was not interested in discussing the event with leaders.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

¹⁹ VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

²⁰ VHA Directive 1004.08.

²¹ The Joint Commission, *Standards Manual*, E-dition, July 1, 2022.

²² Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events (2nd ed.)*, Institute for Healthcare Improvement White Paper, 2011.

²³ A clinical disclosure “is a process by which the patient’s clinician informs the patient or the patient’s personal representative, as part of routine clinical care, that a harmful or potentially harmful adverse event has occurred during the patient’s care.” VHA Directive 1004.08.

Quality, Safety, and Value

VHA strives to provide healthcare services that compare “favorably to the best of [the] private sector in measured outcomes, value, access, and patient experience.”²⁴ To meet this goal, VHA requires that staff at its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.²⁵ Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards (such as those from The Joint Commission).²⁶

To determine whether VHA facility staff have implemented OIG-identified key processes for quality and safety and incorporated them into local activities, the inspection team evaluated the healthcare system’s committee responsible for oversight of healthcare operations and its ability to review data and ensure key executive leadership functions are discussed and integrated on a regular basis.

Next, the OIG assessed the healthcare system’s processes for conducting peer reviews of clinical care.²⁷ Peer reviews, “when conducted systematically and credibly,” reveal areas for improvement (involving one or more providers’ practices) and can result in both immediate and “long-term improvements in patient care.”²⁸ Peer reviews are “intended to promote confidential and non-punitive” processes that consistently contribute to quality management efforts at the individual provider level.²⁹

Finally, the OIG assessed the healthcare system’s culture of safety.³⁰ VA implemented the National Center for Patient Safety program in 1999, which involved staff from across VHA developing a range of patient safety methodologies and practices.

The OIG reviewers interviewed managers and key employees and evaluated meeting minutes, peer reviews, patient safety reports, and other relevant information.

²⁴ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

²⁵ VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. (VHA rescinded and replaced this directive with VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.)

²⁶ VHA Directive 1100.16.

²⁷ 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, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190.

²⁸ VHA Directive 1190.

²⁹ VHA Directive 1190.

³⁰ A culture of safety is “the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization’s health and safety management.” “Hospital Survey on Patient Safety Culture: User’s Guide,” Agency for Healthcare Research and Quality, July 2018, accessed October 3, 2022, <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf>.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of “all health care professionals who are permitted by law and the facility to practice independently.”³¹ These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care “without supervision or direction, within the scope of the individual’s license, and in accordance with individually-granted clinical privileges.”³²

Privileges need to be specific and based on the individual practitioner’s clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP’s credentials and service chief’s recommendation to determine whether “clinical competence is adequately demonstrated to support the granting of the requested privileges,” and submits the final recommendation to the facility director.³³ LIPs are granted clinical privileges for a limited time and must be repriviledged prior to their expiration.³⁴

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs’ professional performance. The Focused Professional Practice Evaluation process occurs when a practitioner is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP’s performance by regularly conducting an Ongoing Professional Practice Evaluation (OPPE) to ensure the continuous delivery of quality care.³⁵

VHA’s credentialing process involves the assessment and verification of healthcare practitioners’ qualifications to provide care and is the first step in ensuring patient safety.³⁶ Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office and aligned under the chief of staff. VHA also requires facilities to have credentialing

³¹ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded and replaced this handbook with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

³² VHA Handbook 1100.19.

³³ VHA Handbook 1100.19.

³⁴ VHA Handbook 1100.19.

³⁵ VHA Handbook 1100.19.

³⁶ VHA Directive 1100.20.

and privileging managers and specialists with job duties that align under standard position descriptions.³⁷

The OIG interviewed key managers and selected and reviewed the privileging folders of 22 medical staff members, including solo or few LIPs, who had a Focused Professional Practice Evaluation or OPPE.³⁸

Medical Staff Privileging Findings and Recommendations

VHA required practitioners with similar training and privileges to evaluate LIPs on an ongoing basis.³⁹ The OIG found that a similarly trained and privileged practitioner did not complete an OPPE for a solo LIP. This resulted in the LIP continuing to provide care without a thorough competency evaluation, which could have jeopardized quality of care and patient safety. The Credentialing and Privileging Manager reported believing that an external provider at another facility evaluated the solo LIP and the external provider's privileges met the requirement.

Recommendation 1

1. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures practitioners with equivalent specialized training and similar privileges complete Ongoing Professional Practice Evaluations of licensed independent practitioners.⁴⁰

³⁷ Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo, "Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020," December 16, 2020.

³⁸ VHA refers to a solo practitioner as being one provider in the facility who is privileged in a particular specialty. VHA Acting Deputy Under Secretary for Health for Operations and Management memo, "Requirements for Peer Review of Solo Practitioners," August 29, 2016. (This memo was rescinded and replaced by the Assistant Under Secretary for Health for Clinical Services memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators" on December 18, 2020. The December 18, 2020, memo was rescinded and replaced by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer's Revision memo, "Implementation of Enterprise-Wide Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) Specialty-Specific Clinical Indicators" on May 18, 2021.) The OIG considers few practitioners as being two providers in the facility who are privileged in a particular specialty.

³⁹ VHA Acting Deputy Under Secretary for Health for Operations and Management memo, "Requirements for Peer Review of Solo Practitioners." VHA now requires another practitioner with equivalent specialized training and similar privileges to complete the professional practice evaluation. VHA Directive 1100.21(1).

⁴⁰ The OIG reviewed evidence sufficient to demonstrate that the system had completed improvement actions, and therefore, closed the recommendation before publication of the report.

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The process for evaluation of VA Pacific Islands Health Care System (VAPIHCS) providers by another provider with similar training and privileges was reviewed by the Credentialing and Privileging Manager and Credentialing and Privileging Analyst. The Credentialing and Privileging Team follow Directive 1100.21(1) [Privileging] and SOP 10N21-010 [Standard Operating Procedure for External Review: Focused Professional Practice Evaluations and Ongoing Professional Practice Evaluations]. Beginning August 03, 2022, copies of privileges and training were requested by the Credentialing and Privileging Analyst from the external provider(s) designated to perform chart review for solo/few providers and other providers within VAPIHCS whose Ongoing Professional Practice Evaluations (OPPE[s]) are conducted outside this facility. The privileges and training of the reviewer are presented by the Credentialing and Privileging Analyst to the respective service chief for comparison with those of the VAPIHCS provider. If there is no match, the Credentialing and Privileging Analyst requests another external reviewer, and the process continues until there is a match of training and similar privileges approved by the respective service chief. An external reviewer compliance tracker was developed by the Credentialing and Privileging Analyst. A compliance rate of 100 percent (100%) was reached for six (6) consecutive months for OPPE reviews conducted by a provider with equivalent specialized and similar training and privileges. The six-month review and reporting time frame was July 1, 2022, through December 31, 2022.

VHA requires that service chiefs incorporate service-specific criteria in OPPEs.⁴¹ The OIG found that both solo or few LIPs' OPPEs lacked evidence service chiefs incorporated service-specific criteria. This resulted in inadequate data to support reprivileging, and LIPs delivering care without a thorough review of their practices. The Credentialing and Privileging Manager stated that the previous Specialty Care Service Chief and staff lacked awareness and understanding of the requirement.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs incorporate service-specific criteria in the Ongoing Professional Practice Evaluations of licensed independent practitioners.

⁴¹ VHA Handbook 1100.19; VHA Directive 1100.21(1).

Healthcare system concurred.

Target date for completion: February 28, 2024

Healthcare system response: The process for service/section-specific criteria on the Ongoing Professional Practice Evaluation (OPPE) form, initially reviewed in 2021 in response to a national suspense, was revisited in 2022 by the respective service chiefs, in addition to the enterprise-wide specialty specific clinical indicators. The facility Credentialing and Privileging Manager and Credentialing and Privileging Analyst met with service chiefs and licensed independent practitioners from April 2022 through September 2022 and provided information on the implementation of the enterprise-wide clinical indicator forms required by Veterans Health Administration. The OIG recommendation regarding service-specific criteria on the OPPE form and corrective actions were discussed at the June 1, 2022, meeting of the Executive Committee of the Medical Staff (ECMS). The compliance tracker for use of OPPEs with criteria specific to the service line or section was presented by the Credentialing and Privileging Analyst at the October 5, 2022, Executive Committee of the Medical Staff meeting. Audits were conducted by the Credentialing and Privileging Analyst at a rate of one hundred percent (100%) to ensure compliance with service-specific criteria. The compliance rate for use of the OPPE format with criteria specific to the service or section was identified as ≥ 90 percent ($\geq 90\%$) for six (6) consecutive months.

VHA also requires an executive committee of the medical staff to recommend continuation of privileges based on OPPE results.⁴² For 8 of 20 OPPEs (including for one solo or few LIP), the OIG did not find evidence the Executive Committee of the Medical Staff recommended continuation of privileges based on OPPE results. This may have resulted in the LIPs continuing to deliver care without thorough evaluations of their practices. The Credentialing and Privileging Manager attributed the noncompliance to the lack of an established process for submitting OPPEs to the Executive Committee of the Medical Staff for review.

Recommendation 3

3. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures the Executive Committee of the Medical Staff recommends continuation of privileges based on Ongoing Professional Practice Evaluation results.

⁴² VHA Handbook 1100.19; VHA Directive 1100.21(1).

Healthcare system concurred.

Target date for completion: February 28, 2024

Healthcare system response: The process for ensuring that the Executive Committee of the Medical Staff (ECMS) recommends continuation of privileges based on Ongoing Professional Practice Evaluation (OPPE) results was reviewed by the Credentialing and Privileging Manager. The presentation at ECMS was updated requiring two (2) years of provider OPPE documentation to be presented by the service chief at the meeting for recertification of privileges. This was effective June 01, 2022. The facility expanded the Credentialing and Privileging Service bringing onboard a Credentialing and Privileging Analyst with a hire date of February 13, 2022. A major focus area for this position is OPPE management and tracking. The ECMS minutes document the recommendation for continuing privileges based on OPPE results. The compliance rate for the ECMS recommendation of continuation of privileges based on OPPE results with was identified as ≥ 90 percent ($\geq 90\%$) for six (6) consecutive months.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. 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.⁴³ The physical environment of a healthcare organization must not only be functional but should also promote healing.

The purpose of this inspection was to determine whether staff at VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG assessed compliance in selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.⁴⁴

An estimated 75,673 of 100,306 drug overdose deaths that occurred in the United States from April 2020 to April 2021 were opioid related. This was an increase from 56,064 in the previous 12 months.⁴⁵ VA implemented the Rapid Naloxone Initiative to reduce the risk of opioid-related deaths. This initiative involves stocking the reversal agent naloxone in Automated External Defibrillator cabinets in nontraditional patient care areas to enable fast response times to emergencies and contribute to a safe healthcare environment.⁴⁶

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected 12 patient care areas:

⁴³ VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016. (VHA rescinded and replaced this directive with VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. VHA amended this directive September 7, 2023.)

⁴⁴ Community living centers were previously known as nursing home care units. VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142, *Standards for Community Living Centers*, October 5, 2023.)

⁴⁵ Centers for Disease Control and Prevention – National Center for Health Statistics, “Drug Overdose Deaths in the U.S. Top 100,000 Annually,” November 17, 2021, accessed March 22, 2022, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.

⁴⁶ Opioids are medications that are “effective at reducing pain” but “when taken in excess, can lead to respiratory arrest.” Naloxone “is a highly effective treatment for reversing an opioid overdose.” “Automated External Defibrillator (AED) Cabinet Naloxone Program: Implementation Toolkit,” VHA. AEDs are devices used to treat sudden cardiac arrest. Food and Drug Administration, “Automated External Defibrillators (AEDs),” accessed December 16, 2021, <https://www.fda.gov/medical-devices/cardiovascular-devices/automated-external-defibrillators-aeds>. “Pharmacy Benefits Management Services,” Department of Veterans Affairs, accessed October 6, 2021, https://www.pbm.va.gov/PBM/academicdetailingservice/Opioid_Overdose_Education_and_Naloxone_Distribution.asp.

- Cardiology clinic
- Endocrinology clinic
- General surgery clinic
- Inpatient mental health unit⁴⁷
- Neurology clinic
- Orthopedic clinic
- Outpatient mental health clinic
- Podiatry clinic
- Primary care clinic
- Pulmonology clinic
- Rheumatology clinic
- Women’s health clinic

Environment of Care Findings and Recommendations

VHA requires staff at facilities with mental health units that treat suicidal patients to perform systematic environmental assessments to eliminate conditions that could facilitate suicide attempts, such as an anchor point.⁴⁸ In all nine patient rooms in the locked inpatient mental health unit, the OIG noted the following anchor points: exposed shower faucets, wall-mounted soap dispensers, and locker doors with exposed hinges and louvers.⁴⁹ Additionally, the OIG found ceramic toilets without tamper-resistant enclosures in eight of nine patient rooms. These conditions provide patients opportunities for possible suicide attempts and increase the likelihood of suicide completion.

The Patient Safety Manager reported previously identifying the ceramic toilets as potential safety hazards that required corrective action. The manager further stated that since this unit is located at Tripler Army Medical Center and it is difficult to affect change in a non-VA owned property, staff implemented a mitigation plan to frequently visit the unit to minimize the risk of patients’ self-harm. In February 2021, the VA National Center for Patient Safety Director issued a

⁴⁷ The VA Pacific Islands Health Care System’s inpatient mental health unit is located at Tripler Army Medical Center, a Department of Defense facility in Honolulu. The unit is staffed by VA employees.

⁴⁸ VHA Directive 1167, *Mental Health Environmental of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017.

⁴⁹ “A louver is a ventilation product that allows air to pass through it...[and contains a] number of fixed or operable blades mounted in a frame [providing] this functionality.” “How Louvers Work,” Architectural Louvers, accessed July 17, 2022, https://www.archlouvers.com/How_Louvers_Work.htm.

statement acknowledging that current practice met the standard, and staff uses it as guidance until Tripler Army Medical Center staff can replace the ceramic toilets.

Additionally, the Assistant Director stated that during environment of care inspections, staff had previously identified shower faucets, soap dispensers, and lockers with exposed hinges and louvers as potential safety hazards. However, the Patient Safety Manager reported believing the unit met the standards' intent because the distance between the shower faucet button and wall made it impossible to use as an anchor point; wall-mounted soap dispensers were considered low-risk due to the frequent unit inspections; and staff had shaved the top of the locker hinges.

Recommendation 4

4. The Assistant Director for Efficiency and Improvement evaluates and determines any additional reasons for noncompliance and ensures managers comply with inpatient mental health unit environmental safety requirements.

Healthcare system concurred.

Target date for completion: December 31, 2023

Healthcare system response: During the Survey, the Patient Safety Manager at VA Pacific Islands Health Care System (VAPIHCS) identified to the OIG survey team that the inpatient Mental Health unit staffed by VAPIHCS staff (3B2 Unit) is physically located in Tripler Army Medical Center. VAPIHCS as the lessee is dependent on Tripler to effect any substantive changes to physical structures within this Mental Health Inpatient Unit including those identified in this recommendation as ligature risks [anchor points]. Multiple attempts have been made by the Compliance Officer in VAPIHCS Facilities Management Service following the completion of each Mental Health Environment of Care Checklist (MHEOCC) to work closely with Tripler on correction of ligature risks. These were reviewed by Chief of Facilities Management Division at Tripler Army Medical Center with each request; however, the way ligature risk is identified in VHA and Defense Health Agency (DHA) are not identical. Tripler's prioritization did not include changes to [the] 3B2 Unit. VAPIHCS is unable to make any physical modifications on this unit without the approval of Tripler. The Compliance Officer will oversee coordination with Tripler to ensure replacement of ligature risk physical structures in the Mental Health Inpatient Unit by December 31, 2023. Further, to meet the intent of ligature risk assessment and provide safe care for our Veterans on this unit, the 3B2 [Unit] nursing staff conduct 15-minute rounds. The 3B2 [Unit] nursing team uses a basic checklist with the name(s) of the patients, conducts the 15-minute rounds and enters the data into the Safety and Attendance form embedded in Tripler's inpatient medical record immediately following completion of the rounds.

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the US healthcare system. To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed review of four clinical and administrative areas and provided four recommendations on systemic issues that may adversely affect patients. The number of recommendations does not reflect the overall caliber of services delivered within this healthcare system. However, the OIG's findings illuminate areas of concern, and the recommendations may help guide improvement efforts. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines four OIG recommendations aimed at reducing vulnerabilities that may lead to patient safety issues or adverse events. The recommendations are attributable to the Chief of Staff and Assistant Director for Efficiency and Improvement. The intent is for leaders to use the recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Recommendations for Improvement
Leadership and Organizational Risks	<ul style="list-style-type: none"> • None
Quality, Safety, and Value	<ul style="list-style-type: none"> • None
Medical Staff Privileging	<ul style="list-style-type: none"> • Practitioners with equivalent specialized training and similar privileges complete Ongoing Professional Practice Evaluations of licensed independent practitioners. • Service chiefs incorporate service-specific criteria in the Ongoing Professional Practice Evaluations of licensed independent practitioners. • The Executive Committee of the Medical Staff recommends continuation of privileges based on Ongoing Professional Practice Evaluation results.
Environment of Care	<ul style="list-style-type: none"> • Managers comply with inpatient mental health unit environmental safety requirements.

Appendix B: Healthcare System Profile

The table below provides general background information for this low complexity (3) affiliated healthcare system reporting to VISN 21.¹

**Table B.1. Profile for VA Pacific Islands Health Care System (459)
(October 1, 2018, through September 30, 2021)**

Profile Element	Healthcare System Data FY 2019*	Healthcare System Data FY 2020†	Healthcare System Data FY 2021‡
Total medical care budget	\$327,769,281	\$456,231,019	\$510,028,321
Number of:			
• Unique patients	36,693	37,314	39,395
• Outpatient visits	336,399	371,219	417,161
• Unique employees§	1,231	1,280	1,391
Type and number of operating beds:			
• Community living center	60	60	44
• Domiciliary	12	12	6
• Mental health	16	16	16
Average daily census:			
• Community living center	43	53	34
• Domiciliary	9	4	2
• Mental health	5	5	3

Source: VHA Support Service Center and VA Corporate Data Warehouse.

Note: The OIG did not assess VA's data for accuracy or completeness.

*October 1, 2018, through September 30, 2019.

†October 1, 2019, through September 30, 2020.

‡October 1, 2020, through September 30, 2021.

§Unique employees involved in direct medical care (cost center 8200).

¹ VHA medical facilities are classified according to a complexity model; a designation of “3” indicates a facility with “low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs.” VHA Office of Productivity, Efficiency & Staffing (OPES), “VHA Facility Complexity Model Fact Sheet,” October 1, 2020. An affiliated healthcare system is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: September 14, 2023

From: Director, VA Sierra Pacific Network (10N21)

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

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

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

1. Thank you for the opportunity to respond to the draft report, Comprehensive Healthcare Inspection of the VA Pacific Islands Health Care System in Honolulu, Hawaii.
2. I have reviewed the findings and recommendations in the OIG draft report. I concur with the submitted action plans.

(Original signed by:)

Ada Clark, FACHE, MPH

Network Director

VA Sierra Pacific Network (VISN 21)

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: September 11, 2023

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

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

To: Director, VA Sierra Pacific Network (10N21)

1. Thank you for the opportunity to review and comment on the Office of Inspector General Comprehensive Healthcare Inspection of VA Pacific Islands Health Care System. I concur with the findings and recommendations in the report.
2. I concur with the submitted action plans. VA Pacific Islands Health Care System is committed to ensuring our Veterans receive outstanding healthcare.

(Original signed by:)

Adam M. Robinson, Jr., MD, MBA, CPE
Director
VA Pacific Islands Healthcare System

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Inspection Team	Robert Ordonez, MPA, Team Leader Debra Baskin, DNP, RN Christine El-Zoghbi, PhD Megan Magee MSN, RN Kara McDowell, BSN, RN Simonette Reyes, BSN, RN Cheryl Walsh, MS, RN
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Other Contributors	Melinda Alegria, AuD, CCC-A Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Tasha Felton-Williams, DNP, ACNP Jennifer Frisch, MSN, RN Reynelda Garoutte, MHA, BSN Justin Hanlon, BAS LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Christopher D. Hoffman, LCSW, MBA Amy McCarthy, JD Scott McGrath, BS Joan Redding, MA Larry Ross, Jr., MS Caitlin Sweany-Mendez, MPH Erika Terrazas, MS Elizabeth Whidden, MS, APRN Jarvis Yu, MS
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