Department of Veterans Affairs
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Office of Healthcare Inspections

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# Healthcare Inspection

# Summarization of Select Aspects of the VA Pacific Islands Health Care System Honolulu, Hawaii

September 22, 2016

Washington, DC 20420

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# Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted a review of the VA Pacific Islands Health Care System (VAPIHCS), Honolulu, Hawaii. The purpose of the review was to collect and summarize supplementary data in support of a Combined Assessment Program review completed in August 2015[1] and to respond to letters sent by Senator Mazie K. Hirono expressing concerns about access to care, travel benefits, cultural diversity, homeless services, and mental health care. We also reviewed the Veterans Health Administration's 6-point plan to address capacity and access to care within VAPIHCS primary care clinics.

VAPIHCS provides medical and mental health care across the Hawaiian Islands, Guam, American Samoa, and Saipan. In addition to the logistical challenges of coordinating care spanning multiple islands and thousands of miles, leadership and staff consistently reported difficulty in recruiting and retaining qualified employees due to the cost of living, distance, and isolation of island life. Further, VAPIHCS staff reported the lack of adequate space at almost all locations to manage the volume of patients seeking care.

We found that VAPIHCS has many of the same administrative and clinician availability issues found across the VA system for non-VA care. At VAPIHCS, these challenges are compounded by a shortage of VA-based providers and enrolled non-VA providers, the complexity of island logistics, and the diversity of the population served. VAPIHCS was in the process of hiring and embedding additional non-VA care staff at the community based outpatient clinics to enhance the timeliness and management of non-VA care.

VAPIHCS Beneficiary Travel Program expenditures are substantial due to the logistics of providing care for patients across multiple islands. VAPIHCS acknowledged a delay in processing travel benefit claims, but staff were expected to resolve the backlog by January 2016. As of August 2016, all but 21 of the unprocessed claims had been resolved.

We found that while there may be occasions when a provider's management of a situation could potentially lack cultural sensitivity and competence, interviewees did not report that this was a wide-spread problem. We also found that VAPIHCS:

- Offers a comprehensive array of programs and services across the islands for homeless veterans.
- Offers a variety of general and specialty mental health services across the islands that, despite staffing challenges, meet mental health access metrics.
- Has improved staffing in the Suicide Prevention Program in the past year to address past deficiencies and expand its outreach efforts.

[1] VAOIG, *Combined Assessment Program Review of the Pacific Islands Health Care System, Honolulu, Hawaii,* Report No. 15-00626-28, November 10, 2015.

In February 2014, VAPIHCS had one of the largest wait lists VA-wide for patients wanting primary care appointments. VAPIHCS implemented a 6-point plan to increase primary care panel sizes, extend clinic hours, increase primary care staffing at the community based outpatient clinics, contact and schedule appointments for wait-listed veterans, and educate veterans on the importance of keeping their appointments or calling to cancel prior to the scheduled time.

In August 2015, VAPIHCS had substantially improved access to care from 77.57 percent appointments completed within 30 days of the preferred date in FY 2014 to a 95.18 percent completion rate within 30 days for new patients awaiting primary care appointments.

We made one recommendation.

## Comments

The Veterans Integrated Service Network and System Directors concurred with our recommendation and provided an acceptable action plan. (See Appendixes A and B, pages 20–22 for the Directors' comments.) We will follow up on the planned actions.

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# Purpose

On July 8, 2015, the Office of Inspector General (OIG) Office of Healthcare Inspections met with representatives from the office of Senator Mazie K. Hirono to discuss concerns about access to care, travel benefits, and cultural diversity at the VA Pacific Islands Health Care System (VAPIHCS), Honolulu, HI. On August 6, Senator Hirono sent a letter requesting evaluation of homeless services and mental health (MH) care.

The Office of Healthcare Inspections conducted a Combined Assessment Program (CAP) review at VAPIHCS in August 2015.[4] CAP reviews evaluate selected health care facility operations, focusing on patient care quality and the environment of care. In this case, the pre-established CAP review topics did not include all of Senator Hirono's concerns, which altered the scope of our work.

The purpose of our review was to collect and summarize supplementary data in support of the CAP review and respond to Senator Hirono's request. Specifically, we (a) conducted a descriptive analysis of current conditions and factors affecting access to care and service delivery throughout VAPIHCS, and (b) evaluated the implementation of the 6-point action plan.

# Background

VAPIHCS provides medical and MH care through a main Ambulatory Care Clinic (ACC), seven community based outpatient clinics (CBOCs), and three "other outpatient service" (alternate coverage) arrangements on the smaller remote islands. The VAPIHCS consists of the Hawaiian Islands (Oahu, Hawaii, Maui, Kauai, Molokai, and Lanai), American Samoa, Guam, and Saipan. VAPIHCS is part of Veterans Integrated Service Network (VISN) 21 and serves a veteran population of about 50,000.

[2] Dr. James Tuchschmidt was the Acting Principal Deputy Under Secretary for Health for the Veterans Health Administration.
[3] In 2014 and 2015, VAOIG Office of Investigations also conducted a review related to scheduling and appointment wait times.
[4] VAOIG, *Combined Assessment Program Review of the Pacific Islands Health Care System Honolulu, HI,* Report No. 15-00626-28, November 10, 2015. We made 18 recommendations in the areas of Quality Management, Environment of Care, and the Suicide Prevention Program. VAPIHCS submitted action plans; we followed up on implementation of the action plans, and closed the recommendations in June 2016.

**Figure 1: VAPIHCS Catchment Area and Distances from the Oahu ACC**


*Source: ArcGIS, version 10.2, mapping software by Environmental Systems Research Institute, Redland, CA.*

In addition to the logistical challenges of coordinating care spanning multiple islands and thousands of miles, leadership and staff consistently reported difficulty in recruiting and retaining qualified employees due to the cost of living, distance, and isolation of island life.[5] Further, VAPIHCS staff reported the lack of adequate space at almost all locations to manage the volume of patients seeking care.

Below is a broad description of the services provided, staffing arrangements, and current or planned improvement actions, by island/clinic location.

ACC

The VAPIHCS ACC, located in Honolulu, provides a broad range of outpatient medical and MH care. VAPIHCS has a sharing agreement with Tripler Army Medical Center (TAMC) and, on the TAMC grounds, VAPIHCS provides long-term and transitional rehabilitative care services (60 beds), inpatient MH care and partial hospitalization (20 beds), and a Post-Traumatic Stress Disorder Residential Rehabilitation Program (12 beds). Medical inpatient care is provided by VA hospitalists and Department of Defense (DoD) physicians or through non-VA care.

CBOCs/Veterans' Centers

VAPIHCS has seven CBOCs, five of which are located on the Hawaiian islands of Oahu (Leeward), Hawaii (Hilo and Kailua-Kona), Maui, and Kauai. The CBOCs provide PC and MH services. The CBOCs are able to provide non-emergent care for veterans with

[5] Staff noted that most employees without a connection to the Islands stay approximately 2–3 years before they return to the mainland.

stable chronic health problems or minor acute illnesses. For emergency services, veterans are referred to local community hospitals for care. VA Central Office approved minor construction projects to build "One Stop Shopping" veterans' centers on Maui and Kauai.[6]

To address space and access concerns, VAPIHCS planned to establish a new 7,500 square foot (sf) CBOC on the Windward side of Oahu. However, as of August 2016, VAPIHCS leaders reported that they had been unable to find a suitable location. A commercial lease broker is assisting VAPIHCS to intensify the search efforts and assist with the leasing agreement once potential space has been identified. In addition, VAPIHCS has established an emergency lease at the downtown Federal Building for 5,000 sf to support administrative functions, thus increasing space at the ACC for clinical functions.

The American Samoa CBOC is located in Pago Pago in the South Pacific Ocean. The CBOC opened in 2008 and provides PC and MH services and uses telehealth for many other services. The CBOC is not equipped to provide emergency services and refers patients to the Lyndon B. Johnson Tropical Medical Center in Pago Pago for urgent and emergent care. Leadership informed us that the local community is trying to build a new hospital. In addition, travel can be difficult, as flights available to and from American Samoa and Oahu are limited.[7]

VAPIHCS leaders reported that renovations that would expand MH, physical therapy, and laboratory services at the American Samoa CBOC were scheduled for FY 2016; however, as of August 2016, VAPIHCS leaders continue to work with VA Contracting Services to resolve construction and contracting issues.

The Guam CBOC is located in Agana Heights, Guam, and provides PC and MH services. The CBOC is not equipped to provide emergency services and refers patients, via a sharing agreement, to the US Naval Hospital emergency room as needed.[8] The US Naval Hospital is located less than 1 mile from the CBOC.

In FY 2014 and FY 2015, 10 staff members left the Guam CBOC. The CBOC currently has seven vacant positions, including two physicians, a psychologist, two specialty care nurses, a pharmacist, and a social worker.

The Guam CBOC occupies 5,818 sf of space, which is not adequate to meet the demand for care. VAPIHCS leadership proposed a $5.5 million construction project that includes renovating the current space and building a 2,800 sf addition. The design phase is scheduled to begin in FY 2016 with an expected completion timeframe of

[6] The "One Stop Shopping" Veteran Centers will move CBOC, Veteran Benefits Administration, VA Vet Centers and State of Hawaii Office of Veteran Services into one location. Funding requests have also been submitted for a center in Hilo, Hawaii.
[7] Hawaiian Airlines offers two flights to Pago Pago from Oahu and two flights from Pago Pago to Oahu per week; the flights are on Mondays and Fridays.
[8] VA Pacific Islands Health Care System website http://www.hawaii.va.gov/locations/Agana_Heights_Guam.asp. Accessed August 7, 2015.

2 years. However, VAPIHCS has no interim plan to provide relief for the space concerns.

Other Outpatient Services

**Molokai** – VAPIHCS has a contract agreement with Molokai General Hospital to use clinic space 30 hours per week and a part-time health technician who is employed by both Queen's Hospital and VAPIHCS. VAPIHCS is currently recruiting for a nurse and anticipates implementing home-based care. PC[9] and MH[10] services are provided at the clinic.

**Lanai** – VAPIHCS has a contract agreement with Straub Lanai Family Health Center to use clinic space once a month, and Straub provides a health technician to work during clinic hours. The health technician located on Molokai and VA staff at the Leeward CBOC coordinate scheduling. Traveling PC[11] and MH[12] clinicians provide episodic care.

**Saipan** – Two non-VA PC providers serve veterans on Saipan. While face-to-face MH care is provided by a traveling MH provider on a recurring basis, many other services are provided via telehealth. Saipan is located approximately 30 miles from Guam and is a US Foreign Territory. If further medical care is needed, patients are flown to Guam.

# Scope and Methodology

The period of review was from February 2014 through March 2016. We updated selected aspects of the review in August 2016. We conducted a site visit the week of August 24, 2015. We reviewed relevant policies, procedures, and data; sharing agreements with the DoD and community providers; patient advocate reports; training information related to cultural sensitivity; travel and reimbursement processes; staffing for the ACC and CBOCs; quality management data; non-VA care coordination (NVCC) information; the Veterans Choice Program implementation plan; reports related to homeless programs; and MH data and staffing.

We interviewed the VAPIHCS Director and Chief of Staff (COS); the veteran who testified during the field hearing in August 2014; and managers in non-VA care programs, transportation and beneficiary travel programs, and PC, MH, and specialty programs. In all, we interviewed more than 60 employees, Veteran Service Organizations (VSOs), and community representatives with knowledge about the topics under review.

VAPIHCS is challenged with staff recruitment and retention, space, and in some cases, high market cost issues that directly influence their ability to deliver timely care. In this

[9] PC provider is located on Molokai.
[10] MH services are provided by traveling MH staff located at the Maui CBOC.
[11] The PC provider is stationed at the Maui CBOC.
[12] The MH providers are stationed in Oahu.

report, we describe the efforts VAPIHCS has taken to address and overcome the challenges that are within its span of control.

In the absence of current VA/VHA policy, we considered previous guidance to be in effect until superseded by an updated or re-certified Directive, Handbook, or other policy document on the same or similar issue(s).

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

# Inspection Results

## Section A – Current Conditions

### Aspect 1: Mechanisms To Access Non-VA Care

*VAPIHCS is taking actions to improve access to non-VA care, but challenges persist.*

VAPIHCS has many of the same administrative and clinician availability issues found across the VA system for non-VA care. At VAPIHCS, these challenges are compounded by a shortage of VA-based providers and enrolled non-VA providers, the complexity of Island logistics, and the diversity of the population served.

When a local VA facility cannot provide needed medical care due to a lack of specialists, high demand for care, geographic inaccessibility, or other limiting factors, eligible veterans may use non-VA care through Patient-Centered Community Care (PC3). PC3 is the Veterans Health Administration's (VHA) nationwide program that utilizes third-party administered contracts to provide eligible veterans with access to non-VA providers. Tri-West Healthcare Alliance is the VA-contracted third-party administrator with responsibility for recruitment and maintenance of a "network" of providers to meet specialty care, geographic, or other demand needs for VAPIHCS. Tri-West also matches veterans with specialized care needs to providers in their areas.

Over the years, non-VA care has evolved from a largely administrative bill payment function (under Fee Basis) to a complex clinical referral and oversight program involving billions of dollars. More recently, non-VA care has undergone a series of revisions and expansions to provide eligible veterans and their providers with more care options that are more conveniently located. NVCC and Veterans Choice are the two non-VA care avenues utilized by VAPIHCS. Simplified descriptions of these programs are as follows.

NVCC: NVCC is staffed at the facility level and provides administrative and clinical coordination of services that cannot be delivered by VA providers or in a specified timeframe through PC3 resources. Clinically relevant information is shared with non-VA providers prior to the patient's scheduled appointment. After a VA provider initiates an NVCC consult, NVCC staff:

- Review the case to determine administrative eligibility.
- Review the case to determine clinical appropriateness.
- Secure authorization for care and payment from the designated official (usually the COS or an Associate COS).
- Assure appropriate authorization and clinical information is forwarded to the selected non-VA provider.

- Coordinate and manage patient care throughout the process, including scheduling of appointments, communicating with the patient, and assuring consult results are returned timely and uploaded to the patient's medical record.[13]

In general, NVCC consults should be completed within 90 days.

Veterans Choice: Veterans Choice is a program initiated in August 2014 through the Veterans Access, Choice, and Accountability Act (VACAA). Veterans Choice is similar to NVCC insofar as it provides administrative and clinical coordination of services that cannot be delivered by VA providers. Veterans Choice expands eligibility for non-VA care to include veterans who cannot be seen by VA providers within 30 days and veterans who reside greater than 20 miles from a VA facility that can provide the needed care.[14] Because of the logistical challenges in the Islands, all veterans enrolled in VAPIHCS are eligible for Veterans Choice. In this program:

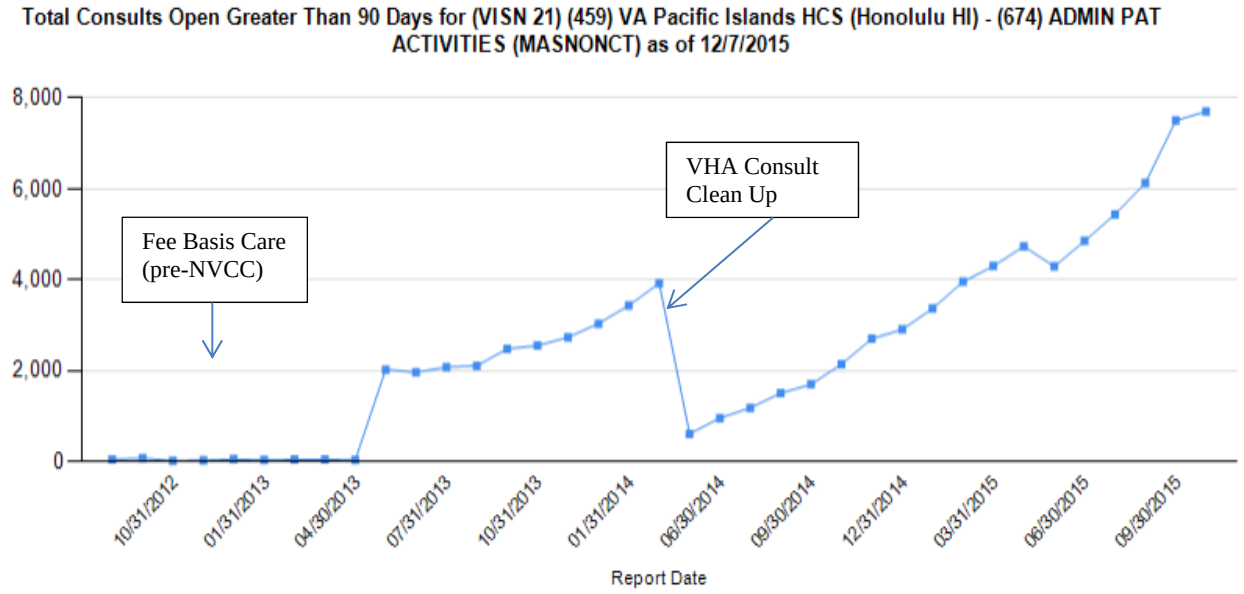
- NVCC staff contact eligible veterans and offer them the option to use a non-VA provider or receive care from a VA provider.
  - If the veteran selects non-VA care, NVCC staff provide necessary documentation to Tri-West to facilitate the appointment.
  - If the veteran selects VA care, he or she is placed on an electronic waiting list (if required) at a VA facility offering the needed care.
- Eligible veterans can opt to self-refer for care through Tri-West without an NVCC consult referral.

Because NVCC requires a clinical consult (which can be tracked) but Veterans Choice does not, we were unable to determine with certainty the number of veterans waiting for non-VA care beyond 90 days. However, we were told that a majority of non-VA care is requested via a clinical consult. The following graph shows the number of VAPIHCS' non-VA care consults greater than 90 days old as of December 7, 2015. The graph clearly reflects an upward trend since June 2014 in delayed non-VA care consults.

[13] VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008. This Directive which was in effect during the time of the events discussed in this report was rescinded and replaced by VHA Directive 1232, *Consult Processes and Procedures,* August 23, 2016. The 2016 Directive states that "…every effort must be made to work with the Non-VA provider to ensure that the facility receives authenticated information and it is scanned into the Veteran health record."

[14] Eligibility requirements include veterans for whom VA cannot schedule an appointment within 30 days of the date clinically determined by their provider, or if no date is provided, the veteran's preferred date, or veterans who reside in a State or a United States Territory without a full-service VA medical facility that provides hospital care, emergency services and surgical care having a surgical complexity of standard, or veterans who reside more than 20 miles from a VA facility, such as Hawaii, Guam, and American Samoa.

**Figure 2: Trends in the Number of Consults Open >90 days FYs 2012–2015**




*Source: Retrieved by OIG from VHA's Consult Switchboard, ALL Consult Performance Report →VISN 21/VAPIHCS (459) + stop code 674 Admin Pat Activities.*[15]

We also could not determine with certainty the basis for the upward trend in delayed non-VA care consults, but the confluence of several factors are likely contributory, as discussed below.

Availability of PC and Specialty Providers in the Hawaiian Islands

The US Department of Health and Human Services has designated many of the counties comprising the VAPIHCS as Health Professional Shortage Areas. These counties have been determined to have a shortage of PC, dental care, or MH providers. Further, according to a report on the findings from the Hawaii Physician Workforce Assessment Project (2015), the Hawaiian Islands currently have a deficit of more than 600 physician providers, with a projected shortage of between 800–1,500 physician providers by 2020.

Recruitment of Non-VA Providers to the "Network"

Tri-West faces provider recruitment challenges due to the limited number of specialty providers available on some of the Islands. In June 2015, Tri-West opened an office on Oahu to facilitate enrollment of non-VA providers to address the unique use and demand issues found in VAPIHCS' catchment area.

[15] In 2013, VHA undertook a series of activities to "clean up" the number of unresolved consults nationwide. Unresolved consults are consults that are still open or active in the electronic health record.

Implementation of VACAA

According to employees we interviewed, the initial implementation and subsequent changes to Veterans Choice were disjointed, confusing, and not clearly communicated to the veterans or staff. Examples included modification of the distance calculation and eligibility criteria. Patient advocates told us that the majority of the complaints they received were related to Veterans Choice. Staff we interviewed stated that veterans reported that the Health Eligibility Center, located in Atlanta, GA, provided incorrect or unclear eligibility guidance to veterans, thus requiring intervention by staff. In addition, a 6-hour time difference may have impacted their ability to intervene timely.

NVCC Staffing

Like other NVCC programs nationwide, the VAPIHCS NVCC program was not adequately staffed to manage the volume of non-VA care consults. We were told that VAPIHCS planned to hire 11 new employees to complement the current 12 full-time and 2 temporary NVCC staff. During FY 2016, VAPIHCS increased the authorized NVCC staff to 81.5 FTEE and had hired 24.5 staff as of August 12, 2016. These positions will be located at selected CBOC locations and will include one nurse and one program support assistant to serve as managed care champions. These two changes are anticipated to jointly enhance the timeliness and management of non-VA care.

Veterans' Preferences

An interviewee reported that some veterans do not want to travel to Oahu for care, which would increase the number of non-VA care consults.

**Aspect 2: Travel Benefits**

*VAPIHCS is taking action to improve the timeliness of claims reimbursement and has set a 30-day goal for future claims processing.*

Beneficiary Travel

VA's Beneficiary Travel Program provides eligible veterans and other beneficiaries mileage reimbursement, common carrier (such as plane, train, bus, or taxi), or when medically indicated, "special mode" (such as ambulance or wheelchair van) transport to and from VA health care or VA authorized non-VA health care appointments.[16]

[16] VA Beneficiary Travel website, http://www.va.gov/HEALTHBENEFITS/vtp/beneficiary_travel.asp. Accessed August 7, 2015. To qualify for "special mode" transportation, the veteran must meet one of the five criteria plus meet both of the following criteria: 1) medical condition requires an ambulance or a specially equipped van as determined by a VA clinician and 2) travel is pre-authorized. The five criteria include service connected rating of 30 percent or more; traveling for treatment of a service-connected condition; receiving a VA pension, or their income does not exceed the maximum annual VA pension rate; income does not exceed the maximum annual VA pension rate; or traveling for a scheduled compensation or pension evaluation.

Veterans may qualify for Beneficiary Travel if they meet specified criteria.[17]

VAPIHCS Beneficiary Travel Program staff work directly with CBOC providers to arrange transportation and to notify veterans of these arrangements. Staff also coordinate with PC case managers for appointments or when travel extensions are requested and indicated. The cost of the program in FY 2014 was about $6.97 million and in FY 2015 was about $6.6 million.

Veterans submit their claim requests to the Beneficiary Travel program for expenses incurred and for mileage reimbursement. In FY 2015, Beneficiary Travel staff processed just over 11,300 claims. As of November 24, 2015, a backlog of over 1,000 unprocessed claims existed; as of August 16, 2016, 21 of the unprocessed claims remained. Beneficiary Travel staff told us that, ideally, veterans would be reimbursed for travel within 30 days of receipt of their claim.

Airlift Program

The Airlift Program provides veterans with emergency air ambulance transportation.

VAPIHCS contracts with American Medical Response for air ambulance services within the Hawaiian Islands and has a sharing agreement with US Transportation Command at Hickam Air Force Base for air ambulance services from American Samoa and Guam. US Transportation Command provides routine weekly flights to and from Guam in addition to any emergency flights.

The cost of the Airlift Program for FY 2014 was about $1.8 million and for FY 2015 was about $2.7 million.[18]

Reportedly, authorization and billing concerns arise when veterans transfer from a private-sector hospital on the island of Hawaii to TAMC (on Oahu) because the private-sector hospital uses a competing airlift company. If travel is not authorized, the patient may be billed.

Veteran Transportation Service

Veteran Transportation Service (VTS) provides qualifying veterans with ground transportation services to and from participating VA facilities or authorized non-VA appointments.[19] VTS has one transportation coordinator and two drivers who respond to 20–30 travel requests daily.

[17] VA Beneficiary Travel website, http://www.va.gov/HEALTHBENEFITS/vtp/beneficiary_travel.asp. Accessed August 7, 2015.
[18] In FY 2014, there were 3 high-cost air ambulance transports; in FY 2015 there were 11 high-cost air ambulance transports.
[19] VA Beneficiary Travel website, http://www.va.gov/HEALTHBENEFITS/vtp/beneficiary_travel.asp. Accessed August 7, 2015.

In addition, the Disabled American Veterans (DAV) organization provides van transportation utilizing volunteer drivers on Oahu,[20] Kauai,[21] Maui,[22] and Hawaii.[23] Veterans may arrange DAV van service by contacting the DAV Van Volunteer Hospital Service Coordinators located at each site.[24]

**Aspect 3: Cultural Sensitivity**

*VAPIHCS is taking actions to assure staff members are culturally sensitive and competent.*

During the August 2014 field hearing and subsequent interviews, a veteran noted that care providers coming from the mainland may not always be aware of the unique needs of Hawaiian/Pacific Islander veterans. We found, however, that while there may be occasions when a provider's management of a situation lacks cultural sensitivity and competence, patient advocate data and interviewees did not report this to be a wide-spread problem.

The VA Office of Diversity and Inclusion (ODI) defines cultural competence as "a defined set of values and principles, and demonstrated behaviors, attitudes and structures that enable employees and leaders to work effectively cross-culturally."[25] Cultural competence is the ability to respond effectively and appropriately to different cultural and generational contexts in the workplace. ODI provides several training programs and resources related to diversity and cultural competency on its website.

As of July 2015, VAPIHCS' total full-time employee equivalent was 1,014. VAPIHCS employees self-identified as Asian (44 percent), White (26 percent), Native Hawaiian/Pacific Islander (13 percent), African-American (7 percent), Native American (2 percent), and other (5 percent). The majority of American Samoa and Guam CBOC employees are native to those islands.

In general, employees and VSO representatives we interviewed did not report concerns regarding cultural competence and sensitivity at VAPIHCS. A majority of the VAPIHCS staff had completed cultural competence training and, in some cases, additional training[26] offered by VAPIHCS. Further, neither the Hawaii Primary Care Association (HPCA)[27] nor Papa Ola Lokahi[28] reported receiving complaints from patients about

[20] Oahu has two DAV vans with five drivers. DAV is looking for two additional drivers. As of October 12, 2015, DAV is awaiting a new vehicle.
[21] Kauai has one DAV van and one driver. DAV is looking for one additional driver.
[22] Maui has one DAV van, but it is not currently in operation due to lack of DAV local chapter support.
[23] Hawaii has four vans with five drivers. Three vans service the Kona CBOC and one van services the Hilo CBOC. DAV is looking for at least four additional drivers.
[24] DAV vans are available 5 days a week from 7:00 a.m. to 4:00 p.m.
[25] https://web.duke.edu/equity/resources/toolkit/cultural_competency.pdf, http://www.diversity.va.gov/training/. Accessed June 1, 2016.
[26] Patient Centered Care–What Matters Most, Equal Employment Opportunity and Cultural Diversity
[27] HPCA is a statewide organization that represents the Federally Qualified Health Centers, who are signing up to provide care to Veterans through the Choice program.

cultural insensitivity at VAPIHCS. In October 2015, VAPIHCS leadership and program managers met with representatives from Papa Ola Lokahi to discuss new employee orientation and annual cultural sensitivity training opportunities. As of August 2016, discussions continue but no specific actions have been taken.

**Aspect 4: Homeless Services**

*VAPIHCS offers a broad range of services to homeless veterans.*

VA, in conjunction with the Department of Housing and Urban Development (HUD) and local agencies, conducts a Point-In-Time Count of all homeless veterans annually.[29] In 2011, VAPIHCS' catchment area included 505 homeless veterans across all counties. In 2015, Homeless Program staff reported 714 homeless veterans, with the largest growth occurring on Oahu (from 332 to 467) and Hawaii (from 67 to 102). The remaining 145 homeless veterans are located across the remaining islands, with the exception of American Samoa where there were no reported homeless veterans.

VAPIHCS Homeless Program is challenged by staffing[30] and space deficiencies, in addition to the lack of affordable housing throughout Hawaii. Nevertheless, since 2010, VAPIHCS has been successful in expanding services for homeless veterans including:

- Increased staff from 5 to over 50, with staff members embedded on Oahu, Hawaii, Kauai, Maui, and Guam.
- Assisted community leaders with the creation of a statewide homeless resource network that utilizes a single screening form, coordinated outreach, and monthly community presentations.
- Collaborated with community agencies, Public Housing Authorities, and government leaders to address homelessness in Hawaii and Guam.
- Conducted a Property Owner Summit in FY 2015 to discuss the benefits of renting to veterans and encouraging more housing options.
- Developed a Homeless Patient Aligned Care Team (PACT) at the Leeward CBOC to provide care to homeless veterans and Homeless Grant and Per Diem (GPD) participants on the Leeward coast.

In addition, 50 new permanent housing units are being developed on Oahu.

<u>GPD</u>

The GPD Program provides funds to community housing and service agencies with the goal of helping homeless veterans achieve residential stability, increase their skill levels

[28] Papa Ola Lokahi is a non-profit organization with a mission to improve the health status and well-being of native Hawaiians and others.
[29] The Point-In-Time Count is to get a statistically reliable, unduplicated count of sheltered and unsheltered homeless veterans, individuals, and families in the US.
[30] The Homeless program currently has four staff vacancies (one for GPD and three for HUD-VASH).

and/or income, and obtain greater independence.[31] Two GPD programs located on Oahu collectively provide 113 beds for eligible homeless veterans, within a reported occupancy rate of about 85–90 percent.

HUD-VA Supported Housing

The HUD VA Supported Housing (VASH)[32] Program combines Housing Choice Voucher rental assistance for homeless veterans with case management and clinical services provided by the VA.[33] VAPIHCS utilizes the Housing First model, which "prioritizes housing and then assists the veteran with access to healthcare and other supports that promote stable housing and improved quality of life."[34] HUD-VASH staff members are located on Oahu, Hawaii, Kauai, Maui, and Guam. VAPIHCS has 604 allocated[35] vouchers (563 on the Hawaiian Islands and 41 on Guam) with 560 of those assigned[36] (520 Hawaiian Islands, 40 Guam).

The limited availability of affordable housing throughout the Hawaiian Islands has negatively impacted VAPIHCS' ability to meet targets for three HUD-VASH performance measures. For example, in FYs 2014–2015, VAPIHCS did not meet the performance measure requiring veterans to be housed within 90 days of entry into the program (target rate of 65 percent).

Transitional and Emergency Housing

VAPIHCS contracts for 45 transitional (short term) and emergency (crisis) housing beds for veterans across Oahu, Kauai, Maui, and Guam. If the contract beds are full, veterans can be referred to the "general population" emergency shelter beds that serve non-veteran homeless individuals. VAPIHCS is soliciting additional contracted emergency beds on Kauai.

**Aspect 5: Mental Health**

*Despite staffing challenges, VAPIHCS meets MH access metrics; however, the Suicide Prevention Program needs to expand its outreach efforts.*

VAPIHCS offers multiple MH services across the Islands including substance abuse treatment programs (SATP), post-traumatic stress disorder treatment, behavioral health integrated programs, geriatric MH services, MH residential rehabilitation programs, and

[31] VA Grant and Per Diem Program website, http://www.va.gov/homeless/gpd.asp, accessed October 27, 2015.
[32] HUD-VASH is a partnership between the Department of Housing and Urban Development (HUD) and the VA Supportive Housing (VASH) to move veterans and their families out of homelessness and into permanent housing.
[33] HUD.GOV website, HUD-VASH Vouchers http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/hcv/vash, accessed October 27, 2015.
[34] VA Housing First website, http://www.va.gov/homeless/nchav/models/housing-first.asp, accessed May 4, 2016.
[35] Allocated vouchers denote the number of vouchers allocated to the facility.
[36] Assigned vouchers denote the number of vouchers assigned to veterans. The veterans may be anywhere in the housing process including being housed.

a Suicide Prevention Program. The MH Service Line includes 250 staff members with approximately 43 vacancies, including newly approved positions funded by VA Central Office. As with other VAPIHCS programs and services, MH has been subject to staffing challenges. For example, at the time of our visit in August 2015, the Maui CBOC's MH staffing was 30 percent below authorized levels. In addition, a long-term psychiatrist retired in December 2015.

Despite insufficient staffing in some locations, it appears that VAPIHCS, as a whole, is able to provide MH services to patients in a timely manner.

General Outpatient MH Services

VAPIHCS has attempted to compensate for staffing deficiencies by using tele-MH or arranging for a MH provider from another island to fly in and provide direct patient care. See Table 1 below for VAPIHCS' performance in relation to MH access measures.

**Table 1: VAPIHCS Outpatient MH Appointment Completion and Average Wait Times for New and Established Patients**

| Mental Health Patients | Total Completed Appointments | | Percent of Appointments Completed within 30 days | | Average Wait Times in Days from Preferred Date | |
|---|---|---|---|---|---|---|
| | FY 14 | FY 15 | FY 14 | FY 15 | FY 14 | FY 15 |
| New | 2,018 | 2,002 | 99.80% | 98.40% | .95 | 1.34 |
| Established | 35,336 | 34,025 | 99.46% | 98.47% | 1.70 | 2.15 |

*Source: Data obtained through VHA Support Service Center (VSSC) – Access & Clinical Administration/Wait Times & Wait Lists/Completed Appointments*

CBOC patients who require more intensive MH care can use E-RANGE (Enhance Rural Area Network for Growth Enhancement), a program staffed by VA clinicians who provide MH case management and services in the patients' homes.[37]

Acute MH Care

VAPIHCS staffs a 16-bed MH unit within TAMC and has a sharing agreement with TAMC for MH resources (staff, bed availability) when necessary. Staff noted adequate staffing on the inpatient MH unit. VAPIHCS has approved funding for a new inpatient unit at TAMC, but construction has been delayed.

SATP

At times, patients are placed on a wait list due to staffing shortages within SATP. However, in August 2015, program staff reported same or next day access. On Oahu, when patients need to detoxify from substances,[38] they are admitted to a TAMC medical

[37] VA Office of Rural Health website, http://www.ruralhealth.va.gov/. Accessed December 7, 2015.
[38] Detoxify is to free (an individual) from an intoxicating or an addictive substance (alcohol or drugs) in the body or from dependence on or addiction to such a substance.

unit until they are medically stable, and then transferred to the inpatient MH unit. Patients on neighboring islands are referred to a local facility for treatment. Staff we interviewed did not report delays or other concerns for patients accessing substance abuse treatment services. However, the VA's contracted bed rate at a 21-day treatment facility on Oahu is below market rate, and because of this, beds are not always available for veterans.

Suicide Prevention Program

The Suicide Prevention Program has undergone substantial staffing changes in the past year after the former Suicide Prevention Coordinator (SPC) left a backlog of 1,000 unsigned progress notes.[39] Management and staff acknowledged that the program was not fully functioning under the previous SPC, and within the past year, a new SPC, suicide prevention case manager, peer support specialist, and program support assistant have been hired.

During a 10-month period from 2014 to 2015, VAPIHCS identified three confirmed veteran suicides. While the behavioral autopsy reports showed that these patients had not recently participated in MH treatment, they reflected that increased suicide prevention outreach was needed. Currently, outreach and education occurs on Oahu. For the neighboring islands, the SPC relies on video teleconferencing and online tools to provide these services.

The SPC told us that the plan is to increase outreach by pairing with the Hawaii Task Force and DoD, attending joint meetings, and conducting community outreach four times per month.

[39] System leaders confirmed in August 2016 that the backlog had been resolved.

# Section B – 6-Point Plan

During a Senate Committee on Veterans Affairs field hearing on August 19, 2014, Dr. James Tuchschmidt, Acting Principal Deputy Under Secretary for Health, presented the VAPIHCS 6-point plan for improving access to PC services. We noted that leaders' actions to address points 3 and 6 were the same; therefore, we consolidated those points below.

According to the VAPIHCS leaders, VAPIHCS had one of the highest wait lists in the Nation in February 2014, when reportedly, approximately 1,800 veterans were waiting on average more than 185 days to see PC providers. VAPIHCS leaders reported that they began instituting the plan at that time.

Table 2 below compares the average number of appointments completed within 30 days from the preferred date and the average wait times for appointments for FY 2014 and FY 2015 for both new and established patients.[40]

**Table 2: Comparison of Patient Wait Times between FY 2014 and FY 2015**

| | | Average Percent of Appointments Completed within 30 days | | Average Wait Time in Days from Preferred Date | |
|---|---|---|---|---|---|
| | | FY 14 | FY 15 | FY 14 | FY 15 |
| **PC** | New | **77.57%** | 95.18% | **43.45** | 7.68 |
| | Established | 98.66% | 97.57% | 3.00 | 4.08 |
| **Specialty Care** | New | 98.70% | 98.86% | 1.72 | 1.59 |
| | Established | 98.87% | 98.87% | 1.50 | 1.53 |
| **MH** | New | 99.85% | 98.68% | 0.95 | 1.34 |
| | Established | 99.47% | 98.52% | 1.70 | 2.15 |

*Source: Data obtained through VHA Support Service Center (VSSC) – Access & Clinical Administration/Wait Times & Wait Lists/Completed Appointments*

Since the field hearing, VAPIHCS has substantially improved access to care for new patients awaiting PC appointments. Further, on average, patients are able to schedule PC, specialty care, and MH appointments within the 30-day timeframe. VAPIHCS managers reported that, as of December 8, 2015, the wait list had decreased to 13 patients.

While we could not determine with certainty the extent to which the 6-point plan impacted the above access measures, we noted that actions had been taken to implement each point, as follows:

[40] In FY 2014, VAPIHCS saw 31,643 unique patients with 92,687 encounters. In FY 2015, VAPIHCS saw 33,351 unique patients with 100,878 encounters. VAPIHCS had an overall 5 percent increase in the number of unique patients seen between FY 2014 and FY 2015.

### Point 1: Increasing panel sizes of the PC physicians on Oahu by 10 percent

VAPIHCS leadership told us that PC panel sizes increased, on average, to 1,300 at the ACC and CBOCs. We retrieved PACT data showing that in August 2015, the Oahu-based PC team panel sizes were about 1,180 (ACC) and 1,250 (Leeward).[41] As of December 18, 2015, leaders reported no patients awaiting PC assignment on Oahu.

### Point 2: Adding clinic appointments and extended hours to provide greater appointment capacity

VAPIHCS Director reported that new patient appointment slots were created for each PC clinic Monday–Friday, and the ACC extended PC clinic hours[42] by 1 day a week and 2 Saturday mornings per month. VAPIHCS Director reported that it was not necessary to extend clinic hours at the CBOCs, as increasing panel sizes at the CBOCs addressed the capacity issue.

### Points 3 and 6: Hiring physicians and nursing staff to increase PACT presence at CBOCs and working to identify and fill crucial vacancies that directly affect Veteran access

VAPIHCS increased PC staffing at the CBOCs by 24.6 percent from February 2014 to August 2015. As stated previously, however, recruitment and retention of staff is an ongoing challenge, and the CBOCs collectively have 75 vacant positions.[43]

### Point 4: Proactively contacting veterans and scheduling their appointments

VAPIHCS leadership reported an enhanced effort to contact veterans to schedule appointments when they were addressing the wait list. VAPIHCS worked through the wait list and scheduled appointments for all veterans still interested in obtaining care.

### Point 5: Informing veterans of the importance of maintaining their scheduled appointments so that appointment slots will not go unfilled

VAPIHCS leaders told us that, when scheduling appointments, staff members educate veterans on the importance of keeping those appointments or calling to cancel prior to the scheduled time. According to leaders, posters have been placed throughout

[41] Team PCP Panel Size Average (PCP/AP Adjusted) – This metric adjusts the PCP (Primary Care Provider) Team Assignments for mid-level providers (nurse practitioners and physician assistants) to that of a full-time MD 1.0 FTE so that comparisons can be made. The adjustments are made based on the Adjusted PCP/AP FTE, which adjusts a mid-level provider's FTE down 25 percent and gives an adjusted Team Panel Size Average at each reporting level. The formula = Team PC Panel Assignment divided by the Team PC FTE (PCP/AP Adjusted). If a PC Provider is a mid-level provider, and his/her FTE entered in the Primary Care Management Module for a team = 1.0, the Adjusted PC FTE= .75. If that provider's PC Panel Assignment for a team = 1000, the Adjusted Team PC Panel Size = 1000/.75 = 1333.33. This adjusts the mid-level provider's panel to that of a full-time 1.0 MD. Retrieved from *Patient Aligned Care Team Compass Data Definitions*, last updated June 25, 2015.

[42] VHA defines PC extended hours as Monday–Friday between 6:00–8:00 a.m. and 4:30–11:59 p.m. and any hours on Saturday and Sunday.

[43] This includes all positions, not just clinical staff.

VAPIHCS that advise patients of this practice and how "no showing" for appointments affects other veterans' ability to get timely care. VAPIHCS also utilizes automated phone calls for next day appointments and appointment reminder letters to veterans prior to their appointments.

VAPIHCS conducted a review of missed opportunity rates in PC[44] from October 2014 through August 2015. Missed opportunities were defined as patient "no-shows" and appointments cancelled by either the clinic or the patient after the scheduled appointment. Patient no-shows were the primary contributor to the missed opportunity rate. The "no-show" rates across VAPIHCS have collectively improved when comparing August 2014 data with August 2015 data.

**Table 3: No-Show Rates for Selected Clinics**

| | August 2014 | | | August 2015 | | |
|---|---|---|---|---|---|---|
| | **Scheduled Appointments** | **Completed Appointments** | **No-Show Rate** | **Scheduled Appointments** | **Completed Appointments** | **No-Show Rate** |
| **Women's Health** | 148 | 108 | 40 (27.03%) | 218 | 193 | 25 (11.47%) |
| **Geriatric PACT** | 111 | 100 | 11 (9.91%) | 118 | 110 | 8 (6.78%) |
| **PC/ Medicine** | 5038 | 4443 | 595 (11.81%) | 5521 | 4892 | 629 (11.39%) |
| **Total** | 5297 | 4651 | 646 (12.20%) | 5857 | 5195 | 662 (11.30%) |

*Source: Data obtained through VSSC – No Show and Cancellation Cube (through Pyramid Analytics).*

VAPIHCS has set a goal that PC no-show rates will be less than 10 percent, and the data show that they are making progress in this effort. We noted that the Hilo and Kona CBOCs were maintaining reasonable no-show rates, but in late FY 2015, these rates increased slightly.

VAPIHCS reported that with the hiring of new staff at the CBOCs, the PACT clerks have more time to complete pre-appointment processing (checking inpatient status, duplicate appointments, appointment still required, or need already met) and educate veterans about the importance of keeping appointments (or cancelling appointments timely).

# Conclusion

VAPIHCS provides medical and MH care across the Hawaiian Islands, Guam, American Samoa, and Saipan, and must routinely manage the logistics of coordinating care across multiple islands and thousands of miles. Leadership and staff consistently reported difficulty in recruiting and retaining qualified employees due to the cost of

[44] PC clinics included Women's Health, Geriatric PACT, and PC-Medicine clinics. The combined PC-Medicine clinics included the ACC and CBOC clinics.

living, distance, and isolation of island life. Further, VAPIHCS staff reported the lack of adequate space at almost all locations to manage the volume of patients seeking care.

We found that VAPIHCS has many of the same administrative and clinician availability issues found across the VA system for non-VA care. At VAPIHCS, these challenges are compounded by a shortage of VA-based providers and enrolled non-VA providers, the complexity of island logistics, and the diversity of the population served. To address these challenges, VAPIHCS is in the process of hiring and embedding additional non-VA care staff at the community based outpatient clinics to enhance the timeliness and management of non-VA care.

We found that the Beneficiary Travel Program's expenditures are substantial due to the logistical challenges of providing care for patients across multiple islands. In addition, VAPIHCS acknowledged a delay in processing claims reimbursements for travel benefits and that they are actively working to address the backlog.

We found that while there may be occasions when a provider's management of a situation could potentially lack cultural sensitivity and competence, interviewees did not report that this was a wide-spread problem.

We found that the VAPIHCS Homeless Program has been successful in expanding services to include development of new permanent housing units on Oahu, the addition of a Leeward CBOC Homeless PACT, and ongoing collaboration with community agencies to address homelessness in Hawaii and Guam.

We found that VAPIHCS offers MH services across the islands and includes a variety of general and specialty treatment programs. Despite staffing challenges, VAPIHCS meets MH access metrics. VAPIHCS acknowledged that the Suicide Prevention Program has undergone substantial staffing changes in the past year. Staff continue efforts to provide a comprehensive program and expand outreach efforts.

In February 2014, VAPIHCS leaders noted that they had one of the highest wait lists for patients wanting primary care appointments in the Nation. VAPIHCS developed the 6-point plan to address the wait lists. VAPIHCS increased primary care physicians panel sizes, added extended clinic hours, increased primary care staffing at the community based outpatient clinics, contacted and scheduled appointments for all veterans on the wait lists who were still interested in accessing care, and educated veterans on the importance of keeping their appointments or calling to cancel prior to the scheduled time. At the time of our visit in August 2015, VAPIHCS had substantially improved access to care for new patients awaiting primary care appointments.

# Recommendations

**Recommendation 1.** We recommended that the VA Pacific Islands Health Care System Director continue efforts to enhance the availability of, and access to, a comprehensive network of care and services.

**Appendix A**

# VISN Director Comments

**Department of Veterans Affairs**

# Memorandum

**Date:** March 24, 2016

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

**Subj:** Healthcare Inspection—Summarization of Select Aspects of the VA Pacific Islands Health Care System, Honolulu, Hawaii

**To:** Director, Atlanta Office of Healthcare Inspections (54AT)
Director, Management Review Service (VHA 10E1D MRS Action)

1. Thank you for the opportunity to review the draft report. The facility concurs with the recommendations and will continue their efforts to ensure a comprehensive network of care and services.

2. Should you have any questions, please contact Terry Sanders, Associate Quality Manager for V21, at (707) 562-8350.

Sheila M. Cullen

Sierra Pacific Network Director

**Appendix B**

# System Director Comments

**Department of Veterans Affairs**

# Memorandum

**Date:** March 23, 2016

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

**Subj:** Healthcare Inspection—Summarization of Select Aspects of the VA Pacific Islands Health Care Systems, Honolulu, Hawaii

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

1. Thank you for sharing your comprehensive Healthcare Inspection report concerning VA Pacific Islands Health Care System (VAPIHCS), in Honolulu, Hawaii, that was conducted August 24-28, 2015. Attached is the VAPIHCS response to the OIG Recommendation that the VAPIHCS Director continues efforts to enhance the availability of, and access to, a comprehensive network of care and services.

2. If you have any questions or would like to discuss this response, please contact Acting Director Tonia J. Bagby, PsyD, @ (808) 433-0100.

Tonia J. Bagby, PsyD

Acting Director

# Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

**OIG Recommendation**

**Recommendation 1.** We recommended that the VA Pacific Islands Health Care System Director continue efforts to enhance the availability of, and access to, a comprehensive network of care and services.

Concur

Target date for completion: Continual Readiness

System response: VA Pacific Islands Health Care System (VAPIHCS) concurs with the above recommendation. As a Health Care Organization, we are committed to providing the best care possible to eligible Veterans throughout the Pacific Islands. As noted within the Office of Inspector General summary report from August 24–28, 2015, VAPIHCS will continue to provide outreach services, and to build effective and collaborative networking relationships with other health care facilities within the community, including the Tripler Army Medical Center and the Choice Program.

**Appendix C**

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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**Appendix D**

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