Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-01643-170

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

July 23, 2009

Washington, DC 20420

## Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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# Executive Summary

## Introduction

During the week of May 18–22, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the VA Pacific Islands Health Care System (VAPIHCS), Honolulu, HI. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also presented fraud and integrity awareness training to 181 employees. The VAPIHCS is part of Veterans Integrated Service Network (VISN) 21.

## Results of the Review

The CAP review covered eight operational activities and one follow-up review area. We also followed up on two additional areas from the prior CAP review. We made recommendations in five of the activities reviewed and in the one follow-up review area. For these five activities and the follow-up review area, the VAPIHCS needed to:

- Implement and maintain an effective structure for the QM and performance improvement (PI) program.
- Ensure physician privileging processes comply with Veterans Health Administration (VHA) requirements.
- Require that patient complaints are analyzed in detail and that the analyses are discussed and acted upon, as appropriate.
- Establish and maintain a consistent process for monitoring medication reconciliation and analyzing data.
- Document quarterly discussions of peer review findings in Executive Committee of the Medical Staff (ECMS) meeting minutes.
- Present patient safety findings to an appropriate committee and ensure that an annual report is presented to senior managers.
- Revise the medical record quality review process to include clinical components and implement monitors for the copy and paste functions.
- Improve oversight of veteran patients' care at Tripler Army Medical Center (TAMC).

- Document pain medication effectiveness within the timeframe established by local policy and document actions taken when medications prove ineffective.
- Improve discharge documentation.
- Ensure timely re-evaluations of patient records with Category II Patient Record Flags (PRFs).
- Complete and document background investigations, as required.

The VAPIHCS complied with selected standards in the following three activities:

- Continuity of Care.
- Environment of Care (EOC).
- Patient Satisfaction Survey Scores.

This report was prepared under the direction of Daisy Arugay, Associate Director, Los Angeles Regional Office of Healthcare Inspections.

## Comments

The VISN and VAPIHCS Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 17–25, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

*(original signed by:)*
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

# Introduction

## Profile

**Organization.** The VAPIHCS provides a broad range of medical care services. It provides outpatient medical and mental health (MH) care through an ambulatory care clinic in Honolulu and six community based outpatient clinics (CBOCs) on the islands of Hawaii (Hilo and Kona), Maui, and Kauai and in Guam and American Samoa. Traveling clinicians also provide episodic care at two outreach clinics on the islands of Molokai and Lanai. The VAPIHCS is part of VISN 21 and serves a veteran population of about 127,600 throughout Hawaii and the Pacific Islands.

**Programs.** The VAPIHCS provides outpatient primary medical, MH, dental, and inpatient services. Long-term care inpatient services are provided in a 60-bed community living center (CLC).[1] Inpatient psychiatric care is provided in a 20-bed VAPIHCS operated unit at TAMC. Acute medical-surgical inpatient care is provided at TAMC through a VA/Department of Defense (DoD) sharing agreement or through non-VA providers in the community.

**Affiliation and Research.** The VAPIHCS is affiliated with the University of Hawaii and provides training annually for more than 250 students, interns, residents, and fellows. It has numerous other affiliations to provide training for other disciplines, including nursing and dentistry. In fiscal year (FY) 2008, the VAPIHCS research program received more than $3.6 million in external funding to conduct studies. Important areas of research included post-traumatic stress disorder, dementia, and hepatitis C.

**Resources.** In FY 2008, medical care expenditures totaled $153.5 million. The FY 2009 medical care budget is $173.2 million. FY 2008 staffing was 550.8 full-time employee equivalents (FTE), including 52.3 physician and 149 nursing FTE.

**Workload.** In FY 2008, the VAPIHCS treated 22,902 unique patients. The inpatient care workload totaled 3,143 discharges from TAMC, and the average daily census, including long-term care patients, was 54. The outpatient care workload totaled 169,980 visits.

[1] A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

## Objectives and Scope

**Objectives.** CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

**Scope.** We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following eight activities and follow-up review area:

- Continuity of Care.
- Contracted/Agency Registered Nurses (RNs).
- Coordination of Care.
- EOC.
- Medication Management.
- Oversight of Veteran Patients' Care at TAMC.
- Patient Satisfaction Survey Scores.
- QM.
- Suicide Prevention Program.

The review covered VAPIHCS operations for FY 2008 and FY 2009 through May 2009 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on recommendations from our prior CAP review of the VAPIHCS (*Combined Assessment Program Review of the VA Pacific Islands Health Care System, Honolulu, Hawaii,* Report No. 06-02003-225,

September 26, 2006). We had identified improvement opportunities in the following review areas: (1) EOC, (2) Contract Community Nursing Home (CNH) Program, and (3) Oversight of Veteran Patients' Care at TAMC.

During our follow-up review, we found sufficient evidence that program managers and staff had implemented appropriate administrative and clinical actions to address the identified deficiencies in EOC and the Contract CNH Program. We consider these issues closed. However, since desired outcomes for formalized mechanisms to improve communication and information sharing between the VAPIHCS and TAMC had only been partially implemented at the time of this CAP review, we reissued a recommendation for this area (see pages 8–9).

During this review, we also presented fraud and integrity awareness briefings for 181 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

# Results

## Review Activities With Recommendations

### Quality Management

The purpose of this review was to evaluate whether the VAPIHCS's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the VAPIHCS's Director and Chief of Staff (COS). We also interviewed QM personnel and several service chiefs. We evaluated plans, policies, and other relevant documents. We identified seven areas that needed improvement.

QM and PI Structure. For the period April 2008 through March 2009, the VAPIHCS did not have an effective structure in place to provide oversight of quality of care and PI activities, as required by accreditation standards**.** We found inconsistent reporting to senior leadership committees, a lack

of analyses of identified problems, and a need for more leadership involvement with enforcing actions.

The Quality Executive Board (QEB) and the ECMS were not effective venues for the reporting of quality data. For example, there was no evidence that peer review, patient complaint, and patient safety reports were consistently discussed at the QEB and ECMS or at any senior leadership committee. Also, the QEB did not meet monthly, as required; it met only four times during the 12-month period. Additionally, it does not appear that actions were taken to address identified problems in mandatory training and utilization management (UM).

Managers acknowledged that the QM program had deteriorated due to loss of key staff and inadequate back-up. Managers need to ensure that QM and PI review results are consistently presented, discussed, and acted upon, as appropriate. We noted that there have been recent efforts to move in a positive direction**.**

**Recommendation 1** We recommended that the VISN Director ensure that the VAPIHCS Director requires that the structure for an effective QM and PI program be fully implemented and maintained, in accordance with accreditation standards.

The VISN and VAPIHCS Directors agreed with the findings and recommendation. The VAPIHCS revised its process for reporting quality data to senior leadership and plans to restructure all committees. Discussion of quality of care issues will be a recurring agenda item for the QEB and the ECMS. Target date for completion is November 30, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Credentialing and Privileging. VHA is committed to exemplary performance in credentialing and privileging processes.[2] We found irregularities in 10 (63 percent) of the 16 privilege request forms reviewed. For example, we noted blank boxes, blank signature blocks, and changes made without initials.

VHA regulations[3] and accreditation standards require a written plan for performance monitoring for privileged

[2] VHA Directive 2006-067, *Credentialing of Health Care Professionals*, December 22, 2006.
[3] VHA Handbook 1100.19, *Credentialing and Privileging*, October 2, 2007.

physicians. This plan must include the ongoing review of performance for all privileged providers. We did not find a written plan, and we did not find evidence that performance data were reviewed for 8 (73 percent) of the 11 physicians reprivileged over the past 15 months. For four newly hired physicians, we found no evidence of Focused Professional Practice Evaluations, as required by accreditation standards and VHA and local policy. We also noted that the ECMS discussed individual competence based solely on continuing medical education and that meeting minutes did not reflect detailed discussion of physicians' performance data prior to reprivileging.

Finally, when physicians are appointed for less than 2 years, privileges are to be granted for the same period of time. Until recently, privileges were routinely granted for 2 years, regardless of the length of appointment. The COS acknowledged some weaknesses in the privileging process and had recently taken action to make improvements.

**Recommendation 2** We recommended that the VISN Director ensure that the VAPIHCS Director requires that physician privileging processes are in compliance with VHA requirements by making necessary corrections to privilege request forms, developing a plan for ongoing performance review, maintaining adequate provider profiles, and granting privileges appropriate to the length of the appointment.

The VISN and VAPIHCS Directors agreed with the findings and recommendation. The privilege request forms were modified, and a comprehensive review of provider folders will be initiated. A standardized Ongoing Professional Practice Evaluation process will be developed, and the credentialing and privileging policy will be modified. Also, there are plans to modify the Medical Staff Bylaws to ensure that privileges are granted in accordance with the length of the appointment. Target date for completion is October 31, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Patient Complaints Management. VHA regulations[4] require that patient complaints data be gathered, critically analyzed, and incorporated into the facility's QM program. The patient advocate received and addressed individual complaints and gathered data regarding complaints. However, for the past

[4] VHA Handbook 1003.4, *VHA Patient Advocacy Program*, September 2, 2005.

12 months, we found a lack of analysis, reporting, and actions. VAPIHCS managers need to determine how organization-wide information will be reported and which committee or council should be responsible for addressing identified problems and taking appropriate actions.

**Recommendation 3** We recommended that the VISN Director ensure that the VAPIHCS Director requires that the patient advocate provide detailed patient complaint trend analyses and that management thoroughly discuss the analyses and take appropriate actions.

The VISN and VAPIHCS Directors agreed with the findings and recommendation. The patient advocate will generate reports quarterly, analyze data for trends, and present analyses to the QEB for discussion and action. Target date for completion is August 31, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Medication Reconciliation. This national patient safety goal topic requires the facility to maintain a list of all medications each patient takes. This list must be reviewed at key points during each patient's care, including clinic visits, admission, and discharge. Any medication duplications, omissions, or potentially hazardous combinations must be addressed or reconciled.

Positive efforts were in place to monitor medication reconciliation for admissions to the MH unit (3B2) and for admissions to and discharges from the CLC. However, we did not find evidence of consistent facility-wide monitoring or identification of problems. Unless the medication reconciliation process is monitored and data are collected and analyzed, the VAPIHCS will not know if their process is effective.

**Recommendation 4** We recommended that the VISN Director ensure that the VAPIHCS Director requires that a consistent process for monitoring medication reconciliation and analyzing data is established and maintained.

The VISN and VAPIHCS Directors agreed with the findings and recommendation. The VAPIHCS will update its medication reconciliation policy, and the Patient Safety Manager has been assigned to monitor compliance. Results will be analyzed and presented to the QEB quarterly. Target

date for completion is July 31, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Peer Review Process. The peer review process was comprehensive and generally in compliance with VHA requirements.[5] However, we found that peer review reports were only discussed at the ECMS in 1 out of the past 4 quarters. It is a VHA requirement to report peer review findings to the ECMS on a quarterly basis.

**Recommendation 5** We recommended that the VISN Director ensure that the VAPIHCS Director requires that the ECMS consistently document quarterly discussions of peer review findings in meeting minutes.

The VISN and VAPIHCS Directors agreed with the findings and recommendation. Discussion of peer review reports is now a recurring agenda item for the ECMS, and the Risk Manager has been assigned to ensure that discussions are accurately documented. The corrective actions are acceptable, and we consider this recommendation closed.

Patient Safety Program. Aggregated and individual root cause analyses were performed consistently and in a timely manner. However, we did not find evidence that findings were consistently reported to an appropriate committee. Also, no annual report was presented to senior managers, as required by VHA.[6]

**Recommendation 6** We recommended that the VISN Director ensure that the VAPIHCS Director requires that patient safety findings are presented regularly to an appropriate committee for discussion and action and that an annual report is presented to senior managers.

The VISN and VAPIHCS Directors agreed with the findings and recommendation. The Patient Safety Manager will present findings to the QEB quarterly, and 4th quarter data will be summarized into the annual report. The corrective actions are acceptable, and we consider this recommendation closed.

[5] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.
[6] VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*, May 23, 2008.

Medical Record Review. VHA regulations[7] and accreditation standards require that facilities have a systematic medical record quality review process. We found no evidence of such a process for the past 12 months. We noted that a review process was implemented in February 2009. However, the review was primarily administrative and needed to be modified to include clinician review of clinical record entries. Also, there was no evidence of monitoring of the copy and paste functions in the electronic medical record. The Chief of Health Information Management Service (HIMS) acknowledged that there was no systematic medical record quality review process until recently and that an action plan is needed to monitor the copy and paste functions.

**Recommendation 7** We recommended that the VISN Director ensure that the VAPIHCS Director requires that the recently implemented medical record quality review process is revised to include clinical components and that monitors for the copy and paste functions be implemented.

The VISN and VAPIHCS Directors agreed with the findings and recommendation. A clinical record review checklist has been developed. The medical record policy will be revised, and a monitoring tool for the copy and paste functions will be developed. HIMS staff will monitor compliance with the copy and paste policy, analyze results, and report findings to the Medical Records Committee. Target date for completion is October 31, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

## Oversight of Veteran Patients' Care at Tripler Army Medical Center

We followed up on recommendations from a prior CAP review. We had recommended that the VAPIHCS: (a) determine all the mechanisms that would provide essential communication and information sharing between the VAPIHCS and TAMC, (b) ensure that these mechanisms were formalized in either the sharing agreement or in standard operating procedures, and (c) ensure that the VAPIHCS representative or a delegate attend all monitoring committees. We reviewed meeting minutes and other applicable documents, and we interviewed the COS at the VAPIHCS and the COS at TAMC. We determined that the corrective action plan was only partially implemented.

[7] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Compliance with Policies and Charters. A current joint sharing agreement is in place that defines and formalizes communication and information sharing mechanisms between the VAPIHCS and TAMC. However, we noted inconsistent compliance with policies and charters of joint groups. For example, metrics delineated in the charter for the Joint Venture Steering Group (JVSG) were not presented or discussed in the meetings held during the period April 2008 through March 2009. Also, we noted that the Joint Clinical Quality Work Group (JCQWG) charter states that the group will meet monthly; however, meeting minutes indicate that the group met in only 4 of the past 12 months. Additionally, the JCQWG did not consistently track open action items from one meeting to the next and did not discuss 3B2 quality and safety metrics. The COS at the VAPIHCS and the COS at TAMC acknowledged the above-identified weaknesses in the joint clinical QM process.

**Recommendation 8** We recommended that the VISN Director ensure that the VAPIHCS Director requires that improvement in the oversight of veteran patients' care at TAMC be implemented with a strong emphasis on consistent communication through regular meetings and monitoring of clinical metrics and actionable items, as defined by the groups' charters.

The VISN and VAPIHCS Directors agreed with the findings and recommendation. The JVSG agreed to set a goal to meet monthly but no less than quarterly. Discussion of quality and safety issues is now a recurring agenda item for the JVSG and the JCQWG. Charters for both groups have been modified to reflect these changes. Target date for completion is July 31, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

## Medication Management

The purpose of this review was to evaluate whether VHA facilities had adequate medication management practices. Accreditation standards require facilities to implement a safe medication management system that includes medication ordering, administering, and monitoring.

We reviewed selected medication management processes in the CLC unit. We found adequate management of medications brought into the facility, appropriate patient identification prior to medication administration, and consistent monthly medication reviews by pharmacists.

Generally, nurses assessed patients' pain levels and recorded these assessments. However, we identified two areas that needed improvement.

Documentation of Pain Medication Effectiveness. Program managers informed us that nurses are expected to record effectiveness of pain medications within 90 minutes of administration. We found that nurses did not consistently document effectiveness of PRN (as needed) pain medications in 16 (57 percent) of the 28 doses reviewed. While we were onsite, program managers revised the local policy, conducted training, and assured us that they would monitor nursing staff performance and compliance with the medication administration policy.

Documentation of Actions for Ineffective Pain Medications. Local policy requires nurses to take appropriate actions when pain medications prove ineffective (as evidenced by a pain score equal to or greater than 4). In 12 (43 percent) of the 28 doses reviewed, nurses recorded pain scores of 4 or greater during their assessments. However, for 4 (33 percent) of the 12 doses, we did not find documented evidence that nurses took actions to manage the pain. Program managers agreed to monitor compliance to ensure that additional interventions are appropriately recorded.

**Recommendation 9** We recommended that the VISN Director ensure that the VAPIHCS Director requires that nurses consistently document pain medication effectiveness within the timeframe required by local policy and document actions taken when pain medications prove ineffective.

The VISN and VAPIHCS Directors agreed with the findings and recommendation. The VAPIHCS revised the local policy to reflect a 4-hour timeframe to document the effectiveness of pain medications and to specify actions to take when pain medications are not effective. The shift charge nurse will monitor compliance, and a goal of 95 percent has been set. The corrective actions are acceptable, and we consider this recommendation closed.

## Coordination of Care

The purpose of this review was to evaluate whether admissions and discharges met VHA and Joint Commission (JC) requirements. Timely admissions and coordinated discharges are essential to optimal patient outcomes.

We reviewed the medical records of 10 patients who were admitted to the CLC. In all cases, physicians appropriately assessed patients within 72 hours of admission, and nurses conducted pressure ulcer evaluations, as required. However, we identified one area that needed improvement.

Discharge Documentation. Accreditation standards require that written discharge instructions be given in a form that the patients or family members can understand. We reviewed the medical records of 10 patients who were discharged from the CLC. We found that clinicians appropriately documented that patients or their family members received copies of the discharge instructions. However, clinicians did not document whether patients or family members understood the instructions in any of the records reviewed. In addition, nurses did not consistently document discharge instructions related to medication, diet, activity level, and recommendations for follow-up care. While we were onsite, program managers revised the nursing discharge instructions report template to ensure complete and consistent discharge documentation.

**Recommendation 10** We recommended that the VISN Director ensure that the VAPIHCS Director requires that clinicians document in the medical record patient and/or family member verbalized understanding of the discharge instructions and that nurses consistently document instructions related to medication, diet, activity level, and recommendations for follow-up care.

The VISN and VAPIHCS Directors agreed with the findings and recommendation. The CLC nursing discharge template was modified to ensure that all required discharge information and instructions are documented. The CLC nurse manager will monitor and report compliance. The corrective actions are acceptable, and we consider this recommendation closed.

## Suicide Prevention Program

The purpose of this review was to determine whether the VAPIHCS had implemented a suicide prevention program that was in compliance with VHA regulations. We assessed whether senior managers had appointed a Suicide Prevention Coordinator (SPC) at the VAPIHCS and any very large CBOCs,[8] and we evaluated whether the SPC fulfilled all required functions. Also, we verified whether medical

[8] Very large CBOCs are defined as clinics with more than 10,000 unique patients enrolled.

records of patients determined to be at high risk for suicide contained Category II PRFs, documented safety plans that addressed suicidality, and documented collaboration between MH providers and the SPC.

We interviewed the SPC, and we reviewed pertinent policies and the medical records of four VAPIHCS patients and six CBOC patients determined to be at risk for suicide. Senior managers had appropriately appointed the SPC, and the SPC fulfilled the required functions. We found appropriate PRFs, documented safety plans, and evidence of collaboration between MH providers and the SPC. However, we identified one area that needed improvement.

PRF Reassessment. The VAPIHCS had established a 90-day review for re-evaluating continued use of PRFs in patients' records. However, in 5 (50 percent) of the 10 records reviewed, reassessments did not take place within this timeframe. Program managers acknowledged that a reminder system is needed to ensure timely review of records with Category II PRFs.

**Recommendation 11** We recommended that the VISN Director ensure that the VAPIHCS Director requires program managers to ensure that patient records with Category II PRFs are re-evaluated according to the established timeframe.

The VISN and VAPIHCS Directors agreed with the finding and recommendation. The SPC and the Suicide Prevention Case Manager have established a review process to ensure that PRFs are re-evaluated 30 days before they expire. Ongoing education will be provided to clinical staff regarding the PRF review process. The corrective actions are acceptable, and we consider this recommendation closed.

## Contracted/Agency Registered Nurses

The purpose of the review was to evaluate whether RNs working in VHA facilities through contracts or temporary agencies met the same entry requirements as RNs hired as permanent staff. We examined the files of two contracted/agency RNs who worked at the VAPIHCS within the past year. We reviewed documents for several required components, including background investigation, licensure, training, and competencies. We identified one area that needed improvement.

Background Investigations. U.S. Government agencies are required to complete background investigations for

employees in sensitive positions.[9] We found no documented evidence that a background investigation was initiated for one contracted RN who has been working at the VAPIHCS since 2007. While we were onsite, Human Resources (HR) staff immediately initiated the appropriate background investigation for this RN.

**Recommendation 12** We recommended that the VISN Director ensure that the VAPIHCS Director requires the HR manager to ensure that appropriate background investigations are completed and documented, as required.

The VISN and VAPIHCS Directors agreed with the finding and recommendation. HR staff conducted a review of personnel requiring background investigations and identified intermittent fee-basis employees with pending security clearances. Computer access for these employees has been suspended, and the employees were contacted and instructed to complete the required security clearance. In addition, the VAPIHCS has appointed a personnel security specialist to ensure that background investigations are conducted. Target date for completion is September 30, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

# Review Activities Without Recommendations

## Continuity of Care

The purpose of this review was to evaluate whether communication between clinical providers and community hospitals was adequate. Such communication is essential to continuity of care and optimal patient outcomes.

We reviewed the medical records of 10 patients who had been hospitalized in the local community or at TAMC at VA expense during March 2009. We found comprehensive documentation of admissions and continued stay reviews by UM nurses. In addition, relevant clinical information was scanned for easy viewing by clinical providers. Therefore, we made no recommendations.

## Environment of Care

The purpose of this review was to determine if the VAPIHCS maintained a clean, safe, and secure environment. VHA facilities are required to establish a comprehensive EOC

[9] Executive Order 10450, *Security Requirements for Government Employment*, April 27, 1953, Sec. 3.

program that fully meets VHA, Occupational Safety and Health Administration, and JC standards.

We inspected Primary Care, 3B2, and the CLC. We also inspected the main laboratory, the pharmacy, and radiology. Overall, we found the areas we inspected to be clean and well maintained, and managers expressed satisfaction with the housekeeping staff assigned to their areas.

In the CLC, we identified improper storage of used sharps containers in the medication room and improper installation of an alcohol hand hygiene dispenser. Managers took immediate actions to correct these deficiencies. Therefore, we did not make any recommendations related to these findings.

In addition, we identified outstanding issues on the MH EOC tracking sheet related to unit 3B2 that needed to be addressed. Because this unit is physically located at TAMC, any improvements had to be approved by TAMC managers. VAPIHCS managers assured us that they will discuss these outstanding items at a joint VA/DoD engineering meeting. Therefore, we made no recommendations.

## Patient Satisfaction Survey Scores

The purpose of this review was to assess the extent that VHA medical centers use the quarterly survey results of patients' health care experiences with VHA to improve patient care, treatment, and services. VHA set performance measure results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients.

Figures 1 and 2 (on the next page) show the VAPIHCS's patient satisfaction performance measure results for inpatients and outpatients, respectively.

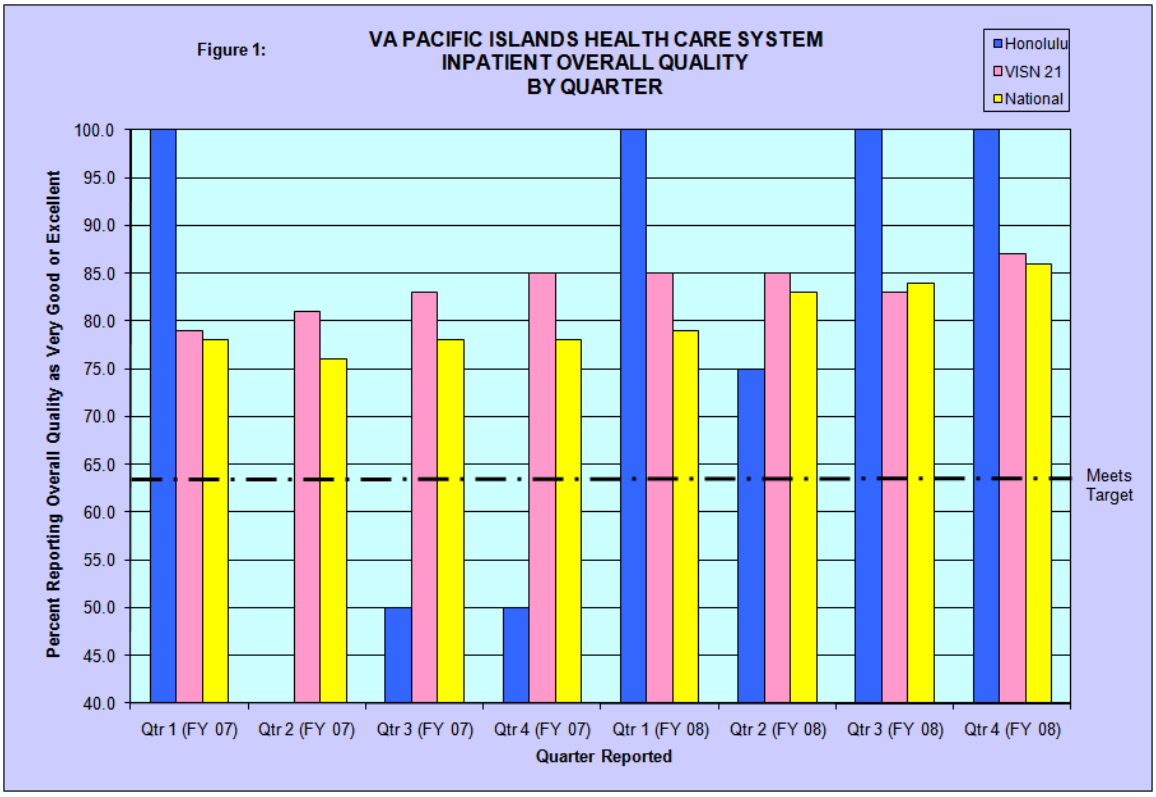
Figure 1:
VA PACIFIC ISLANDS HEALTH CARE SYSTEM
INPATIENT OVERALL QUALITY
BY QUARTER
Honolulu
VISN 21
National
Percent Reporting Overall Quality as Very Good or Excellent
100.0
95.0
90.0
85.0
80.0
75.0
70.0
65.0
60.0
55.0
50.0
45.0
40.0
Meets Target
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Qtr 1 (FY 08)
Qtr 2 (FY 08)
Qtr 3 (FY 08)
Qtr 4 (FY 08)
Quarter Reported

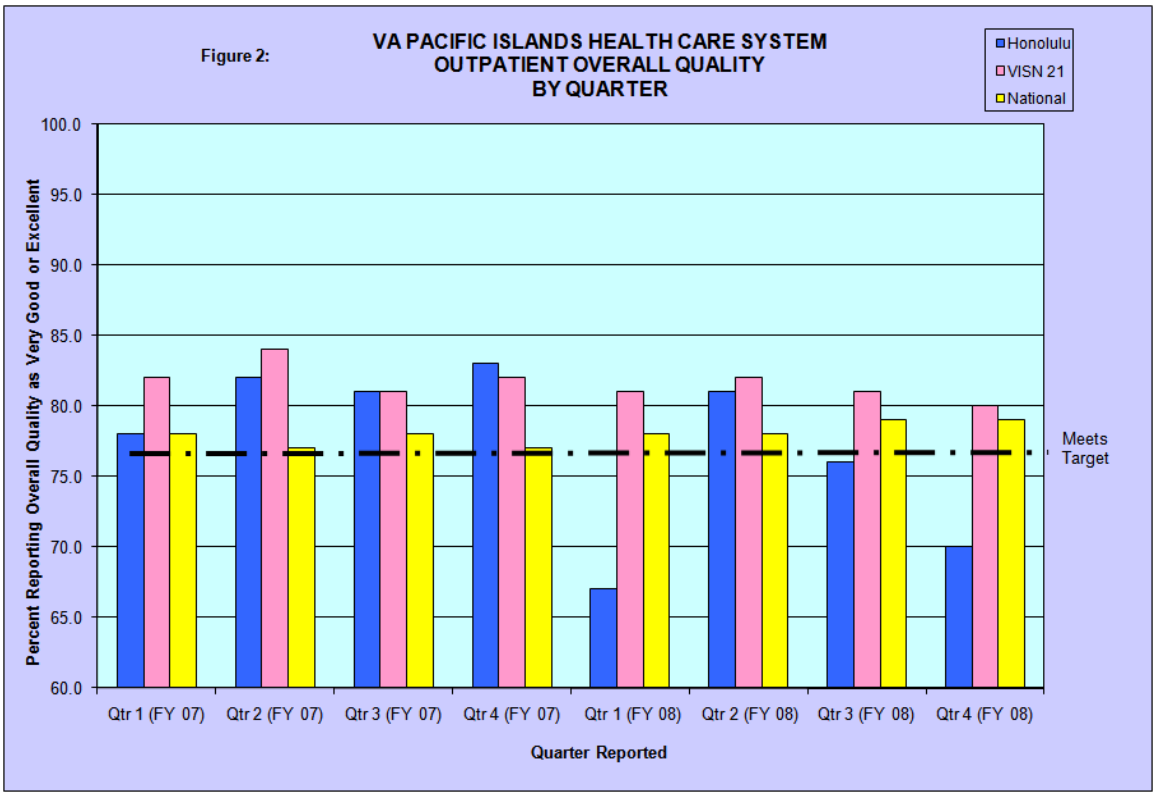
Figure 2:
VA PACIFIC ISLANDS HEALTH CARE SYSTEM
OUTPATIENT OVERALL QUALITY
BY QUARTER
Honolulu
VISN 21
National
Percent Reporting Overall Quality as Very Good or Excellent
100.0
95.0
90.0
85.0
80.0
75.0
70.0
65.0
60.0
Meets Target
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Qtr 1 (FY 08)
Qtr 2 (FY 08)
Qtr 3 (FY 08)
Qtr 4 (FY 08)
Quarter Reported

For FYs 2007 and 2008, the VAPIHCS's inpatient scores exceeded the target in 5 of the 7 quarters reported.[10] Outpatient scores exceeded the target in 5 of the 8 quarters reported. Effective October 1, 2008, VHA changed to a new survey process. We reviewed FY 2009 1st quarter data and noted that the inpatient data was inconclusive due to a low number of inpatient responses; however, outpatient data met the target. Therefore, we made no recommendations.

[10] Inpatient data for the 2nd quarter of FY 2007 was not available.

# VISN Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** June 30, 2009

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

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

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

1. I appreciate the opportunity to review the draft report on the Combined Assessment Program Review of the VA Pacific Islands Health Care System (VAPIHCS), conducted during the week of May 18–22, 2009. I concur with the recommendations, and VAPIHCS staff has completed five of the 12 recommendations resulting from the review. We will ensure the remaining recommendations are addressed and implemented as described in the attached plan by the established target dates.

2. If you have any questions regarding the responses and actions outlined in the implementation plan, please contact Ms. Terry V. Sanders, VISN 21 Associate Quality Management Officer, at 707-562-8370.

(*original signed by:*)
Sheila M. Cullen

Attachments

# Health Care System Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** 29 June 2009

**From:** Director, VAPIHCS Honolulu (459/00)

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

**To:** Director, VISN 21 Network

1. We appreciate the opportunity to comment on the draft report of the Combined Assessment Program (CAP) review of the VA Pacific Islands Health Care System (VAPIHCS). In brief, we concur with the findings and suggested improvement, which are already in progress.

2. We would like to express our thanks to the CAP review team. The collective interest and efforts of the CAP review team have helped improve our clinical practices at VAPIHCS.

(*original signed by:*)
James E. Hastings, MD, FACP

## Comments to Office of Inspector General's Report

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

**Recommendation 1.** We recommended that the VISN Director ensure that the VAPIHCS Director requires that the structure for an effective QM and PI program be fully implemented and maintained, in accordance with accreditation standards.

**Concur.**

**Target date of implementation/completion: November 30, 2009**

**Planned Action:** To ensure that the Quality Executive Board (QEB) and the Executive Committee of the Medical Staff (ECMS) are effective venues for the reporting of quality data, Senior Leadership will conduct a comprehensive review of all VAPIHCS committees and their place in the facility's committee structure. The role and responsibilities of each committee will be clearly defined. Included in the revision will be development of standing agenda items that will be reported on a scheduled basis. Minutes and tracking logs will be standardized across the system to facilitate follow-up of items until closure. A process will be initiated to ensure that meetings are occurring as directed by local or VHA policy. Training for staff responsible for chairing, facilitating and recording meetings will be initiated. All committees are to be restructured and operational by November 30, 2009.

**Recommendation 2.** We recommended that the VISN Director ensure that the VAPIHCS Director requires that physician privileging processes are in compliance with VHA requirements by making necessary corrections to privilege request forms, developing a plan for ongoing performance review, maintaining adequate provider profiles, and granting privileges appropriate to the length of the appointment.

**Concur.**

**Target date of implementation/completion:**
**Planned Action 2a – October 31, 2009**
**Planned Action 2b – August 31, 2009**
**Planned Action 2c – August 31, 2009**

**Planned Action:**

a. Privilege request forms have been modified in such a fashion as to avoid any ambiguity. VAPIHCS Medical Staff Office personnel will conduct a comprehensive review of a minimum of two provider folders per day to identify deficiencies and the appropriate provider will be asked to make a notation where there are discrepancies or blank boxes and complete the signature blocks if missing. Weekly reports will be provided to the Chief of Staff detailing the progress of the review until complete.

b. A proposed standardized Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) process will be presented to the Executive Committee of the Medical Staff at the July meeting. This process will evaluate provider-specific data for the six broad areas of practice as well as service specific data (developed at the service level) for any provider on an ongoing basis (every 6 months) and at the time of re-privileging. The current VAPIHCS Credentialing and Privileging policy will be modified with an addendum detailing the specifics. By August 31, 2009, all credentialing and privileging actions taken up at the Professional Standards Board will require the documentation to support the OPPE and/or FPPE and the minutes will reflect the discussions.

c. All providers whose appointments are less than 2 years (16 contract providers) have been granted privileges that are concomitant with the length of their appointment. The Medical staff Bylaws will be modified to include the following statement by August 31, 2009: "*Medical Staff appointments and privileges will not be granted for a period longer than the formal relationship with the facility. If a contract is terminated prior to expiration of the contract, privileges must be terminated since there is no legal agreement for the practitioner to be providing care."*

**Recommendation 3.** We recommended that the VISN Director ensure that the VAPIHCS Director requires that the patient advocate provide detailed patient complaint trend analyses and that management thoroughly discuss the analyses and take appropriate actions.

**Concur**

**Target date of implementation/completion: August 31, 2009**

**Planned Action:** The Patient Advocate will ensure that the data is entered timely into the National Patient Advocate Tracking (PATS) package by utilizing administrative support from the Quality Management Office. Issues identified from the data will be presented as necessary at the weekly Primary Care Staff meetings. The Patient Advocate will also meet regularly with Service Chiefs to discuss reported or perceived

customer/patient service issues. Quarterly reports will be generated and analyzed for trends by the Patient Advocate and presented for discussion and action at the Quality Executive Board (QEB). This report will be made a standing agenda item for the QEB and will be presented quarterly starting at the August 2009 meeting.

**Recommendation 4.** We recommended that the VISN Director ensure that the VAPIHCS Director requires that a consistent process for monitoring medication reconciliation and analyzing data is established and maintained.

**Concur.**

**Target date of implementation/completion: July 31, 2009**

**Planned Action:** Outpatient visits (approximately 120) randomly selected for all areas (to include the CBOCs on the other islands) will be reviewed quarterly by the Patient Safety Manager to ensure medication reconciliation is being accomplished. From the review that was completed during the month of June, it was noted that further refinement of the process to document that medication reconciliation is occurring was necessary. The policy will be updated to reflect the changes and staff will be educated on the changes. Results from monitoring medication reconciliation that is already occurring in the Center for Living (CLC) and on the MH Unit will be analyzed and included in a report along with the outpatient results and presented to the Quality Executive Board on a quarterly basis as part of the Patient Safety Quarterly report. Actions taken to improve the medication reconciliation process will be annotated in the minutes

**Recommendation 5.** We recommended that the VISN Director ensure that the VAPIHCS Director requires that the ECMS consistently document quarterly discussions of peer review findings in meeting minutes.

**Concur.**

**Target date of implementation/completion: Completed**

**Planned Action:** Quarterly Peer Review reports are presented to the Executive Committee of the Medical Staff (ECMS) on a scheduled basis. They are now a regular standing agenda item for the months of March, June, September, and December. The Risk Manager will ensure that the minutes reflect accurately the discussion of the presentation.

**Recommendation 6.** We recommended that the VISN Director ensure that the VAPIHCS Director requires that patient safety findings are presented regularly to an appropriate committee for discussion and action and that an annual report is presented to senior managers.

**Concur.**

**Target date of implementation/completion: Completed**

**Planned Action:** The Patient Safety Manager will present a quarterly report at the Quality Executive Board. Of note, the fourth quarter data will be rolled into the annual report. The report will now be a regular standing agenda item for the months of March, June, September, and December. The Patient Safety Manager will ensure the minutes reflect accurately the discussion.

**Recommendation 7.** We recommended that the VISN Director ensure that the VAPIHCS Director requires that the recently implemented medical record quality review process is revised to include clinical components and that monitors for the copy and paste functions be implemented.

**Concur.**

**Target date of implementation/completion: October 31, 2009**

**Planned Action:** The revision of the medical record review process to ensure that a clinical component is included will be accomplished in the following steps:

a. Primary Care has developed a clinical record review checklist that is available on the CPRS tool bar. Primary Care providers are assigned a set number of records each quarter to review utilizing the checklist. The first review occurred during third quarter and those results will be presented at the August Medical Records Committee meeting.

b. The new C, Health Information Management Service (HIMS) will be taking over the process and exporting it to all other services within the facility and will modify the checklist as appropriate. The medical records policy will be revised to reflect the process and presented to the Medical Records Committee at the August meeting. Once accepted the process will be implemented first quarter FY 2010.

c. The current policy on Copy and Paste will be reviewed by the C, HIMS and revised if necessary and presented to the Medical Records Committee at the August meeting along with a monitoring tool that will be developed. During the month of September records will be reviewed to obtain a baseline. Beginning in October, the monitoring of the copy and paste function will be accomplished by the staff in HIMS, and results will be analyzed and reported on a rotated schedule to the Medical Records committee beginning in 1st quarter FY 2010.

**Recommendation 8.** We recommended that the VISN Director ensure that the VAPIHCS Director requires that improvement in the oversight of

veteran patients' care at TAMC be implemented with a strong emphasis on consistent communication through regular meetings and monitoring of clinical metrics and actionable items, as defined by the groups' charters.

**Concur.**

**Target date of implementation/completion: July 31, 2009**

**Planned Action:** Findings of the IG CAP review were discussed at the Joint Venture Steering Group (JVSG) meeting. Discussion regarding the meeting frequency was undertaken and the members agreed that the goal is to meet monthly but quarterly meetings must be held at a minimum and that the quality and safety issues will be a standing agenda item at least quarterly and more frequently if necessary. The charters for the JVSG and the Joint Clinical Quality Work Group (JCQWG) have been modified to reflect the changes and are in the process of routing thru the front offices of both facilities. The changes and revised process have been put into effect and will be reflected in the meetings minutes.

**Recommendation 9.** We recommended that the VISN Director ensure that the Director requires that nurses consistently document pain medication effectiveness within the timeframe required by local policy and document actions taken when pain medications prove ineffective.

**Concur.**

**Target date of implementation/completion: Completed**

**Planned Action:** The local policy has been revised to reflect the requirement that pain medication effectiveness must be documented within 4 hours of administration of the medication and what action should be taken when pain medications are not effective. The staff has been educated on the revised policy. Monitoring of compliance will be accomplished by the shift charge Nurse who is required to run the BCMA PRN effectiveness report twice a shift to assure resident's pain effectiveness is being documented and actions are taken when they are not effective. Findings from the report will be feedback to the nursing staff for corrective action during the shift and weekly the information will be analyzed and provided to the Community Living Center (CLC) Nurse Manager and Assistant Nurse Manager. A monthly report will be presented at the CLC Performance Improvement meeting monthly beginning July 13, 2009. The report will continue until performance is maintained at the 95% target for three months.

**Recommendation 10.** We recommended that the VISN Director ensure that the VAPIHCS Director requires that clinicians document in the medical record patient and/or family member verbalized understanding of the discharge instructions and that nurses consistently document

instructions related to medication, diet, activity level, and recommendations for follow-up care.

**Concur.**

**Target date of implementation/completion: Completed**

**Planned Action:** The Center for Living (CLC) nursing discharge template was modified in the following manner:

a. Mandatory documentation requirements for instructions related to medication, diet, activity level, and recommendations for follow-up care.

b. Mandatory documentation requirements that the veteran/significant other were provided a copy of the nursing discharge note, the information was reviewed, and that they verbalized understanding of the information.

c. Mandatory documentation requirements that the veteran/significant other were given a copy of the physician's discharge note and the information was reviewed and that they verbalized understanding of the information

d. Monitoring of this process will be done by the CLC Nurse Manager and reported to the CLC Performance Improvement Committee for the next three months.

**Recommendation 11.** We recommended that the VISN Director ensure that the VAPIHCS Director requires program managers to ensure that patient records with Category II PRFs are re-evaluated according to the established timeframe.

**Concur.**

**Target date of implementation/completion: Completed**

**Planned Action:** The Suicide Prevention Coordinator and Suicide Prevention Case Manager have established a process to review the Patient Records Flags report from DHCP to determine those flags that need to be reviewed. For any flag that is due for review within 30 days of the expiration date, they will consult with the veteran's treatment team to determine the next action. The Patient Record Flag committee for suicide high risk will continue to meet every two weeks to review the information received from the treatment team. The decision to inactivate or continue the flag will be recorded in CPRS as an addendum to the original note for flag placement using templates for either continuation or discontinuation of the flag. The veteran's primary care and Mental Health providers are included as additional signers to communicate the information. Dates will be updated in DHCP so that a new review date or discontinuation date will

appear. Currently there are 47 patients with High Risk Suicide flags and none are beyond the 90 day review timeframe. A quarterly report will be provided to the Associate Chief of Staff for Mental Health Services on all patients who have a suicide flag for review. Ongoing education will be provided to clinical staff regarding the High Risk for Suicide Flag process.

**Recommendation 12.** We recommended that the VISN Director ensure that the VAPIHCS Director requires the HR manager to ensure that appropriate background investigations are completed and documented, as required.

**Concur.**

**Target date of implementation/completion: September 30, 2009**

**Planned Action:** Since the contractor in question was brought on board two years ago, our processes for new hires has improved significantly. In revising the process, the link to the Information Security Officer (ISO) was noted to be the important part that was missing. With that link now in place no access is given by the ISO without an HR security concurrence and validation of fingerprinting and adjudication. As a double check, HR receives a copy of the quarterly list of all those with access and reviews that to ensure background checks have been completed. A complete review was completed and it was noted that some intermittent fee basis employees are pending completion of security clearance review. Those employees have been contacted and in the interim their computer access has been suspended until they report to HR and complete their security/fingerprinting process. Additionally, an individual was selected to replace our vacant Personnel Security Specialist and we expect that person to be onboard in July.

# OIG Contact and Staff Acknowledgments

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