US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

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

Healthcare Facility Inspection	25-04253-243	August 14, 2026

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Executive Summary

The VA Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the VA Pacific Islands Health Care System (the facility) from December 1 through 4, 2025. The facility is rated as *low complexity* and in fiscal year 2025, provided care to about 48,000 veterans across the Pacific Island region, encompassing Hawaii, Guam, American Samoa, and Saipan.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The OIG made no recommendations.
- **Patient Safety.** The OIG ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The team found that facility leaders did not develop service-level workflows that define staff roles in communicating test results, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[3] The OIG made one recommendation.
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[4] The OIG made no recommendations.

[1] VHA classifies facilities based on their complexity level. Low-complexity facilities have "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." VA, *Facility Trip Pack (VISN [Veterans Integrated Service Network] 21) Spark M. Matsunaga Department of Veterans Affairs Medical Center*, last updated February 11, 2026.

[2] See appendix A for a description of the OIG's inspection methodology.

[3] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

[4] VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

- **Veteran-Centered Safety Net.** The inspection also evaluated facility programs that offer support services to vulnerable veterans who are experiencing or at risk of homelessness or have recently been incarcerated. The OIG made no recommendations.

What the OIG Recommended

1. The Chief of Staff and Associate Director for Patient Care Services develop workflows that describe how each team member participates in the process for communicating test results.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the recommendation and provided an acceptable action plan (see the response in the report body appendixes B and C).[5] Based on information provided, the OIG considers recommendation 1 closed.

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[5] Veterans Integrated Service Networks (VISNs) are "regional care systems working together to better meet local healthcare needs and provide greater access to care." "Veterans Integrated Service Networks," VA, last updated July 24, 2026, https://department.va.gov/visn. In December 2025, VA announced plans to reorganize and consolidate its VISNs from 18 networks to 5. All VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles within the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise.

Abbreviations

FY	fiscal year
HCHV	Health Care for Homeless Veterans
HUD-VASH	Housing and Urban Development–Veterans Affairs Supportive Housing
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Contents

Introduction

The Office of Inspector General's (OIG's) Office of Healthcare Inspections focuses on overseeing the Veterans Health Administration (VHA), which offers care to more than nine million enrolled veterans through its 1,380 healthcare facilities.[6] VHA's vast care delivery structure requires sustained and thorough OIG oversight to ensure the nation's veterans receive high-quality care.

The OIG established the Healthcare Facility Inspection program to routinely evaluate VHA medical facilities on an approximately three-year cycle. Healthcare Facility Inspection reports provide insight into the experience of staff working in VHA facilities and veterans receiving care. They inform veterans, the public, and Congress about the conditions for care delivery and patient safety and highlight specific corrective actions leaders and staff can take. Each inspection focuses on five domains and assesses facilities' adherence to VA standards and other governing authorities:

Culture: VA supports a system of shared values that shape an organization's behavioral norms. Effective responses to system shocks as well as favorable employee and veteran experiences are elements of positive organizational culture.[7]

Environment of Care: Medical facilities must maintain safety, cleanliness, and accessibility. VHA established a comprehensive program that addresses physical spaces, equipment and systems, privacy, and other concerns.[8]

Patient Safety: VHA has programs to identify and reduce system vulnerabilities and risks of harm to veterans.[9]

Integrated Veteran Care: Facilities must comply with directives and guidance governing the VHA multidisciplinary care model.

Veteran-Centered Safety Net: VA offers coordinated medical care and social support services to vulnerable individuals, including those experiencing homelessness or recent incarceration.[10]

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[6] "About Us," VA, last updated June 2, 2026, https://department.va.gov/vha/about-us.

[7] Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11, https://doi.org/10.1136/bmjopen-2017-017708.

[8] VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

[9] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

[10] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

The VA Pacific Islands Health Care System (the facility) is situated in a vast and geographically complex region. Staff deliver care at the Spark M. Matsunaga VA Medical Center in Honolulu and eight community-based outpatient clinics on the Hawaiian Islands, Guam, American Samoa, and Saipan, which extend access to veterans living in remote areas. In fiscal year (FY) 2025, the facility served about 48,000 veterans and had a medical care budget of about $800 million. It had 12 hospital, 10 domiciliary, and 44 community living center beds.[11]

Figure 1. *Facility photo.*
Source: "VA Pacific Islands Health Care," VA, accessed March 24, 2026, https://www.va.gov/pacific-islands.

The OIG team inspected the facility from December 1 through 4, 2025. The executive leaders referred to throughout this report include the Interim Medical Center Director (Director), Acting Deputy Medical Center Director, Chief of Staff, Acting Deputy Chief of Staff, Associate Director of Patient Care Services, Assistant Director, Associate Director, and Chief of Quality and Patient Safety. The deputy associate director of patient care services position was vacant.

CULTURE

The OIG team examined the facility's culture across multiple dimensions, including unique circumstances, system shocks (planned or unplanned events that disrupt an organization's daily operations), and both employees' and veterans' experiences.[12] The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and assess their level of trust in VA).[13] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[14]

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[11] A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, accessed June 29, 2026, https://department.va.gov/homeless/dchv. A community living center is also referred to as a VA nursing home. "Geriatrics and Extended Care," VA, last updated March 27, 2026, https://www.va.gov/VA_CLC.

[12] Valerie M. Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies," *BMJ Quality and Safety* 28 (2019): 74–84, https://doi.org/10.1136/bmjqs-2017-007573.

[13] "Veteran Trust in VA," VA, last updated June 4, 2026, https://www.va.gov/initiatives/veteran-trust-in-va.

[14] Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Patient Advocate," VA, last updated May 9, 2022, https://www.va.gov/patientadvocate. For more information on the OIG's data collection methods, see appendix A.

System Shocks

Executive leaders reported that the August 2023 wildfire in Lahaina created a system shock that revealed geographic and operational challenges unique to the facility and, by the time of the inspection in December 2025, had strengthened emergency-response capabilities and improved cross-island coordination. The Director said the disaster disrupted infrastructure and communications, which required staff to rapidly adapt to maintain patient care delivery. The Associate Director said facility leaders coordinated emergency operations through the Incident Command System (a standard, organized response framework for emergency situations) for 14 days and used innovative solutions such as Starlink satellite technology to restore internet connectivity.[15]

The Chief of Staff noted that facility staff were the first federal employees to provide care in Lahaina after the wildfire. The Associate Director explained that although many staff had family and neighbors affected by the disaster, they still came to work and cared for veterans in shelters, delivered medications to veterans in temporary housing, and expedited the distribution of over $30,000 in donations. The event drove leaders to implement process improvements such as a formal donation management plan, stronger crisis communication strategies, and rapid deployment methods for personnel and supplies. The Director also reported that the Wildfire Relief Team, composed of facility staff based at the Maui clinic, received a VHA High Reliability Organization award for their exceptional response, giving meaningful validation of their efforts, resilience, and dedication during a profoundly challenging time. By the time of the OIG inspection, executive leaders had activated the Incident Command System nine additional times since the wildfire, demonstrating the facility's ongoing use of improved practices.

Employee Experiences

Most respondents to the OIG questionnaire indicated that VA's mission, pay and benefits, and job satisfaction kept them at the facility. However, most also identified stress and burnout as reasons why they have considered leaving. To improve experiences, leaders expanded and engaged in whole health initiatives with employees, such as yoga, tai chi, meditation, and wellness walks.

Although VA did not conduct a formal all-employee survey in FY 2025, the Assistant Director said leaders within the facility continued employee engagement efforts. For example, service chiefs met with their teams to review existing improvement plans to determine whether to continue previous initiatives or develop new goals.

[15] VHA Directive 0320(1), *VHA Comprehensive Emergency Management Program*, July 6, 2020, amended February 16, 2024; "What is Starlink?," Starlink, accessed January 14, 2026, https://starlink.com/ca/support/article.

In the OIG questionnaire, employees described executive leaders' communications as frequent and useful, and most said they would be comfortable reporting safety concerns. Executive leaders said they communicate with employees across the geographically dispersed facility through monthly all-employee town halls, weekly supervisor meetings, and daily tiered huddles (short meetings between leaders and employees).

Veteran Experiences

Patient advocates indicated that veterans' most common concerns involved delays in community care authorization and consult (referral) processing.[16] Leaders acknowledged that community care remains one of the most significant challenges for serving veterans, particularly in remote areas of American Samoa, Saipan, and Guam. The Director explained that these regions often lack specialty care providers, which forces veterans to travel long distances—sometimes requiring flights—for essential care. The Chief of Staff reported the travel expenses for American Samoa veterans exceed $9 million annually and do not include the cost of care. Executive leaders discussed the following efforts to address these issues:

- Establishing new laboratory services in Guam and American Samoa
- Using integrated primary care and telemental health hubs
- Improving infrastructure for new specialty care and mental health areas in the American Samoa clinic

Despite their reported concerns, veterans' trust in the facility increased from FY 2024 to FY 2025.

[16] VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[17] The OIG team assessed how a facility's physical features may shape the veteran's perception of the health care they receive. The team also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

The inspectors examined compliance with key VA and VHA guidelines and standards, as well as with Architectural Barriers Act and Joint Commission standards. Best practice principles from academic literature were also considered.[18]

General Inspection

The OIG team inspected the Spark M. Matsunaga VA Medical Center in Honolulu and the Daniel K. Akaka VA Clinic in Kapolei. The facility's medical center was accessible by public transportation and offered shuttle services to transport veterans to and from the parking area.

Although veterans frequently reported insufficient parking to patient advocates, the team noted ample options at both the medical center and clinic—general and accessible spaces. The medical center's parking garage had bright lighting, security cameras, and emergency phones on each level.

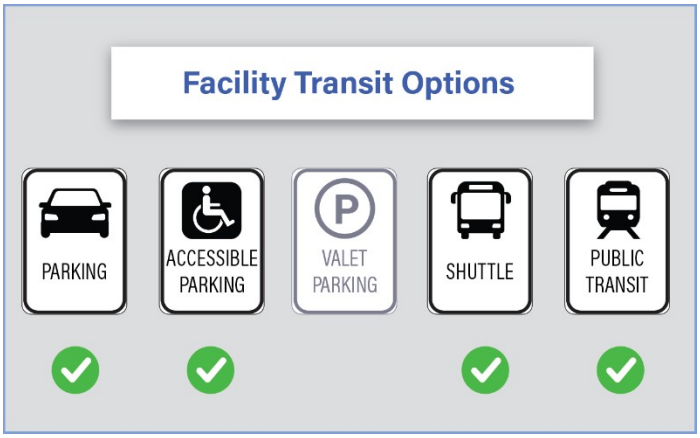

Figure 2. *Transit options for arriving at the facility. Source: OIG observations and questionnaire responses from facility staff.*

[17] "Informing Healing Spaces through Environmental Design: Thirteen Tips," VA, last updated May 1, 2024, https://www.va.gov/WholeHealth/Healing-Spaces.

[18] VA, *Integrated Wayfinding & Recommended Technologies*, December 2012; VA, *VA Signage PG-18-10, Design Manual*, May 16, 2023, revised February 19, 2025; VA, *VA Barrier Free Design Standard*, January 1, 2017, revised May 1, 2025; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook*, 2025; Access Board, *Architectural Barriers Act (ABA) Standards*, 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2025.

Figure 3. *Accessibility tools available to veterans with impairments.*
Source: OIG team observations and facility liaison questionnaire response.

The main entrances at the medical center and clinic had natural light, covered loading zones, power-assisted sliding doors, seating, and available wheelchairs. Information desk staff were at both entrances to give directions and answer questions. Although neither the medical center nor the clinic displayed wall maps, staff provided printed maps on request. The OIG team also observed large-print signs that directed veterans to clinical and nonclinical locations.

The medical center entrance was welcoming but crowded with furniture and equipment. Facility leaders and the interior designer reported future renovation plans; therefore, the OIG did not make a recommendation.

The elevators at the medical center were equipped with audio cues and braille labels. Staff at the information desk stated they communicate with hearing-impaired veterans by writing and using a sign language service as needed. Staff also stated they escort visually impaired veterans to appointments when requested. The team did not find any issues with safety, cleanliness, and privacy in the inspected patient care areas.

PATIENT SAFETY

The OIG inspectors examined the facility's patient safety processes. They focused on communication procedures for urgent but noncritical test results, the sustainability of changes made by leaders in response to previous oversight recommendations, and improvement projects.

Communication of Urgent but Noncritical Test Results

The OIG found the facility's test result communication policy had not been updated, and facility leaders did not develop service-level workflows that define staff members' roles in communicating test results, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[19] When staff lack defined workflows, they may not understand their

[19] VA Pacific Islands Health Care System, MCP [medical center policy] 11-23-125, *Communication Test Results to Providers and Patients*, May 31, 2023; VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

responsibilities for communicating test results, which may delay patient care. The Chief of Staff acknowledged the issue, and staff provided an updated policy in March 2026. However, leaders still had not developed the service-level workflows.

Recommendation 1

The Chief of Staff and Associate Director for Patient Care Services develop workflows that describe how each team member participates in the process for communicating test results.

__X__ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

Chief of Staff and Chief, Quality and Patient Safety reviewed the VHA Directive 1088(1), Communicating Test Results to Providers and Patients, dated July 11, 2023, amended September 20, 2024, and the Facility Medical Center Policy (MCP) 11-23-125 Communication Test Results to Provider and Patients, dated March 20, 2026, and the VHA Office of Primary Care's Communicating Test Results SharePoint, "Sample Service-Level Workflow Template." On June 26, 2026, the VHA Chief Operating Officer and the VHA Office of National Policy advised that no new local policy development or revisions should occur until further guidance is issued. After review and consultation with clinical services, MCP 11-26-125 was rescinded on July 20, 2026, and Standard Operating Procedure (SOP) A11-26-029 Communication of Test Results to Providers and Patients was published on July 20, 2026, including Service workflows defining provider and staff responsibilities and following guidance provided by the VHA Office of Primary Care. The MCP recission and publication of the new SOP was communicated facility-wide on June 20, 2026. The Facility is requesting closure of this recommendation.

OIG Comments

The OIG reviewed evidence sufficient to demonstrate that leaders had completed improvement actions and therefore closed the recommendation before the report's publication.

VHA Directive 1088(1) also requires each facility to have a process for monitoring how staff communicate test results to both providers and patients. The Chief of Staff and the Associate Director of Patient Care Services stated the external peer review program coordinator regularly reports data on communications of abnormal test results to the Quality and Patient Safety Council. The OIG team reviewed the council meeting minutes and found facility leaders consistently monitored test result communications and addressed identified issues.

Action Plans and Process Improvements

Leaders implemented all corrective actions related to the OIG's recommendations from the most recent comprehensive healthcare inspection report published in 2023.[20] Quality management staff develop action plans with service leaders in response to oversight recommendations. They then monitor these plans, and the Quality and Patient Safety Council updates executive leaders at least twice a month. To ensure accountability, the Chief of Quality and Patient Safety reported that responsible personnel, including service chiefs, remain assigned to each action item until the plan is fully implemented.

Additionally, the Chief of Staff, Associate Director of Patient Care Services, and quality management staff explained that facility staff report patient safety concerns and improvement opportunities through the Joint Patient Safety Reporting system—a database for employees to document patient safety events (adverse events and close calls).[21] The patient safety manager also discussed lessons learned during bimonthly patient safety forums.

The OIG team reviewed patient safety events from April through September 2025 and noted an increase in reports related to staff not clearly labeling test kits (to detect hidden blood in the stool) used for colorectal cancer screening.[22] The chief of primary care acknowledged this trend and shared that the laboratory received many returned specimens with smudged or unreadable patient names, which prevented proper identification and processing. The patient safety manager reported that facility staff installed specialized label and barcode printers at all outpatient clinics and updated standard operating procedures. Quality management staff stated these actions improved label accuracy.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[23] The OIG evaluated facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in increasing access to care.

[20] VA OIG, *Comprehensive Healthcare Inspection of the VA Pacific Islands Health Care System in Honolulu, Hawaii*, Report No. 22-00229-15, November 7, 2023.

[21] VHA National Center for Patient Safety, *JPSR Guidebook*, *Version 6.0*, October 2025.

[22] National Library of Medicine, *MedlinePlus Medical Encyclopedia*, "Fecal immunochemical test (FIT)," last updated July 22, 2025, https://medlineplus.gov/ency/patientinstructions/000704.htm.

[23] "Community Care," VA, accessed June 29, 2026, https://department.va.gov/vha/community-care.

Primary Care Staffing and Access to Care

The OIG team reviewed facility data approximately three weeks prior to the inspection in December 2025 that showed primary care had vacancies for 4 providers, 6 registered nurses, 10 licensed practical nurses, and 4 administrative assistants. Primary care leaders identified the high cost of living and the long distance from the US mainland as recruitment challenges, and said they used float providers (unassigned care providers) to cover vacant positions and absences. Primary care staff added that team members also often perform additional tasks because of the vacant positions. For example, a registered nurse may also cover the licensed practical nurse role. The staff said at the time of the inspection in December 2025 that they addressed veterans' immediate care needs but were unable to focus on preventive care.

To support new staff, primary care leaders assigned clinical trainers to work with them, which improved performance and retention. The leaders also implemented team-building initiatives and staff recognition programs to boost morale and reduce burnout.

The team found that many primary care panel sizes (the number of patients assigned to a team) were below the expectation of 1,200 patients, as stated in VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*.[24] Panel management coordinators explained that a panel size decreases when the team has vacancies and when they can only use one exam room due to space constraints. To address issues related to space, leaders opened the Daniel K. Akaka VA Clinic in 2024 to serve the growing veteran population on Oahu's west side; they also plan to expand the Guam clinic.

The facility's wait time for new patient appointments averaged 32.96 days in the first through third quarters of FY 2025, although it declined to 23.5 days in the fourth quarter of FY 2025. The Code of Federal Regulations (title 38, section 17.4040) states that patients may be referred to community providers if the primary care wait time is greater than 20 days.[25] To further decrease wait times, primary care leaders said they reassigned patients to clinics with available capacity, and staff used virtual care when appropriate.

Community Care Staffing and Access to Care

The OIG team reviewed community care data for the fourth quarter of FY 2025 (July 1 through September 30, 2025) and found that approximately 48 administrative and 5 clinical positions were vacant within the facility. A community care leader attributed many of the administrative vacancies at that time to staff leaving for similar but higher-paying positions in other

[24] VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026.

[25] 38 C.F.R. § 17.4040 (2025).

departments and the hiring freeze.[26] In response, leaders hoped to convert the administrative positions to a higher-paying position, which they believed would improve retention.

Community care leaders and staff reported that vacancies and an increase in referrals have delayed consult (community referral) processing. Efforts to address the backlog included

- mandatory overtime of 20 hours per pay period for community care staff,
- cross-training for staff from other departments to assist,
- primary care and community care leaders' cooperation to reduce process redundancies,
- collaboration with the community care network administrator to improve providers' timeliness to submit medical record documents, and
- a scheduled consultative visit from the Veterans Affairs Central Office's Office of Integrated Veteran Care.

The OIG reviewed Health Care for Homeless Veterans (HCHV), Housing and Urban Development–Veterans Affairs Supportive Housing (HUD-VASH), and Veterans Justice Programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The inspection team analyzed enrollment and performance data and interviewed facility program staff.

Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[27]

[26] Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025). Shortly after the hiring freeze memorandum was issued, the Acting Secretary provided guidance and identified a list of exempted "positions critical to delivering care to Veterans in" VHA. Acting Secretary, "Hiring Freeze Guidance," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, January 21, 2025. As of December 1, 2025, VA adopted new policies for filling vacancies and creating new positions in compliance with the executive order for Ensuring Continued Accountability for Federal Hiring. Executive Order 14356, 90 Fed. Reg. 48387 (Oct. 20, 2025); Assistant Secretary for Human Resources and Administration (006), "Updated Department of Veterans Affairs Hiring Guidance (VIEWS 13474675)," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, December 1, 2025.

[27] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

VHA uses performance measures to determine the success of each medical facility's program. HCHV1 measures the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional residences for veterans with mental health or substance use conditions).[28] HCHV2 measures the percentage of veterans who are discharged from the program's contracted residential services or low-demand safe haven beds due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff (referred to as negative exits)."[29]

Performance and Improvement Highlights

- The HCHV program coordinator credited meeting the exit to permanent housing (HCHV1) target for the second quarter of FY 2025 to the contracting officer's representative, who monitored contractor performance to ensure delivery of emergency housing and supportive services. As a result, many veterans accessed permanent housing programs.
- The program did not meet the negative exit (HCHV2) target in quarter two of FY 2025. The coordinator explained that negative exits can increase when veterans move to the area for only a short period, such as the winter months. Facility program staff stated they work with the contracted emergency residential services liaison to address other issues that lead to negative exits, such as substance use.
- The coordinator noted that early in FY 2025, the outreach social worker position was vacant for several months, making engagement with veterans difficult. However, at the time of the inspection, they had hired an experienced social worker for the position and expanded coverage.

Housing and Urban Development–Veterans Affairs Supportive Housing

The HUD-VASH program combines HUD rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including "serious mental

[28] VHA sets targets for HCHV1 at the national level each year. Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*, November 2024. Contract residential services programs include both contracted emergency residential services and low-demand safe haven programs. For contracted emergency residential services, veterans can usually stay from 30 to 90 days. For low-demand safe havens a veteran can typically stay between 4 to 6 months. VHA Directive 1162.04(1), Health Care for Homeless Veterans Contract Residential Services Program, February 22, 2022, amended March 7, 2025.

[29] VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

illness, physical health diagnoses, and substance use disorders."[30] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[31]

VHA measures how well the program meets veterans' needs by using nationally determined targets, including the number of housing vouchers assigned to the facility currently used by veterans or their families (performance measure HMLS3) and the percentage of veterans in the program who are employed (performance measure VASH3).[32]

Performance and Improvement Highlights

- The facility program did not meet the voucher use (HMLS3) target for the second quarter of FY 2025. Program staff attributed this to the high cost of housing and limited availability of affordable options. To address housing challenges, the program coordinator said they are establishing project-based units (rental units tied to vouchers) and master leasing arrangements (in which the program directly pays rent).

- The program met the employment (VASH3) target for the second quarter of FY 2025. The program coordinator credited it to program employment specialists who help match veterans with job opportunities based on their skills and experience and assist with bus passes and clothing for interviews. After a veteran secures employment, the specialists continue to work with the employers to hire additional veterans.

Veterans Justice Program

The Veterans Justice Program serves veterans throughout all stages of the criminal justice process—from contact with law enforcement to court appearances and their reentry into life in the community after incarceration.[33] Recognizing incarceration as a strong predictor of homelessness on release, the program focuses on connecting veterans to VA health care, services, and benefits. VHA sets a target for the number of veterans entering the Veterans Justice Program each fiscal year (performance measure VJP1).[34]

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[30] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[31] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[32] VHA sets the target for facilities to provide a minimum of 90 percent of their allotted housing vouchers to participants and at least 50 percent of the participants in the facility's program should be employed. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

[33] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[34] VHA sets escalating targets for this measure at the facility level each year, with the goal to enroll all identified veterans by the end of the fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

Performance and Improvement Highlights

- The facility program did not meet the enrollment (VJP1) target for the second quarter of FY 2025. The program supervisor explained that a social worker vacancy caused staff to travel between islands, which took additional time.
- Program staff receive referrals from families, the public defender's office, attorneys, courts, probation officers, and veterans. During outreach to veterans in jails, staff discuss the option of VA services and support instead of standard criminal justice processes.

Conclusion

To assist leaders in evaluating the quality of care at the VA Pacific Islands Health Care System, the OIG conducted an inspection across five domains. The OIG made one recommendation related to test result communications. Facility leaders have started to implement corrective actions, which resulted in the OIG closing recommendation 1. The OIG's findings and recommendation may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

As to the OIG's Healthcare Facility Inspection program of VHA medical facilities across the nation, OIG leaders are aware of the ongoing transformation to VHA's management structure that could affect future areas of oversight. The OIG will monitor VHA's change management and maintain its focus on risks to the effectiveness and efficiency of VA programs, operations, and services that can affect the health and welfare of veterans and their families.

Appendix A: Methodology

The OIG inspection team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[35] The OIG administered voluntary questionnaires to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. The team inspected the facility from December 1 through 4, 2025. The OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected various areas of the medical facility.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[36] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not AI-generated content. The inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, *Accelerating Federal Use of AI through Innovation, Governance, and Public Trust.*[37]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[38] The OIG acknowledges potential bias because the facility liaison selected employees who participated in the interviews; the OIG asked for this selection to minimize the impact of the inspection on patient care responsibilities and primary care clinic workflows.

During site visits, the team refers concerns that are beyond the scope of the inspections to the OIG's hotline management personnel for further review.

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[35] The accreditation reports covered the time frame of October 1, 2021, through September 30, 2024—the most recent available at the time of the inspection.

[36] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation,* December 2020.

[37] Director for the Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," memorandum to Heads of Executive Departments and Agencies, April 3, 2025.

[38] Self-selection bias is when individuals with certain characteristics choose to participate in a group, and response bias occurs when participants "give inaccurate answers for a variety of reasons." Dirk M. Elston, "Participation Bias, Self-Selection Bias, and Response Bias," *Journal of American Academy of Dermatology* (2021): 1-2, https://doi.org/10.1016/j.jaad.2021.06.025.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[39] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 23, 2026

From: Director, VISN 5 – Health Service Area 5.2 (10N21)

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

To: Director, Office of Healthcare Inspections (54HF05)

Chief Integrity and Compliance Officer (10OIC)

Thank you for the opportunity to review the draft report for the VA Pacific Islands Health Care System in Honolulu, Hawaii.

I concur with the recommendations and action plans submitted by the VA Pacific Islands Health Care System.

If you have any questions, please contact the VISN 21 Acting Quality Management Officer.

(Original signed by:)

Ada YC Clark, FACHE, MPH
VISN 5 – Health Service Area 5.2 Director

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 20, 2026

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

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

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

Thank you for the opportunity to review the OIG Draft Report- Healthcare Facility Inspection of the VA Pacific Islands Health Care System. I have completed a full review of the draft report and concur with the OIG's recommendations.

I have reviewed the documentation and concur with the response as submitted. I respectfully request closure as we have successfully completed the necessary corrective actions.

Should you need further information, please contact the Chief, Quality and Patient Safety Service.

(Original signed by:)

Thomas A. Steinbrunner, FACHE
VISN 5 – Health Service Area 5.5 Director

OIG Contact and Staff Acknowledgments

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Pursuant to Pub. L. No. 117-263 § 5274, codified at 5 U.S.C. § 405(g)(6), nongovernmental organizations, and business entities identified in this report have the opportunity to submit a written response for the purpose of clarifying or providing additional context to any specific reference to the organization or entity. Comments received consistent with the statute will be posted on the summary page for this report on the VA OIG website.