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STATEMENT OF  
JULIE WATROUS, R.N.  
REGIONAL DIRECTOR, OFFICE OF HEALTHCARE INSPECTIONS  
OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS  
BEFORE  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES SENATE  
ON  
HEALTH CARE AND BENEFITS FOR VETERANS IN HAWAII  
HONOLULU, HAWAII  
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INTRODUCTION

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify today on VA health care in Hawaii. I will discuss the relationship between the Tripler Army Medical Center (TAMC) and the Spark M. Matsunaga Medical Center (part of the VA Pacific Islands Health Care System), as well as the status of findings from two reports the Office of Inspector General (OIG) issued in 2006. I am accompanied by Michael Shepherd, M.D., Physician, Office of Healthcare Inspections, OIG.

In preparation for this hearing, I traveled to Honolulu July 23-24, 2007, to interview managers and staff at the VA Pacific Islands Health Care System and at TAMC. Based on these interviews, as well as previous reviews conducted here, I would like to highlight three issues in the sharing agreement relationship that would benefit from further attention. The first concerns differences between the two facilities' electronic patient health record systems, which make it difficult for clinicians to document veterans' care, as well as to review other clinicians' documentation. The second issue concerns the billing and payment systems, which both facilities' managers complained result in problems such as late billings and delayed payments. The third issue concerns equal access to care for veterans at the TAMC. Because of TAMC staff deployments and the influx of active duty military members needing care, access to care for veteran patients at TAMC is not always consistently available or timely. I will discuss this issue in more detail later in my testimony.

Combined Assessment Program Review

The OIG conducts periodic reviews of VA health care facilities. These Combined Assessment Program (CAP) reviews are part of the OIG's efforts to ensure that high quality care is provided to our Nation's veterans. We reviewed documents and medical records and visited the Honolulu facility June 19 through 23, 2006, and in September 2006, we published the CAP review report of the VA Pacific Islands Health Care System.

In the CAP report, we noted four areas that were in compliance: quality management, breast cancer management, patient satisfaction survey results action plans, and monitoring patients on atypical antipsychotic medications. We made recommendations concerning security of patient information, follow-up care for patients in community nursing homes, and communication and oversight of veteran patients treated at TAMC.

With regards to security of patient information, we found unsecured patient information in hard copy paper and on unattended computer terminals and recommended that the facility's managers ensure that all patient information is protected. In response to our recommendation, managers provided privacy training and increased their oversight of patient information management throughout their facilities.

With regards to follow-up care for patients in community nursing homes, we recommended that the facility's managers improve care plans for veterans residing in community nursing homes and increase facility oversight of these homes. In response, managers standardized care plan notes and increased the membership on the oversight committee.

The issue of communication about and oversight of veteran patients treated at TAMC was not a new finding. We had a similar finding during our 2001 CAP review and closed the recommendation based on the corrective action plan submitted. However, the corrective actions were only partially implemented. We again recommended that senior managers at the two facilities formalize their communication mechanisms and ensure that key staff attend the meetings. Several committees were formed as a result of this recommendation, including a Joint Venture Committee, to address clinical care and quality improvement issues between the two organizations.

We reviewed the actions taken by the facility's managers in response to our CAP recommendations and concluded that the recommendations were appropriately addressed. We closed the report on March 30, 2007.

#### Review of Access to Care in the Veterans Health Administration

In early fiscal year (FY) 2006, at the request of Senator Akaka, we reviewed access to non-institutional care, appropriateness of enrollment practices, and timeliness of clinically indicated elective procedures. We visited five medical facilities in this national review, including the Spark M. Matsunaga VA Medical Center. We interviewed facility personnel, reviewed medical records, and analyzed workload data through FY 2005 provided to us by the facilities.

Non-Institutional Care. The Millennium Act, passed in 1999, directed VA to provide veterans eligible for medical services with certain non-institutional care services—services that are provided to veterans in their own homes or in community settings. In response, VHA implemented policies requiring medical facilities to provide non-institutional care services to all eligible veterans, when appropriate. These services include:

- Home based primary care.
- Purchased skilled home health care.
- Homemaker and home health aides.
- Adult day health care.
- Geriatric evaluation and management.
- Respite care.
- Hospice and palliative care.
- Care coordination and telehealth.

We noted that veteran access to non-institutional care services had increased from FY 2003 to FY 2005 in several of the non-institutional care services. However, we found that improvement was still needed and made a number of recommendations aimed at further increasing access. VHA agreed with the recommendations and submitted an action plan that included monitoring the demand and supply of non-institutional services, increasing capacity, and expanding coverage to geographic areas that did not offer non-institutional care services. The VA Pacific

Islands Health Care System's FY 2006 workload numbers show that all the non-institutional care services are available, and the number of veterans using these services increased in FY 2006 in almost all services.

**Enrollment Process.** The enrollment process at the five facilities we visited complied with national enrollment policies. We made several recommendations aimed at improving the tracking of new veterans who desire VA care. VHA agreed with the recommendations and planned to issue revised directives establishing policies for use of electronic wait lists and scheduling processes. VHA issued the directive "Process for Ensuring Timely Access to Outpatient Clinical Care" on May 8, 2006.

**Timeliness of Elective Specialty Procedures.** Eligible veterans did not always receive clinically indicated specialty procedures within reasonable timeframes. VHA has not established a method to measure the length of time veterans wait for elective procedures; in some cases, veterans experienced excessive waiting times. While a VHA performance measure requires facility directors to track the length of time veterans wait for their specialty care appointments, facilities are not required to track the length of time veterans must wait from the requests or authorizations for elective procedures until the procedures are actually performed. To better assess and manage their workload and ensure that veterans receive timely care, facility managers need to track veterans' entire waiting time—not just the waiting time to the appointment.

We reviewed elective procedures that had been performed in FY 2005 in three specialty areas: (1) cardiology, (2) gastroenterology, and (3) orthopedic surgery. We found lengthy average waiting times. For example, at the VA Pacific Islands Health Care System, the average wait for elective orthopedic procedures was 182 days, and the range was 14-379 days.

We could not locate any timeliness standards within VHA or United States medical organizations for the procedures we reviewed. However, several countries with national health systems have set timeliness goals of 6 months for orthopedic surgery. Evidence indicates that deterioration in functional health status occurs in patients waiting more than 6 months for joint replacement surgery.

We interviewed the chiefs of cardiology, gastroenterology, and orthopedic surgery services, as well as a number of primary care providers, to gain their perspectives on the timeliness of elective procedures. Although the five facilities varied greatly in size and capacity, the reasons for delays given by these providers were consistent and fell into four themes:

- Physician vacancies and difficulty recruiting specialty physicians.
- Lack of support staff, such as nurses, physician assistants, and anesthesiologists.
- Insufficient space, including inpatient beds and operating rooms.
- Lack of equipment, such as scopes and data processors for colonoscopies.

Some barriers to timely care were unique to one or two facilities. For example, some orthopedic surgery for Hawaii veterans occurs in operating rooms at TAMC. Delays occurred when procedures scheduled to be performed at TAMC were cancelled due to military deployments.

Some of these veterans had to be re-prioritized and worked into the referral lists to the VA Palo Alto Health Care System. In other cases, veterans were referred to community providers at VA expense, depending on veteran condition and availability of fee basis funds.

Within the past year, the VA Pacific Islands Health Care System hired a part-time orthopedic surgeon to operate at TAMC. Both facilities' managers agreed that this move has helped stabilize the planning for orthopedic surgery but stated that more staffing is needed to manage the workload. Additional operating rooms that will be constructed as part of the VA Pacific Islands Health Care System's same-day surgery project will provide more capacity, but only when fully

staffed. We were told repeatedly about the difficulty in recruiting specialists to work in Hawaii. In preparation for this hearing, we reviewed the VA Pacific Islands Health Care System's FY 2006 elective procedures data and found that the average wait times from authorization until the procedures had been performed had improved in cardiology and gastroenterology, but had actually gotten worse in orthopedic surgery.

In our report, we recommended that VHA establish appropriate performance metrics to evaluate and improve the timeliness of elective procedures and implement prioritization processes to ensure that veterans receive clinically indicated elective procedures according to their clinical needs. VHA agreed with the recommendation and plans to develop performance metrics to evaluate timeliness of elective procedures. This recommendation remains open.

#### SUMMARY

With respect to VA care in Hawaii, we believe that VHA, Veterans Integrated Service Network 21, and the VA Pacific Islands Health Care System have responded appropriately to specific recommendations made by the OIG in these two reports. However, the three issues related to TAMC - electronic medical record systems, billing and payment systems, and consistent and timely access to care - would benefit from additional attention.

Mr. Chairman, thank you again for this opportunity. I would be pleased to answer any questions that you or other Members of the Committee may have.