

**QUALITY OF CARE, PATIENT AND EMPLOYEE
SAFETY, AND MANAGEMENT EFFECTIVENESS AT
THE MARION VA MEDICAL CENTER**

HEARING
BEFORE THE
SUBCOMMITTEE OVERSIGHT AND INVESTIGATIONS
OF THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
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THURSDAY, JUNE 1, 2000

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC

The subcommittee met, pursuant to call, at 9:55 a.m. CST at the Marion VA Medical Center Theater Building, Marion, IN, Hon. Bob Stump (chairman of the subcommittee) presiding.

Present: Representatives Stump and Buyer.

OPENING STATEMENT OF HON. BOB STUMP, CHAIRMAN, FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. STUMP. If the meeting will please come to order. Good morning to all of you out there. I want to thank you for coming. Let me first invite the witnesses as well as for those of us up here, to take off your jackets. I think you're gonna have to with the heat. So feel free to do that.

We're not intending to cut anybody off or short. We have asked that everybody try to limit their remarks to 5 minutes. I think at the 4½ minute mark I'll just give one little tap will tell me—'cause we don't have a clock, I'll just give one little tap. Not to cut you off, you can finish and wrap it up whenever you can.

My name is Bob Stump. I'm Chairman of the Veterans' of House Affairs Committee from the House of Representatives. Congressman Steve Buyer and I are members of the Subcommittee on Oversight Investigation. The Subcommittee Chairman couldn't be here today and he asked me if I would sit in for him. I told him I'd be glad to do that. I consider Steve Buyer one of our most dedicated members of the House of Veterans' Affairs Committee. He's a true Veterans advocate and is a veteran of the Persian Gulf War himself. He also serves as Chairman of the House Armed Services Personnel Committee.

This hearing will examine quality of care, patient and employee safety, management effectiveness here at the Marion VA Medical Center. Let me tell you that this committee has a responsibility to oversee a \$44 billion budget for the Veterans' Affairs—Veterans' Administration. Now, we have oversight of 172 hospitals, over 600 outpatient clinics, 116 national cemeteries, other long-term health care, many rehabilitation training centers for our veterans. And we

try to look out for 'em the best way we can. We would also examine the adequacy of clinical—clinical staffing, medication security and other facility management issues. The Subcommittee will hear testimony from the VA Inspector General's Office, employees, union representatives and Veterans' service organizations. We'll also hear from the VA about what the medical center's doing to correct any deficiencies and to address the various recommendations that have been made.

I want to make it clear that this Subcommittee as well as the full Veterans' Affairs Committee expects high quality health care for Indiana's Veterans, and for that matter, for any of our veterans wherever they reside in this country. We also expect a clean, safe and well managed workplace for our VA employees.

Last year we sent to the VA, the Veterans' Administration, a budget of \$1.7 trillion almost all of it for health care—pardon me, a billion dollars—\$1.7 billion, almost all for health care. Largest increase in the history of the Congress. Now, with these increases, VA hospitals around the country should have adequate resources if the money is properly managed. I look forward to learning more about Marion.

And now I'd like to recognize my friend and colleague and your Congressman, Steve Buyer for any statements he may wish to make.

OPENING STATEMENT OF HON. STEVE BUYER

Mr. BUYER. Well, Mr. Chairman, I would like to welcome you to Indiana. Indiana is a State of a strong work ethic, strong patriotism, very active Veterans' service organizations and their auxiliaries. We're home of the National Headquarters of the America Legion. And, all you have to do is visit our State Capital in Indianapolis, to see that we have a lot of different monuments that recognize the level of service by many who've come before us. I also want to express my deep gratitude for holding this hearing at the Marion VA campus, and more importantly, for your leadership on the House Veterans' Affairs Committee. Mr. Stump, having served in combat during World War II in the U.S. Navy, you know firsthand the importance of taking care of America's veterans. Since coming to Congress, I've witnessed firsthand your commitment to serving veterans and their families to include those on active duty and their dependents. Under your leadership, Congress has consistently increased veterans' spending above President Clinton's request.

You'll note, Mr. Chairman, for some years there that was a flat-line budget that we had to deal with. There were pains within the system as we moved to streamline different delivery of health care and moving toward outpatient services. Let me take a moment and tell you what we negotiated last year, an unprecedented \$1.7 billion increase in the VA budget. It was great work and I want to extend my gratitude on behalf of veterans here in Indiana and across the country to you. This year, Congress is targeting VA for another large increase of approximately \$1.4 billion. And if you think about it, Mr. Chairman, 2 years ago when the Veterans' Service Organizations testified they had requested an increase of \$3 billion. We're going to be \$4.4 billion, above the—above the

mark that they requested 2 years ago. So, I want to extend my gratitude to you.

In addition, you were instrumental when the House passed legislation to improve the GI education benefits and provide for a 25 percent increase in educational assistance. I'm hopeful that the Senate will act on this legislation. When we begin the conference on the Armed Services Committee bill, I'll make sure that they steer that out of Armed Services Committee and directly to the Veterans' Affairs Committee so you can negotiate it directly in your own conference.

Mr. STUMP. Thank you.

Mr. BUYER. Whether ensuring VA provides adequate health care for sick Persian Gulf War veterans, victims of Agent Orange or radiation exposure, or ensuring VA delivers earned veterans' benefits, your leadership has been instrumental. Your continued efforts on behalf of veterans and their families have resulted in vast improvements in the Department of Veterans Affairs. While Congress and the VA have made significant improvements in the Department, there is still much work to be done. That's why we're here today, to discuss the quality of the VA care, patient and employee safety, and overall management effectiveness. While some of those who present testimony today will raise issues that cast the VA and its delivery systems in a negative light, I also believe there are many good things about the system here in Northern Indiana. As outlined in the VA Inspector General's report dated May 25, there are significant strengths at this facility, the Fort Wayne facility and of the satellite outpatient clinics. For example, the Inspector General noted that the Intensive Psychiatric Community Care, Chaplain Services, POW services, the Pharmacy Service technicians, the infection control surveillance program, and as ulcer treatment programs all received high marks. Nevertheless, when Congress provided for an increase in resources, as it has done, I believe it is also our duty to ensure the proper utilization of the resources.

Again, I wish to express my sincerest gratitude, Mr. Chairman, that you're here today and I reiterate that your commitment to veterans is unparalleled. Veterans and their families should be thankful that we have advocates such as yourself serving in Congress. I'd also like to thank the Marion VA staff for supporting this hearing. And more importantly, for the staff's dedication and commitment toward servicing the needs of veterans. I noted at the end of the IG's report in the Summaries of the Inquiries, that they had focused on 99 issues from 41 individuals. The individuals that were interviewed placed the quality of care, the environment and workplace safety as their top concerns. Their concern was how to deliver quality care to the veterans population and I think that the IG report was a great complimentary to the quality of the employees at Marion. I yield back the balance of my time.

[The prepared statement of Congressman Buyer appears on p. 43.]

Mr. STUMP. Thank you, Steve. Let me say once again that we would please request the witnesses to limit their statements to 5 minutes. I would do that, at 4½ minutes just to give you an indication, if you don't have your watch. Your complete statement, of course, will be included in the record.

The first panel consists of Mr. Alanson Schweitzer, the Assistant Inspector General for the Health Care Inspections. And Mr. Schweitzer is accompanied by Mr. William DeProspero, Chicago Audit Operation Division from the Office of the Inspector General. I'm sorry, I had another name here. And—pardon me. And Miss Verena Briley-Hudson of the same Chicago office. If you would come forward, please.

Mr. BUYER. Will the Chairman, yield?

Mr. STUMP. Certainly.

Mr. BUYER. For housekeeping measures, Mr. Chairman, when I was in the back of the room I noted that there are many different veterans, widows and dependents of veterans who are here and have questions. We have the professional staff of the Veterans' Affairs Committee here to address these questions. Kimo Hollingsworth, from my staff over there, standing next to Art Wu, a professional staffer from the Veterans' Affairs Committee. If anyone has any direct questions related to the quality of care or delivery of the health care system please see the staff. Thank you, Mr. Chairman.

Mr. STUMP. Thank you. Please be seated.

Mr. Schweitzer?

Mr. SCHWEITZER. Yes, sir.

Mr. STUMP. If you would like to lead off, please, sir.

STATEMENT OF ALANSON SCHWEITZER, ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS, OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY WILLIAM DePROSPERO, CHICAGO AUDIT OPERATIONS DIVISION, OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS

Mr. SCHWEITZER. Mr. Chairman and Members of the Subcommittee I am pleased to be here today to discuss—Can you hear me?

Mr. BUYER. Pull the mike closer.

Mr. SCHWEITZER. How's that? I am pleased to be here today to discuss the results of our review of the Department of Veterans Affairs Northern Indiana Health Care System. As you stated, I am accompanied today by Bill DeProspero, the IG's Director of the Chicago Audit Office, and my director of Health Care Inspections in Chicago, Miss Verena Briley-Hudson.

Mr. STUMP. Mr. Schweitzer, if you could pull the microphone just a little closer and speak a little louder, please.

Mr. BUYER. Real close.

Mr. SCHWEITZER. I will talk louder.

Mr. STUMP. Thank you.

Mr. SCHWEITZER. As a part of our cyclic program of reviews of VA field facilities, the VA Office of Inspector General conducted a Combined Assessment Program or a CAP review of the Northern Indiana Health Care System from March 6th to 10th of 2000.

The purpose of the CAP review is threefold: First, health care inspectors evaluate how well the facility is accomplishing its mission of providing quality care and improving access to care, with high patient satisfaction. Second, auditors review selected administrative and financial activities to insure that management controls are effective. And then finally, investigators conduct Fraud and Integrity Awareness briefings to improve employee awareness of fraudu-

lent activities that can occur in VA programs. In addition to these activities, we also examine issues or allegations that are referred to us by facility employees, patients, members of Congress and others. For the record, I'd like to submit our final Northern Indiana Health Care System CAP report, which I ask to be included as part of the record.

Mr. STUMP. It will be made part of the record, sir.

(See p. 111.)

Mr. SCHWEITZER. Thank you, sir. That report contains the details of our review, our conclusions and 17 recommendations for improvement. The report also contains management's concurrence with all of our recommendations, as well as implementation plans that we believe are both responsive and constructive.

To summarize, our review of the Northern Indiana Health Care System covered health care operations for fiscal years 1998 to the early part of 2000. In performing the review, health care inspectors, auditors, and investigators inspected work areas; interviewed medical center employees, managers and patients; and we reviewed pertinent administrative, financial and clinical records. They also examined 26 separate health care activities and 22 separate administrative activities. Although we concluded that the administrative and clinical activities generally were operating satisfactorily, we did make observations and recommendations in several areas that appeared vulnerable to fraud, waste, or abuse, and other areas that were in need of improvement. These areas included, quality of care issues involving long-term care activities for elderly and psychogeriatric patients; the physical, aesthetic and functional condition of patient care areas; quality management and performance improvement; medication policy and availability; patient care services; and employee assistance and training. We've also noted administrative issues involving administration of the South Bend community-based outpatient clinic contract. Accountability and security over controlled substances, narcotics and sedatives; contracting for radiology services; laboratory service staffing; procedures for obtaining surgical informed consents; reviews of Indiana State inspection reports for VA contract nursing homes; control of medical supplies; supply processing and distribution operations; timeliness of agent cashier audits and controls over third-party payer checks.

We also looked at access authority for inactive information technology users and drug prescription backlog monitoring. In addition to these, OIG investigators conducted four fraud and integrity awareness briefings for a total of 65 health care system managers and employees. The briefings included a lecture, a video presentation and question and answer opportunities. Each session provided discussions of how fraud occurs, criminal case examples, and information to assist employees in preventing and reporting fraud.

During the week of our visit, we received inquiries from about 40 patients and employees on about 100 different issues which we categorized into five different areas: concerns over quality of care; alleged mismanagement of VA resources; personnel-related issues; alleged minor unlawful activities; and other miscellaneous issues. A large number of these issues related in some fashion to staffing concerns. We found that the health care system managers were generally aware of the staffing concerns and the implications of re-

sultant decreased staffing patterns. They were attempting to adjust staffing to better provide medical services. For example, they told us that they were initiating a system-wide position management analysis that should ultimately result in realigned staffing patterns that should ensure a logical and effective deployment of direct patient care employees.

Mr. Chairman, this completes my opening statement. I will be happy to answer any questions that you or members of the Committee may have.

[The prepared statement of Mr. Schweitzer appears on p. 44.]

Mr. STUMP. Thank you, sir. Mr. Buyer, questions?

Mr. BUYER. I have a series of questions. Let me congratulate the IG team. This is an extensive analysis. You gave us an excellent snap—snapshot in time of the health delivery system here in North Central Indiana. I have some questions that I'll try to ask sequentially. I'll start from the beginning and head toward the end of the IG report. My questions will follow your order, from the report they aren't in any prioritized order.

Mr. SCHWEITZER. All right, sir.

Mr. BUYER. Just because I bring something up first, it doesn't mean that it's my major focus, all right?

Mr. SCHWEITZER. All right, sir.

Mr. BUYER. What is the impact of your finding that the admission criteria and delineation of clinical responsibilities for the sub-acute rehab program are not clear? You then made a bottom line recommendation that the sub-acute rehab be transferred to Fort Wayne. However, later in the report you said that long-term care should be transferred from Fort Wayne to Marion. Would you please discuss that?

Mr. SCHWEITZER. Well, I—I suppose that—that it's essentially an issue of efficiency. That is, without specific admitting criteria, the patients who are admitted to the sub-acute unit could be patients who either need more clinical resources to care for them or less intensive resources. So, it's better to be able to provide a consistent level of care in the given unit. In terms of the delineation of clinical responsibilities, it's a matter of employees trying to be all things to all patients and it's simply not an efficient way to take care of a group of patients. It's true that it gives the employees an opportunity to know all the patients, but they can't necessarily focus their level of expertise at the individual patient's needs.

Mr. BUYER. Were you able to assess whether or not we're putting undue burdens upon patients, by making them go from Marion to Fort Wayne when their requirement changes from sub-acute to acute care?

Mr. SCHWEITZER. In terms of the recommendation to put the sub-acute unit in Fort Wayne?

Mr. BUYER. Yes.

Mr. SCHWEITZER. It's simply a matter of, as I understand it, placing the sub-acute unit closer to where the acute care is actually being given. That would obviate the need to transfer, possibly ill patients the 55 or 60 miles from Fort Wayne down to the Marion campus.

Mr. BUYER. I noted in the report along with the interviews you conducted with personnel, the issues of patient and employee safety.

Mr. SCHWEITZER. Right.

Mr. BUYER. Have past clinical staffing practices contributed to employee safety issues?

Mr. SCHWEITZER. Well, I—That'd be very difficult for me to answer and possibly better for Dr. Murphy, but I think when you have a sub-standard staffing situation you put both the employees and patients at risk. You can move personnel around to only so much of an extent without there—or before you start reaching a point of diminishing returns. And employees start getting tired by working double shifts. You start experiencing a good deal of overtime to replace employees who call in sick because they're simply too tired to work. And you frequently have to move employees from a well-staffed ward to a lesser staffed ward and possibly raise the— the potential for something serious to happen in that secondarily staffed unit.

Mr. BUYER. Do you have your report with you?

Mr. SCHWEITZER. I do.

Mr. BUYER. When you look at page one at the opening introduction you'll note the budget scenario. Go through fiscal year 1997 all the way to 2000 and notice the medical care budgets. The medical care budgets are being drawn down. When we look at the outpatient and unique patient visits, we notice an increase. What we have is an increase in patient load, and a decrease in the care budgets. It's similar to the Armed Forces. When you cut budgets or you increase operational tempo and you reduce staff, you stretch the force. It is the same way in our health delivery systems, if you increase the patient load and decrease medical care budgeting, then we'll start hearing concerns from the work force.

Mr. SCHWEITZER. Right. And the transition between inpatient care and ambulatory care is still an issue that VHA nationwide is struggling with and trying to achieve the balance of employees that they need to take care of the—the ambulatory care patients versus the remainder of the patients who are in the inpatient setting.

Mr. BUYER. I note that when you look at 1999 and then fiscal year 2000 and 2001, we are spending a lot of money. We've negotiated those budgets and put a lot more money into the system. Perhaps the money is not being distributed properly. Even though we're sitting here in Marion, the Chairman's concern and mine is for this region. So it's Fort Wayne, Marion and the satellites. Your report was also very critical of the sanitation and the cleanliness of the Fort Wayne campus canteen. Would you eat in that canteen?

Mr. SCHWEITZER. Well, I have eaten in that canteen but given the tenor of the report I would hesitate. My understanding is, though, that as soon as my team talked to the director about it, he took immediate action to be sure that it was brought back up to standards.

Mr. BUYER. All right. Would you comment on the pharmacy management issues in your report, specifically about the breaches of medication security and inconsistent availability of medications. And if you could also mention the poor reporting of particular incidents and how it raises questions in the peer review process.

Mr. SCHWEITZER. Well, there are several issues with medication and controlled substances security. My inspectors did find medications lying around in unexpected areas without being secured properly. For example, there was a refrigerator in the ICU, I believe in Fort Wayne that had narcotics sitting in it but the medication—the refrigerator—there's a compartment in the refrigerator that is subject to being locked, it wasn't secured. There were other medications found in non-patient care areas, such as an office across from the ICU. So, things such as that. Crash carts were secured by locks that are easily broken and easily replaced from the commercial market.

Mr. BUYER. Miss Hudson, do you have a comment on this? You're leaning forward in the chair.

Ms. BRILEY-HUDSON. No, actually he covered it very well. And of course, the utmost concern is that all medications are locked and secured, particularly controlled substances, which must be double-locked in all facilities. Because we have patients who are unable to sometimes ascertain what's going on with them, they may take medications as well as visitors, families, others who may have another use to pick up medication. So, it's very important to keep medications secured and such.

Mr. BUYER. I have very strong concerns about the South Bend Community Based Outpatient Clinic and the fact that you're going to rebid the contract. It raises some concerns that these satellite outpatient clinics are adequately supervised. Something went wrong in Fort Wayne. Would someone from the IG team please comment on this.

Mr. SCHWEITZER. I'm gonna defer that to Mr. DeProspero.

Mr. DEPROSPERO. Yes. Congressman, Mr. Chairman, I would say that the South Bend Community based outpatient clinic was an experiment that showed us what not to do in the future in such clinics. It was one of the first, if not the first, contracted CBOC. And because the Department of Veterans Affairs medical system was going to a capitation based funding it was thought that a capitation based funding mechanism for this clinic would be a good idea. And, therefore, we contracted with a local HMO in South Bend and we said, "We will pay you \$36 per enrolled veteran per month for you to take care of all of their health care needs." I would say that the contractor did not perform effectively. For one thing, they did not adequately document the care, or at least did not timely document the care that was provided, even though VA was paying on a per capita basis for each of the veterans who was seen in the facility. In some cases the HMO was also billing Medicare, a matter that we referred to our office of investigations for coordination with HHS. In addition, the medical center staff were not dis-enrolling veteran patients who did not use the facilities. In other words, with enrollment we estimate the number of patients who will use the facilities and we pay on that basis. If a veteran patient chooses not to use that facility in a 45-day period, we should dis-enroll and stop paying for that veteran until and unless he or she decides to use the facility. So, as a result we were paying approximately \$237 per veteran visit using the per capita funding method, which was not efficient. The administration at the hospital has told us that they are planning to let a new contract for the CBOC which will take

into consideration all of the criticisms we have of the current contract. And we feel confident that the next time out they'll have a CBOC that is providing the best for the veterans and the best for the taxpayers.

Mr. BUYER. I have a comment and then a last question, Mr. Chairman. I appreciate the level and depth that you went into concerning staffing issues. I think that your recommendations and the concurrence by the Director will lead to external reviewers coming in and reassessing the staffing levels here. Then we can go in and do a reassessment of the proper budgets to make sure it happens. It's the right thing to do. So I want to thank you for that.

Mr. SCHWEITZER. Thank you.

Mr. BUYER. This is a tough question to ask. You've put in a lot of time doing this assessments and, and I need for you to give me your assessment of the overall senior management here at the Marion VA Medical Center.

Mr. SCHWEITZER. I'm—all I'll give you as my thumbnail impression is that they're a very competent team. I say that because during the CAP review, the team leaders briefed medical center managers usually on a daily basis to let them know what the findings on any given day are and what they think should be done about them. Of course, managers also are gonna do what they think is best for their medical center. And my understanding is that each day that our team leaders brought issues to Dr. Murphy, they were aware within 24 hours that he was taking affirmative action to repair or to fix some of the issues. Case in point being the—the patient safety issues in the psychiatry building. Many of the issues that are discussed in the report were being—were in the process of being repaired within 24 hours after we presented the issues to Dr. Murphy. Not all medical center directors respond that quickly. And I think that speaks well of his resolve to ensure a safe patient environment in this medical center.

Mr. BUYER. Does the rest of the panel concur with his statement?

The PANEL. (Panel nods.).

Mr. BUYER. They nod in the affirmative.

Thank you, Mr. Chairman.

Mr. STUMP. Thank you, Steve. Mr. Schweitzer, thank you. And Mr. DeFlors—DeProspero—I'll get it right—and thank you, ma'am, for your testimony.

If we can get our second panel to come up, please. Dr. Michael Calache, staff psychiatrist at Marion VA; Mr. Bill Overbey, president of AFGE Local 1020; and Mr. Steve Stewart, Marion VA employee. Please be seated.

Doctor, do you care to lead off, please.

STATEMENTS OF MICHEL CALACHE, M.D., MARION VA STAFF PHYSICIAN, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; BILL OVERBEY, PRESIDENT, LOCAL 1020, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES; AND STEVEN STEWART, MARION VA EMPLOYEE, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF MICHEL CALACHE

Dr. CALACHE. Mr. Chairman and Honorable Members of the Subcommittee on Oversight and Investigations. It's a privilege for me to be trusted to serve as a witness to your investigative panel. Over the past 3 years there have been tremendous changes in the VA in Marion. Many of these changes are positive due to the hard work of the current administration and employees of this medical center. I'm reporting disappointments and fallacies in our facilities. This should not undermine the progress already made. More importantly, I do not mean to blame, defame, degrade or judge others, but only to testify to the best of my ability. I'm going to talk about safety and then staffing and management. Regarding safety, on January 14, 2000 around 3 o'clock p.m., I survived an attempted murder by one of my patients when I was in the nurses' station on unit 172-2-E. My recovery up to this time has not been easy. I need to bring to you some of my concerns and disappointments regarding this incident. I ask myself, how could the patient walk in the hallway of the unit with a belt wrapped around his wrist without being noticed? Why did the nurse sitting between the patient and myself not see, hear or respond to the patient's threats? Why was the patient, whether agitated or not, able to enter the nurses' station, unnoticed and unchecked by staff? Was it because they were inattentive, or they were overly preoccupied because of their overload and the shortage of staff?

While I was in the hospital my superior called me for the first time after the accident. She was unempathic in her statements, to say the least. I felt provoked and angry. I'm disappointed that despite contradictory statements between myself and nurses and the clerk on 2-E, as reported by outside investigators, the administration remains indifferent and is seeking—and is keeping its silence by avoiding addressing this issue. Also, I requested that work—work—my workman's comp papers to be filed as soon as possible starting February 29. Six or 7 weeks later I was told that my papers were not submitted as I—we had agreed. I was then told that I must go on leave without pay for 2 to 6 weeks before I would receive these benefits. Three weeks ago, I was surprised and shocked when I was called by the engineering department stating that I need to come to their office to sign lease papers for 6 months for renting quarters on the grounds. I have the hope and the right to go back to work within 12 months after my injury. The problem was quickly fixed, but this insensitivity caused additional stress and frustration to me.

Regarding staffing and management. On call duties: Psychiatrists are required to provide emergency medical care to patients admitted to the medical floor and the admission area. Psychiatrists in this facility have repeatedly expressed their dissatisfaction re-

garding this issue. The administration disregarded their concern. It is not the standard of care in the VA nor in this country and does not represent an excellence of care. In fact, I believe that this is the only VA hospital in the country which provides such type of care. It is not true that primary care physicians who live on grounds were willing to come to the hospital after hours whenever there was a need. I personally discussed this was—this was—with those living on grounds and denied that. I believe there are other issues that are in the report. And I'd like to thank you for this opportunity to express my feelings to you and be heard. This means you are concerned, empathic about what happened to me and do not wish this to happen again to me or to my coworkers. Also, I am thankful that this report will be available to you and that you'll make it available on the internet. It will be up to you, the media and the veterans to judge and decide.

Mr. STUMP. Thank you, Doctor. We'll hold the questions until the entire panel has testified. Mr. Overbey.

[The prepared statement of Dr. Calache, with attachment, appears on p. 50.]

STATEMENT OF BILL OVERBEY

Mr. OVERBEY. Chairman Stump and Representative Buyer, my name is Bill Overbey and I'm the local President—

Mr. STUMP. Could you pull the microphone over just a little bit, sir.

Mr. OVERBEY. Chairman Stump and Congressman Buyer, my name is Bill Overbey and I'm the local president of the American Federation of Government Employees which represents all non-managerial employees at the Marion Campus of the VA Northern Indiana Health Care System. It is not my intention today to lay blame on any specific person or persons. Rather it is to address specific problems and issues at this facility that are adversely affecting service delivery to our veterans. To ignore, delay or deny the existence of agency-wide problems serves only to perpetuate and promote low staff morale and deteriorates our ability to provide high-quality patient care.

My comments today are guided by two key principles. One, veterans' health care needs are unique and veterans are entitled to medical care that is provided by employees whose training and focus is dedicated to serving only veterans. Two, it is the front-line health care workers and support staff that give meaning to VA's mission.

I want to speak on four issues today that are crucial to improving quality of veterans' health care. One is inadequate staffing levels. The second is the use of private contractors to replace federal employees to provide medical services and support services to veterans. The third is arbitrary budget constraints. And the fourth is the integration of the Fort Wayne and the Marion VA Medical Centers to create the Northern Indiana Health Care System.

Staffing levels: Even the most professional and dedicated employees cannot provide adequate, let alone world class, quality health care without proper staffing-to-patient ratios, adequate support staff and supplies. Adequate numbers of well-trained staff are essential to manage workloads, to prevent harmful delays in care, to

avert medical errors and improve services. Downsizing by means of attrition has been the standard operating procedure to reduce staff at the VA Northern Indiana Health Care System. However, the result of this management practice has created dangerously low staffing levels across the board for direct patient care and related ancillary support services. Both voluntary and forced overtime are used by management in an attempt to compensate for the negative effects of chronic understaffing and downsizing. Management is relying on overtime in an attempt to provide minimum nursing staffing levels on all 24 hour shifts, 7 days per week. There are times when, even with this overtime, the minimum staffing levels are still not met.

The DVA often wants to ignore the real effects that low staffing levels have on the veterans' care. For example, the national DVA's analysis of reporting medical errors does not call for an analysis of whether the staff-to-patient ratio was adequate, whether staff were involved on overtime, or whether staff involved were performing additional duties beyond their regular duties because of staffing shortages. Understaffing in the direct patient care areas puts patients and staff at an increased risk for potential danger and harm. Psychiatric and Extended Care Units simply cannot function safely with inadequate staff. In the past few years in the Marion division of VA NIHCS there have been numerous employees attacked and assaulted, including a brutal assault and rape and a recent attempted murder. AFGE strongly feels that all of these critical incidents could have been averted with properly trained and adequate staff.

I want to talk about contracting. AFGE believes that veterans are best served by a unique veterans' health care system that is dedicated to serving only veterans. The DVA researchers, clinicians and other health care employees have focused their practice on the unique illnesses and disabling conditions that affect veterans as a result of their military service. The DVAs nationwide experience with private contractors shows serious problems in monitoring quality of costs. In a 1996 study, the GAO found that roughly two-thirds of medical centers didn't even monitor contractors for basic performance indicators related to the quality of care such as rate of patient deaths, whether patients had bed sores, infections, or had visits to the emergency room. As in the case of our Muncie-Anderson Community-Based Outpatient Clinic, contractors are frequently paid on per-patient basis, regardless of the costs of the patient. Under such arrangements, treating healthier veterans and using fewer diagnostic tests and providing less costly treatments maximizes profits. Decisions for a veteran's care should be driven by that veteran's health care needs and the professional, independent assessment of DVA employees and not those of contractors whose primary interest is profit. In addition to the quality of care concerns raised by the DVA's increased use of contractors to provide veterans care, there's also the issue of cost. DVA rarely, if ever, performs any adequate cost comparisons of whether it is more efficient to use contractors or DVA employees to provide veterans with health care services. And this is the case with our Muncie-Anderson CBOC. There has never been, nor is there any intention to do, a genuine cost comparison study between the current contrac-

tor-operated CBOC and a federally staffed CBOC in the Muncie-Anderson area.

Some other negative effects of the contracting out that we've experienced: When our laundry operation was being done in-house at Marion, it was completed in a highly efficient and well-done manner. The turn-around for the laundry was generally no more than one day and patient clothing was neat, pressed, dried and clean. Now, under the contract model, if the patients are lucky enough to get their clothes back, they're often badly smelling, they're damp, wrinkled, stained.

Due to budget constraints under the current VERA funding model, VA NIHCS management has deemed it necessary to discharge VA Nursing Home Care veterans, long-term psychiatry, and extended-care patients to community nursing homes where they do not receive the same standard of care that the VA provides. Many of these veterans are former POW's and Purple Heart recipients. AFGE strongly takes exception to this policy of indiscriminately discharging any patients who have honorably served their country when they were called. The discharge criteria has gone from being appropriate for community care to how much money can VA NIHCS save by getting rid of the veterans out of the wards. AFGE asserts that veterans health care needs are an entitlement and local facility management should not have the authority to determine who will receive VA health care services.

And in closing, I would like to discuss the integration. It is the position of AFGE that the integration of the Marion and Fort Wayne Medical Centers to create the Northern Indiana Health Care System has been a failure in terms of achieving the intentions and objectives of the integration. Mr. Chairman, since the Inspector General's Office reports to the House Veterans' Affairs Committee, I am requesting that you direct the IG to do a comprehensive review of the VA Northern Indiana Health Care System integration from a quality management, efficiency, customer satisfaction and access standpoint. I would like for you to do an evaluation of the integration based on the original concept for which the medical centers were integrated. If, as I think, the integration of the two medical centers 60 miles apart has, in fact, increased the cost of patient care and has not met any of the objectives of the integration.

Chairman Stump and Representative Buyer, I want to thank you for holding this hearing in Marion and I want to ask for your support in ensuring that VA workers have the necessary resources to continue to provide the unmatched quality of service that our Nations veterans deserve. Thank you.

Mr. STUMP. Thank you, Mr. Overbey. Let me remind you that your entire statement will be included in the record and will be scrutinized by staff and other members of the full committee. Thank you. Mr. Stewart.

[The prepared statement of Mr. Overbey appears on p. 61.]

STATEMENT OF STEVEN STEWART

Mr. STEWART. Thank you for coming, Chairman Stump. I represent a group of employees that are union stewards that represent the employees in all the matters pertaining to altercations with management. My statement will be brief, but there are some things

that need to be said. Partnersshipping, as it is supposedly had in our contract is nonexistent here. We've had several problems with that. At different times we've had a partnership; other times we have not had one. They recently—we've started one. It's too early to tell whether this thing's gonna go or not on the partnership. When you approach management they—it's a common knowledge among the union stewards when you have an employee that's in trouble, that management around here practices the four D's of management style, that is delay, deny, defend and try to destroy the issue or distort it. We—we have long-times, especially on our patient abuse cases; people are displaced and put in other areas. We've tried to shorten this process. At one time the chief nurse was willing to do that with us. However, it went to the director's level and I don't know where it went from there. But the process was delayed or done away with. We are still under the same process. It has a lot to do with the staffing problems. Our staff is dislocated during these investigations and are not using any kind—are not being used to any useful service. Plus the fact that it's just not the way we do things around here and. . .

Getting back to some of the other things. The performance appraisal system as it is right now, the pass/fail, in my opinion, it is management's opportunity to not rule. We—we have high-level employees that are never recognized. We have disparity between worker groups and some people are rewarded, some people are not. And that's just the way it is.

Broad banding—I've been told about broad banding. This is management's term for combining jobs, making—making you—making a worker do two jobs as opposed to cover—because of the shortages, generally for the same compensation. I don't have to tell you that—that doesn't do much for morale. Just the total employment picture for the people that are left after these—these cuts is very bleak at best. And people are being asked to do more with less. And these staff shortages have got to—some—someplace down the road we gotta stop and we're gonna have to put this thing back together, labor and management. We're at each others' throats most of the time. Some way or other, this has got to be put back together and be worked into a workable facility. That's just not the case now. That's the only thing I have.

Mr. STUMP. Thank you, Mr. Stewart.

[The prepared statement of Mr. Stewart appears on p. 71.]

Mr. STUMP. You said—you mentioned something about disparity between working groups. And I assume that you're speaking of salary or hours or seniority?

Mr. STEWART. Well, awards and—and a lot of times awards are not—we have a committee that does this. I've never seen minutes from it. One group may—it seems likes one group will—may get something and the other groups do not. And we don't—and we as a union don't understand this policy at all. And I don't suppose any union would. But that's—that's the problem there.

Mr. STUMP. Is this contrary to the contract you have with the VA?

Mr. STEWART. We have a contract with Veterans' Administration. I have a copy of it here today. We have an awards committee and that's—and they're—and they're totally responsible for this.

Mr. STUMP. Mr. Overbey, let me ask you. How is the union's relationship with management here at Marion?

Mr. OVERBEY. It's really increased in the past 30 days. But prior to that—prior to that it's a—it's not very good—it wasn't very good.

Mr. STUMP. What's the significance of the 30 days? Is that when the notice went out on the hearing?

Mr. OVERBEY. I believe so, yes.

Mr. STUMP. All right. Thank you, sir. From your perspective, what would be the most important thing that you could do to improve relationship with management?

Mr. OVERBEY. Well, I—Boy, that's a tough one. Well, we have to be able to take the boxing gloves off and we have to be able to walk in the room together and sit down and collaboratively work together to resolve the problems that we have and the issues that we have in the best interest of the staff and the patients—for everyone.

Mr. STUMP. Would that include the seniority clause. You mentioned—

Mr. OVERBEY. Correct.

Mr. STUMP. It's no wonder the union members are unhappy. I think I would be too. But if you make changes in the seniority system, I understand you would have to negotiate these with management, if those were made, would that improve the seniority system alone, would that improve the workplace and the environment here at Marion.

Mr. OVERBEY. Well, you're going to have some people that will be disappointed and some people that would be in favor of it, obviously. As our seniority definition is right now, we have the local authority to define seniority for days off—preference of days off, preference of—of tours of duty, annual leave, things like that. For all other purposes, the master agreement says that seniority will be defined as service computation date. Some employees are not happy; they do not like our current seniority definition. I do not like our current seniority definition. But I have said repeatedly to everyone, that it will be the employees that will determine what that seniority definition will be when we negotiate a new local agreement. I really don't think that management has a dog in that fight. I think that will be a—a debate between the employees themselves.

Mr. STUMP. Thank you. Let me say at this point that written questions may be submitted to you to answer for the record—you and the rest of the witnesses. If you could promptly answer those for the record as quickly as possible it would be appreciated.

Mr. STUMP. Mr. Buyer.

Mr. BUYER. Thank you. Doctor, I'd like to thank you for coming here today and submitting your written testimony. Your assault this past January was very physically and mentally traumatic. Your recovery has understandably been slow. But I don't think anyone should be subjected to what happened to you, or what happened to the nurse. I read the report of the incident and the report and the actions that the staff took after the incident. It's part of our culture, I suppose. We take massive corrective actions after a terrorist bombing or an airline disaster whenever something terrible happens. I am hopeful that a hearing like this when the IG

comes in and does their assessment, will lead us to take presumptive action. It's why Mr. Stump and I on the Armed Services Committee work so hard during times of peace to make sure that we're prepared and ready to respond. So, let's not wait for another incident. You've had a lot of time to be reflective in your rehabilitation. In your statement you mentioned how you were being treated during the recuperation. That's very disturbing to me. No one should be treated like that. You stated the—that the VISN did not have a uniform basis for establishing staffing needs for your service. How would you compare Marion and Battle Creek VA in Michigan in terms of patient populations and clinical staffing?

Dr. CALACHE. I cannot be very specific but I can share with you my—my opinion and my feelings about it. I have been told from a field visit by staff—multi-disciplinary staff from this hospital visited Battle Creek maybe a month ago, maybe more—that the inpatient population in Marion is larger; the outpatient population in Battle Creek is more intensive. However, we do have seven full-time psychiatrists in Marion and five full-time psychologists, while Battle Creek had 14 full-time psychiatrists and 14 full-time psychologists. That came as a parallel finding or observation why we were trying to organize the service in Marion. We requested a basis for staff—assessing staffing needs. How many patients and what type of patients needs how many doctor? And we did request through the union to provide this information to us both in psychiatry and in primary care. The basis of staffing was gradually formulated by the chief of primary care and several months later and up 'til now, there is no formula for how many—what's the basis of hiring how many, and how many do we need. We know we are stretched out but how much and how many do we need. And by extending that concern and that problem trying to fix here, we came to realize that the administration is comparing the staffing between this hospital and Danville VA, which is in the same VISN and Battle Creek; and there is no uniform basis to define staffing needs, physicians, psychologists, social workers or even clerks. And I—we—when—we talked to our chief for several months about it and we are not going anywhere.

Mr. BUYER. Now, when you testified to the numbers at Marion versus Battle Creek?

Dr. CALACHE. Uh-huh.

Mr. BUYER. The Marion VA provides similar services but to a larger inpatient population; would that be correct?

Dr. CALACHE. Correct.

Mr. BUYER. So, would a proper systems analytical approach be that the problem is more at VISN?

Dr. CALACHE. Well, first problem, we didn't have the VISN. The hospital—the chief of the service needs to be able to say we need so many psychiatrists, so many psychologists because our—the number of veterans we serve are 10,000, 20,000 whatever, and these are their needs; these are long-term, these are acute and these are outpatient. In addition to that, the administration by trying to find a solution and—and answers to our question, is comparing other institutions, long-term institutions competing amongst themselves in the VISN. And I realized then that maybe that we do not only need a definition for basis of assessment of staff need

in the Marion VA, we need it maybe through all the VISN's service for all the (inaudible).

Mr. BUYER. Thank you.

Mr. STUMP. Thank you, gentleman. You're excused.

If we can have the Veterans Service Organization come up.

Mr. BUYER. Mr. Chairman?

Mr. STUMP. Yes.

Mr. BUYER. May I—

Mr. STUMP. Oh, I'm sorry.

Mr. BUYER. May I ask another question?

Mr. STUMP. I thought you were through.

Mr. BUYER. I have two more questions.

Mr. STUMP. I apologize to you, Mr. Buyer.

Mr. BUYER. I apologize. To Mr. Overbey, in your written testimony you devote a lot of time to the staffing concerns and you have testified to that again today. However it caught my attention when you commented on Marion's requirement to have the right workers in the right places at the right time. How that's a nice little statement but can you tell me what you meant by that?

Mr. OVERBEY. I think if you were to look at our overall—the amount of salary dollars—and I think I put that in there—but the amount of salary dollars that we spend annually and the workload that we have, it would probably come out to lead one to believe that we're adequately staffed. But the numbers do not differentiate between those people who are actually providing the direct patient care and those who are not. We have a multitude of employees that, in AFGE's opinion, really contribute very little or nothing to our mission here. And while we don't want to see anyone—we're not suggesting that anyone be removed or anything like that. But we would like to see employees—the work distributed a little bit more fairly. We have some employees, managers and bargaining unit alike, that work amazing amounts of hours. I mean, they're here until 8 or 9 o'clock at night and they're here on weekends and holidays; and we have some other people that really their workload is—is—is not very great. And the challenge is, I don't know how—exactly how to do it, but the challenge is to get the people willing to work harder so we don't have one person really overloaded with work and one person with not a lot to do.

Mr. BUYER. Mr. Chairman, I think that Mr. Overbey's testimony, along with Mr. Stewart covers a litany of issues that we won't be able to cover here today. If we could have the medical director respond to those issues that have been raised and submit answers those to the Committee, it would be very helpful.

Mr. STUMP. We will see to that, yes. We'll take it up with the medical director. I think it's only reasonable that they ought to do that.

Mr. BUYER. Thank you. I sensed that when the Chairman asked you how the relationship was going that you said it's improved in the last 30 days. What this is about, is that management and the work force are running parallel. Your concerns are the same and how you get there may be different, which means communication between you is everything.

Mr. STUMP. Agreed.

Mr. BUYER. What we're hopeful for is that by getting a good snapshot at this hearing, that we can discuss the concerns with regard to staffing and its impact on quality care. We're also learning that maybe this is also coming from a little bit higher up also. What are your recommendations that you think could help bridge the gap in communications between yourself and management?

Mr. OVERBEY. Well, I think I testified earlier. We just have to be willing to—to end the adversarial role and sit down as—as cooperative partners working together. That would take effort from both sides. And I don't know if—frankly if either side is willing to commit to that at this point.

Mr. BUYER. Well, I'm most hopeful that you are.

Mr. OVERBEY. Well—well, I am. But I'm unfortunately one person out of a large organization.

Mr. STUMP. Gentleman, yield with that?

Mr. BUYER. Yes.

Mr. STUMP. You said cooperative agreement; has there been any hesitancy on the part of your management, so to speak, to sit down and negotiate in a serious manner?

Mr. OVERBEY. Yes.

Mr. STUMP. There has been?

Mr. OVERBEY. Yes.

Mr. STUMP. Thank you. Thank you, Mr. Buyer.

Mr. BUYER. Well, I noticed that it's part of your request for negotiating a new employee contract.

Mr. OVERBEY. Yes.

Mr. BUYER. I'll even ask Marion's director about his willingness to negotiate. I believe he has a legal obligation to do that and we'll be interested in hearing his response. Let me ask one last question, Mr. Chairman, before I yield back to you. Mr. Stewart, you raised questions about the disparity between working groups and then you mentioned that some aren't necessarily being rewarded. That can be very sensitive and can affect morale of the work force. I appreciate your testimony here, Mr. Stewart. I've known you for a while and you've always been such a straight shooter with me. I applaud your dedication. Would you tell us more about how the new performance appraisal system fails to work for lower-level employees and leaves them without cash awards?

Mr. STEWART. The new pass/fail system, as I see it, just essentially says you meet all your standards or you don't meet all your standards and you get training to—so that you would meet your standards. This is the old—the new system. The old system had several different categories of employees. There was an "outstanding;" there was a "highly;" there was a—"there was a "met;" there was a "minimal;" and then there was a—what was the last one? If it's not met, it was "failing." Most employees fell in the fully. I mean, it was a very archaic system. It didn't work, it was replaced. However, what—what I'm saying and in my statement is what it was replaced with was not adequate either. Employees were rewarded for highly and outstanding, depending on the budget constraints of that particular year. Most employees fell in the fully. However, most employees feel they're worth more than just fully. The problem was that the fully's were never rewarded with anything. And it was easy for the managers to go with the fully be-

cause they did not have to document anything other than—if it's a fully, they did not have to document. If it was highly or an outstanding, they would have had to document that. What I'm saying is what you replaced it with just made is easier for the managers to not rate the employees as a full—a pass/fail system. It's not working and it's not fair.

Mr. BUYER. Mr. Overbey, would you concur or non-concur with Mr. Stewart's assessment?

Mr. OVERBEY. I would concur with that.

Mr. BUYER. You know, sometimes we make changes to improve things and then the changes don't deliver the positive impact that you thought they would. Then reassessments need to be done.

Mr. OVERBEY. I would like to clarify one thing on my comment, if I may. My comment earlier about both sides being willing to sit down—willing to sit down and work cooperatively. I think that—that the reason for that is a missing layer or level of trust. There's mistrust on both sides and this is something that—I mean, this situation hasn't developed overnight and it's not going to, you know, fix itself overnight. I think it will be a long, challenging process but I think we can get there if both sides are willing to commit to that.

Mr. BUYER. Mr. Overbey, reinforced by your oral testimonies the Chairman and the staff may walk away from here with the opinion that no one can point and say the problems are caused by budget problems. That just can't happen. We can't add \$4 billion to the VA system over the last couple of years and for then have someone say, oh, it's because of budgets. That just fails. I yield back.

Mr. STUMP. That was correct. Gentleman, Mr. Buyer used the term snapshot. That we're getting just a snapshot of what's going on. In a sense, that's true. It's unfortunate we don't have enough time to hear every word that everybody wants to offer today. But that's the reason for questions. After we get back and review your testimony and staff reviews it, we will have questions and we will expedite those to you; and if you in turn would expedite those back to us we keep the record open and we will get the answers, and that goes for both sides. Thank you, gentleman. Now if we could have the Veterans' Service Organizations.

Mr. BUYER. Mr. Chairman, I feel like we're in Montgomery, AL. Summer's arrived.

Mr. STUMP. All right. We'll have to just take a little—not a break to leave the room, we'll give the recorder time to change paper here.

[Recess.]

Mr. STUMP. On the third panel we have Mr. John Hickey, Director of Rehabilitation, American Legion, Indiana Department; Mr. William Caywood, Commander of the Indiana Department of DAV; and Mr. William Hahn, Past 5th District Commander of the VFW. Gentleman, welcome. And Mr. Hickey, if you would like to begin, we're ready. Thank you.

STATEMENTS OF JOHN HICKEY, DIRECTOR OF REHABILITATION, INDIANA DEPARTMENT, THE AMERICAN LEGION; WILLIAM CAYWOOD, COMMANDER, INDIANA DEPARTMENT, DISABLED AMERICAN VETERANS; AND WILLIAM HAHN, PAST 5TH DISTRICT COMMANDER, VETERANS OF FOREIGN WARS

STATEMENT OF JOHN HICKEY

Mr. HICKEY. Thank you. Dear Mr. Chairman and members of the subcommittee, The American Legion Department of Indiana appreciates the opportunity to express our views on quality of the care and management issues at the Marion Campus, Department of Veterans Affairs Northern Indiana health care System. As you know, Marion, IN and Fort Wayne, IN VA Medical Center facilities have been merged together into the Northern Indiana Health Care System. This makes it difficult to discuss management and quality of care issues of one facility without also including the other facility. Overall, the American Legion Department of Indiana enjoys a good working relationship with the Northern Indiana Health Care Systems management staff. Whatever concerns we bring to their attention are answered in a timely and courteous manner. We may not always agree with their answers, but solutions to some problems are sometimes beyond their means. We have, though, several concerns including: Number one, market penetration; number two, the practice of consistently contracting out physical medical services normally provided and expected at major medical facilities; number three, long waits for appointments in certain speciality clinics; and number four, employee relation problems between the two different unions at each medical center campus.

Our national organization informs us that the national mean market penetration rate, that is, veterans using VA health care compared with eligible veterans, is 14.21 percent. We understand, though, that the Northern Indiana Health Care Systems penetration rate is less than eight percent. We also understand that the Marion campus has very limited physical medical doctor staffing. This causes a need to transfer many veteran patients to either the Fort Wayne campus more than 60 miles away or to the local non-VA hospital for usual health care needs. For instance, we have found that the Marion facility transfers patients experiencing cardiac emergency-like symptoms to the Marion General Hospital. The answer we received for this practice is that the Marion VA facility does not have enough veteran patients to justify staffing of additional medical doctors. Possibly, the medical—the Marion facility could have an adequate number of patients for this purpose if it would work to reach at least its fair share of VA's overall penetration rate. Our National Organization also informs us that as of July 31, 1999, Northern Indiana Health Care Systems waiting times for geriatric—geriatric clinic appointments were 160 days and urology clinic appointments were 100 days. With the average National VA geriatric population now exceeding 35 percent, adequate staffing of urology and geriatric clinics should be a priority, not an afterthought. These waiting times are simply not acceptable to The American Legion and honorable combat veterans of WW II. It is hoped that this problem has since been resolved without simply transferring long waiting times to other speciality clinics.

During a site visit at both facilities last September, the two separate unions at each facility seemed to blame patient care problems on management focusing too much on the other facility. In response to this, our National Field Service Representative wrote in his report quote, Someone must step forward and explain not only the benefits of team work, but the meaning as well, unquote. It is also hoped that management and the two unions have since worked to resolve their differences. Evidently through testimony today, they have not. What we see is a stressed medical care system attempting to perform the best job possible with very limited resources. Each year The American Legion and other service organizations petition Congress for adequate VA health care funding, and each year Congress and the President falls short on their commitment to veterans' health care. VA budgets hardly keep pace with inflation, while at the same time VA managers are asked to maintain a high quality of health care services, increase patient case load, and increase services in special areas, such as geriatrics, hepatitis C treatment, prosthetics, and extended long-term care. Continued pressure on VA management and VA employees without adequate resources will simply stress the system to the breaking point. The American Legion has a plan called the GI Bill of Health and we have been trying to have it passed into law for several years. If it becomes law, the GI Bill of Health would allow VA to treat all veterans and their families by obtaining funding from resources other than just the Federal Government. If the Federal Government believes budget restraints present it—prevent it from offering veterans and their families the health care veterans have earned and deserve, it's about time Congress passed all aspects of the GI Bill of Health into law. Mr. Chairman, that concludes our statement.

Mr. STUMP. Thank you. Mr. Caywood.

[The prepared statement of Mr. Hickey appears on p. 72.]

STATEMENT OF WILLIAM CAYWOOD

Mr. CAYWOOD. Mr. Chairman and members of the Subcommittee, good afternoon. My name is William Caywood, Commander of the Disabled American Veterans Department of Indiana. I am pleased to provide you with the views of more than 20,900 members of the DAV and our Women's Auxiliary. I have prepared a written response to your invitation and ask that the entire statement be entered into the record. I would like to take the opportunity to express DAV's appreciation for the leadership, compassion, and expertise Linda Belton, Director of Veterans Integrated Service Network (VISN) 11. Because of her leadership and openness, last year members of Congress were able to hear that without additional funding, Network 11 was facing a shortfall that would not have enabled the network to maintain services.

For VA health care providers and veterans, it is troubling that as a result of the balanced budget agreement, VA health care funding was flat-lined for 3 consecutive years. Although the total veteran population is declining, the demand for health care by sick and disabled veterans is rising. Congressman Buyer, within the 5th District—Congressional District of Indiana, VA reports that there are over 60,000 veterans using over 23 million in medical services.

Facility reorganizations are not inherently detrimental to the VA health care system. Reorganizations that are solely budget-driven that decrease services and access and imperil the VA's veteran-focused programs, must be opposed.

Earlier this year, the DAV heard a number of stories from demoralized and frustrated health care workers, including physicians and nurses. As the Marion campus—at the Marion campus, we have heard that clinicians are being limited to a 15-minute appointment time to provide primary care. This limited treatment time would not necessarily be bad, if it were not for the fact that the clinician's schedule also requires that he or she perform administrative details during the appointment rather than devoting the time to the patient. In other words, trained professionals have to perform administrative duties in addition to their clinic—clinical duties. This is all the result of staffing reductions due to insufficient budget resources.

Last year, the Congress heard testimony and received objective evidence that enabled the full committee to justify the \$1.7 billion increase in the VA's appropriation for health care. For this, the veterans' community is thankful, because a fourth consecutive flat-lined budget would have decimated the VA health care system.

Recently the VA National Mental Health Program Performance Monitoring System released its physical—fiscal year 1999 report. This report contained the Mental Health Program performance report card for fiscal year 1999. It is noted that out of 22 networks, VISN 11 had an average rank of 18.2. What these statistics tell us is that, in this VISN's attempt to do more with less, the needs of mental health patients could not be met. This inability should not be looked upon as a fault of the network, but as a fault of Congress for not providing sufficient funding levels.

Last year, the DAV and members of the Independent Budget (IB) requested an appropriation of \$20.3 billion for veterans' health care for fiscal year 2000 to keep pace with the rising health care costs of our Nation's sick and disabled veterans. But this past Monday the DAV in Indiana joined forces with hundreds of others and conducted very successful voter registration drives at VA Medical Centers in Marion, Indianapolis and Fort Wayne. The purpose of these rallies was to involve more people in the election process, to tell Washington to keep America's Promise to our Veterans. This year, the members of the IB have asked the Office of Management and Budget, the Administration, and Congress to appropriate 20.766 billion for medical care in fiscal year 2001. The 2001 IB request is approximately \$1.9 billion more than this year's appropriation of 19 billion. Assuming that there are no new large-scale military engagements, the veterans population is expected to decline from 25.1 million to approximately 20 million in 20—in the year 2010. While the number of veterans is projected to decline in the future, the health characteristics of the veteran population served by VHA will actually result in increased demand for health care services. The DAV's sole mission is building better lives for America's disabled veterans and their families. We ask that you and your colleagues in Congress assist us in fulfilling our mission. Again, thank you and the Committee for taking the time to hear our concerns.

Mr. STUMP. Thank you, Mr. Caywood. Mr. Hahn.

[The prepared statement of Mr. Caywood appears on p. 74.]

STATEMENT OF WILLIAM HAHN

Mr. HAHN. Mr. Chairman, members of the Subcommittee, I would like to thank you for allowing me to testify. My name is William L. Hahn, and I'm a representative of the Veterans of Foreign Wars. I am a past 5th District Commander and at the present time I am the VAVS representative for the Veterans of Foreign Wars for this hospital. In my testimony I will tell the Committee what I see wrong with this hospital. It started back several years ago with the closing of the fire department and downsizing of staff here. We used to have two fire trucks, one which was—was sent down south to the VA facility and the other one was given to Marion so we could have fire protection on the grounds here. I still see the VA fire truck running around town, still painted yellow, with the VA sign still on them. If there ever was a major fire out here, I do not think the City of Marion could respond in time. Marion says they can make it out here in 8 minutes or less but I have timed them before and it took right at 13 minutes to respond out here. I also would like to point out that this hospital is surrounded by railroad tracks and if a track is blocked it would take longer than 8 minutes for the fire department to arrive. A lot of times the trains have blocked the tracks for switching and it has been blocked for at least an hour or so.

The older buildings, they're in bad shape and the Government has let 'em go because they say it's too expensive to fix up. They are real old and it is a disaster waiting to happen. If anyone goes in there, from what I was told, they could easily fall through the floor. And there's holes in the roof big enough to fit a car through. Also, an act of God could set these buildings ablaze by lighting. And I assure you, it would go up real fast and just easily spread to other buildings. My suggestion is to tear down—tear them down even though they're on our National Registry and give part of the land to the National Cemetery and the rest maybe make a Veterans park for our Veterans and their families. I also recommend that we keep one or two buildings for historical matters to be used as a museum.

Patient care, well, I feel we need the work—wood shop back out here as it would be great therapy for the patients and they can use their hands and their minds to build things. I feel like we need more therapists to take patients outside for activities instead of going 50 feet to a smoking area.

Also, what we do—why do we send our patients to nursing homes when this hospital can hold between 400 and 500 patients? We have only 290 inpatients. And I feel we could give far more better care than they would at a nursing home. I feel in some areas that we are understaffed as we only have 100 RNs, 34 LPNs, and 133 Nursing Assistants. Whenever we have meetings out here, all we hear about is the budget and how we need to cut back more. We put too much focus on the budget instead of patient care. We must remember these Veterans fought and served our country well. They deserve the best, just the same as you would want the best in your lives as well as your health care; and to help them live a

more fuller life the same as you want to live the full—your life to the fullest.

I also have an attachment. At the time of my first letter, there was a fire on May 23, 2000, 2 days after I had prepared this first letter. It was a serious fire. It was brought to my attention that they were using torches to cut out a dryer. On the scanner I heard the fireman say there was a lot of black smoke. I also found out several of the fire trucks were delayed because of a train blocking the tracks. I went and talked to the Chief of the Marion Fire Department and he informed me that this was a major fire. He said that any time there is a fire it should be treated as a major fire. He also told me that they need either the fire trucks back out here or have a better system than what they have now. He informed me that there is a lot of problems with the VA over fire protection. I feel like Congress should run a full investigation on this and get with both sides to get the problem resolved. The Chief also said that the older buildings are a disaster waiting to happen. And Members of Congress, this does involve patient care from a safety point as our patients' lives are involved. We must remember that whenever there is a fire, the patients, the staff and the firefighters' lives are all—are involved. I have enclosed a copy from the Marion paper of the fire and the fire report, which on page two shows that the fire engines had to make detours because of blocked tracks. I also have another attachment from the Chief of the Marion Fire Department and this is his words—of Mike Hutcheson. And he says, "Dear Congressional Committee Members, I have advised the Marion VA Center of my concerns of the fire coverage of the facility. This concern is geared towards the best interest of patient safety and protection of the premises. I feel it is imperative that personnel should understand fire terminology and basic fire behavior. Personnel with this knowledge should be on this site 24 hours a day, 7 days a week to meet the fire department when it arrives on scene. The current working system does—does—does provide for this. I am concerned that assigning personnel with lesser knowledge to greet the Marion Fire Department suspension—suppression crews will reduce their capabilities. I feel the facility should continue to provide a fire person to greet the Marion Fire Department suppression crews around the clock. I also want this fire person to be informed about our concerns as stated." I would like to thank you for letting me speak.

[The prepared statement of Mr. Hahn, with attachments, appears on p. 80.]

Mr. STUMP. Thank you, gentlemen. Thank you for your testimony. And—and also what you do for our veterans throughout the country. You and your respective organizations, you do a great job.

Mr. Hickey, you spoke about the unreasonable delays and times for an appointment. There are horror stories out there, not only of time for appointments but adjudication for claims. And we had 16-and-a-half million people in World War II and we're down to under a little—about six-and-a-half million left. Now, some of these guys don't have a hundred plus days to wait. We are losing World War II veterans at a rate of over 1,100 a day; and we thank you. Mr. Buyer?

Mr. BUYER. Thank you, Mr. Chairman. You know, I can never examine issues in a vacuum. That said, I have a very good memory of where we've been and where we presently are. So, I may take some exception to the testimony. I get a sense that perhaps your Washington office helped you a little bit or gave recommendations on what to say. I'm a life member of the American Legion; of the VFW; AMVETS; and with God's blessings, not the DAV. But I have great respect for the members of the DAV. And I recall your national commander's testimony in 1995 as we were working to balance the Nation's budgets. It's what the country is asking for. And of all the veterans' services organizations, it was the DAV that stepped forward and said, we will help lead the country. I was impressed. Now, Commander, I don't know if you recall that or not but I remember when the DAV said, We're going to take care of the needs of veterans but we also demand that you balance this Nation's budget, put our fiscal house in order. It was the most impressive testimony I had seen.

Mr. CAYWOOD. Yes, I recall that.

Mr. BUYER. So, as we negotiated with the President, and enduring his Government shutdown, we now are in this climate of budgetary surpluses. We kept Washington from getting into the Social Security trust fund and using it as a slush fund to grow government. When we put our fiscal house in order, that's when you come in and I salute you and say, well done. Unfortunately, the American Legion and the VFW and others can't get him to endorse that budget.

Mr. CAYWOOD. No.

Mr. BUYER. It appears that you're not part of the group. The \$3 billion that you asked for in fiscal year 2000 come in 1.7; this time it's 1.4. I guess I get sensitive when you say you continuously fall short. I like you cracking the whip on us.

Mr. CAYWOOD. We do too.

Mr. BUYER. The harsh fact is that there aren't as many veterans left in Congress.

Mr. CAYWOOD. Yes, that's true.

Mr. BUYER. So we have a lot of education to do with our own members in Congress. The more you crack that whip and the more you educate, the more important it is. I had to put a little history in order here. I have to ask this question about the level of coordination between veterans' groups here in Indiana. Are you satisfied with the quality of stake-holder consultation received from the VA with regard to integration issues between Fort Wayne, Marion and satellites? Are communications good, Mr. Hickey?

Mr. HICKEY. We believe VA could do a lot more if they were more aggressive. There's a lot of veterans that are not being served that they're leery about the VA health care system and for good cause. We believe the VA has done a lot in recent years to change their image to provide better veterans health care services. But we don't think that the VA is going out aggressively seeking—or offering their services to veteran patients.

Mr. BUYER. Mr. Caywood?

Mr. HICKEY. It's almost like a mirrors game—shadows and mirrors—smoke and mirrors. The services are there, but they're not always available for the veteran to use. Such as long clinic appoint-

ments. If—if individuals find that when they seek those services and they're—they're not provided timely, especially in health care services, don't you believe that services delayed are services denied?

Mr. BUYER. Commander?

Mr. CAYWOOD. I feel we've had a very close relationship with the VA regional office in Indianapolis as well all of the VA medical centers. And I believe we've had a history of working with the directors and staff of these facilities in a close enough way that we work—try to recognize any problems and meet those problems head-on and try to—you know, try to work through those problems with the VA staffs and then from there move ahead in a positive manner.

Mr. BUYER. Mr. Hahn?

Mr. HAHN. I do believe we have a good relationship with the VA but I think we have room for improvements. I hear reports that a lot of our patients are—like one transferred from here that were—transported from here to Fort Wayne for treatment to get up there in time not to able to get their treatment, he has to come back without treatment. I feel like that there's still a lot of room for improvements between the VA and I think that—between the veterans' organizations and I think that the VA should have a lot of improvements.

Mr. BUYER. Does the VA senior level management at Fort Wayne and Marion view the Veterans' Service Organizations positively?

Mr. CAYWOOD. Yes.

Mr. BUYER. Would you concur with that?

[Panel nods in the affirmative.]

Mr. BUYER. So often in hearings we focus on the negative side. It's part of our character. We always want to make things better for someone else. It is just as important to let us know what is being done well. Would you please let the Committee know what you believe is being done well here at the Marion and the Fort Wayne facilities to include our satellite facilities? Mr. Hickey?

Mr. HICKEY. Yes. Over the past few years we've seen a very large improvement on the courtesy provided by employees to veterans. We've seen, of course, the doors open to all veterans through the act that took place in 1996. That is certainly an improvement. And probably the best improvement of all. We've seen veterans now who are not concerned about going to VA for their health care services. And when they have those services, they compare them and they say that they're not only as good, but most likely better than the services that they could have received in a private facility.

Mr. BUYER. Commander?

Mr. CAYWOOD. I feel over the past 9 or 10 years the Disabled Veterans—American Veterans in Indiana have established a transportation network that I'm sure that everybody here is familiar with. And we have hospital service coordinators stationed in each medical center and we can now have over 40 vans in the State of Indiana helping supply transportation to veterans to get them in for the care or treatment that they need. And I feel simply by having this successful program installed and by having these hospital service coordinators located in—in each VA medical center that

that in itself has very much assisted in our positive relationship with the—with the staffs at the various medical centers.

Mr. BUYER. Thank you. Mr. Hahn?

Mr. HAHN. I believe that there's better communications, you know, we get along better with the staff and I think that the patients get along better with the staff too. But I also hear a lot of concerns from the veterans that they're worried about the VA going out—going out, contracting out and they feel like they may not get as good a care being contracted out to other—other places. They feel like they come to the VA and they get better care here than what they do other places.

Mr. BUYER. Let me thank all three of you for coming and testifying here today and for what you do for the veterans. Mr. Chairman, I yield back.

Mr. STUMP. Thank you, Mr. Buyer. You know, Mr. Hickey, you bring out a good point, and that is the number of veterans within a Congress that we have to fight—not fight, but of those left to fight, especially in administration. We've had an increase in the administration budget every year for the last 8 years or more. We only have about 12 World War II era veterans, only four with combat experience. No Korean War veterans that I know of; about 30 Vietnam veterans; and of course a few of the Gulf War veterans, including Mr. Buyer here. Thank you.

Mr. STUMP. If we can have the final panel come up today, please. The final panel consists of Ms. Linda Belton, VISN 11 Network Director; Dr. Michael Murphy, Director Northern Indiana Health Care System; and Dr. Allen Mellow, Director of Network Mental Health Service Line. If you would you care to proceed, Ms. Belton, please.

STATEMENTS OF LINDA BELTON, DIRECTOR, VETERANS INTEGRATED SERVICE NETWORK 11, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; MICHAEL MURPHY, PH.D., DIRECTOR, NORTHERN INDIANA HEALTH CARE SYSTEM, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; AND ALLEN MELLOW, MD., DIRECTOR, NETWORK MENTAL HEALTH SERVICE LINE

STATEMENT OF LINDA BELTON

Ms. BELTON. Thank you. Mr. Chairman, Mr. Buyer, I'm Linda Belton, Director of VISN 11. VISN 11 provides care to veterans in lower Michigan, northwestern Ohio, most of Indiana and central Illinois. In 1999, we cared for nearly 147,000 veterans. We are subject to the same forces which drive change in all health care. Most notably, rapid growth in spending and shift from hospital to outpatient care. We also struggle to meet key VA goals in quality, costs satisfaction and access. You have noted that the budget has increased this past year. I will tell you that networks still struggle with costs associated with inflation, pay raises, new technologies. And at the same time, eligibility reform in the VA basic benefits package has introduced more services to more veterans. So, it becomes essential for us to find ways to deliver good care more efficiently. Let me give a couple of examples. Regarding quality, our VA facilities are all accredited by Joint Commission, CARF and a

number of other surveying bodies. You've heard about the recent IG assessment and I will assure you that we take all such reviews seriously and we use them as opportunities for improvement. We've developed mental health and extended care service lines to enhance continuity and access in distribution of resources. We've taken actions to improve safety of staff and patients by working with the National Center for Patient Safety, which identifies systems problems and solutions and also encourages staff to come forward to report near misses so that we can prevent some accidents from occurring. We're also in the process of implementing bar coding for medication administration. We completed an assessment of violence in the workplace. We hired an occupational health nurse to focus on accident prevention and wellness. And the network has initiated critical incident reviews when unfortunate events have occurred.

Regarding cost: In fiscal year 2000, the network received a VERA allocation of about \$650 million. After funding national program support and network initiatives, that budget is distributed to network facilities using a single price capitation model based on veteran users, plus a transfer pricing methodology for veterans who receive care at more than one facility. The network also supplements the care of patients with lengths of stay greater than 100 days and the higher expense of operating a dual-campus facility like Northern Indiana.

Regarding Access: We'll have 22 community based outpatient clinics established by this summer and that will bring 85 percent of our users within 30 miles of a VA primary care site. We've invested in a 24-hour clinical phone care system. And have tele-medicine projects underway in psychiatry, ophthalmology, radiology and home care. We've also made active efforts to communicate and collaborate with our stake-holders. We receive direct input from veteran and union representatives on our Management Assistance Council, our Service Line Boards and at our annual VSO Forum. We're working with VBA on co-locations of the regional offices and we've worked with labor partners to implement network staff recognition programs.

Northern Indiana plays an integral role in VISN 11's health care delivery system. It's the only integrated site in this network. It's clearly recognized that integration creates distinct complexities. This integration preceded many of the aggressive business and care practices adopted by VHA in recent years. And the pace of change I think has often surpassed our capacity to communicate with staff and veterans and to help them adapt to sometimes distressing shifts in practice. I believe this has really had an impact on morale. I think we are pleased that significant accomplishments have been made without across the board reductions in force, or any RIFs that resulted in employees losing jobs. Instead we've really tried to focus our efforts on programmatic changes like shifting from inpatient to outpatient; like consolidating laundry services; early retirement and buy-out authority; and offering displaced workers alternative positions. Our philosophy has been, and remains, that RIFs are the alternative last resort.

We're going to continue to face challenges in managing within resources and improving standards and communicating effectively. We recognize the need to maintain a safe environment as these

changes are implemented. And we understand that employees and veterans who are partners in the change process are critical to our success. So, we sincerely hope to continue to strive to provide excellence and that all of our partners will work with us in that process. Thank you.

Mr. STUMP. Thank you, Ms. Belton.

[The prepared statement of Ms. Belton appears on p. 88.]

Mr. STUMP. Dr. Murphy?

Dr. MURPHY. Yes, sir.

Mr. STUMP. This is your house, if you need to exceed that 5 minutes that we tried to impose, why feel free to do so, sir.

STATEMENT OF MICHAEL MURPHY, PH.D.

Dr. MURPHY. Okay. Thank you. Mr. Chairman, Congressman Buyer, thank you for the opportunity to speak on various issues related to VA Northern Indiana Health Care System. The integration of the VA Medical Centers in Fort Wayne and Marion into the VA Northern Indiana Health Care System was announced in March of 1995. The Fort Meade campus is a primary and secondary medical and surgical facility, with an outpatient clinic and a nursing home. The Marion campus is a psychiatric and long-term care facility with primary medical services and an outpatient clinic. Marion also serves as a neuropsychiatric referral center for the entire State of Indiana.

The two campuses are separated by approximately 60 miles and provide inpatient services in 243 authorized hospital beds and 180 nursing home beds. A Community Based Outpatient Clinic or CBOC was opened in the South Bend-Elkhart area in April of 1998 and a second CBOC was opened in Muncie in August of 1999. Both of those CBOCs provide area veterans convenient access to primary outpatient services. Our multiple outpatient care sites will serve approximately 17,000 veterans this fiscal year, with an estimated 135 outpatient visits.

Northern Indiana also provides administrative support to a Veterans' Readjustment Counseling Center in Fort Wayne and the Marion National Cemetery.

Much of the Marion campus is well over 100 years old, with the Fort Wayne campus having been constructed in 1949 and 1950. Recently completed renovation and construction projects and projects currently underway with a combined total of nearly \$70 million in capital improvements, insure Northern Indiana veterans a modern, attractive and state-of-the-art health care environment as we move into the 21st century. At Marion, a two year old, 240 bed geropsychiatry building and a 100 bed general psychiatry building nearing completion provide the newest psychiatric and long-term care environment within VISN 11 and perhaps within the VA. With these facilities, Northern Indiana will be uniquely positioned to meet the changing psychiatry and long-term health care needs of those veterans who do require hospitalization and institutional care.

A new ambulatory care addition was opened in November of 1998 at the Fort Wayne campus. It provides 23 modern examination rooms, accommodating the increased emphasis on outpatient care. This project, together with a 4-year old renovation of the am-

bulatory care facilities in Building 138 here at Marion, ensure veterans appropriate settings for ambulatory outpatient care services.

Northern Indiana is fully accredited by the Joint Commission on Accreditation of Health Care Organizations; The College of American Pathologists; the Commission on Accreditation of Rehabilitation Facilities; and the Nuclear Regulatory Commission. NICHS recognized shortly after I arrived here as the Director nearly 4 years ago the need to accelerate our shift from an inpatient to an outpatient care model in order to meet contemporary care standards. As a result, we have decreased our total bed days of care by approximately 34 percent or the equivalent of six fully occupied wards or 65,000 annual bed days of care. We've developed an intensive psychiatric community care program which in the past 20 months has served 91 veterans with 68 currently in the program and an average daily participation of 53 over those past 20 months. Those are veterans now living out in the community under supervision. Previously they would have been institutionalized as long-term care patients.

Our Substance Abuse Treatment Program and our Combat Vet Treatment Program for PTSD have also been converted to an outpatient format in accordance with VA program guidance and outcomes research. Our length of stay in acute medicine is 5.4 days, very comparable to the community for similar aged patients and medical conditions. And over 90 percent of our surgery is now done on an outpatient or ambulatory basis. With all of these changes, we still have further work to do in adjusting our delivery models and practices. We continue to emphasize and prioritize the need to adopt treatment concepts and models consistent with current clinical practices both within the VA and in the private sector, especially in psychiatry and long-term care.

Today, Northern Indiana is providing more care and better care to more veterans than at any time in the history of our combined organization. However, like every organization we recognize the need and the opportunities to improve and we have an active and ongoing program of continuous process improvement.

Through a number of operational initiatives, we have achieved efficiencies that have allowed us to redirect resources into direct care and services to veterans.

We have been able to close more than a dozen buildings here at the Marion campus and we will likely close more in the future. We successfully worked with the City of Marion to appropriately obtain fire suppression services from the Marion Fire Department.

We avoided an expenditure of over \$3 million to replace an aging laundry plant and now obtain our laundry services through the VISN 11 consolidated laundry which is operated under a contract with NISH. These operational changes together with the clinical changes that I mentioned earlier have made us a more efficient and effective organization and have allowed us to better support our core business, which is delivery of health care to veterans.

That concludes my remarks. Thank you, Mr. Chairman.

[The prepared statement of Dr. Murphy appears on p. 101.]

Mr. STUMP. Thank you. Thank all of you. Dr. Murphy, you just mentioned about closing x number of buildings and I didn't understand exactly the number you said. But do you have any plans for

those? I'll back up. I'm sorry. I'm out of order again. Dr. Mellow, I apologize to you.

STATEMENT OF ALAN MELLOW, M.D.

Dr. MELLOW. Mr. Chairman and Congressman Buyer, my name is Alan Mellow. I am Director of the Mental Health Service Line for VISN 11 and Associate Professor of Psychiatry at the University of Michigan. Thank you for the opportunity to discuss with your committee today the Mental Health Service line in our network and as it relates to the VA Northern Indiana Health Care System.

A network-based approach to mental health services was an early priority in VISN 11. In 1996, a VISN Mental Health Task Force recommended the development of a continuum care for all psychiatric patients and, consistent with current trends in health care, movement of the sites of cares from traditional inpatient settings to outpatient community-based venues. Implementation of these recommendations resulted in a successful reinvestment from fiscal year 1996 through fiscal year 1999, of \$12 million recouped from mental health and substance abuse inpatient program changes into alternative venues of mental health and substance abuse care for our veteran patients, allowing us to treat 20 percent more mental health patients with the same level of expenditures. This has been achieved through a combination of enhanced outpatient programming, community-based case management, implementation of residential and partial hospital/day treatment programs and a variety of contractual agreements. Since this re-engineering is far from complete, and in order to sustain momentum in improvements in mental health care, the network leadership decided to establish a formal network-based Mental Health Service Line. I was recruited as full-time Mental Health Service Line Director in March of 1999. The strategy of the Service Line is to provide excellence in mental health services throughout VISN 11 by organizing all mental health care, education and research into an integrated delivery system with consistency in clinical practice, process and outcome measures and with a unitary budget and management structure. The Network Service Line provides mental health care to approximately 30,000 veterans with an annual expenditure of about \$100 million or about 15 percent of the network's appropriated budget.

Since its inception, the Service Line has developed a number of strategic initiatives and has improved on several performance measures as I have detailed in my written remarks, which have been submitted to your Subcommittee. In addition to its strategic focus, the Mental Health Service Line provides operational leadership for mental health activities in the network as well as consultation to facility top management. For example, the Service Line organized the focused review of the recent patient assault incident here at Marion.

One important initiative of the Service Line has been to develop a strategy for improvement in the National Mental Health Performance Monitoring System, which is an annual VHA-wide ranking of all VISN mental health programs on the domains of population coverage, inpatient care, outpatient care, economic perform-

ance and customer satisfaction. In its aggregate score VISN 11 has ranked in the bottom quartile of all VISN's since these reports became available in 1995. Although we have made considerable progress in our rankings with respect to outpatient care, we have seen a decrement in our performance on measures of inpatient care relative to the rest of VHA. We have made major changes in our inpatient care processes, but we have not moved as quickly as the rest of the system, leading to a drop in our ranking. In addition, our economic performance ranking remains near the bottom of the Nation. Both of these are directly related to our long-term mental health care activity.

The provision of long-term care to those patients with the most severe forms of psychiatric illness, such as schizophrenia and bipolar disorder is a major priority and challenge for VHA. VA neuropsychiatric facilities throughout the country were initially established to provide long-term inpatient care for the vast majority of those patients, often in hospitals isolated from their communities of origin. There are many veterans whose illness renders them so functionally disabled that they require permanent inpatient care. There is however, a growing body of evidence that many of these patients can be treated in outpatient community-based settings with better outcomes and a more efficient use of resources.

The challenges to our system to implement these fundamental transformations in our clinical care are enormous and involve the development of new staff competencies, cultivation of community-based resources, education of our patients and their families, as well as a cultural change among dedicated staff. We have made great strides in this transformation, but we have much more to accomplish. As one of the major mental health facilities in our network, Northern Indiana is critical to our mental health mission, but, consistent with the standard of care at its founding, its focus has been long-term inpatient mental health care. Although this is and will continue to be an important part of our spectrum of mental health services, it is no longer the standard of care for many patients. We look forward to continuing to creatively channel the expertise of the Northern Indiana staff into these new forms of care, so this facility and VISN 11 can continue to provide first-rate mental health services for all our veteran patients. And that concludes my comments.

Mr. STUMP. Thank you.

[The prepared statement of Dr. Mellow appears on p. 106.]

Mr. STUMP. Now, as I was about to say, Dr. Murphy, you said you were closing some of your buildings here on this—I might add, it's a very beautiful campus, especially when you come from the desert area like I come from. But do you have any plans for some of those surplus buildings or surplus land that maybe could turn into—be turned into a source of revenue to aide our veterans in any way?

Dr. MURPHY. Most of those buildings that we have closed as surplus to current operational need are 75 to 100 plus year-old structures. It's difficult to convert them to current day usage. It's expensive. We have been out in the community on several occasions seeking opportunities to get other folks to come in and use these buildings. VISN 11 has just created a enterprise office and has hired a

gentleman to work that office for us. And part of his challenge will be to help us find alternate use for some of these buildings. Some of them, however, are aged to the point that they are not usable in the future. Some of them, in fact, are hazardous to go in. They've been closed for as many as 20 years. We are working with the Indiana Department of Natural Resources, which is the Historical Treasure—National Register agent for Indiana. We proposed demolition of upwards of 18 buildings on campus, with the proviso that we would protect some historically significant buildings and develop appropriate video and audio recordings to document the demolished buildings and their history for historical purposes.

Mr. STUMP. Is the cemetery that's adjacent, I believe, do they have unlimited space out there or are they going to be running short one of these days?

Dr. MURPHY. I can't tell you as to what their current life cycle is on—on—on burial space. But I know that shortly before I got here in the summer of 1996, the VA—VHA did convey additional property to the cemetery and they are working through that property. If there is a need for additional cemetery development, we certainly have the property to turn over to them for that need—a very worthwhile need.

Mr. STUMP. Thank you. And thanks to Mr. Buyer's help on Armed Services Committee, we managed to add about 45 acres to Arlington National Cemetery of continuous land, which is almost impossible to do there, and it has extended the life of that cemetery out for another 10, 15 years, probably in about 20, 30 or so. Thank you. Mr. Buyer?

Mr. BUYER. Thank you, Mr. Chairman. Dr. Murphy, I don't know whether I should go first with you or last.

Dr. MURPHY. I'm at your disposal, sir.

Mr. BUYER. Dr. Mellow, there was some testimony earlier from another panel and I asked some questions with regard to the staffing. Would you please share with me your thoughts as we move into this issue of adequately addressing the staffing concerns within this Northern Indiana Health Delivery System?

Dr. MELLOW. Again, my role and the role of the Service Line is an evolving one and it really represents a matrix of the way we're providing leadership for those activities. And so my Service Line then transcends the individual facilities and at the same time collaborates with them. However, we have conducted some analysis looking at the very issue of staffing patterns between facilities and also examined that in the context, of—of course, the recent unfortunate incident in January because of the concerns about staffing. And we have noted a number of issues. One—in fact—

Mr. BUYER. He?

Dr. MELLOW. Pardon?

Mr. BUYER. Who's he? He noted a number of—

Dr. MELLOW. No, I said we. I'm sorry.

Mr. BUYER. We.

Dr. MELLOW. We noted. We noted a number of—of facts. First of all, with respect to the incident that occurred, it is certainly clear that a number of factors went into that incident and converged to create the situation that occurred, including the physical plant and the staffing. But our external focused review team made it very

clear when they reviewed this that there were aspects of team functioning to—and team communication that contributed to that particular incident that could have occurred regardless of the staffing levels. And I want to make sure that the committee doesn't come away with the notion that this is the proximate cause. With respect to the Service Line looking at other staffing issues—in fact, when we look at our three long-term care facilities——

Mr. BUYER. Can I interrupt you for just a second?

Dr. MELLOW. Yes.

Mr. BUYER. That was a very long answer and it was hard for me to track. I'm not saying that that is direct correlation between understaffing and what happened and that it could have been prevented. That's the easy thing to say but what we is a track record. So, when staff, and veteran service organizations, and veterans who use the facility talk about the issues, they've got to be real. Otherwise, they're just perceptions. When the IG comes in and notes these things and then hear detailed testimony comparing the Battle Creek VA facility in Michigan to Marion, we see more patients here with regard to there and they have twice the level of staff. Those are some basic things you have to begin to scratch your head about.

Dr. MELLOW. Actually, the staffing patterns at Marion are—actually in the middle if we look at all three facilities. And again taking the Danville staffing patterns are actually lower on those long-term care units than Marion. And it is true the ones at Battle Creek are—are higher. And there's no question that is based on an external review, we're making those adjustments.

Mr. BUYER. All right.

Dr. MELLOW. But I do want to make the point that the mission has changed. And comparing Battle Creek and Marion is an important one. But there's a fundamental change that is going on in the way we're providing care. And we haven't done it as quickly at Marion as we have in Battle Creek and that's getting patients out into the community—always increasing staffing levels for a facility like this is not going to necessarily be the answer in the long run. In the short run, we are committed to those safety issues to the utmost and you know that. And our review—the review that we conduct will allow to us to act on that. But the kind of inpatient care that's provided for many patients is no longer the standard. And in the long-run we're probably—we're going to have to change the way we provide care. One of the other panel members talked about——

Mr. BUYER. Can you answer this question for me?

Dr. MELLOW. Yes.

Mr. BUYER. Are you responsible? And if you're not, then it shifts back to Dr. Murphy. Who's responsible?

Dr. MURPHY. I am.

Mr. BUYER. All right. Dr. Murphy, please respond.

Dr. MURPHY. To whether staffing was——

Mr. BUYER. Let's get—yeah, let's just go ahead and jump right into the pool. I mean, a lot—you've heard a lot of allegations with regard to levels of—of staffing here, one by a doctor whom was almost murdered. He brings up and says I believe this even goes beyond you and goes up to division level. I wasn't completely sure

whether Dr. Mellow was going to say, yes, that is—that is me. And now you've said it's you.

Dr. MURPHY. I'm locally responsible for assuring that we have an appropriate distribution of the staff that we have and that we can support. That covers Fort Wayne campus and the Marion campus and so we have staff divided between two places. Where—on the unit where the assault took place in the fall of 1997 and in the unit where the assault took place this past January, as Dr. Mellow indicated, there were a number of factors which contributed to letting those incidents occur. Part of it was environmental. That building was not designed as an acute psychiatry building to be used for seriously and chronically mentally ill patients. We moved them in that building pending the completion of the new building, which came about as—partially as a result of the closing of Coldsprings Road in Indianapolis, as you recall. We moved them into that building knowing that it was not fully appropriate but it was much better than the buildings and the environment that we moved them out of. So, the environment was part of it. Communication within that environment may have contributed to it. The staffing levels in both units at the time of the incident was consistent with nursing services established minimum level staffing for that unit. As Dr. Mellow indicated, the external review showed or suggested that the treatment teams management and communication was partially at issue. I think we are taking steps to address all of those components. We have revised our prevention and management of disturbed behavior training program, we've modified the approach to that program and the number of employees that are going through it, with the priority being given to employees who are working in our most risky environments. We are working on developing communication systems in there. We've provided on a test basis employees with personal sounding devices to call for assistance. We have a program of mutual support from one ward to another. Right after the incident in January, we put locks on the doors into—actually we changed the locks; we had locks on the doors into the nursing station. We are evaluating raising the counter height or putting additional petitions in there. However, before we could get that accomplished with a fully appropriate project, we will be moving in to Building 185, the building specifically designed for chronically and seriously mentally ill patients. That building will address all of the specific staffing and safety issues that we can point to as contributing to Dr. Calache's incident.

Dr. MELLOW. Congressman, if I could just clarify something. And sorry—I apologize for the confusion before. Just to make clear the role of the Service Line now remains programmatic authority and consultative with respect to allocation of resources. So that was the reason for the other answer.

Mr. BUYER. Mr. Chairman, it is with your help that we received the funding. The committee authorized over \$17 million to build this psychiatric hospital that will be opening this fall. We appreciate your leadership. I'm going to go right into this. When you have the responsibility to lead, you're also accountable. And judgments that leaders make are always criticized. You always will have a critic. It's the constructive critic that is the one that I always listen to because they're trying to improve. I'm going to give

you an ample opportunity here, because I believe the IG's report creates a perception and want you to have an opportunity to publicly respond to the perception that's been created by the report. I've read your concurrence with all of their recommendations. In their combined assessment program, some corrective actions have been completed. There were some pretty serious findings. The questions is: Why did it take an IG review to uncover what appears to be weak leadership and management in terms of patient and employee safety, lack of oversight on your outpatient clinic in South Bend and radiology contracts, minimal adherence to your own internal controls and policies regarding the pharmacy issues, and the peer review process? And facility safety and cleanliness? There is a perception and I want you to have an opportunity to respond about the perception.

Dr. MURPHY. I guess I would say, first of all, management doesn't see everything. Folks coming in from the outside see things that—that you don't when you're there with it every day. I know when I visit other VA medical centers I see things that the director there doesn't and I wonder why she or he didn't. And I understand. The findings from the IG report were very helpful. I think that Northern Indiana has been challenged in a variety of ways over the last several years. The integration process itself is a very disruptive maturation process to an organization and it bleeds off a lot of management effort and time. So, that is a piece of it. We've been through 4 years—3 years of a flat budget before the appropriation last year. That process has continued to challenge Northern Indiana. One of the speakers mentioned that our penetration rate appears to be about eight percent. I think by the end of this calendar—excuse me, this fiscal year we will be penetrating 12 plus percent. In 1996, we saw for care either inpatient or outpatient, approximately 12,250 veterans. This year we expect to see, as I said earlier, 17,000 veterans. So, we have reached out. Part of that outreach has been accomplished through our CBOCs. The South Bend CBOC that was spoken to earlier, we were the first to develop that kind of a contract. A lot of folks have since gone to school on what we learned. We've learned a lot from that. It was a shared risk management model. We agreed that we would pay a set amount for primary outpatient care from the Ancilla Group up in South Bend. We boarded and privileged their physicians to see our patients and assigned patients to them. We think some veterans up in that area enrolled as a insurance package for care without intending to use it. And before the IG visit we had identified and, in fact, altered the contract with the Ancilla Group to dis-enroll folks who were not using the health care system. We had also identified, through a patient report, the billing to Medicare. And what appears to have happen is a veteran who is enrolled and assigned to a specific provider went into Ancilla, saw another provider who saw that individual as a non-veteran. We don't think that's right and we're taking steps to correct that. That CBOC in South Bend was one which we thought would have appeal to veterans because we offered multiple sites across the northwest corner of Indiana and veterans could receive care at the same place—actually from the same provider that their family or spouse did. That has turned out, apparently, not to be as appealing. Veterans seem to appreciate more a

clinic which is dedicated to veteran service only. So, when we put the bid—the clinic in Muncie, that's how we bid it out, as a dedicated veteran only center. And it is—in fact, a busier CBOC at this point than South Bend has been up to this point. We will re-specify the bid offering for South Bend area and renegotiate that contract and have one that will provide tighter service and tighter controls than we currently have. We recognize that we needed some schooling on that as a—as a first—first go.

Mr. BUYER. Dr. Murphy, I recall my 3 years of active duty in the Army as the legal advisor to an Army hospital. I was very alarmed to see the lack of concern about low reporting of incidents within the pharmacy. I learned a long time ago that a pharmacy can be the biggest headache to a medical director. Would you concur with that?

Dr. MURPHY. Pharmacy can be, that's correct.

Mr. BUYER. Pharmacy can be but what that says to me is that if pharmacy incidents aren't reported or if incidents are hidden, then what other types of incidents are not being reported or are hidden? Perhaps it means that we have a fraud in our peer review, quality assurance and risk management systems. If I were the medical director, I would be pretty concerned about that. Would you please respond?

Dr. MURPHY. As you are, I am concerned about it. We're looking into it. We're working to develop better reporting processes and requirements. The VA nationally has adopted patient safety and has taken a leadership, even before the Institute of Medicine report came out on patient safety and incidences related to health care with adverse outcomes to patients. We are implementing a new reporting process across the VA. Our staff last week 23rd, 24th, 25th of May, were in Detroit or Ann Arbor, I believe, for training on that. And we have already initiated our first incident against that new processing and reporting system. I signed off on the review of it yesterday afternoon late in the day. Medication errors I think is another area that it is always a concern. If you get too many reported, you got too many errors. If you don't get enough, they're not reported. I don't think anyone knows what the report number ought to be. Our reported number is probably low. Our new reporting process standardized through the VA is designed to be a non-threatening, non-adversarial reporting system but it is a system designed to ferret out errors and opportunities to improve, should help us generate more complete reporting on incidents as they occur.

Mr. BUYER. I think that peer review is the most difficult. It doesn't matter what environment we're in, because we all know that as humans we're subject to error. The key is the aspiration of the high standards and it's a very thin line for those of us who follow a system of honor and ethics. It doesn't matter where we work or what field we're in. So I just want to let you know, I'm going to keep my eyes on this one. I also can't help but note that you appear to have a very reactive management style. I just want you to know my personal observations of this.

Dr. MURPHY. As opposed to?

Mr. BUYER. I don't know, as opposed to what?

Dr. MURPHY. I guess we do react to things as they come up and we wouldn't want it any other way, however the ideal would be to be more proactive.

Mr. BUYER. Thank you.

Dr. MURPHY. And I think we are challenged to be that. Some of the things that we're implementing now will be proactive against future issues and problems. The corrective actions that we're taking following the two incidents or the corrective actions that will be implemented will be a proactive issue relative to incidents which hopefully don't happen in the future.

Mr. BUYER. I'm going to jump in the weeds. This deals with communications. As we listened to the president of the union testify it occurred to me that if we have such a division between management and the work force, how could we bring them together? How do you get them to work cooperatively at a time when both are digging in their heels. So, the issue is communications. Communications is the key to everything almost in life. For example, you had a unique opportunity, Dr. Murphy, to meet with the professional staff of the Veterans' Affairs Committee who had come out here a day early, and you weren't even here. The Chairman brought professional staff out to Marion, and they have the ability to open any door in the system and take massive corrective changes. These decisions on budgets and numbers get made somewhere, right?

Dr. MURPHY. Right.

Mr. BUYER. You had a unique opportunity but when they were here, you went to Fort Wayne. You didn't even meet Mr. Kingston until this morning in your office. I just want you to know that's very concerning to me because we're taking a massive effort to come here and be helpful and constructive. If you're not being proactive then no one should be surprised that we're having to rebid a contract for the satellite facility in South Bend. Communications is extremely important. So, having said this, tell me what you're going to do to be more proactive, to lean forward and work with the union in working out some of these issues? Dr. Murphy, do you have a response?

Dr. MURPHY. Yes, sir. We have an environment at Northern Indiana where we have two locals of AFGE. They are campus oriented and as Mr. Overbey said—or Mr. Stewart said, they represent everyone that is not a supervisor or a manager. Mr. Overbey mentioned developing and building trust. Trust relationships don't develop and build over night. Management at Northern Indiana is at the moment working with its fifth union leadership group in less than 4 years. We've been through three union leadership groups at the north campus in 40 months and we're in our second group at Marion in 40 months. So, we've got some challenges just learning to work together with our labor partners. When I got here, Northern Indiana had a partnership agreement which predated the integration at the south campus and no agreement at the north campus. During that first summer that I was here, we developed a partnership agreement with two unions and management. The partnership met for a period of time and then stopped meeting because we did not have a designated quorum for various—for meetings. And a quorum was defined as representatives from each

union plus management. And we went several months with one or the other labor organization not present so we could not meet. A few weeks ago, probably three or four or five now, maybe five, six, we re-initiated the effort to negotiate and reestablish the partnership agreement with 1020 on this campus and 1384 north. And I think we're very close to having an agreement that we can all work with and begin working on those things which are, in fact, partnership appropriate. We've also got some challenges related to change. Now, change is very difficult. And—and it can be threatening. But as Dr. Mellow has pointed out, we need to change. The Rosenheck report suggests that if Northern Indiana is going to survive as a viable health care organization, the changes that we have been making are changes which we must make. Those are changes which have gone counter to the culture at the Marion campus which was oriented towards inpatient care. I think we need to be sensitive to—to the employees and the changes that that imparts in their—their lives. There is concern that as we have drawn down inpatient care that Marion may quote "close." When I go up north, I get anxieties that north campus is going to "close." The fact of the matter, I don't see any circumstances short of—of demise of the entire VA, that either that Marion campus or the Fort Wayne campus is going to close. The nature of their missions may change. The IG has recommended that we consider moving nursing home care activity from north to south. We would look at inpatient medicine at this campus as a possibility to move from south to north. One of the earlier speakers addressed to sending veterans away from here for care. Marion is a primary care facility. We do not attempt to be a secondary level of care provider and certainly not tertiary. Indianapolis is our tertiary facility and Fort Wayne Medicine has the ability to provide a higher level of medical care on an ongoing basis than this campus. We run our census of about five and a half patients on any given day in medicine at the Marion campus here to date. So, I think those things all go together to create anxieties on everybody's part, managers' employees' part of service organizations, veterans and other constituents. But I don't see a scenario that is going to "close" either of these campuses but their mission may change. We've got almost \$70 million in construction here focused on long-term care, which is not just long-term psychiatry, but nursing home care as well. And that's going to be a big piece of the VA's business as we move into the next 15 to 20 years. We will be prepared with the environment to provide that care.

Mr. BUYER. Mr. Chairman, if I may. I'm almost done.

Mr. STUMP. Please, sure.

Mr. BUYER. That was about a 4 minute response and I still never heard what proactive steps you're going to take that will help bridge the gap between you and the unions.

Dr. MURPHY. We are in the process of setting up a mediation training program with Mr. Overbey and his vice president, Mr. Beller and myself. Hopefully that will lead us to be able to develop a sense of trust and relationship. We may need to do a similar kind of effort with the leadership of 1384 at the north campus. And out of that, as Mr. Overbey stated, we've got to both be willing to sit down and meet halfway, recognize the realities of what health care is all about in the 21st century and do what's best for Northern In-

diana and agree that we're both going to be uncomfortable in some of the things that we have to recommend, support and do, but if we're going to survive as an organization; that communication between the leadership of union and management is going to be essential and we're not going to go anyplace without it. And without it, we won't have a place for veterans to be cared for or employees to work.

Mr. BUYER. You're correct that either management nor the force can always be right. I recall when the Speaker of the House asked me to conduct a review of all of the sexual harassment issues that came out of the Aberdeen case. I recall that the commander at Aberdeen, a two-star Army General pulled me aside and told me that, you know, he just couldn't be responsible for everything that happens on his fort. To which I had to tell him that as I understood military culture, commanders are responsible not only for what they know, but what they should have known. That two-star general ended up receiving a letter of reprimand and retiring. So, I don't know, Dr. Murphy, if I'm leaving this hearing with the perception that your management style is reactive or proactive. Maybe it's proactive and you're reactive to constructive criticisms that can be help the system. Good communications just aren't present. I'm just being very honest with you. The unions stressed the lack of communications and I know that over the last 4 years I've come to Marion but you've never picked up the phone and called me. You have a wonderful opportunity here because the Chairman has taken the time to come from Arizona to Indiana to listen to how we can deliver better health care here in Indiana. While the Indiana Northern Health Delivery System is now under a microscope, we have to ensure that adequate financing is available to make sure you have appropriate levels of staffing. That is an extraordinary opportunity, and if I were a medical director, I would welcome the assistance. So, I will also will move closer. Is that all right?

Dr. MURPHY. Yes, sir.

Mr. BUYER. I yield back to you, Mr. Chairman.

Mr. STUMP. Thank you, Mr. Buyer. And thanks to this panel. Let me say again to all the witnesses how much we appreciate you coming out today and offering your testimony. As I mentioned, there will be questions submitted to some of you as—after we review this—your statements when we get back to Washington. And we will—this Committee will continue in its responsibility of oversight of our various institutions within the Veterans' Administration. And if necessary, we will be back. Thank you all very much. Mr. Buyer?

Mr. BUYER. Mr. Chairman, may I?

Mr. STUMP. Mr. Buyer.

Mr. BUYER. There are some individuals I'd like to recognize who were very helpful to the Committee in helping organize this hearing today. Dr. Murphy and his staff, Bob Beller, the associate director of Marion campus, and Mike Breden, the public affairs officer here in Marion. I've worked very well with Mike over the years and I have great respect for him. Also, Barry Baker, business support services and Don Goshenower. (Laughter.)

Unidentified speaker. Got it.

Mr. STUMP. Obviously you missed it.

Mr. BUYER. Well, when you have a name like mine you have to be very careful. He's a lieutenant with the VA police and he's been very helpful to our staff. Mr. Chairman, let me thank you and the professional staff for the work that they did to prepare for this hearing. What will be very telling will be, whether the concerns that we have within the delivery system here in Northern Indiana, are representative of what's happening across the country. So, we'll have a good view of this system and we'll see whether how it the issues are present across all health delivery systems within the VA. Mr. Chairman, we thank you for being here and we'll make you an honorary Hoosier if you promise to root for the Pacers.

Mr. STUMP. Only after the Suns are out.

Mr. BUYER. All right.

Dr. MURPHY. The sun is rarely out in Indiana, sir.

Mr. STUMP. Well—

Mr. BUYER. Let me extend a compliment to the communities of Fort Wayne, Marion, Muncie and South Bend. There are many individuals out there that help the VA system and they do so for many reasons. It's a thankless job but they do it for the intangibles and all across the country. We have a great hospital at Rodavich Facility and it's one of the prides of Indiana. It works very well with the medical teaching facility. I want to briefly discuss the excess buildings here at Marion. About a month ago I was over at the Danville VA Hospital and they were able to convert some of the buildings to other uses. I know this is a difficult subject with regard to the IG's report and all these excess facilities. We also have to deal with the environmental hazards that are also in these buildings and the concerns that Mr. Hahn brought up about whether these buildings have become just attractive nuisances and fire hazards. It's an issue we're going to have to confront. Hopefully you're working with the State to make decisions about whether you can tear down some of these buildings and which ones could be re-used. We want to work with you on this issue Dr. Murphy.

Dr. MURPHY. Thank you.

Mr. BUYER. Mr. Chairman, thank you very much.

Mr. STUMP. Well, let me add my thanks to all of those that are responsible for making everything happen today. And Dr. Murphy, particularly to you for hosting this meeting. And also to Mr. Buyer for making it possible for me to come back here and enjoy this weather. Makes me realize how much I like Arizona.

There are no other questions or any other statements? Meeting's adjourned. Thank you all.

[Whereupon, at 12:26 p.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF HON. STEVE BUYER

Mr. Chairman, I want to express my sincere gratitude for holding this hearing at the Marion VA Campus, and more importantly, for your leadership on the House Veterans' Affairs Committee.

Having served in combat during World War II in the United States Navy, you know firsthand the importance of taking care of America's veterans. Since coming to Congress, I have witnessed firsthand, your commitment to serving veterans and their families.

Under your leadership, the Congress has consistently increased veterans spending above President Clinton's request. Last year alone, you helped to negotiate an unprecedented \$1.7 billion or 10 percent increase in the VA budget. This year, Congress is targeting the VA for another large increase of approximately \$1.4 billion.

In addition, you were instrumental when the House passed legislation to improve GI Bill education benefits and provide for a 25 percent increase in educational assistance. Hopefully, the Senate will soon act on this legislation.

Whether ensuring VA provides adequate health care for sick Persian Gulf War veterans, victims of Agent Orange or radiation exposure, or ensuring VA delivers earned veterans benefits, your leadership and insight has been instrumental. Your continued efforts on behalf of veterans and their families have resulted in vast improvements in Department of Veterans Affairs.

While Congress and the VA have made significant improvements in the Department, more work still needs to be done.

That is why we are here today, to discuss the quality of VA care, patient and employee safety and overall management effectiveness.

While some presenting testimony today will raise issues that cast VA in a negative light, there are many good things about the Marion VA. As outlined in the VA's Inspector General report dated May 25, 2000, there are significant strengths of this facility.

For example, the Inspector General noted the quality of the Intensive Psychiatric Community Care, the Chaplain Services, POW services, Pharmacy Service technicians, a comprehensive infection control surveillance program, as well as outstanding services in treating ulcers and certain types of infections.

Nevertheless, when Congress provides for an increase in resources, as it has done over the last several years, I believe it has a duty to ensure the proper utilization of these resources.

Again, my sincere gratitude to you Mr. Chairman. I want to reiterate that your commitment to veterans is unparalleled. Veterans and their families should be thankful for advocates like yourself. I know I am.

I also want to thank the Marion VA staff for supporting this hearing. More importantly, for your dedication and commitment to serving the needs of veterans.

I also want to thank today's witnesses for agreeing to provide testimony. Your testimony will prove invaluable as the House Veterans' Affairs Committee seeks to make continued improvements to the VA Health Care system.

Finally, I want to extend a hearty welcome to our veterans in the audience. Ultimately, the House Veterans' Affairs Committee works for you. Myself and other Members of Congress truly appreciate the sacrifice and commitment that it takes to serve in this Nation's armed forces.

For your services, America is appreciative.

STATEMENT OF**ALANSON SCHWEITZER
ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE
INSPECTIONS**

Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to discuss the results of our review of the Department of Veterans Affairs Northern Indiana Health Care System. I am accompanied by Bill DeProspero, the Director of the IG's Chicago Audit Office, and Verena Briley-Hudson, the Director of the Chicago Office of Healthcare Inspections. As part of our cyclic program of reviews of VA field facilities, the VA Office of Inspector General conducted a Combined Assessment Program or CAP review of the Northern Indiana Health Care System from March 6 to 10, 2000. The purpose of the CAP review is threefold:

- Healthcare Inspectors evaluate how well the facility is accomplishing its mission of providing quality care and improving access to care, with high patient satisfaction.
- Auditors review selected administrative and financial activities to ensure that management controls are effective.

- Investigators conduct Fraud and Integrity Awareness Briefings to improve employee awareness of fraudulent activities that can occur in VA programs.

In addition, we examine issues or allegations that are referred to the OIG by facility employees, patients, members of Congress, or others.

For the record, I submit our final Northern Indiana Health Care System C.I.P report which I ask to be included as part of the record. That report contains the details of our review, our conclusions, and 17 recommendations for improvement. The report also contains management's concurrence with all of our recommendations, as well as implementation plans that we believe are responsive and constructive.

To summarize, our review of the Northern Indiana System covered health care operations for Fiscal Years 1998 to 2000. In performing the review, healthcare inspectors, auditors, and criminal investigators inspected work areas; interviewed medical center managers, employees, and patients; and reviewed pertinent administrative, financial and clinical records. They examined 26 separate health care

activities and 22 separate administrative activities. Although we concluded that administrative and clinical activities generally were operating satisfactorily, we did make observations and recommendations in several areas that appeared vulnerable to fraud, waste, or abuse, and other areas that were in need of improvement.

These areas included quality of care issues involving:

- Long-term care activities for elderly and geropsychiatric veterans;
- The physical, aesthetic, and functional condition of patient care areas;
- Quality management and performance improvement;
- Medication policy, and availability;
- Patient care services; and
- Employee assistance and training.

Also, we noted administrative issues involving:

- Administration of the South Bend community-based outpatient clinic contract;
- Accountability and security over controlled substances, narcotics, and sedatives;
- Contracting for radiology services;
- Laboratory Service staffing;
- Procedures for obtaining surgical informed consent;
- Reviews of Indiana State inspection reports for VA contract nursing homes;
- Control of medical supplies;
- Supply Processing and Distribution operations;
- Timeliness of Agent Cashier audits and controls over third-party payer checks;
- Access authority for inactive information technology users; and
- Drug prescription backlog monitoring.

In addition, OIG investigators conducted four fraud and integrity awareness briefings for 65 health care system managers and employees. The briefings included a lecture, a videotape presentation, and question and answer opportunities. Each session provided discussions of how

fraud occurs, criminal case examples, and information to assist employees in preventing and reporting fraud.

During the week of our visit, we received inquiries from about 40 patients and employees on about 100 issues which we categorized into 5 general issue areas:

- concerns over quality of care;
- alleged mismanagement of VA resources;
- personnel-related issues;
- alleged minor unlawful activities; and
- other miscellaneous issues.

A large number of the issues related in some fashion to staffing concerns. We found that the health care system managers were generally aware of the staffing concerns and the implications of resultant decreased staffing patterns. They were attempting to adjust staffing to better provide medical services. For example, they told us that they were initiating a system-wide position management analysis that should ultimately result in realigned staffing patterns that

should ensure a logical and effective deployment of direct patient care employees.

Mr. Chairman, this completes my opening statement. I will be happy to answer any questions that you or the Members of the Committee may have.

Michel Jean Calache, M.D.
1700 38 th Street Qtrs 29 B
Marion, Indiana 46953

May 29, 2000

Honorable Congressman Terry Everett
Chairman
Subcommittee on Oversight and Investigations:
U.S. House of Representatives
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

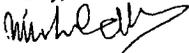
Dear Honorable Terry Everett:

Please find enclosed a copy of my written testimony for the purpose of the field hearing on the quality of care and management issues at the Marion campus of the Department of Veterans Affairs, Northern Indiana Health Care System (NIHCS) scheduled on June 1, 2000.

As I indicated by phone to Mr. Kingston Smith, I apologize for not being able to locate a copy of a letter I forwarded to Dr Kizer in early 1998 or late 1997 regarding on call issues at the Marion Campus, nor the letter I received from Ms Belton, Director, VSN 11 in response to my letter to Dr Kizer. Should I locate these copies prior to the hearings I shall make them available to your staff. Please find attached a copy of a memorandum dated June, 1998 forwarded to Dr Vitalpur, COS at NIHCS, from all full time psychiatrists regarding the on call issues as well as a copy of my CV. Also attached is a copy of an e-mail message regarding temporary coverage in psychiatry. I am a full time federal employee and have not received any federal grants.

I would like to thank you for trusting me as a witness and I am looking forward to serve my duties on June 1, 2000.

Sincerely,



Michel Jean Calache, M.D.
Staff Psychiatrist
NIHCS- Marion Campus

Mr. Chairman and Honorable Members of the Subcommittee on Oversight and Investigations:

It is a privilege for me to be trusted to serve as a witness to your investigative panel. I understand that the focus of your investigation is on quality of care and management at the Marion VA NIHCS.

I was hired as a staff psychiatrist at the Marion VAMC on January 13, 1991. During the past nine years, I gave my best to my patients, was loyal to this facility, and would like to believe that I interacted well with my colleagues, subordinates and superiors in a professional and ethical manner. More recently I have been interested in and looking forward to the changes occurring in VISN 11. I believe the collaboration between the VA hospitals in VISN 11 will standardize the level of care provided throughout the VISN allowing the Marion Campus to become a valuable resource as a specialized neuropsychiatric center in VISN 11.

As you may be aware I am still recovering from the sequelae of a head trauma. I would appreciate your understanding that my current health condition makes my task more difficult and may have an impact on my testimony. Also, my knowledge in matters of safety, staffing and management are limited with my experience and knowledge being a clinical psychiatrist. Furthermore, I have been off work since January 14, 2000 and may not be aware of recent changes occurring in matters of interest to this investigation. Please allow me to express my intentions to you and to all who are interested and/or involved in this matter. Over the past three years there have been tremendous changes at VA NIHCS. Many of these changes are positive due to the hard work of the current administration and the employees of this medical center. I am reporting disappointments and fallacies in our facility. This should not undermine the progress already made. More importantly I do not mean to blame, criticize, defame, degrade or judge others, but only to testify to the best of my ability. I will not hesitate to respond fully to all questions from your investigative panel. Should I experience difficulties in concentrating, remembering, or have difficulty controlling my emotions, I will let you know. I trust in your understanding and compassion.

I. Safety :

A. Assault incident on 1/14/2000 :

On January 14, 2000 around 3:00 pm I was in the nurses' station on unit 172-2-E. I was standing between a column on the south side of the station and the central island where the charts are located. I was facing the front of the nurses' station. Two nurses were sitting in the nurses' station working with their backs toward me. One of the nurses was on the telephone. The unit clerk was sitting in front of the computer on the north side of the station. A patient, Mr. W., was walking fast coming from the hallway and passing in

front of the day room. When he reached the middle at the front of the nurses' station, he raised both of his hands showing a light brown colored belt twisted around one of his wrists and stretching a piece of it with his other hand. He was staring and yelled at me "I am going to kill you, you s... of a b....". At that time he was about 6 -7 feet in front of me. We were separated by the counter of the nurses' station. Both nurses were sitting halfway between the patient and myself. The patient continued to walk fast and entered the nurses station through the west entrance walking toward me. I told him Mr. W., you are not allowed to enter/come into the nurses' station. A moment later I added, Mr. W. seems to be agitated! The patient then quickly put his belt around my neck and moved behind me. I remember beginning to black out, attempting to remove the belt from my neck, then letting go of the belt with my hands. I have been told that the patient later used the belt to swing my head toward the column I was standing beside, hitting the left side of my head. Though I cannot recall the following events, I now know that a code blue was called, I was transferred to Marion General Hospital and was later taken by helicopter to the head trauma center at Methodist Hospital in Indianapolis. Additional details can be found in the reports completed by the VA police and by an independent group of investigators appointed from other VA facilities.

My recovery up to this time has not been easy. I still do not know how much or how long it is going to take for me to fully recover. I look the same, but I am not the same person that I was. Everyone has dreams of who they want to be. I had those dreams. But now, until I know who I am and what I will be able to do, I can no longer dream. I know I am not doing well. I am far from being able to tolerate or handle an angry or agitated person. I am suffering from financial losses including loss of income from working in the community in addition to my VA job. I am not able to keep up on my Continuing Medical Education requirements and will have to inactivate some of my medical licenses. I still need treatment and rehabilitation. Preparing this report took an enormous effort from me and I had to hold all my rehab homework assignments for this week. My last assignment was to drive my car to an autoshop to switch my snow tires to regular tires, to go through personal papers, and to resummarize a chapter of a lay book on head injury. By knowing this, you may understand that writing this report is an extremely exhausting and demanding task for me at this time. However, I have been advised by my treating therapists that it might be beneficial to me to serve as a witness as I need to feel useful to society and others. This offers me an opportunity to contribute to that cause. I have received support from many people. I did not know how many people cared about me. I feel enriched with new friendships that are priceless. Dr Vitalpur, COS, provided me with support and assured me that I only need to worry about my recovery and to come back to work only when I am ready. Dr Mellow called me several times offering his assistance; although, I believe he is becoming impatient.

I need to bring to you some of my concerns and disappointments :

1. I ask myself, how could the patient walk in the hallway of the unit with a belt wrapped around his wrist without being noticed? Was it because there was not enough staff? or Was the staff not attentive?
2. Why did the nurses sitting between the patient and myself not see, hear or respond to the patient's threats? Was it because they were inattentive, or were they overly preoccupied because of their workload and the shortage of staff?
3. Why was the patient, whether agitated or not, able to enter the nurses' station, unnoticed and unchecked by staff?
4. Why did the nurses not hear me when I made two statements as the patient entered the nurses' station?
5. I regret that I was not more authoritative in seeking the staff's intervention.
6. I am copying this paragraph from my own written diary while I was in the hospital.

" I'm emotional and am frequently tearful. I was asked to tell OT students the reason I am in the hospital. I cried uncontrollably, being hurt that Dr T. insisted on dwelling and arguing about the incident and emphasizing her perception that I ought to care differently for the patient because of his hostile attitude toward Dr D'Mello and myself. I felt jittery, angry and provoked by her unempathic statements. "

This was written in January 2000 following the first contact my superior had with me after my accident. I had to insist that my therapist not contact my supervisor requesting that she not call me again. My impression at that time was that the administration was trying to cover up any possible blame.

7. Indifference of the Marion VA administration

a. I am disappointed that despite contradictory statements between myself, the nurses and the clerk on 2-E , as reported by outside investigators, the administration remains indifferent and is keeping its silence by avoiding addressing this issue.

b. Although I have no doubt that no one wanted me to be harmed, and that all the people I know regret what happened to me, I am disappointed that nobody from the administration called stating "we'll try to do better" or "we wish we could do better".

c. I requested that my workman's compensation papers be filed as soon as possible, starting February 29,2000. This was agreed upon. I understood that I would use my sick leave until OWCP payments arrived as I have to pay child support and it was tax time. Then 6-7 weeks later, I was told that my papers were not submitted as we had agreed. I was then told that I must go on leave without pay for 2 to 6 weeks before I would receive these benefits. I can buy back my leave, but this definitely added to my frustration and anger.

d. I was surprised and shocked when I was called by the engineering department stating that I needed to come to their office to sign lease papers for 6 months for renting quarters on the grounds. When I asked why they used six months, they said that it can be renewed later. I had to ask for others to intervene. I have been told that initially it was even asked that this be signed on a monthly basis, but the staff objected. I have been living in the quarters for more than 9 years. No leases have been signed. This is not the first time I have been on leave without pay. Six years ago I was on leave after a cardiac bypass surgery. I was not asked to sign a lease at that time. I have the hope and the right to go back to work within 12 months after my injury. The problem was quickly fixed, but this insensitivity caused additional stress and frustration for me.

8. Impact of the trauma on my loved ones

a. I am mostly disappointed that I have not been able to see my children as often as before the trauma. I have not been able to drive until 2-3 weeks ago and cannot have passengers that could distract me from concentrating. I still cannot take my children places. Furthermore, I may not be able to have my children for the annual four weeks visitation I have with them every summer. I will not be able to take them for a vacation this year.

b. I am hurt and hurting those who are surrounding me. My daughter is having difficulties adapting to what happened to me. Three weeks ago my daughter stood up in class stating that her father is mental, that he cannot drive anymore and that he has signs on his door limiting visitations to two hours a day. The teacher recommended that she be seen by her pediatrician who referred her for psychotherapy. Seeing my loved ones hurt is more painful and disappointing than my own losses.

9. I am disappointed that I am not able to serve and contribute to the community I live in. Marion is underserved in psychiatry. The need in public psychiatry is tremendous. There is a scarcity of psychiatrists, no geriatric psychiatrists and difficulties recruiting in this county.

10. I am thankful that I have this opportunity to express my feelings to you and be heard. This means you are concerned, empathic and do not wish this to happen again to me or to my coworkers.

B. Safety in admission area

Several of my colleagues/coworkers and myself, believe that the admission area and the hallways of the Mental Hygiene Clinic need better security. It has been suggested to have videocameras with monitors in the security office. This issue remains unsolved.

II. Staffing and management :

A. On call duties :

Psychiatrists are required to provide emergency medical care to patients admitted to the medical floor, the admission area at the Marion campus. Psychiatrists may call a back up

primary care physician for consultation, medical advice or assistance. Some of the primary care physicians live at least one hour away from Marion. This medical practice is highly unusual in the VA and does not meet the standards of medical care in this country. Although licensed physicians, psychiatrists are not trained to deliver this level of acute medical care which is beyond their areas of expertise. This practice places critically ill veterans at risk, places ill employees or visitors at risk, and increases the risks for malpractice. This imposed requirement places unnecessary stress on the psychiatry staff and creates job dissatisfaction resulting in lowering their morale.

Psychiatrists in this facility have repeatedly expressed their dissatisfaction regarding this issue. The administration disregarded their concerns. About two to two and a half years ago, I expressed these concerns in a medical staff meeting. I was told by the COS "Be my guest, leave" although I had not expressed an intention to leave. I responded that I had sent a letter to Dr Kizer regarding this matter. The immediate response from the COS was "OK. We will have a double roster for psychiatry and primary care". However, this time coincided with a rapid reduction in fee basis physicians who shared most of the calls, and a reduction of the full time staff physicians. This posed a tremendous demand on primary care physicians in this facility. Their level of frustration was growing and the delivery of services was compromised. Collegiality among primary care physicians and psychiatrists suffered. Later, I received a letter from Ms. Belton, Director of VISN 11, responding to my letter forwarded to her by Dr Kizer. To the best of my recall she acknowledged the concerns and conveyed to me the response she received from the administration at NIHCS. There were three reasons given to justify having a single roster with psychiatrists providing emergency medical care at this facility. The first is that the more severe medical cases will be transferred to the Fort Wayne campus. The second was that the back up physicians will provide support. The third reason was that primary care physicians living on grounds are available to provide support. A few months after initiation of a double roster with the least number of physicians employed by this facility for years, a single roster was reimplemented. All full time psychiatrists at that time sent a memorandum to Dr Vitalpur expressing their request to maintain double rosters. Dr Vitalpur responded negatively stating that the single roster had been a trend in this campus for years and that he consulted with Dr Mellow, Director of the BS&MH product line, who approved of this plan. (See attached a copy of the memo sent from all full time psychiatrists at that time to Dr Vitalpur, COS). During the past year there has been an increased number of fee basis physicians that provide emergency care. However, psychiatrists continue to rotate and share with primary care physicians, emergency medical calls from 1- 4 hours daily and coverage when the fee basis physicians are on vacation or are unavailable. I have been told that the administration is negotiating contracts to provide emergency medical services after hours and weekends to replace fee basis physicians. However, the administration continues to refuse to use fee basis

physicians or negotiate for contracts for the remaining few hours of each day.

In response, I would like to make the following statements:

1. This is not the standard of care in the VA or in this country and does not represent an excellence of care. In fact, I believe that is the only VA hospital or one out of two which provides this type of care. I believe that if such a request was placed on psychiatry staff at the Ann Arbor VA or Indianapolis VA, it would not have been possible to implement it.
2. It is unethical that the veterans in the acute medicine and admission areas, and the employees, who require emergency medical care, not be informed that a psychiatrist might be providing the acute medical care.
3. It is NOT true that primary care physicians who live on grounds were willing to come to the hospital after hours whenever there was a need. I personally discussed this with those living on the grounds at the time I received the letter from Ms. Belton.
4. As much as I am aware, at least 50 % of malpractice cases are due to faulty assessment, and not management. Despite telephone screening to refer veterans calling for emergency medical care to a local hospital, the nature of medical care is more complex. For example, a patient may present for what he believes to be a mild ailment but may have a serious illness not detected by a psychiatrist. Though more severe cases are forwarded to the local hospital and to the Fort Wayne campus, at that time, the administration was exploring the possibility of closing the medical unit in the Marion.
5. The morale of the psychiatrists has been low, and it has affected the recruiting and maintaining of new psychiatrists. I personally know three psychiatrists who left this facility over the past 5 years for this very specific reason.
6. I know that Dr Thangavelu, Chief of BS&MH, shares with the majority of the psychiatry staff this same point of view.
7. The Advance Cardiac Life Support training (ACLS certificate) does NOT mean that the trainee is licensed nor that he/she has the expertise to manage acute problems. It only means that the carrier of the certificate successfully completed the course (per definition of ACLS and one of its questions in the test).
8. When I think of my patients that I expose to risk of harm and possible death, my career that I put in jeopardy and my children who might lose financial security because of possible malpractice suit, I do not have a choice and without hesitation I will continue to complain. All of the psychiatrists have been compliant with the requirements of the administration; however, we disagree with them. I am thankful that this report will be available to you and that you'll make it available on the internet. It will be up to you, the media and the veterans to judge and decide.

B. Poor staffing planning and continuity of care :

1. For the past 2 years and up to the end of October 1999 I was assigned to the two long term psychiatry units 172-2B and 172-2C. Both of these units were transferred

administratively under Extended Care product line and consequently the Chief of BS & MH needed to reassign me to another psychiatric area. My reassignment was not made clear until late or early December to the best of my recall. I received directions from her office, initially daily, then every few days, then weekly (see attachment). Though I was mostly assigned to the same units, 172-1C and 172-2E. This lack of permanent assignment interfered with the delivery of care for refractory long term psychiatric patients. It was not unusual that by discussing patients' care with the nurses on these units, either I or the nurses, would ask whether I would be the assigned physician the following day. Also, consultations for extended care patients were being rotated among the psychiatrists. This resulted in some patients being seen by a different psychiatrist every day. Staff psychiatrists and particularly myself frequently complained of this fragmented patient care. It was a few months later at matter, after the Union's intervention, that each of the psychiatrists was assigned as a consultant to one of the long term psychiatry wards. The same problem occurred in the outpatient Mental Hygiene Clinics when we did not have an assigned psychiatrist to the Post Traumatic Stress Disorder Clinic. Patients were dissatisfied with the inconsistency of staffing and seeing a different psychiatrist everytime. Also, the psychiatrists felt handicapped in initiating any long term plan or medication changes as we would not see the same patient again.

2. Staffing and comparative staffing at the VISN level : For several months and up until now, the Chief of BS & MH at NIHCS has been unable to formulate a basis for assessing staffing needs for the service. This basis was rapidly formulated by the Chief of Primary Care. She has been formally asked identify state the number of physicians needed per patient type and population served.

This problem extends to the VISN level. The administration does not have a uniform basis for establishing staffing needs. In comparison to Battle Creek VA in Michigan, Marion VA provides similar services to a relatively larger inpatient population. Marion has 7 full time psychiatrists and 5 psychologists, while Battle Creek has 14 full time psychiatrists and 14 full time psychologists in Battle Creek.

3. Several of my colleagues, both in psychiatry and primary care, continuously express to me similar complaints which make the day to day practice stressful, and unsatisfactory to both patients and physicians. The demands of management are often unrealistic and not practical. There has been marked staff reductions. My colleagues frequently complain of changing assignments without convincing causes or consideration of their wishes and interests. They perceive such changes as a cause of disruption of patients' continuity of care leading to patients' dissatisfaction. One of my colleagues informed me that he has been frequently reassigned to different clinics. The work load is not feasible within the scheduled time. Most primary care physicians almost daily are required to remain after hours to complete their

assignments. This is without compensation. Physicians who do not remain after hours leaving patients' needs unattended and are at risk of being delinquent. Recently I have been told that three patients were scheduled to be seen within 15 minutes by one of my colleagues. This is not feasible and causes a prolonged waiting time for the patients and a decrease in their satisfaction. Physicians share with other employees the belief that the financial constraints of the administration has caused a staff shortage resulting in decreased quality of care and decreased patients and staff satisfaction.

C. Managerial role model :

It is with embarrassment that I have to admit that my superior Dr. Thangavelu is less than efficient both clinically and managerially. This is not only my personal opinion but also what I have been told by several of my colleagues and coworkers whether in clinical or administrative and clerical disciplines. The following are only examples :

1. Very frequently evading her clinical assignments, or after several official debates about, she delegates her clinical to one of the psychiatrists ; refusing to be on certain categories of call stating "Because I am very busy" as she wrongfully undermined the work load of her colleagues.
2. Ineffective and unable to organize the service: stating in an official meeting that she has a plan written and ready when her own supporting staff indicates differently, responding to e-mail messages several weeks or months later.
3. Unacceptable professional ethics and conduct : coworkers report her to be disrespectful to subordinates; and that she goes home to take naps during working hours; goes home at 10 am because she missed breakfast as she had to attend staff meeting at 7:30 am; recently asked a colleague to drive her home as she took a benadryl capsule for a cold, felt drowsy and was unable to work . In my own experience if a first year resident behave in such a manner he/she might not graduate.

Memorandum

Date : June 3, 1998
From : Psychiatry staff
To : V. Vitalpur, M.D. Chief of Staff
Subject : Call duties

1. We appreciate very much your efforts in hiring physicians for after hours and weekend duties. We recognize that it is a difficult and demanding task.
2. With the proposed roster only a few (about 5 shifts) remain vacant for the month of July. This should markedly decrease the burden of staff shortage during the day.
3. We would like to express some of our many concerns regarding requesting from psychiatrists to assume medical duties.
4. These concerns are :
 - a. We were trained as psychiatrists. We did not receive training in acute medicine.
 - b. The brief training that we received in primary care was several years ago, was never maintained or required to be maintained by practice. That training was never intended to prepare us to handle the medical conditions that we face in acute medicine. It is only natural to have experienced a loss of knowledge as our involvement with medicine as a branch has been tangential.
 - c. Obtaining a license to practice medicine a decade (or more) ago does not translate into an ability to adequately practice all fields of medicine without maintaining those skills. The skills we maintained are in psychiatry. We are licensed physicians even if we only practice psychiatry. Licensure Departments across the country do not require from psychiatrists to maintain skills in medicine to maintain their licenses. CME limited to psychiatry is sufficient.
 - d. We do not feel comfortable and in fact feel extremely vulnerable in managing acute and complicated medical conditions.
 - e. The complexities and emergency of certain cases in both diagnosis and management is beyond our expertise. Neither phone calls nor a waiting for 20 minutes or an hour for a back up medical assistance or a transfer to another facility is relevant.
 - f. The current close scrutiny in patient's care make us much more vulnerable and inadequate for these tasks.

g. The requested duties and responsibilities are a source of tremendous stress and dissatisfaction among all of us psychiatrists. Moreover, an undetected previous poor health care delivery is not a justification to continue wrong doing.

2. We, the staff psychiatrists, believe that a single MOD roster

a. Will compromise the quality of care and contributes to less than excellence in health care"

b. Compromises professional ethics by forcing psychiatrists into role for which were ill-suited.

c. Invite litigious individuals to bring lawsuits.

d. Contribute to disillusionment and loss of morale.

e. Contribute to perception of being unconcerned re: the serious needs of our patients and lacking in respect for their medical needs.

f. Make it difficult to recruit and retain qualified psychiatrists

g. Likely increase morbidity and mortality in our patients.

4. Our legal counselor informed us that most malpractice in our facilities are due to faulty assessment and diagnosis.

5. The misunderstanding of our medical colleagues and the administration despite of what appear evident to the lay, the nurse and the paramedical, increases our unjustified alienation and humiliation. These demands are completely foreign to us psychiatrists. Neither during our training nor in our career expectations were we prepared to face such demands. If Dr. Mellow is involved in the decision process we invite him as "one of us" that we may speak common language and discuss this issue with him. Data about patients' diagnoses on the medical floor should be helpful.

6. We the staff psychiatrists demonstrated are willingness to work more and to put more time and effort than ever encountered before in this facility.

7. We request a. to maintain a dual MOD roster

b. not to be asked to assume duties differently than other psychiatrists in other VA and non VA facilities.

c. to accept this document as a reference that might be used in legal and non legal disputes regarding patients care.

d. to continue to recruit physicians for on call duties

e. the understanding that each one of us is devoted to our patients and this facility and would like to cooperate with the administration in the prescription of change for excellence in care.

STATEMENT SUBMITTED BY WILLIAM T. OVERBEY, LOCAL PRESIDENT OF THE AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO, LOCAL 1020

Chairman Stump and Representative Buyer, my name is Bill Overbey. I am the Local President of the American Federation of Government Employees (AFGE) Local 1020, which represents approximately 600 bargaining unit employees at the Marion Division of VA Northern Indiana Health Care System (VA NIHCS) My Local represents the full range of health care workers and support staff at this facility. We represent all non-supervisory employees in this hospital including physicians, nurses, pharmacists, psychologists, engineers, carpenters, and food service workers. Thank you for holding this hearing in Marion. Thank you for listening to the people on the front lines who provide the direct services for America's veterans. I ask that my written statement be included in the record.

My comments today are guided by two key principles. One, veterans' health care needs are unique and veterans are entitled to medical care that is provided by employees whose training and focus is dedicated to serving *only* veterans. Two, it is the *front line health care workers and support staff that give meaning to VA's mission.*

It is not the VISN Director or facility managers honing their skills as the "cost cutting experts" who delivers on the promises explicit in the laws and legislation governing veterans' health care. It is the Nursing Assistant reassuring an anxious veteran being escorted to chemotherapy treatments who makes a difference in quality of care in an individual and personal way. It is the Licensed Practical Nurse who is quick to recognize signs of a patient's adverse reaction to medication that gives practical application to VA policies on patient health and safety. It is the food service worker who not only delivers or serves a veteran his meal but offers kind words of support because that employee also served in Vietnam and has fought his own battles with post-traumatic stress disorder and depression. It is the social worker who finds a homeless veteran shelter in a safe and supportive environment, and vocational training to raise his or her morale and become a self-sustaining member of society.

I hope you are beginning to get a picture of daily life in the VA.

Using these two guiding principles I want to speak to three issues that are crucial to improving the quality of veterans health care. One is inadequate staffing levels. The second is the use of private contractors to replace federal employees to provide medical and support services for veterans. The third is arbitrary budget constraints and the VA management's inability to respond in the best interest of patient care needs.

STAFFING LEVELS

Even the most professional and dedicated employee cannot provide adequate – let alone world class – quality health care without proper staff-to-patient ratios, adequate support staff and supplies. Adequate numbers of well-trained staff are essential to manage workloads, to prevent harmful delays in care, to avert medical errors and to improve services. Adequate staffing levels are a big problem nationwide at the DVA

and in Marion. Between 1992 and 1999, DVA eliminated roughly 1 out of 8 medical care staff. And it will get worse in FY 2001. Under DVA's proposed FY 2001 budget request, staff will be down by 29,652 from DVA's 1994 staffing levels, although DVA projects it will be treating more veterans and those veterans will be frailer and sicker than ever before.

Downsizing by means of attrition has been the standard operating procedure to reduce staffing at VA NIHCS. However, the result of this management practice has created dangerously low staffing levels across the board for direct patient care and related ancillary support services. One problem with downsizing through attrition is that the vast majority of job reductions have come from essential direct patient care occupations. These employees are often the low paid positions with great exposure to strenuous physical activity and bodily injury due to their work environment. Both voluntary and forced overtime are used by management in an attempt to compensate for the negative effects of chronic understaffing and downsizing. To the contrary, VA downsizing through attrition has had the opposite effect on management officials who are very well paid and do not engage in direct patient care. These officials do not continually face the threat of having their jobs eliminated. They in fact spend much of their time going to non-productive meetings and committees which impose even more responsibilities and obligations on the bargaining unit employees under their supervision than already exists. The comparatively low relevant and necessary workloads of some of these management officials are deemed "none of anyone's concern" when questioned as to their contribution to the mission and values of VA NIHCS by AFGE.

When looking at the Department of Veterans Affairs (DVA) as a whole, one could be led to believe that the agency is adequately staffed in terms of staff-to-patient ratios. However, the overall statistics do not differentiate between those who provide direct patient care and those who do not. AFGE has been challenging management officials for many years to realign staff to where the actual work is rather than where the work is created to justify the existence of non-essential personnel.

Inadequate staff-to-patient ratios can have serious consequences for patients. For example, research shows patients at hospitals with fewer nurses per patient have a greater incidence of urinary tract infections, pneumonia, blood clots, pulmonary congestion and other lung-related problems following major surgery.

Management is relying on overtime "In an attempt" to provide minimum nursing staffing levels on all shifts 24 hours a day, seven days a week. There are times when, even with overtime, the minimum staffing levels still are not met. Additionally, veterans have been medically diagnosed to be in need of PEG feeding tubes, and have been put on a waiting list for the procedure which may last up to several months. In the interim, these patients may suffer from aspiration pneumonia and other related illnesses which could lead to further suffering and/or death.

DVA often wants to ignore the real effects that low levels of staffing have on the

veterans' care. For example, nationally DVA's analysis of reported medical errors does not call for an analysis of whether the staff-to-patient ratio was adequate, whether staff involved were on overtime, or whether staff involved were performing additional duties beyond their regular duties because of staffing shortages.

Nationwide, nearly 20 percent of the reported medical errors at DVA facilities involved a patient falling. AFGE believes that nursing staff-to-patient ratios may be a factor in these falls. One-third of the reported medical errors were a suicide or attempted suicide, yet DVA's protocols on investigating these events do not require an examination of how the extensive elimination of inpatient psychiatric beds and the concurrent reduction in staff affected those veterans in need of mental health services.

Chairman Stump, I ask that you call a study by DVA of the relationships between adverse incidents (including "close call" medical errors) and the reductions in clinical and supporting staff levels, as well as elimination of inpatient beds for mental health services.

Low staffing levels affect worker safety as well. Understaffing in direct patient care areas puts patients and staff at an increased risk for potential danger and harm. Psychiatric and Extended Care Units simply cannot function safely with inadequate staff. In the past few years at the Marion division of VA NIHCS there have been numerous employees attacked and assaulted, including a brutal assault and rape and a recent attempted murder. AFGE strongly feels that all of these critical incidents could have been averted with properly trained and adequate staff. AFGE has made a suggestion to management encouraging the development and implementation of a "buddy system" for all psychiatric and extended care units. This system calls for all nursing functions on these units to be performed with no fewer than two employees to provide for a back-up system. In addition, this system would call for a nursing employee to accompany all clinicians and/or visitors when they are present on the units.

Chairman Stump and Representative Buyer we would appreciate any help you can lend to get management to the negotiating table to discuss these issues. AFGE wants to talk about real improvements in safety for workers and for patients but we have a resistant partner in management.

CONTRACTING

AFGE believes that veterans are best served by a unique veterans health care system that is dedicated to only serving veterans. DVA researchers, clinicians and other healthcare employees have focused their practice on the *unique* illnesses and disabling conditions that affect veterans as a result of their military service. DVA has developed world-class expertise in treating spinal cord injury, blindness, traumatic brain injury, amputation, serious mental illness, and post-traumatic stress disorder. DVA is unmatched in its research and treatment of diseases, illnesses and conditions that are

linked to the chemical and environmental hazards of combat, whether it is exposure to nitrogen or sulfur mustard gas, nerve gas, Agent Orange or other toxic substances affecting Persian Gulf War veterans. The DVA developed the first cardiac pacemaker, conducted the first kidney transplant in the U.S., developed a vaccine for hepatitis, and developed the MRI and CAT scans.

We understand that there are some lawmakers who would like to privatize veterans' health care because they believe that veterans might be better served by paid-for private-sector health care. These proponents of privatization believe that veterans would receive better care and that taxpayers would save money.

DVA's nationwide experience with private contractors shows serious problems in monitoring quality and costs. For example, DVA has a nationwide contract for nursing home care with Beverly Enterprises. DVA will make an onsite visit – at best – once a month to check on quality of care. DVA's contract doesn't require monitoring on bedsores or staff-to-patient ratios or a bar code medication administration program or other indicators that veterans are receiving high quality and safe care.

Neither DVA's Medical Inspector nor DVA's Inspector General, Office of Healthcare Inspections, study the medical errors that may be occurring at facilities in which DVA contracts for veterans medical care or conduct audits of the quality of care that veterans receive at contractor operated facilities.

In a March 1996 study, GAO found that DVA did not monitor the quality of home health care services provided by contractors directly or with the same scrutiny it does of the care provided by its own home health care programs. GAO found that roughly two-thirds of the medical centers didn't even monitor contractors for basic performance indicators related to quality of care such as the rate of patient deaths, whether patients had bed sores, infections, or had to visit emergency rooms.¹ DVA often relies upon the fact that its contractors are certified as Medicare reimbursement eligible as a proxy for oversight. Such reliance is misplaced. In September 1997, the federal agency which certifies home health agencies as eligible for Medicare reimbursement issued an unprecedented moratorium on the entry of any new contractors because waste, fraud and abuse was so prevalent in the home health industry.

Unlike the DVA's in-house operations, DVA's contractors are not required to inform veterans or their families of medical errors or adverse events that occur in a contractor facility. Nor are veterans entitled to additional compensation or disability benefits when they suffer medical malpractice or negligence at the hands of contractors with the DVA.

While the DVA has exemplary clinical protocols for treating veterans with spinal cord injury, blindness, traumatic brain injury, amputation, serious mental illness, and post-traumatic stress disorder, contractors are not required to follow these protocols. Even if

¹ GAO/HEHS-96-68 (March 1996).

DVA required contractors to follow its practices, DVA has demonstrated that it is not able to monitor compliance adequately or even annually.

As in the case of our Muncie-Anderson Community-Based Outpatient Clinic (CBOC), contractors are frequently paid on per-patient basis, regardless of the costs for that patient. Under such arrangements treating healthier veterans and using fewer diagnostic tests and providing less costly treatments maximizes profits. Decisions for a veteran's care should be driven by that veteran's health care needs and the professional, independent assessment of DVA employees and not those of contractors, whose primary interest is profit.

In addition to the quality of care concerns raised by DVA's increased use of contractors to provide veterans with care, there is also the issue of cost. DVA rarely, if ever, performs an adequate cost comparison of whether it is more efficient to use contractors or DVA employees to provide veterans with health care services, and this is the case with the Muncie-Anderson CBOC. There has never been, nor is there any intention to do a genuine cost comparison study between the current contractor-operated CBOC and a federally staffed CBOC in the Muncie-Anderson area.

The examples of contracting out at Marion also show that privatization does not work out as wonderful as management claims.

For example, when the laundry operation was being done in-house at Marion, it was completed in a highly efficient and well-done manner. The turn-around time for laundry was generally no more than one day. Patient clothing was neat, clean, pressed and dried very well. Patients who were admitted with soiled clothing to the acute care inpatient units could have their laundry cleaned and back to them ready to wear in one to two hours. This was, and still is a frequent need for newly admitted patients. Personal items left in patients' pockets were always returned to the patients.

Under the current contracted out laundry operation it takes one week to return laundry back to the patients, if they are lucky enough to get their own clothing back at all. The clothing returned from the private contractor often smells badly, is damp, wrinkled, stained, and missing altogether. Personal items inadvertently left in patient clothing is never returned (for example, we used to average about \$25.00 per week in canteen books left in pockets). We have yet to have one canteen book returned since the contractor has been doing our laundry. Cash money has always been found in patients' pockets which goes to the laundry for cleaning. To this day not one penny has been returned since the operation was contracted out. Other personal items have not ever been returned (such as watches, eyeglasses, wallets, etc.). Furthermore, VA NIHCS management officials have admitted that contracted out the laundry services has not resulted in a more cost-effective operation.

VA NIHCS Management is gearing up to contract out the Medical Officer of the Day (MOD) duties for all non-administrative hours. These duties have always been covered

by in-house and fee-basis physicians. The current management proposal to contract out the MOD responsibilities would result in an increased cost of over \$5,000.00 a year over the current practice of covering these hours with federal employees. The contracting-out proposal has been generated in spite of enough physicians to cover these hours. This proposed contract would serve only to show the DVA that VA NIHCS management has every intention of contracting-out as many services as possible, regardless of the increased cost or sacrifice of quality of service provided by federal workers who are committed to providing the highest quality of care to veterans. Private contractors are only motivated by profit margins.

With millions of dollars at stake, DVA should be making viable and quality cost comparisons on all its current and proposed contracted out services. If this is not done, the VA should adhere to a moratorium on any further contracting out activities.

Representative Buyer as the Congressman from this district, I urge you to join Representative Hostettler as a co-sponsor of the TRUTHFULNESS, RESPONSIBILITY, AND ACCOUNTABILITY IN CONTRACTING (TRAC) ACT. This bill is H.R. 3766.

The TRAC ACT would enable congressional oversight of the contracting out process and ensure that federal agencies are held accountable to demonstrate that such contracting improves service performance and is cost effective. It requires a temporary suspension on new service contracts until agencies have established systems to track costs and savings from contracting subjected work to public-private competition before giving it to contractors. It also would abolish arbitrary personnel ceilings, and would ensure that contracting-in is emphasized at least to the same extent as contracting-out.

To prevent any disruption to veterans after the imposition of a suspension, the suspension can be waived for individual contracts that are needed for critical patient care. This way DVA could still contract for veterans to receive emergency or critical medical care that could not otherwise be provided at the DVA.

I urge you to strongly consider supporting the TRAC ACT for the sake of veterans every where, and to stand up against selling veterans health care to the "lowest bidder."

ARBITRARY BUDGET CONSTRAINTS AND VA NIHCS MANAGEMENT'S INABILITY TO RESPOND IN THE BEST INTERESTS OF PATIENT CARE NEEDS.

Federal budget constraints, while having possible good intentions by the Agency, Congress, or the Executive Branch of government, often results in reductions of the quality of care provided to patients. What is devised at the top levels of government as a way to improve efficiency and care for veterans, far too often ends up adversely impacting patient care at the facility level. One issue is that while the original intention by Congress or DVA to help improve the quality and care provided to veterans may be just and honorable, the mid and lower level management officials tasked with carrying

out these directives often times are not invested in ensuring the successful and just completion of the original intended results. The blame for the overall failures of the programs and tasks can then be blamed on "inefficient" employees who have little to no influence in the decision-making process. One example of this is the current proposed Service Line model by VA NIHCS management. It does not provide adequate clinical and clerical coverage for essential patient care areas. This would place the employees in the untenable position of being ordered to provide services to patients without being provided the necessary resources and personnel to carry out their instructions. This would put everyone at risk for personal and/or professional harm.

Another example of VA NIHCS management's failure to deal with budget constraints in the best interest of patient care is the closing of our patient wood shop. This gave patients the opportunity to constructively engage in therapeutic activities for occupational rehabilitation, and provided toys for underprivileged children in our community for many years. This program was terminated in the interest of saving money for VA NIHCS.

A widespread practice at VA NIHCS and across the nation in VA Medical Centers is the "forced servitude" of physicians without compensation. The DVA has interpreted 38 USC to mean that the 24 hour a day, seven day a week availability required as a condition of employment for certain Title 38 physicians entitles management officials to schedule the physicians for non-administrative hours of duty including evenings and weekend hours as a routine practice. The physicians have no formal compensation in terms of overtime pay or time off as a result of their working more than 40 hours a week due to their interpretation of the law. It is AFGE's contention that the 24/7 requirement for availability to work by physicians was meant for instances of local, state, federal, or natural disasters or emergencies. This should not be an opportunity to take advantage of "free labor".

Due to budget constraints and the current VERA funding model, VA NIHCS management has deemed it necessary to discharge VA Nursing Home Care Unit (NHCU), long-term psychiatry, and extended care inpatients to community nursing homes where they do not receive the same standard of care that the VA provides. Many of these veterans are former POW's, Purple Heart recipients, service-connected and non-service connected veterans. AFGE strongly takes exception to this policy of indiscriminately discharging any patients who have honorably served their country when they were called. The discharge criteria has gone from being appropriate for community care to how much money can VA NIHCS save by getting rid of the veterans from the wards. AFGE asserts that veterans health care needs are an entitlement and local facility management should not have the authority to determine who will receive VA health care services. In fact, the treatment teams for these hospitalized veterans are strongly encouraged to avoid offering any VA nursing home contract placements when possible. The preference is for as many veterans as possible to be placed directly on Medicare or Medicaid status, thus saving the VA the cost of any ongoing care for the veteran (this includes both service-connected and non-service connected veterans).

Another example of how patient care needs have been compromised due to budget constraints is the drive at the national level to transfer all Substance Abuse Treatment Programs (SATP's) from inpatient to outpatient programs. This directive from the Undersecretary of Health of the DVA resulted in the closing of inpatient SATP's regardless of the success of the individual programs. The current outpatient SATP of VA NIHCS Marion Division has suffered from a multitude of problems both internally and externally because of the forced change. Some examples of the problems are:

- 1.) SATP has gone from a 28-day program down to a 15-day program since the conversion.
- 2.) The capacity of the program to serve patients has declined from 34 to 20 patients at a time from inpatient to outpatient Lodger status.
- 3.) Staffing lost during the conversion to outpatient care has included one physician assistant, three registered nurses, six nursing assistants, one dual diagnosis counselor, one outpatient remote location counselor, one outpatient aftercare counselor, one program evaluator, one admission intake counselor, and one community half-way house clerk.
- 4.) The number of patients not completing the program since conversion has doubled. This includes patients with positive drug urinalyses, discharges for threats against staff or other persons, and persons leaving against medical advice (AMA).
- 5.) The following specific treatment programs have been discontinued with the change from inpatient to outpatient care:
 - a. Saturday Family day programs- eight hours of lectures, training and family group therapy administered by a social worker twice monthly.
 - b. Sunday Chaplain's Lecture and individual counseling Sessions four hours per week.
 - c. Saturday Outpatient Relapse Prevention Aftercare groups and individual sessions twice monthly for eight hours for patients coming from long distance locations.
 - d. Evening outpatient aftercare groups and individual sessions three evenings per week.
 - e. Outreach Aftercare groups and individual sessions at Anderson, IN three days per week.
 - f. Adult Children of Alcoholics program weekly.
 - g. Smoking Cessation Program weekly.
 - h. Capability to treat handicapped patients decreased by 50% due to the long distance between where the patients are lodged and are treated.

- i. Severe Dual Diagnosis patients are very limited in their participation in the program due to the lack of supervision in the evening and weekends. The majority of these patients are no longer being accepted for treatment.
- j. Local follow-up of outpatient for aftercare is no longer being done due to the lack of staff to perform treatment.
- k. There is an extended delay for admission to the program now due to delays in returning phone calls for screenings due to the lack of an admissions intake coordinator.
- l. Alcoholics Anonymous (AA) programs are no longer offered at night. They had to be moved to days due to loss of staff. This results in inactivity of patients during the evenings, and loss of 50% attendance by AA members in the local community.
- m. The veteran service organizations are no longer able to provide day trips to their lodges or posts on weekends and holidays.

Another example of the negative effects of budget constraints at the facility level is our current Fire and Safety operation.

The Marion division of VA NIHCS used to have its own fire department, complete with firefighters, fire trucks and an ambulance. In 1995, a decision was made by VA NIHCS management to eliminate the fire department and leave the fire protection services in the hands of the City of Marion Fire Department (MFD). While the MFD is a very high quality and professional organization, the physical distance between the VA and the city fire stations, combined with the problem of having active railroad tracks between the VA and any given city fire station, leaves the VA at a greater risk for structural damage and loss of life.

When the decision was made to eliminate our fire department, four of the firefighters remained and were reassigned and downgraded to GS-5 Fire and Safety Inspector positions. VA NIHCS management promised the city of Marion leadership that we would keep at least one Fire and Safety Inspector on duty at all times.

VA NIHCS management is now proposing to eliminate the 24-hour fire prevention and protection coverage provided by these employees. The reason that VA NIHCS management wants to end the 24-hour coverage is so that they can consequently discontinue the 25% premium pay that the fire and safety inspectors receive for their "down-time" in a 24-hour tour. There are currently two GS-12 and two GS-11 management officials employed in our Safety and Fire Prevention Program, and one of the GS-11's has been receiving an additional 15% of his annual salary as a "retention allowance" for the past several years. Yet, VA NIHCS management wishes to eliminate 25% of four GS-5 employees' pay or order to trim operational cost. This proposal would further increase the risk for possible loss of life and/or structural damage.

In the past couple of months, there have been two fires at this facility. One of these fires was set intentionally by a patient and the other was started by a private contractor, who

was removing our laundry equipment. In the case of the fire that was set by a patient, our fire and safety inspectors were on the scene and extinguished the fire within a few minutes. During this fire, MFD was dispatched and arrived at the VA within 6-7 minutes. However, because MFD isn't informed by their dispatch of the exact location of a fire at the VA, and because our fire and safety inspectors were tied up with extinguishing one fire and responding to another fire alarm at the same time, it was an additional 10-12 minutes before MFD arrived at the scene of the fire. We all know what a fire can develop into if action is not taken quickly.

AFGE strongly opposes the elimination of our current 24-hour fire prevention and protection coverage.

Chairman Stump and Representative Buyer, I want to again thank you for holding this hearing in Marion and I want to ask for your support in ensuring that VA workers have the necessary resources to continue to provide the unmatched quality of service that our nations veterans deserve.

This concludes my statement. Thank you again for the opportunity to testify before you today.

William T. Overbey, President
AFGE, Local #1020

May 21, 2000

Statement
 Committee on Veterans' Affairs
 U.S. House of Representatives
 Washington, D.C. 20515

Testimony for June 1, 2000 Field Hearing of the Subcommittee on Oversight and Investigations

I wish to make a statement regarding the quality of the management at the Marion VA. I have been employed with the VA since June 7, 1987. I am a U.S. Army veteran having served from 1963 to 1966. I was honorably discharged in May 1966 and received the Army Commendation Medal and the Good Conduct Medal. I was employed as a municipal police officer in Marion, Indiana from 1966 to 1987. I currently work as a certified central service technician in the Supply Processing Distribution (SPD) area (Central Service) of the Marion VA. I also serve as the current Sergeant of Arms and an executive board member with the American Federation of Government Employees Local 1020. Additionally, I serve as a union steward for AFGE #1020.

The area in which I work has been suffering under a man power shortage as has most of this medical center. The management has made drastic cuts in man power to the point that we have had problems serving our patients. The area in which I work has gone from five to two people! The impact of that decision has hurt patient care and worker safety. There has been a potential for noscomial infections, hospital acquired infections, because of the way SPD is operated. The grievance filed regarding this concern was ignored by upper level management.

A new performance appraisal system has been introduced by management. It does not work for lower level employees. The new system of pass/fail has left out those employees from any kind of recognition for their performance, including any cash award. Management at this medical center never finds the time or resources to properly reward high level of worker performance. There is a disparity between worker groups with some being rewarded while others are ignored.

There is an uncaring attitude displayed to all our workers. I have never had more cases than I have now as a union steward. Partnershiping, as is required, is non-existent at this medical center. The locals 1020 & 1384 have both pulled out of this practice and only recently tried to reinstitute it. It is too early to tell if this attempt will be successful.

Management was required to restructure and try to eliminate or combine jobs. This has not happened at this medical center. There were very few management jobs eliminated. Names and titles changed, but few positions were cut. The bargaining unit jobs on the other hand were told to "broadband." "Broad banding" is a management term for combining two jobs into one and generally without increased compensation.

The total employment picture at this medical center is very bleak under this management team. Worker safety has suffered and we have had nurses and doctors assaulted by patients. There have been numerous resignations and the loss of nurses is becoming critical. I feel that at some point that upper level management must realize there is a problem. They need to understand this facility should be run for all the patients and the staff.

I have at no time been a recipient of any federal grant or contract during the past two fiscal years.

Steve Stewart

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The American Legion, Department of Indiana
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STATEMENT OF JOHN W. HICKEY, DIRECTOR OF
 REHABILITATION AND DEPARTMENT SERVICE OFFICER
 THE AMERICAN LEGION, DEPARTMENT OF INDIANA
 BEFORE THE US HOUSE OF REPRESENTATIVES VETERANS' AFFAIRS
 SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

JUNE 1, 2000

Dear Mr. Chairman and Members of the Subcommittee:

The American Legion Department of Indiana appreciates the opportunity to express our views on quality of care and management issues at the Marion Campus, Department of Veterans Affairs Northern Indiana Healthcare System (NIHCS).

As you know, Marion, Indiana and Fort Wayne, Indiana VA Medical Center facilities have been merged together into the Northern Indiana Healthcare System. This makes it difficult to discuss management and quality of care issues at one facility without also including the other facility. Overall, the American Legion Department of Indiana enjoys a good working relationship with the Northern Indiana Healthcare System management staff. Whatever concerns we bring to their attention are answered in a timely and courteous manner. We may not always agree with the answers, but solutions to some problems are beyond their means.

We have, though, several concerns including: (1) market penetration; (2) the practice of consistently contracting out physical medicine services normally provided and expected at major medical facilities; (3) long waits for appointments in certain specialty clinics; and (4) employee relation problems between the two different unions at each medical center campus.

Our National Organization informs us that the national mean market penetration rate, that is, veterans using VA healthcare compared with eligible veterans, is 14.21%. We understand though, that the Northern Indiana Healthcare System penetration rate is less than 8%.

We also understand that the Marion Campus has very limited physical medicine doctor staffing. This causes the need to transfer many veteran patients to either the Fort Wayne Campus more than 60 miles away or to the local non-VA hospital for usual healthcare needs. For instances, we have found that the Marion facility transfers patients experiencing cardiac emergency-like symptoms to the Marion General Hospital. The answer we received for this practice is that the Marion VA facility does not have enough veteran patients to justify staffing of additional medical doctors. Possibly, the Marion facility could have an adequate number of patients for this purpose if it would work to reach at least its fair share of VA's overall market penetration rate.

Our National Organization also informs us that as of July 31, 1999, Northern Indiana Healthcare System waiting times for geriatric clinic appointments were 160 days and urology clinic appointment were 100 days. With the average National VA geriatric population now exceeding 35%, adequate staffing of urology and geriatric clinics should be a priority -- not an after thought. These waiting times are simply not acceptable to The America Legion and honorable combat veterans of WWII. It is hoped that this problem has since been resolved without simply transferring long waiting times to other specialty clinics.

During a site visit at both facilities last September, the two separate unions at each facility blamed patient care problems on management focusing too much on the other facility. In response to this, our National Field Service Representative wrote "Someone must step forward and explain not only the benefits of team work, but the meaning as well." It is also hoped that management and the two unions have since worked to resolve their differences.

What we see is a stressed medical care system attempting to perform the best job possible with very limited resources. Each year the American Legion and other service organizations petition Congress for adequate VA healthcare funding, and each year Congress and the President fall short on their commitment to veterans' healthcare. VA budgets hardly keep pace with inflation while at the same time VA managers are asked to maintain a high quality of healthcare services, increase the patient case load, and increase services in special areas, such as, geriatrics, hepatitis C treatment, prosthetics, and extended long term care. Continued pressure on VA management and VA employees without adequate resources will simply stress the system to the breaking point.

The American Legion has a plan called the GI Bill of Health that we have been trying to have passed into law for several years. If it becomes law, the GI Bill of Health would allow VA to treat all veterans and their families by obtaining funding from resources other than just the Federal Government. If the Federal Government believes budget restraints prevent it from offering veterans and their families the healthcare veterans have earned and deserve, it's about time Congress pass all aspects of the GI Bill of Health into law.

Mr. Chairman, that concludes our statement.

STATEMENT OF
COMMANDER WILLIAM T. CAYWOOD
DEPARTMENT OF INDIANA
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
U.S. HOUSE OF REPRESENTATIVES
JUNE 1, 2000

Mr. Chairman and Members of the Subcommittee.

I am pleased to provide you with the views of the more than 20,900 members of the Disabled American Veterans (DAV) and its Women's Auxiliary here in Indiana on the quality of health care and management issues at the Department of Veterans Affairs' (VA's), Marion Campus

I wish to express our appreciation to you and the Subcommittee for holding this extremely important hearing and for accepting DAV's assessment of the difficulties our members and other veterans face in obtaining quality assured health care in a timely manner.

I would also like to take this opportunity to express our appreciation for the leadership, compassion, and expertise Linda Belton, Director of Veterans Integrated Service Network (VISN) #11, has brought to sick and disabled veterans of Indiana, Michigan, central Illinois and northwest Ohio. Because of her leadership and openness, last year, members of Congress were able to hear that without additional funding, network 11 was facing a shortfall that would not have enabled the network to maintain services, expand Community-Based Outpatient Clinics (CBOCs), and address the need to reassess functioning clinics.

For VA health care providers and veterans, it is troubling that, as a result of the balanced budget agreement, VA health care funding was flat-lined for three consecutive years. It was because of the flat-lined budget that VA and the Veterans Integrated Service Network (VISN) #11 which serves this area of the nation was forced to restrict access to health care by postponing treatments, while forcing health care providers to work longer and more hazardous shifts in order to provide necessary services

Although the total veteran population is declining, the overall national demand for health care by

the more than three million aging veterans who rely on and use VA as their primary health care resource is rising

Congressman Buyer, within the 5th Congressional District of Indiana, VA reports that in 1995, there were 60,610 veterans using over \$23 million in medical services. This is due, in large part, to the aging process—the chronic nature of age-related conditions—the fact that veterans are generally sicker and more severely disabled than the general population, and to the reliance of the system on outpatient treatments. The increased patient demand has placed additional pressures on the system, and these pressures have been further increased because VA is forced to support an aging infrastructure of vacant buildings and potentially valuable, but unused land.

VA medical facilities are becoming large intensive care units, with the need for cardiac monitoring, respiratory assistance, and intense physical and psychological treatment becoming an increasing part of the average patient's plan of care. With this comes the increased need for skilled and specialized nurses. Increased acuity in hospital staff has become necessary due to the declining average length of stay coupled with the new technology that allows for rapid assessment, treatment and discharge of patients.

Last year, the General Accounting Office (GAO) stated that VA "was," "might," or "could be" wasting millions of dollars on unnecessary or under-utilized facilities and structures. The media and some in Congress used this report to state that the VA was "wasting a million dollars a day" on their facilities. In some quarters, this assumption generated the solution that if the VA began closing down and selling off hospitals, the budget crisis would be solved.

Facility reorganizations are not inherently detrimental to the VA health care system—but reorganizations that are solely budget driven, that decrease services and access and imperil the VA's veteran-focused programs, must be opposed.

VA has begun to address the issue of capital asset realignment in all 22 VISNs. However, the DAV is concerned that the current process lacks a comprehensive and objective focus without veterans service organization involvement in planning. Veterans must be assured that the proceeds garnered from the sale or lease of capital assets are reinvested in the VA health care system, and that the system is enhanced.

All constituencies must also be equally assured that Congress and the Administration maintain their commitment to the preservation of VA's core programs while continuing to address the full continuum of health care delivery, from preventive through hospice.

These core programs are:

- Specialized services (spinal cord injury, blind rehabilitation, amputations, long-term care, and mental illness)
- Research
- Education of America's health care professionals

- Emergency preparedness

There is no question that VA must restructure its capital assets to ensure the proper delivery of high quality and timely health care to all enrolled veterans while maintaining its legislatively mandated missions. Congress and VA must establish an objective and systematic capital assets management system that includes the input of veteran stakeholders and safeguards VA assets. Congress must ensure that the proceeds from the sale or lease of capital assets are considered a supplement to VA's appropriation and reinvested in VA's health care system for the benefit of America's military veterans and, for that matter, the entire nation.

Earlier this year, the DAV heard a number of stories from demoralized and frustrated health care workers, including physicians and nurses. The mutually shared concern was that, by working with patients who are sicker and the need for working double shifts, patients and their providers' safety has been put at risk.

At the Marion campus, we have heard that clinicians are being limited to a 15-minute appointment time to provide primary care. This limited treatment time would not necessarily be bad if it were not for the fact that the clinician's schedule also requires that he or she perform administrative details during the appointment rather than devoting the time to the patient.

In other words, trained professionals are having to perform administrative duties in addition to their clinical duties. This is all the result of staffing reductions due to insufficient budget resources.

While the total number of veterans is declining, the demand for health care for eligible veterans is increasing. As the veterans' population ages, the need and complexities of health care increase. Additionally, as long as there are hostilities around the world, there are going to be sick and disabled veterans; therefore, there will always be a need for an accessible, quality-assured, cost-effective, independent veterans' health care delivery system.

Last year, the House Veterans' Affairs Subcommittee on Health Chaired by Representative Cliff Stearns of Florida heard testimony and received objective evidence that enabled the full committee to justify the \$1.7 billion increase in the VA's appropriation for health care. For this, the veteran's community is thankful, because a fourth consecutive flat-lined budget would have decimated the VA health care system.

It is the DAV's belief that quality health care is achieved when health care providers are given the freedom and resources to practice the most effective and scientifically proven medicine available. It should also be based on agreement about standards of care and the reduction of variations in practice.

An integral part of health care requires the creation of a system that is patient focused, coupled with procedures that ensure timely access to appropriate care. High quality health care is the right of every veteran. We are concerned that VA's increasing emphasis on cost efficiency has prompted some VA administrators to compromise and, on occasion, jeopardize the quality of care.

by focusing purely on reducing costs which, when not implemented properly, reduces quality of care.

Since 1985, the buying power of VA medical care appropriations has fallen sharply. Even with the 79 percent increase in medical care appropriations from 1985 to 2000, the effects of inflation have not been offset. The total fiscal year 2000 VA medical care appropriation is only worth 82 percent of the medical care appropriation in 1985. VA's deteriorating buying power has crippled its ability to deliver accessible, high quality services to veterans.

The DAV is fortunate to be able to represent our members on three advisory committees to the Secretary of Veterans Affairs: Seriously Mentally Ill (SMI), Prosthetics and Special Disabilities; and Geriatrics. The committees on Serious Mental Illness and Prosthetics and Special Disabilities met as part of their Congressional mandate last month in Washington.

It is not surprising that both committees concluded that VA is *not* maintaining its organizational capacity as required under section 1706 of title 38, United States Code. It is also not surprising that the GAO reached the same conclusion in its April 2000 report.

Whether it is in the care of veterans with serious mental illness, or veterans who suffer physical injury or diseases requiring specialized programs or rehabilitation, the variation of care throughout the nation is alarming.

Serious Mental Illness (SMI)

The number of veterans who have sought VA care for serious mental illness has increased 11 percent since 1996. What is appalling is that VA's own statistics indicate that the ability of programs to treat persons with serious mental illness vary from negative 26 percent to 53 percent, compared to last year.

In other words, some facilities are meeting the capacity mandate while others in the same system are allowing veterans with serious mental illness to go without the necessary care and treatment programs VA is required to maintain.

A recent poll of CBOCs reported that well over half do not maintain a mental health treatment component. This information came to the DAV at the same time as VA's own data indicated that one in every five veterans seeking care require some form of mental health service.

On March 14, 2000, the VA National Mental Health Program Performance Monitoring System released its Fiscal Year 1999 report. This report contained the Mental Health program performance report card for FY 1999. We note that, out of 22 VISNs, this network scored the following:

- 18th in population coverage
- 16th in inpatient care
- 14th in outpatient care

- 21st in economic performance
- 22nd in patient satisfaction
- 18 1/2 average rank
- 21st overall

What these statistics tell us is that, in this VISN's attempt to do more with less, the needs of mental health patients could not be met.

This inability should not be looked upon as a fault of the network, but as the fault of Congress for not providing sufficient resources to ensure that needed services are provided. It is especially troubling when this network has the most veteran-focused management and the clinical support in place to ensure adequate mental health treatment.

Equally alarming is the fact that substance abuse programs for veterans with serious mental illness and diagnosed as suffering from substance abuse have decreased five percent.

Budget Impact

VA is now suffering the results of three years of flat-lined budgets, and the Veterans Health Administration (VHA) has lost focus on its mandate of maintaining organizational capacity.

Last year, the DAV and members of the *Independent Budget* (IB) requested an appropriation of \$20.3 billion for veterans' health care for fiscal year 2000 to keep pace with the rising health care costs for our nation's sick and disabled veterans.

The request—\$3 billion more than requested by the Administration—received a lot of attention from Congress, the Administration, the veterans' community, and a supportive American public. In response to what was \$3 billion less than needed for adequate health care, the DAV organized nationwide rallies on Memorial Day weekend to draw the attention of Congress and the public to a woefully inadequate VA health care budget.

Thanks to the numerous veterans and friends in attendance, these rallies were tremendously successful. During the rallies, the DAV was also able to spread the word of VA's accomplishments, while communicating the message that additional appropriations were necessary to maintain the nation's commitment to sick and disabled veterans.

This past Monday, the DAV in Indiana joined forces with hundreds of others and conducted very successful voter registration drives at VA Medical Centers in Marion, Indianapolis, and Fort Wayne. The purpose of the rallies was to involve more people in the election process, to "Tell Washington to Keep America's Promises to Veterans."

For fiscal year 2001, we face a new year and the continued need for increased congressional appropriations. This year, the members of the IB, have asked the Office of Management and Budget, the Administration, and Congress, to appropriate \$20.766 billion for medical care in fiscal year 2001. This will provide VA with an overall health care budget authority of \$21.341 when

factoring in Medical Care Cost Fund proceeds

The DAV is aware of the efforts by Congress and the Administration to meet the funding level necessary to meet the needs of veterans health care. However, it appears that Congress is unwilling to spend as much on veterans' programs as the IB identified as necessary to cover the costs of the recently passed new health care initiatives for hepatitis C, long-term care, and emergency care.

The 2001 IB request is approximately \$1.9 billion more than this year's appropriation of \$19 billion. The IB's \$20.766 billion health care appropriation request includes the following additions:

- \$673 million for employee compensation,
- \$459 million for the long-term care provisions of the Millennium Health Care Act (Public Law 106-117), based on the Congressional Budget Office (CBO) calculation,
- \$270 million for emergency care services under the Millennium Health Care Act, according to CBO calculations,
- \$240 million for hepatitis C, according to a VHA calculation,
- \$65 million for research, and
- a pharmaceutical inflation factor.

Again, assuming that there are no new large-scale military engagements, the veteran population is expected to decline from 25.1 million in 1998 to 23.1 million in 2003 and to about 20 million in 2010. While the number of veterans is projected to decline in the future, the health characteristics of the veteran population served by VHA will actually result in increased demand for health care services.

The DAV's sole mission is building better lives for America's disabled veterans and their families. We ask that you and your colleagues in Congress assist us in fulfilling our mission. Again, thank you and the committee for taking the time to hear our concerns.

This concludes my testimony.

Veterans of Foreign Wars
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Subcommittee on Oversight and Investigations

Dear Committee Members,

My name is William L. Hahn I represent the Veterans of Foreign Wars . I am a past 5 Th. District Commander and at the present time I am the VAVS representative for the Veterans of Foreign Wars for this hospital.

In my testimony I will tell the committee what I see wrong with this hospital. It started back several years ago with the closing of the fire dept. and down sizing of staff here. We use to have two fire trucks one which was sent down south to a VA facility and the other one was given to Marion so we can have fire protection on the grounds here, I still see the VA fire truck running around town still painted yellow with the VA sign still on them.If there ever was a Major fire out here I do not think the city of Marion could respond in time. Marion says they can make it out here in 8 min. or less but I have timed them before and it took right at 13 minutes to respond out here. I also would like to point out that this hospital is surrounded by R.R. tracks and if a track is blocked it would take longer than 8 minutes for the fire dept. to arrive, alot of times the trains block the tracks for switching and it has been block for at least an hour or so..

The older buildings are in bad shape and the Govt. is letting them go because they say it is to expensive to fix up. They are real old and it is a disaster waiting to happen. If any ones goes in there from what I was

told they could easily fall through the floor and there is holes in the roof big enough to fit a car through. Also A act of God could set these buildings a blaze by lighting and I assure you it would go up real fast and could easily spread to other buildings. My suggestions is to tear them down even though there are on our Natl. Registry and give part of the land to the Natl. Cemetery and the rest maybe make a Veterans park for our Veterans and there famillies. I also recommend that we keep one or two buildings for historical matters to be used as a museum.

Patient Care well I feel that we need the wood shop back out here as it would be great therapy for the patients They can use their hands and minds to build things. I feel like we need more therapist to take patients outside for activities instead of going 50' to a smoking area. Also why do we send our patients to nursing homes when this hospital can hold between 400 and 500 patients and we have only 290 inpatients, I feel they would get far more better care here than they would at a nursing home. I feel in some areas that we are understaffed as we only have 100 RNs,34 LPNs, and 133 Nursing Assistant.

Whenever we have meetings out here all we hear about is the budget. and how we need to cut back more. We put to much focus on the budget instead of patient care. We must remember these Veterans fought and served our country well , they deserve the best just as same you would want the best in your lives as well as your health care and to help them live a more fuller life the same as you would want to live your lives the fullest.

Thank you for allowing me to talk about some of the more important issues as there are others that are just as important.

Thank You

William L. Hahn

William L. Hahn

VAVS Representative

Veterans of Foreign Wars

Veterans of Foreign Wars3612 Lincoln Blvd
Marion Indiana 46953Fax 765 674 8674
Home Phone 765 674 3309

May 26, 2000

Attachments

After typing my first letter , there was a fire on May 23 ,2000 two days after I had prepare the first letter. It was a serious fire. It was brought to my attention they were using torches to cut out a dyer. On the scanner I heard the fireman say there was a lot of black smoke I also found out that several of the fire trucks were delayed because of a train blocking the tracks.

I went and talked to the Chief of the Marion Fire Dept and he informed me that this was a Major fire. He said anytime there is a fire it should be treated as a Major fire.

He also told me that they need either the fire trucks back out there or have a better system than what they have now. He informed me there is a lot of problems with the V A over fire protection. I feel like congress should run a full investigation on this and get with both sides to get the problem resolved. The Chief also said that the old buildings are a disaster waiting to happen. Members of Congress this does involve Patient care from a safety point as our patients lives are involved.

We Must remember that when ever there is a fire , the patients , Staff and the firefighters lives are involved.

Enclosed is a copy from the Marion Paper and also a copy of the Fire report which page 2 shows that the Fire engines had to make Detours because of Blocked tracks .

This completes my testimony

Thank you very much



William L. Hahn

MARION FIRE DEPARTMENT

NFIRS Incident Report

A	FDID 27008	Incident/Exp 00-001074-00	Date 05/23/2000	Day Of Week Tuesday	Alarm 2035	Arrived 2038	In Service 2157
B	Type of Situation Found [1] Structure Fire			Type of Action Taken [1] Extinguishment		Mutual Aid [0] None	
C	Fixed Property Use [331] Hospital/Infirmary			Ignition Factor [35] Cutting, welding too close to			
D	Correct Address 1700 E 38TH ST - Marion, IN 46953 DRYER FIRE						Census Trac
	Incident Names V A HEALTH CARE OCCUPANT 765 674 3321 1700 E 38 TH ST MARION, IN 46953						
G	Method of Alarm From Public [1] Telephone Direct			District 6	Shift [2] B		# Alarm 1
H	Personnel Responded 14	Engine 3	Mini-Pump 0	Aerials 1	Tankers 0	Squad 0	Brush 0
I	Injuries Fire Service 0 Other 0		Fatalities Fire Service 0 Other 0				
J	Complex [33] Medical care complex			Mobile Property Type [8] No mobile property			
K	Area of Origin [26] Laundry room, area			Equipment Involved In Ignition [87] Torches			
L	Form of Heat Ignition [17] Spark\flame from equi		Type of Material Ignited [71] Man-Made Fiber		Form of Material Ignite [81] Dust, Fiber, Lint		
M	Method of Extinguishment [6] Preconnect w/ hydrant/dra		Level Of Fire Origin [1] Grade to +9'			Estimated Loss 45,000	
N	Number of Stories [1] One story			Construction Type [4] Unprotected non-combustible			
O	Extent of Flame Damage [3] Room of origin			Extent of Smoke Damage [6] Structure of origin			
P	Detector Performance [8] No detectors present			Sprinkler Performance [1] Equipment operated			
Q	Type of Material Generating/Smoke [71] Man-Made Fiber			Avenue Of Smoke Travel [5] Opening in construction			
R	Form of Material Generating/Smoke [81] Dust, Fiber, Lint						
T	Equip. Involved	Year 00	Make	Model	Serial Number		
U	In Charge IRELAND			Making Report IRELAND			

MARION FIRE DEPARTMENT

NFIRS Incident Report

Report Continued 27008 00-001074-00

Property/Vehicle Value: 200000	Property/Vehicle Loss: 0
Contents Value: 300000	Contents Loss: 45000
Property/Vehicle Insurance: 0	Contents Insurance: 0
Total Loss: 45000	
Property/Vehicle Insurance Company:	
Contents Insurance Company:	

Narrative

DISPATCHED TO VA AND PUMP 6 REPORTED SMOKE SHOWING. FIRE WAS CONTAINED TO A BIG DRYER UNIT THAT WAS BEING REMOVED. SOME FIRE DID GET INTO INSULATION AND INTO THE OVERHEAD. PUMP 6 CALLED FOR AN INCH AND 3/4 . GOT FIRE OUT IN GOOD TIME FRAME .OPENED BUILDING AND CLEARED SMOKE AS BEST WE COULD.A COMPANY CALLED TRELOAR ENTERPRISES INTERNATIONAL WAS USING A CUTTING TORCH ABOVE THE DRYER AND SPARKS FROM THAT CAUGHT IT ON FIRE, ALSO WHILE OTHER PUMPS P1, P4 ALSO A-1 WERE STOPPED BY TRAIN AND HAD TO TAKE ANOTHER ROUTE. THERE WAS A LITTLE TIME DELAY.

User Codes

Called by
Entry by
Coded 3
Coded 4

User Fields

Hydrant # 0
48 Given

Responding Units

Unit	Description	Dispatch	On Scene	In Service
A1	Aerial, Marion	2035	2038	2157
P1	Pump, Marion	2035	2038	2157
P4	Pump, Marion	1203	2038	2157
P6	Pump, Marion	2035	2038	2157
T2	Suburban, Marion	2035	2038	2157

Responding Personnel

FID	Name	Unit	Assignment	On Duty
BARLEY2	Barley, Larry W.	P4	PVT	
BLOCHER	BLOCHER, MATT	P1	PVT	
CAMPBELL	CAMPBELL, BILL	P1	PVT	
GARR	GARR, CURTIS	P6	PVT	
IRELAND	Ireland, Arthur	T2	A\C	
JACKSON	Jackson, Steven	P6	CAP	
MCMULLEN2	McMullen, Freddie	P6	PVT	
MILLERS	MILLER, EDDY L.	P6	ENG	

MARION FIRE DEPARTMENT

NFIRS Incident Report

Report Continued 27008 00-001074-00

OVERMYER2	OVERMYER2, EDDIE	P1	ENG
OWEN2	Owen, Dale	A1	PVT
SMITH	SMITH, MONTY L	P4	ENG
THOMPSON	Thompson III, Paul	P1	ENG
WELLER	Weller, Merrill Andrew	P1	CAP
WILLIAMS2	WILLIAMS, GEOFF	P4	PVT

Equipment Used

[00001	] 1 3/4 hose	200FT
[00004	] 4" hose	50FT
[00019	] Dry Powder	1
[00022	] Roof Ladder	1
[CO2	] CO2	1
[PPV	] PPV Fan	3

ocal

WEDNESDAY, MAY 24, 2000 / A3

n wreck

nown reason,
the west side
e," Hotchkiss

ion's vehicle,
a southbound,
l down an
It then went
before strik-
r-trailer rig
an entrance
st area. The

truck's driver, Gary Power, Bowmanville, Ontario, had been asleep in the truck cab.

McCoy-O'Banion apparently had not been wearing a seat belt, according to a news release from the Indiana State Police.

The crash remains under investigation by officers from the state police post at Fort Wayne.

up dispute

Huston said.
Jordan into
Brian Sharp
ist. The man
busive, charg-
ers and trying
away, Huston
has placed in

preliminarily
battery on a
a Class D
is public intox-
g law enforce-
e battery and
t, all misde-

meanors.

Motton was preliminarily charged with public intoxication, interfering with an officer and resisting law enforcement.

Both were remanded to the Grant County Jail, where they remained Tuesday evening. Bond for Motton was set at \$1,000; for Jordan, \$1,400.

Faw was treated for the wound to his forehead at Marion General Hospital and released.

Scoping the scene



LAUNDRY FIRE — Dale Owens of the Marion Fire Department looks over the scene at Building 79 at the Marion VA Medical Center after a fire broke out Tuesday in the former laundry facility. An employee of a company contracted to remove laundry equipment dropped a piece of hot metal that ignited lint that had accumulated under an ironing machine. The fire spread to nearby building insulation and was extinguished by Marion Fire Department within 20 minutes.

Council may change utility jurisdiction

Current situation discuss such a policy in the near future.

MARION FIRE DEPARTMENT
MARION, INDIANA

FROM THE OFFICE OF
THE FIRE CHIEF

301 S. BRANSON ST.
(765) 668-4474

May 30, 2000

Congressional Committee Members

Dear Congressional Committee Member,

I have advised the Marion VA center of my concerns on the fire coverage of the facility. This concern is geared toward the best interest of patient safety and protection of premises. I feel it is imperative that personnel should understand fire terminology and basic fire behavior. Personnel with this knowledge should be on site 24 hours a day, 7 days a week to meet the fire department when it arrives on scene. The current working system does provide for this. I am concerned that assigning personnel with lesser knowledge to greet the Marion Fire Department suppression crews will reduce their capabilities.

I feel the facility should continue to provide a fire person to greet the Marion Fire Department suppression crews around the clock. I also want this fire person to be informed about our concerns as stated.

Sincerely,



Mike Hutcheson
Fire Chief

Cc: file

Statement of
Linda Belton, Director
Veterans Integrated Service Network (VISN) 11
Veterans Health Administration
Department of Veterans Affairs
Before the
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
U.S. House of Representatives
June 1, 2000

Mr. Chairman and Members of the Committee, I have been invited to discuss Veterans Integrated Service Network (VISN) 11 and the VA Northern Indiana Healthcare System (NIHCS).

VISN 11 is one of 22 Veterans Integrated Service Networks in the Veterans Health Administration (VHA). This Network provides services throughout a large and geographically diverse region, across the lower peninsula of Michigan, northwest Ohio, most of the state of Indiana and central Illinois. In 1999 we served nearly 147,000 veterans, representing approximately 11 percent of the total veteran population. More than 83 percent of these veterans had service-connected medical conditions or earned low incomes.

The mission of this network is to be an integrated veterans healthcare system providing high quality, coordinated, comprehensive and cost-effective services to veterans and other customers in Michigan, Indiana, central Illinois and northwest Ohio.

Reflective of the healthcare industry, VISN 11 responds to forces driving the changing healthcare market, including:

- ◆ Exponential growth in healthcare expenditures
- ◆ Transition from hospital-centered care to ambulatory care
- ◆ Reduction of hospital beds
- ◆ Increased consolidation and integration of providers
- ◆ Technological advances

At the Department level, the VA responds to the Government Performance and Results Act and National Performance Review, which challenge federal departments to conduct effective strategic planning, measure performance and demonstrate increased efficiencies. To these ends, the network is a key player in meeting VA goals of:

- ◆ Becoming more customer-focused
- ◆ Adopting innovative approaches to improving access to care
- ◆ Increasing emphasis on primary care services
- ◆ Maximizing value of financial resources
- ◆ Integrating delivery assets to provide a seamless continuum of care

For several years, the VHA medical care budget has remained essentially flat in inflation-adjusted dollars. As a result, networks have absorbed increased cost associated with inflation, pay raises, new initiatives, and new technologies. At the same time, decisions surrounding eligibility reform and definition of the VA basic benefits package have introduced the potential for large numbers of veterans to enroll with VA and obtain access to a broad range of services. Budgetary considerations and other performance goals are driving all networks to find ways to provide care more efficiently, including continuation of the shift of workload from inpatient to outpatient settings. In addition, networks must find new sources of revenue to supplement the appropriation, including maximizing medical care cost recovery, sharing agreements, enhanced use leasing, TRICARE participation and other partnerships.

Plans and actions throughout the Veterans' Health Administration are organized along six Domains of Value: Quality, Cost, Access, Satisfaction, Functional Outcomes and Community Health. These domains serve as the cornerstones for this network's management of care within available resources, ensuring the viability of the system into the future. Critical activities in the areas of Quality, Cost, Access and Communication and Collaboration are as follows:

Quality

All network facilities participate in nationally recognized external accreditation processes, including Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Commission on Accreditation of Rehabilitation Facilities (CARF) and College of American Pathologists (CAP). The most recent JCAHO survey process was

conducted in this network in 1997, with hospital accreditation scores of 90-95 and no type I recommendations remaining outstanding. The next JCAHO surveys are scheduled for the Fall 2000. Network medical centers with rehabilitation programs are proceeding with CARF accreditation; to date Indianapolis and NIHCS have each received 3-year accreditations.

We have collaborated with the Institute for Healthcare Improvements (IHI) to decrease waiting times in clinics and delays for veterans scheduling appointments. The clinics involved in the projects include primary care, rheumatology, general surgery, ophthalmology and 10-10M clinics. Our early successes include achieving open access for many primary care clinics appointments, improving customer satisfaction scores and reducing individual patient waiting time from check-in to check-out for a given appointment.

In 1997, the network began the development of service line management in the areas of mental health and geriatrics and long term care. Planning for these service lines was an effort to improve the quality and value of care for veterans across the network. Objectives of a service line approach include improving the consistency of care, access to care and distribution of resources across the network. In addition, service lines enable greater integration and communication across management structures, leading to planned improvements in service delivery, patient-centered management approach and cost effectiveness.

In 1998, VA launched its National Center for Patient Safety, designed to apply "systems approaches" to patient safety. VA also partners with other organizations to share lessons and help develop strategies; maintains a national registry of adverse events; developed a handbook for employees on patient safety improvement and is instituting a large educational effort to make patient safety a priority. Some specific actions taken to date include implementing bar coding for medication administration, using bar-coding technology for blood administration in the operating room, and computerized order entry. Network staff training by the National Patient Safety Program was conducted in Chicago just last week. The objective of the current patient safety program is to identify system problems and solutions, not to assign fault to individuals. VA also maintains current review processes to investigate incidents and take appropriate corrective actions, as

needed. Corrective actions may include disciplinary actions, staff education and training to improve competencies, or changes in processes and procedures.

VHA has also undertaken an aggressive performance measurement system, including establishing baseline performance and outcome goals in the areas of prevention, clinical guidelines and chronic disease management. As we all know, preventing illness and successfully managing chronic disease processes improve not only the quality of care provided, but improve patients' quality of life.

Cost

The 22 Networks receive appropriated funds from VA Headquarters through the Veterans Equitable Resource Allocation (VERA) model, as well as specific allocations for special purpose funding, e.g. prosthetics, and for research and medical education support. The VERA model is based on inpatient and outpatient workload in program areas of medicine, surgery, psychiatry, as well as workload in long-term care programs. Adjustments are made for geographic pay differences as well as variable costs in education and research.

Once this appropriated budget – approximately \$650 million for VISN 11 in FY00 - is distributed to the network, leadership determines necessary funding for critical network initiatives, e.g. CBOCs, leases, special projects, employee education, fire and safety program and national program support. These initiatives were funded at a level of \$10.2 million in fiscal year 2000. Prosthetics special purpose funding as distributed from VA headquarters totaled \$15 million in fiscal year 2000, with the network funding an additional \$3.9 million in order that prosthetics funding in 2000 would be at the level of actual spending in 1999. Research and Education support funding are passed-through to facilities as allocated to the network from VA headquarters.

Budget distribution from the network to facilities (Ann Arbor, Detroit, Battle Creek, Saginaw, Northern Indiana, Indianapolis and Danville) uses a single price capitation rate based on veteran users at each facility and includes a transfer pricing methodology for veteran users at more than one network facility. The facility providing the majority of primary care gets the credit for the individual veteran user. This methodology reflects the important and necessary shift of care from the inpatient to the outpatient setting. The capitation rate in FY00 was approximately \$5,500 (\$650 million

appropriation, minus network initiatives noted above, divided by the number of unique users in the network). Hospital patients treated at multiple facilities within the network are funded using a transfer pricing methodology based on 80% of applicable HCFA rate. Long term care patients treated at multiple facilities within the network are funded at the VA national average per diem cost. In addition, the network budget methodology provides for financial supplementals for the care of patients with lengths of stay more than 100 days, at the level of \$20,000 per patient. The higher expenses of operating the dual campus facility of Northern Indiana are also funded at the level of \$1.5 million in FY00.

VISN 11 maintains a reserve of 2% of the operating budget, \$13.2 million. This is made up of \$10 million in no-year funding and \$3.2 million in capital two-year funding. These reserves help to ensure funding for unexpected shortfalls due to increased workload, catastrophic patient care needs and acts of nature such as weather-related emergencies.

Another source of funding are non-appropriated funds which are distributed to facilities based on their individual collections. For the most part, non-appropriated funds in this network are made up of third party collections under the Medical Care Cost Fund (MCCF) program. Collections in 1998 totaled \$26.4 million, in 1999 totaled \$28.9 million, and through April 2000 total \$13.8 million.

Access

In an attempt to better manage care within allocated resources, the network has undergone a significant shift during the past five years along several dimensions, most notably moving from a healthcare delivery system traditionally rooted in inpatient care to a more outpatient based system. Examples of change from FY95 through FY99 include Bed Days of Care reduced 38%; Outpatient Visits increased 30%; Ambulatory Procedures increased 78%; and, Number of Users increased 16%.

An integral part of the expansion of outpatient access is the establishment of new Community-Based Outpatient Clinics (CBOCs). VISN 11 expects to have a total of 22 CBOCs established and serving veterans by this summer. This will bring 85% of veteran users in our Network within 30 miles of a VA primary care site.

Another investment in improving access for veterans is our 24-hour clinical phone care program. Our network leadership views the clinical phone care program as a basic underpinning of self-care, demand management, disease management and health promotion programs. This initiative has been designed with a capital investment of \$500,000 and an annual operation budget of \$450,000 which we expect to result in improved access, better customer service, a reduction in unnecessary clinic visits and decreased waiting times.

Investments in information technology will also have positive impacts on access, timeliness and quality. Within this network, telemedicine initiatives include telepsychiatry between care sites, a teleophthalmology pilot between Indianapolis and Danville, teleradiology between Indianapolis and NIHCS and Danville for off-tour coverage and tele-home care at Indianapolis to allow data and limited video transmission over standard phone lines. These, and other, technology initiatives have been possible by investment and installation of a Wide Area Network (WAN) which provides the technical capacity to transmit quality data and pictures.

Communication and Collaboration

Communication with important stakeholder groups is of high priority throughout the network. In order to assure these communications across all care sites, the network has designed an annual Veteran Service Officer (VSO) Forum. The first Forum was held in December 1997 with approximately 75 national, state and county service officers in attendance. The program grew to over 100 attendees at the 1999 Forum. These Forums cover a wide variety of topics important to veteran groups including eligibility, womens' health, service line development, program changes and access.

VISN 11 staff work closely with colleagues in the Veteran Benefits Administration (VBA) regional offices in Detroit and Indianapolis to meet veterans needs regarding compensation and pension examinations. C&P processing times are consistently below the national standard of 35 days, and was at 25 days during the most recent reporting period in March 2000. The C&P sufficiency rate is a consistent 99% in the network. In a collaborative effort to continuously improve performance, VHA and VBA officials in this network developed joint performance standards to reduce incomplete C&P examination rates by 25% and to provide training to VBA rating

specialist staff in the use of electronic medical record information to clarify information, as needed. VHA and VBA staffs in Indianapolis have developed a co-location plan to the medical center, with a construction project submitted for consideration in fiscal year 2001. Officials in Detroit are currently working on a co-location plan, as well. These collaborative efforts with VBA will improve service to veterans as they seek medical care and benefits.

In 1999, the network implemented a network award and recognition program in partnership with American Federation of Government Employees (AFGE) and Service Employees International Union (SEIU) labor officials. This program recognizes significant employee contributions in the areas of Provider of Choice, Employer of Choice, Multicultural Workplace and Performance Management. The program's objectives are to recognize employee contributions, communicate those contributions throughout the network and to share best practice initiatives. The Northern Indiana Healthcare System has been recognized at the Exceptional level for the Multicultural Workplace Award and the Provider of Choice Award in the past 12 months.

Closing Comments

The VA Northern Indiana Healthcare System plays an integral role in VISN 11's healthcare delivery system, providing primary, secondary and long-term care. As a system, future challenges of balancing the need for programmatic investment and current operations, maximizing value, and ensuring effective communication will be met in partnership with other VA components, community providers, educational affiliates, labor partners and veteran groups. As the only integrated site in this network, it is clearly recognized that the integration of the Ft. Wayne and Marion medical centers presents a number of unique challenges. This integration was undertaken immediately prior to the VA adopting a very aggressive plan to change significant business and healthcare practices. The necessary pace of change was not fully met with a concomitant aggressive communication plan with employees and other stakeholder groups, which has had an impact on employee morale. It is important to note that the significant changes within the network, generally, and at NIHCS, specifically, have been accomplished without implementing reductions-in-force (RIFs) resulting in employees losing jobs. Programmatic changes such as shifting from inpatient to outpatient care to the extent

possible, consolidating laundry services, and discontinuing programs have been accomplished through the use of early retirement and buyout authority, and by offering displaced employees alternative positions, including necessary retraining. Some other networks have implemented RIFs affecting hundreds of employees, but this network's firm commitment to valuing employees has allowed significant change without job loss.

We recognize the need to establish and maintain a safe environment for patients and employees as changes are implemented. The best patient care can only be delivered when patients and staff are comfortable and secure. To that end, this network has completed workplace evaluations at each medical center by the Chief, Police and Security Service, VAMC Detroit, and a consultant expert from VISN 2. These evaluations have resulted in physical plant improvements, changes in operating policies and procedures, purchase of personal safety equipment and employee education and training.

VISN 11 continues to face a number of challenges including managing and operating within appropriated funding, increasing market share, continuously improving quality of care, fully integrating administrative and clinical programs and processes, investing in capital improvements and information technology and effectively communicating with all stakeholder groups. As we meet these challenges we will continue to strive to meet employee needs through effective, ongoing communication. Employees who understand the need for change and who have input into the change effort are critical to ensuring success. The most valuable resource we have is a well-trained and well-informed workforce.

**Statement of
Michael W. Murphy, Ph.D.
Director, VA Northern Indiana Health Care System (NIHCS)
Veteran Integrated Service Network (VISN) 11
Veterans Health Administration
Department of Veterans Affairs
Before the
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
U.S. House of Representatives
June 1, 2000**

Mr. Chairman and members of the Committee I have been invited to discuss the VA Northern Indiana Health Care System (NIHCS). NIHCS is dedicated to serving America's veterans and ensuring that they receive the medical care benefits they deserve.

The integration of the VA Medical Centers in Fort Wayne and Marion IN into the VA Northern Indiana Health Care System was announced in March 1995. VAMC Fort Wayne was a primary and secondary medical and surgical facility, with an outpatient clinic and nursing home, located in the second largest city in Indiana. The primary service area (PSA) served 19 counties in the northern third of Indiana along with 7 counties in northwest Ohio, with an estimated veteran population of 150,224 (1994 data). VAMC Marion was a psychiatric and long term care facility with primary medical services and an outpatient clinic, and served as the neuropsychiatric referral facility for the entire state of Indiana. The computer databases were merged and NIHCS commenced operations as an integrated facility on October 1, 1995.

Upon integration the veteran catchment area for NIHCS was redefined to include 28 counties in Indiana and 7 counties in Ohio. The Marion campus serves as the neuropsychiatric referral facility for Indiana. The two campuses are separated by 60 miles and provide complementary services. Medical and surgical services are available at the Fort Wayne campus, psychiatry and extended care are provided at the Marion campus. Primary care clinics and nursing home care units are available at both campuses.

Inpatient services are provided in the 243 authorized hospital beds and 180 nursing home care beds. A Community-Based Outpatient Clinic (CBOC) was opened in the South Bend-Elkhart area in April 1998, extending care to the state's largest population of underserved veterans. In August 1999 a second NIHCS CBOC was opened in Muncie, providing area veterans convenient access to primary care services.

NIHCS also provides administrative support to a veteran's readjustment counseling center (Vet Center) in Fort Wayne and to the Marion National Cemetery.

Although the Marion campus is well over 100 years old and the Fort Wayne campus was constructed in the 1950's, recently completed renovation and construction, in addition to projects currently under way, ensure a modern and attractive state-of-the-art healthcare environment. A 240 bed geropsychiatry building was occupied at the Marion campus in July of 1997 and a 100 bed general psychiatry building is scheduled to be activated in the fall of 2000. A new ambulatory care addition was opened in November of 1998 at the Fort Wayne campus.

NIHCS is fully accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in the Hospital Accreditation Program (HAP), Home Health Care, Long Term Care Program, and Behavioral Health Care. Our most recent cyclic survey in 1997 resulted in scores of 89, 90, 91, and 98 respectively. Two random unannounced JCAHO surveys in the spring of 1999 resulted in our scores being raised to 94, 94, 94, and 98. We are also fully accredited by the College of American Pathologists (CAP), the Commission on Accreditation of Rehabilitation Facilities (CARF), and the Nuclear Regulatory Commission (NRC).

A Combined Assessment Program (CAP) Review by the Office of Inspector General (OIG), Department of Veterans Affairs was conducted at NIHCS March 6-10, 2000. During the exit interview and subsequent conference calls, the IG made a number of recommendations for improvement, including the need to review staffing levels; review specific patient care programs in terms of reprogramming or relocation of current programs and development of new programs, e.g. dementia unit; improve safety features; and, improve medication management and security. We have concurred with all recommendations and some corrective actions have been completed, with implementation

plans being developed for all others. We have discussed these actions and plans with two members of the review team.

Our emphasis continues to be on providing high quality health care services for all veterans in the appropriate clinical setting. We have expanded our efforts in serving homeless veterans by partnering with a provider in the Anderson area, through the Homeless Provider Grant and Per Diem Program. Additionally we work closely with the Homeless Task Force of Fort Wayne in supporting "stand downs" and other essential homeless services. Our Home Based Primary Care (HBPC) program provides in-home primary medical care services to home-bound veterans with chronic diseases and terminal illnesses. Our Adult Day Health Care program provides maintenance and rehabilitation services to veterans in an outpatient setting. Our Respite Care program provides care givers brief periods of needed relief from the responsibility of providing 24 hour care to their loved ones.

The shift in emphasis at NIHCS, from a hospital-based healthcare system to an ambulatory care, outpatient focused system, has resulted in many changes in the delivery of quality health care for our veterans. This shift is consistent with the current delivery paradigm in the private sector and more specifically within the VA in medical, surgical, psychiatric and mental health care.

- From FY96 through FY99, total inpatient bed days of care (BDOC) decreased more than 33.8%, (from 190,450 to 125,950 respectively).
- The average length of stay (ALOS) in acute medicine has reduced from 8.25 days in FY96 to 5.70 days in FY99. Adjusted for age and diagnosis, our ALOS is comparable to that in the private sector.
- From FY96 to FY99, the number of outpatients treated per year increased by over 20.6% (from 12,445 to 15,014 veterans served). Thus far in FY00 we are up more than 20% over FY99 and expect to see over 17,000 veterans this fiscal year. This will represent an increase in the number of veterans being served by NIHCS of approximately 36.6% from FY96, the first year of integration.
- In FY96 NIHCS saw 6,013 veterans in outpatient primary care clinics, by FY99 the number of veterans seen in primary care had risen to 10,281, an increase of over 70%.

- Surgeries performed in an ambulatory setting increased from 64.5% of all surgeries performed in FY96 to approximately 89.3% in FY99.
- As a result of workload shifts and program changes, employment (FTEE) at NIHCS has decreased from 1,283.4 in FY96 to 1,064.5 at the end of FY99.
- Our inpatient substance abuse treatment program (SATP) converted to an outpatient model early in FY99. Federal and private health care studies have revealed that more successful outcomes are obtained in outpatient treatment models that emphasize patient commitment and provider support compared to those obtained in the traditional inpatient setting. The SATP professional team carefully monitors patient care and provides care management; coordinating services with veterans, families and community providers. By shifting our emphasis from inpatient to outpatient treatment we are able to increase the number of veterans we serve, while achieving cost efficiencies. Alternative living arrangements were developed for those veterans who were homeless or who could not commute daily to this treatment program.
- Our combat veterans treatment program (CVTP) for patients diagnosed with post traumatic stress disorder (PTSD) was converted to an outpatient program for those patients not otherwise requiring hospital care. Those patients in need of inpatient psychiatric care are admitted to an existing psychiatry unit with their PTSD treatment being provided in the Mental Health Clinic. As with the substance abuse program, alternative living arrangements have been made for those veterans that are homeless or otherwise cannot commute from home while participating in the PTSD program.
- An Intensive Psychiatric Community Care (IPCC) program was started in FY 1999 in an effort to return patients to a community setting. The driving force of this program is to improve the quality of life and the quality of care for those veterans whose psychiatric care does not require that they be treated in an institutional setting.
- NIHCS has opened two CBOCs to improve the access to care for veterans. These CBOCs reduce the distance veterans travel to receive their outpatient primary medical care.

- In 1997 the City of Marion entered into a Memorandum of Understanding with NIHCS to provide fire suppression services to the VA allowing us to close our VA fire department and thereby, achieve cost efficiencies and reprogram resources into patient care.
- In 1996 NIHCS began reviewing our aging laundry plant to determine whether it was more cost effective to replace this facility or to contract for laundry services. The cost of equipment replacement alone was estimated at \$3 million. The network's new consolidated laundry at VAMC Battle Creek had excess capacity and it was determined the workload from NIHCS could be accommodated at that facility. The network's consolidated laundry was already providing services to all four Lower Michigan VA medical centers and had some experience in managing inventory and transportation. In 1999 NIHCS decided to close the existing laundry facility and obtain laundry services from the VISN 11 consolidated laundry. It is recognized there continue to be some operational issues as this consolidated laundry strives to meet the needs of many facilities, most notably the handling of patient personal clothing, but we are working to correct these problems with the Laundry Plant Manager and the Network Laundry Oversight Board.
- Since 1996 NIHCS has closed approximately 12 buildings at the Marion campus. Most of these buildings were nearing or over 100 years old and were very inefficient to operate and maintain. The estimated annual saving on the utilities and maintenance from these closures is \$227,000. Some of the closures were made possible by the reduction in the bed days of care for inpatients, which allowed us to consolidate buildings and wards; other closures resulted from the opening of the new geropsychiatry facility (Building 172) in the summer of 1997. Additional building closures and program consolidations will be possible when we activate the 100 bed general psychiatry building in September 2000.

NIHCS supports the Veterans Health Administration, and VISN 11 in developing programs for veterans consistent with the six nationally adopted domains of value: Quality, Cost, Access, Satisfaction, Functional Outcomes and Community Health. We are committed to providing America's veterans the highest quality health care in the most cost effective manner and in the least restrictive setting. We have an equivalent commitment to our employees to improve communication and participation in implementing new programs. The many changes that have taken place at NIHCS and that will be necessary in the future have a significant impact on employees in terms of how they do their jobs, the settings where care is provided, the skills sets necessary to do the quality work we all strive for, and overall job satisfaction.

Statement of
Alan M. Mellow, M.D., Ph.D.
Director, Mental Health Service Line
Veterans Integrated Service Network (VISN) 11
Veterans Health Administration
Department of Veterans Affairs
and
Associate Professor of Psychiatry
University of Michigan
Before the
Subcommittee on Oversight and Investigation
Committee on Veterans' Affairs
U.S. House of Representatives
June 1, 2000

Mr. Chairman and Members of the Committee, I have been invited to discuss the Mental Health Service Line in Veterans Integrated Service Network (VISN) 11 and as it relates to the VA Northern Indiana Healthcare System (NIHCS).

Historical Background

A network-based approach to mental health services was prioritized soon after the formation of VISN 11. In 1996, a Mental Health Task Force was charged by the Network Director with examining the current provision of mental health care in our network and making recommendations concerning how it could be improved, consistent with the Veterans' Health Administration's six domains of value: Quality, Cost, Access, Satisfaction, Functional Outcomes and Community Health. That group recommended a sustained effort throughout all facilities within the network to develop a continuum of care for patients with psychiatric disorders, and specifically, consistent with current trends in healthcare, to move the sites of care from traditional inpatient settings to outpatient and community-based venues.

Implementation of these recommendations resulted in VISN 11, from FY 1996 through FY 1999, successfully reinvesting \$12 million recouped from mental health and substance abuse inpatient program changes into alternative venues of mental health and substance abuse care for our veteran patients, allowing us to treat 20% more mental health patients with essentially the same level of expenditures. This has been achieved through a combination of enhanced outpatient programming, community-based case management, implementation of residential and partial hospital/day treatment programs and a variety of contractual agreements.

Mental Health Service Line

Although the changes mentioned above are significant, positive changes that are continuing, our reengineering efforts are far from complete. In order to sustain momentum in improvements in mental health care, the network leadership decided, in 1997, to plan for the development of a formal network-based Mental Health Service Line (MHSL); along with a parallel effort in Geriatrics and Extended Care. The service line was initiated in October, 1998 with the establishment of a MHSL Board, and formally operationalized in March, 1999 with the recruitment of a full-time MHSL Director.

The strategy of the MHSL is to provide excellence in mental health services throughout VISN 11, by organizing all mental health care, education and research into an integrated delivery system with consistency in clinical practice, process and outcome measures and with a unitary budget and management structure, consistent with the strategic goals of the network. The network's MHSL provides mental health care to approximately 30,000 veterans with expenditures of approximately \$100 million, or 15% of the network's appropriated budget. Within the network there are three academic Mental Health Services (Ann Arbor, Detroit and Indianapolis), where the bulk of the research activities in mental health are conducted, as well as training of new mental health professionals. In addition, educational and research activity occurs at the other facilities in the network. Long-term inpatient mental health care is provided at three facilities (Battle Creek, Danville and NIHCS). All facilities provide specialized treatments for patients with

Posttraumatic Stress Disorder (PTSD) and Substance Abuse Disorders, and all have developed enhanced outpatient programming over the past several years, including intensive case-management programs for patients with persistent, severe psychiatric disorders.

MHSL Initiatives

In the short time since the inception of the MHSL, the establishment of an organizational structure involving the mental health leadership at each facility has allowed for a sharing of information and best practices not previously achieved. In addition, several initiatives have been undertaken:

- A task force on PTSD has recommended the consistent implementation of interdisciplinary team evaluations for all patients with PTSD in the Network; implementation is ongoing.
- An advisory group on substance abuse has recommended and is now implementing the development of standardized functional outcomes measures for all patients with substance abuse disorders in our Network as well as a network-wide educational initiative in substance abuse.
- The service line has conducted an analysis of the mental health needs of veteran patients in the geographic areas surrounding the community-based outpatient clinics (CBOCs) in our network and is working with ambulatory care leadership to deploy mental health services to all CBOCs.
- A telepsychiatry initiative, involving consultations between medical centers in the network as well as to CBOCs will be implemented by the end of the current fiscal year.
- The MHSL has implemented a network-wide action plan to address network performance on the National Mental Health Program Performance Monitoring System (see below).
- The MHSL is currently developing a unified budgetary structure for mental health in the network.

In addition to its strategic focus, the MHSL provides operational leadership for mental health activities in the network, as well as consultation and advice to

facility top management. For example, the service line organized the focused review of the recent patient assault incident at NIHCS.

Performance Improvement

The MHSL has achieved some quantitative performance improvement since its implementation:

- A 15% increase in the number of patients screened for Major Depressive Disorder in primary care clinics.
- A 10% increase in the number of patients receiving outpatient follow-up within 30 days after a psychiatric hospitalization.
- A 20% decrease in cost per capita for outpatient mental health treatment.

National Mental Health Program Performance Monitoring System

Since 1995, VHA, through the Northeast Program Evaluation Center (NEPEC), has monitored its mental health programs on a variety of measures, covering the domains of population coverage, inpatient care, outpatient care, economic performance and customer satisfaction. NEPEC publishes a yearly report card, ranking each of the twenty-two VISN's in VHA on these domains, with data available for each facility within every VISN. VISN 11 has ranked in the bottom quartile of this ranking since these reports became available. Although we have made significant progress in our rankings with respect to outpatient care, we have seen a decrement in our performance on measures of inpatient care, relative to the rest of VHA. We have made major changes in our inpatient care processes, but we have not moved as quickly as the rest of the system, leading to a drop in our ranking. In addition, our economic performance remains near the bottom of the system. Both of these are directly related to our long-term mental health activity.

Long-term Mental Health Care

One of the most challenging aspects of the Veterans' Health Administration's mission to provide modern mental health care to veterans involves the provision of long-term care to those patients with the most severe forms of psychiatric illness, such as schizophrenia, bipolar disorder, and dementia complicated by psychiatric disturbance. VA neuropsychiatric facilities throughout the country were established to provide long-term, inpatient care for the vast

majority of these patients, often in hospitals isolated from the communities of origin of the patients. It is true that there are many veterans whose illness renders them so functionally disabled that they require permanent inpatient care. There is however, a growing body of evidence that many of these patients can be treated in outpatient, community-based settings, with better outcomes and more efficient use of resources. In order to develop plans for managing the resources for long term mental health care, the VA's Serious Mental Illness Treatment, Research and Evaluation Center (SMITEC) located in Ann Arbor was asked to conduct a preliminary review of these programs at Battle Creek, NIHCS and Danville. This information will be used to evaluate staffing levels and patterns of care, needed community-based services, discharge planning efforts and the number and types of VA programs.

Closing Comments

The challenges to our system to implement these fundamental transformations in our clinical care are enormous, and involve the development of new staff competencies, cultivation of community-based resources as well as a cultural change among dedicated staff. In our network we have made great strides in this transformation, but we have much more to accomplish. As one of the major mental health facilities in our network, NIHCS is critical to our mental health mission, but consistent with the standard of care at its founding, its focus has been long-term inpatient mental health care. Although this is and will continue to be an important part of our spectrum of mental health care, it is no longer the standard of care for many patients. We look forward to continuing to creatively channel the expertise of the NIHCS staff into these new forms of care, so NIHCS and VISN 11 can continue to provide first-rate mental health care for all of our veteran patients.

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Mellow, page 1

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Department of
Veterans Affairs

Office of Inspector General

Redacted

COMBINED ASSESSMENT PROGRAM REVIEW

VA NORTHERN INDIANA
HEALTH CARE SYSTEM

FT. WAYNE AND MARION, INDIANA

Generally, administrative and clinical activities were operating satisfactorily. However, we found several opportunities for improvement that warranted management's attention.

Report No. 00-01199-72

Date: May 25, 2000

Office of Inspector General
Washington DC 20420

VA Office of Inspector General Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) effort 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, Audit, and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. CAP review teams perform independent and objective evaluations of key facility programs, activities, and controls:

- Healthcare Inspectors evaluate how well the facility is accomplishing its mission of providing quality care and improving access to care, with high patient satisfaction.
- Auditors review selected financial and administrative activities to ensure that management controls are effective.
- Investigators conduct Fraud and Integrity Awareness Briefings to improve employee awareness of fraudulent activities that can occur in VA programs.

In addition to this typical coverage, a CAP review may examine issues or allegations that have been referred to the OIG by facility employees, patients, members of Congress, or others.

Executive Summary

Combined Assessment Program Review of the VA Northern Indiana Health Care System, Ft. Wayne and Marion, Indiana

1. The Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Department of Veterans Affairs (VA) Northern Indiana Health Care System (NIHCS) with principal campuses at Ft. Wayne and Marion, IN. The review included evaluations of selected operations, focusing on quality of care and management controls. During the review, we also provided "fraud and integrity awareness" training to about 65 employees.

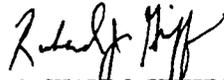
2. NIHCS delivers primary and long-term health care to veterans in northern Indiana. As of December 31, 1999, NIHCS operated 243 medical care beds and 180 nursing home care beds. Primary care is offered mainly at the Ft. Wayne campus, and long-term psychiatric care is offered at the Marion campus. Both campuses operate nursing home care beds. NIHCS also operates outpatient facilities at Ft. Wayne, Marion, Muncie, and South Bend, IN. NIHCS is part of Veterans Health Administration's Veterans Integrated Service Network 11. There is no medical school affiliation.

3. The OIG CAP team visited NIHCS from March 6 to 10, 2000. Based on our testing, there were areas that appeared vulnerable and in need of improvement:

- **Quality of Care Issues** - The patient care quality management review identified the following areas that required management attention:
 - Long term care.
 - Facility treatment environment.
 - Quality management and performance improvement.
 - Medication policy, availability, and security.
 - Patient care services.
 - Employee assistance and training.
- **Management Control Issues** - The following areas were identified in which management controls should be strengthened:
 - Management of the South Bend contract community based outpatient clinic.
 - Accountability and security over controlled substances.
 - Contracting for radiology services.
 - Laboratory Service staffing.
 - Procedures for obtaining informed consent for surgery.

- Reviews of State of Indiana inspection reports for VA contract nursing homes.
 - Implementation of the Generic Inventory Package for control of medical supplies.
 - Supply Processing and Distribution operations.
 - Timeliness of Agent Cashier audits and controls over third-party payer checks.
 - Access authority for inactive users of information technology systems.
 - Drug prescription backlog monitoring.
- Office of Investigations Fraud and Integrity Awareness Briefings - These briefings for NIHCS employees discussed issues concerning the recognition of fraudulent situations, referral to the Office of Investigations, and the type of information needed to make such referrals.

4. In the body of this report, we make a series of observations and recommendations that we believe warrant management attention. In his response, the NIHCS Director concurred with all of our recommendations. He also provided acceptable implementation plans that will be carried out in partnership with employees and other NIHCS stakeholders. We consider all issues in this report resolved; however, the Office of Inspector General may follow-up at a later date on corrective actions taken.



RICHARD J. GRIFFIN
Inspector General

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Introduction

Purpose

The purpose of a Combined Assessment Program (CAP) review is to help management of Department of Veterans Affairs' (VA's) facilities by identifying opportunities for improvement and to help prevent fraud, waste, and abuse. (See the inside cover for a full description of the CAP process.)

Background

The Northern Indiana Health Care System (NIHCS) is a primary and long-term care "integrated" system with two main campuses in Ft. Wayne and Marion, IN. As of 1998, the system had 197,366 veterans in its service area. Ambulatory surgery and most inpatient general medical care are offered at Ft. Wayne, and both acute and long-term psychiatric care are offered at Marion. Both locations offer nursing home care and outpatient services. As of December 9, 1999, NIHCS had 243 medical care beds consisting of 26 internal medicine beds at Ft. Wayne, another 16 internal medicine beds at Marion, and 201 psychiatry beds at Marion. NIHCS also operated 180 nursing home care beds: 53 at Ft. Wayne and 127 at Marion. Besides outpatient facilities at Ft. Wayne and Marion, NIHCS also operated community based outpatient clinics (CBOCs) at Muncie and at South Bend, IN. NIHCS is part of the Veterans Health Administration's Veterans Integrated Service Network (VISN) 11. There is no medical school affiliation.

The following table shows key workload indicators for the last 4 years:

Fiscal Year	Medical Care Beds	Unique Patients	Outpatient Visits	FTEE¹	Medical Care Budget
1997	393	13,203	115,551	1,234	\$77,567,519
1998	371	14,117	123,198	1,133	\$73,937,791
1999	346	15,293	136,198	1,088	\$73,074,702
2000	243	11,794 ²	53,097 ³	1,042 ⁴	\$70,859,939 ⁵

1. Cumulative full time equivalent employees (FTEE).

2. As of January 31, 2000.

3. As of February 29, 2000.

4. As of March 11, 2000.

5. Spending authority as of February 11, 2000.

Objectives and Scope

Quality of Care

We reviewed numerous quality assurance documents and 46 patient medical records. We also inspected the physical environment of inpatient and outpatient treatment facilities that comprise NIHCS. Using structured survey instruments, we interviewed and analyzed the results of responses from 65 clinicians/clinical managers, 10 senior managers and 95 patients. We also distributed questionnaires to 202 randomly selected full-time employees. The questionnaire return rate was 44 percent (89/202). We summarized the results and shared them with NIHCS management. Also, we reviewed the following patient care and quality management areas:

Acute Care Medicine and Surgery	Physical Therapy
Substance Abuse Treatment Program	Occupational Therapy
Day Treatment Program	Recreation Therapy
Ambulatory Care Services	Employee Staffing
PTSD Program	Employee Education
Long Term Care	Pharmacy Service
Physical and Rehabilitation Medicine	Psychology Service
Dental Service	NIHCS Police Service
Social Work Service	Homeless Program
Chaplain Service	Employee Assistance Program
Community Based Outpatient Clinics	Quality Management Program
Respiratory Therapy	Nutrition and Food Services
Pathology and Laboratory Service	Radiology Service

Management Controls

We also reviewed the following selected medical center administrative activities and management controls to determine if they operated effectively.

ADP Acquisitions	Information Technology Security
Agent Cashier Activities	Informed Consent – Surgical Procedures
Compensation and Pension Examinations	Laboratory Quality Controls
Contract Nursing Home Care Activities	Lodger Program Activities
Construction Program	Mail Out Pharmacy Activities
Decision Support System	Medical Supplies Inventory Controls
Employee Transportation	Pharmacy Accountability/Security
Emergency Medical Equipment Controls	Rehabilitation Medicine and Recreation Activities
Emergency Care Operations at Marion	
Equipment Accountability	Scarce Medical Specialist Contracts

Government Purchase Cards
Hazardous Materials Handling

Supply Processing and Distribution
Operations

In addition, we received 99 inquiries from 41 patients and staff during the review. The details of our follow-up on many of these inquiries are contained in Appendix I.

Fraud and Integrity Awareness Briefings

In addition, we conducted four fraud and integrity awareness briefings for NIHCS employees. The presentations were well received by approximately 65 staff from all services at the medical center. The briefings included a lecture, a videotape presentation, and question and answer opportunities. Each session lasted approximately 60 minutes and provided a history of the Office of the Inspector General, discussions of how fraud occurs, criminal case examples, and information to assist in preventing and reporting fraud.

Scope of CAP Review

The review covered medical center operations for Fiscal Years 1998 to 2000. In performing the review, we: inspected work areas; interviewed medical center management, staff, and patients; and reviewed pertinent administrative, financial, and clinical records. The review was performed in accordance with Quality Standards for Inspections, issued by the President's Council on Integrity and Efficiency.

Results and Recommendations

Quality of Care Issues

Organizational Strengths

We concluded that clinical activities lead to quality patient care in the following areas:

- The Intensive Psychiatric Community Care (IPCC) program provides effective patient care. The IPCC serves chronically mentally ill patients who need intensive support to facilitate their community adjustment and shorten their occasional periods of psychiatric hospitalization. Patients who receive treatment through the IPCC primarily have schizophrenia and assorted major affective disorders. IPCC patients reside in a variety of community placement settings, such as residential care homes and halfway houses.

Two registered nurses (RN) and two Masters-prepared social workers case-manage approximately 48 IPCC patients. IPCC employees visit patients frequently and are proactive in problem solving, and facilitating adjustment to community living and compliance with outpatient treatment. IPCC patients had an average length-of-stay of 295 days during their last psychiatric hospitalizations prior to IPCC enrollment. During December 1999, only three enrolled IPCC patients were hospitalized. IPCC statistics show that, through this program, the NIHCS has achieved an annual avoidance of 1,147 inpatient bed days of care.

An Office of Healthcare Inspections (OHI) inspector visited an IPCC home in the local community and interviewed eight patients. All of the patients were very positive in their descriptions of, and appreciation for, the IPCC program. They enthusiastically described their routine participation in outpatient treatment, such as injection clinics¹ and group counseling. The IPCC appears to be effective and is a least-restrictive option to managing the chronically mentally ill veteran population.

- Chaplain Service (CS) effectively utilizes volunteers. The CS has enlisted support from many community groups to assist in escorting patients to a variety of worship services on patient care units and in the chapel. CS employees provide volunteers with an initial orientation concerning appropriate interactions with patients and assisting with transportation.

¹ These are clinics in which patients who cannot, or will not, take medication orally come in to have the medications injected by a nurse. These clinics are also used to administer certain medications, like Prolixin, which can only be administered by injection.

- Positive communication and a supportive environment are offered for former Prisoners of War (POW). Former POWs benefit from involvement in an outpatient therapy group that is led by a staff psychologist. POW examinations are scheduled with an appropriate time allotment and the physician for former POWs has received training regarding the completion of the VA-required Protocol Examination for POWs.
- All Pharmacy Service technicians are nationally certified. This is a laudatory achievement since national certification is a relatively new process in the pharmacy profession.
- Clinicians' actions have achieved a low incidence of decubitus ulcers and a significant reduction in urinary tract infections (UTIs) in long-term care areas. The occurrence rate of UTIs in long-term care has been significantly reduced. This has been accomplished through employee education, which focused on fluid hydration of patients before meals. Data extracted from the Patient Assessment Instrument (PAI) demonstrate a pressure ulcer rate significantly lower than the expected computed rate. (The PAI is a tool to assess the care needs of long-term patients.)
- NIHCS has a comprehensive infection control surveillance program. The infection control nurse has achieved the Certified Infection Control Nurse credential and is actively and visibly involved in infection control practices. The occurrence of blood stream infections, surgical site infections, and UTIs is below the facility-established 3 percent threshold.

Although identified instances of Methicillin Resistant Staphylococcus Aureus (MRSA)² have persistently exceeded the facility-established 30 percent threshold, NIHCS clinicians have initiated comprehensive actions for MRSA reduction and containment. Specifically, these actions include providing medical and nursing employees with training pertaining to prevention and control measures for MRSA. Additionally, clinicians were encouraged to improve documentation on the medical record problem list regarding MRSA colonization versus infection. Follow-up reviews indicate that clinicians have improved documentation and prevention measures related to MRSA.

Opportunities for Improvement

We identified opportunities to further improve: long-term care; the facility treatment environment; quality management (QM) and performance improvement (PI); medication security, policy, and availability; patient care services; and employee assistance. Specific

² MRSA is an infectious organism that is resistant to Methicillin, which is the antibiotic typically utilized for the treatment of staphylococcus.

aspects of those areas that require greater management attention are discussed fully below.

➤ **Long-Term Care**

The Sub-Acute Rehabilitation Program warrants a comprehensive review and the development of clearly defined clinician responsibilities. A review of the Sub-Acute Rehabilitation Program, located on the Marion campus, included a unit tour, employee interviews, and medical record reviews, including a review of the document entitled "Sub-Acute Rehabilitation Program Plan of Care." The employees who are responsible for rehabilitation services were clearly defined in policy; however, the policy did not specifically delineate the procedures, and employees who are responsible, for the management of the patients' medical conditions. The unit admission criteria does not define the term "medically unstable," which may result in the admission of patients who require levels of care that exceed the sub-acute unit's capabilities. Although the unit's admission procedure is formally defined, it does not involve interdisciplinary participation.

OHI recognizes that the leadership of the sub-acute unit is in transition. However, the absence of an interdisciplinary admission process, unclear admission criteria, and vaguely articulated responsibilities for medical services on the sub-acute unit are sufficiently significant to require immediate attention and clarification by management.

Improvement is needed in the interdisciplinary team admission criteria and policy so that the interdisciplinary team is able to more accurately determine patients' medical stability, as well as the ability of sub-acute unit clinicians to meet the patients' healthcare needs. Therefore, the NIHCS Director should ensure that the Chief of Staff revises the Sub-Acute Rehabilitation Unit admission criteria and program policy to include:

- Delineation of patients' medical conditions that may not be manageable on the unit.
- Evaluation of the patient's problem list, previous diagnostic testing results, and rehabilitation potential by an interdisciplinary screening and admission process.
- A clear delineation of employee responsibilities for medical management of Sub-Acute Rehabilitation Unit patients.

Operations of the Sub-Acute Rehabilitation Unit could benefit if the unit were moved from Marion to Ft. Wayne. Relocating the Marion campus' Rehabilitation Unit to the Ft. Wayne campus should decrease the need to move patients from the Ft. Wayne campus to the Marion campus after they receive treatment for an acute illness or a surgical procedure that requires continued inpatient interventions. This measure could be achieved by reassigning nine sub-acute medical beds at the Ft. Wayne campus as

rehabilitation beds, within NIHCS' total number of approved operating beds. This measure would fill an identified, but unmet, need for a level-of-care between "acute care" and "skilled nursing care" at Ft. Wayne. The proposed sub-acute unit at Ft. Wayne, with an anticipated length-of-stay of 14-16 days would assist the facility in reducing the overall acute care length-of-stay. The location of this combined unit on the Ft. Wayne campus would allow timely access to acute care services for patients who may require these services. The NIHCS Director should consider relocating the Sub-Acute Rehabilitation Unit from the Marion campus to the Ft. Wayne campus for the reasons cited above.

Long-term care would benefit if the Nursing Home Care Unit (NHCU) were consolidated to the Marion campus. The Ft. Wayne campus' NHCU, which is located on the 5th floor of the main hospital building, is not well maintained and has numerous safety concerns. The physical environment does not meet Veterans Health Administration (VHA) standards pertaining to space for dining and long-term care patients' activities. The NHCU also has rooms with raised floors that represent a falling hazard for geriatric patients. One room had the nurse-call system dangling from the ceiling and hanging loose beside the patient's bed, thus creating a potential safety hazard. Patients were located in the hallway, with oxygen tubing running across the floors of patient rooms and the hallway, creating a falling hazard for employees and patients. This latter hazard also created the potential for accidentally disconnecting the patient from the oxygen source. In addition, we found environmental maintenance closets and carts unattended, with unsecured chemicals.

Although employees and consultants had presented multiple proposals and recommendations to management aimed at improving the NHCU and at developing more efficient methods to operate the Unit, senior managers apparently had not taken any corrective actions. NIHCS top managers should consider consolidating long-term care inpatient programs to the Marion campus and closing the Ft. Wayne NHCU. This move would be consistent with NIHCS' strategic initiative to become recognized as a center of excellence for long-term care.

The proposed consolidation would allow for focused employee development and performance improvement (PI) initiatives associated with caring for geriatric patients. This action would also strengthen the facility's recruitment efforts to attract clinicians who have specialized training in dementia and geriatric care. A concerted effort to become a recognized center of excellence may also have a positive impact on overall employee staffing and morale, with improved quality of patient care. The NIHCS Director should consider moving the NHCU from Ft. Wayne to Marion or, barring such a move, should correct the deficiencies in the current NHCU identified above.

Establishment of a dementia unit would be beneficial for NIHCS and patients. From our discussions with employees, a review of medical records, treatment unit tours,

patient observations, and data reviews, the facility is operating a *de facto* dementia unit. The unit is not identified as such and lacks documentation to establish the level-of-care, unit goals, and employee competencies that would be geared toward the care of dementia patients. Dementia patients occupied two different units within the NHCU's general population. This arrangement over-stimulates and confuses dementia patients, creating an environment that is not conducive for effective management. The facility and the patients would benefit from designating one unit as a dementia unit, transferring all patients with appropriate diagnoses to that unit, and notifying accrediting bodies of the change in services. NIHCS managers should also develop a comprehensive orientation, training, and competency program for all interdisciplinary team members to assist in the management of dementia patients. Finally, clinical managers should develop support groups to address dementia patients' and family members' needs.

The NIHCS Director should establish a dementia patients' unit in the NHCU, with procedures to improve the care of such patients, as outlined above.

The use of physical and chemical restraints in long-term care needs to be reviewed. NIHCS policy endorses restraint use to address safety issues, including falls. During our review, Marion campus clinicians had placed one patient in a vest restraint, in the evening hours. This was done because the patient represented a falling risk, and also to ensure that the patient would not attempt to get out of bed. However, inspectors also observed numerous situations involving the use of bed rails as restraints. We observed the same pattern of physical restraint use in the Ft. Wayne facility. Clinical managers should initiate a procedure to review all NHCU restraint usage by the treatment team, with the responsibility for the review assigned to the Chief of Geriatrics.

The current high use of psychoactive medications as chemical restraints was demonstrated by a report presented to the OHI inspector. That report showed 108 sedatives, 2 hypnotics, 78 anti-psychotics, and 58 antidepressants included in active medication orders for a total of 102 NHCU patients. As there were a total of only 113 NHCU patients at the time, more than 90 percent of the NHCU patients were receiving one or more psychoactive medications. NIHCS clinical managers should initiate a focused review of all psychoactive medications being used in the NHCUs, with a goal of decreasing the use of such medications. Also, Pharmacy Service managers should continue the NHCU medication reviews that they began in January 2000. They should also initiate a PI initiative on the use of psychoactive medications. The results of these reviews and monitors should be reported to long-term care service leadership. The facility's restraint policy requires revision since it is not consistent with the facility's stated philosophy of a "least-restrictive environment."

Recommendation No. 1

The NIHCS Director should improve the provision of long-term care in the areas outlined above.

VA Northern Indiana Health Care System Director Comment

Concur.

A comprehensive review of the Sub-Acute Rehabilitation Program including development of clearly defined clinician responsibilities will be undertaken.

A listing of medical conditions that may not be manageable on the unit will be added to the program's plan of care.

Sub-Acute Unit admission criteria and program policy will include a definition of "medically stable"; evaluation of the patient's problem list, previous diagnostic testing results, and rehabilitation potential by an interdisciplinary team including the following: social worker, dietitian, chaplain, primary care physician and registered nurse. Responsibilities for each discipline for the medical management of sub-acute rehabilitation patients will be delineated.

Operations of the Sub-Acute Rehabilitation Unit could benefit if the unit were moved from Marion to Fort Wayne.

A study will be undertaken, in cooperation with VISN 11, to determine the advantages and disadvantages of moving the Sub-Acute Rehabilitation Unit from Marion to Fort Wayne, following which we will take appropriate action as necessary.

Long-term care would benefit if the NHCU were consolidated to the Marion Campus.

NIHCS will complete a thorough review, in cooperation with the VISN 11 Service Line, of the benefits of consolidating all long-term care operations at the Marion Campus, following which we will take appropriate action as necessary.

Establishment of a dementia unit would be beneficial for NIHCS and patients.

NIHCS recognized the need to establish a dementia unit and appointed an interdisciplinary clinical team to develop a program based on JCAHO Dementia Unit Standards Criteria. The team finished their work on the program just prior to the OIG visit. An implementation plan has been developed for a dementia unit at the Marion Campus.

The use of physical and chemical restraints in long-term care needs to be reviewed.

The External Peer Review Program (EPRP) has initiated a monitor on use of chemical restraints in NHCUC. Use of physical and chemical restraints in long-term care has undergone an in-depth review. As a result, a policy on the use of restraints, specific to long-term care is in the process of being finalized. Training and education initiatives are being developed for clinical staff who work with long-term care patients regarding alternate methods of providing a safe environment for patients at risk to falls or elopement. Equipment to adapt environment, i.e., mats at bedside, etc., has been ordered.

Office of Inspector General Comment

The NIHCS Director's comment and implementation plans are responsive to this recommendation and we consider this issue resolved, although we may follow-up on all planned actions until completion.

> Facility Treatment Environment

- (b)(5) **Previous violent incidents on [REDACTED] have created a climate of concern for personal safety among employees.** Personal safety concerns focus on the need for [REDACTED]. NIHCS managers initiated several safety initiatives as a result of a 1997 violent incident that involved an employee. The following specific actions were taken by management: 1. increased nurse staffing levels; 2. distributed cell phones with quick-code access to nursing units throughout the facility; 3. implemented a standard operating procedure for employees to use when entering a darkened room; 4. evaluated and changed the patient case mix on each psychiatric unit; 5. installed convex mirrors in areas of decreased visibility; 6. revised training for the prevention and management of disturbed behavior; 7. developed a sensitivity training module focused on employees for use following a sexual assault; 8. implemented quarterly safety assessments of the acute and geropsychiatry units; and 9. instituted continuing PI monitors of workplace violence.
- (b)(5) In addition, a 1999 violent incident involving a patient assault on an employee resulted in the installation of locks on the nurses' station doors. While the facility is making many efforts to improve employee safety, vulnerabilities still remain. For example, NIHCS managers should [REDACTED]
- (b)(5) [REDACTED] **security at Ft. Wayne needs to be enhanced.** One of the two hospital [REDACTED] at Ft. Wayne is [REDACTED]. This is [REDACTED] area for patients, employees, and visitors, but there is no [REDACTED]. Also, [REDACTED]

██████████ NIHCS managers should install a system to monitor ██████████ and should also provide some protection for employees who work ██████████. Managers should also initiate a task force to review, develop, and implement methods to ensure ██████████
 ██████████ (b)(5)

Nutrition and Food Service (N&FS) and Environmental Management Service (EMS) areas need to be separated at Ft. Wayne. N&FS shares the loading dock with EMS's hazardous waste containers. Dirty EMS and red biohazard carts are located next to the area where food is transported to the kitchen. Inspectors also observed benches and ashtrays in this area. The area has a "no smoking" sign, but we observed several employees smoking. NIHCS managers should explore alternative locations to store hazardous waste containers and EMS carts. Managers also need to ensure that the established policy that designates smoking areas is followed.

The Ft. Wayne campus' Canteen warrants thorough cleaning and assistance with storage of food items. The Ft. Wayne campus Canteen's floors badly needed cleaning. Inspectors observed cooking equipment that needed to be cleaned, sitting on open racks. Bulk frozen food items were lying on carts, and the carts themselves were blocking egress from the Canteen. The refrigerators contained uncovered, open food containers. Inspectors also observed instances in which employees did not wash their hands between handling customers' money and handling food. NIHCS managers should review Canteen operations and place increased emphasis on the essential need for cleanliness and proper storage of food items. Managers should also ensure that infection control reviews focus on Canteen environmental cleanliness and employee hand washing.

Recommendation No. 2

The NIHCS Director should take action to improve the facility treatment environment as outlined above.

VA Northern Indiana Health Care System Director Comment

Concur.

(b)(5) NIHCS is reviewing options for providing ██████████
 NIHCS will conduct a review of community facilities ██████████ and ensure our security meets or exceeds the local community and VA safety and security standards. NIHCS will initiate a complete review of the dock area incorporating outside experts to determine necessary actions to avoid potential cross contamination issue. NIHCS will review possible ways to separate N&FS and EMS areas at the food delivery dock. The canteen floors will be stripped, scrubbed and waxed by June 1, 2000, and will be maintained on a recurring schedule. The problem with food storage occurred when a

refrigerator failed and has been corrected with a new refrigerator. Labels have been provided for labeling opened containers of food, and employees have been educated to wash their hands. This was already a Canteen policy and it is being reinforced with all canteen employees.

Office of Inspector General Comment

The NIHCS Director's comment and implementation plans are responsive to this recommendation and we consider this issue resolved, although we may follow-up on all planned actions until completion.

> Quality Management and Performance Improvement

A consistent medical peer review process is needed. The NIHCS "Medical Staff Peer Review" policy no. 11-6-99, is basically sound to the extent that the Chief of Staff (COS) assigns Peer Review Committee-identified cases for peer review. When peer review results disclose significant out-of-line clinical or patient care findings, the COS appropriately refers them to responsible clinical managers for corrective action.

While changes to peer reviewers' level-of-care designations (levels 1 through 3) should generally be rare, we identified many instances in which responsible service chiefs revised peer reviewers' recommended level-of-care designations. We did not evaluate all of the peer review cases, but we recommended additional reviews of several cases that involved a particular type of care by one practitioner. The COS and the Director should review and address the PI Coordinator's data, with the ultimate goal of ensuring that the peer review process is effective.

Placing the PI Coordinator organizationally under the NIHCS Director may reduce the potential for conflict of interest regarding medical care reviews. A potential conflict of interest may exist if sensitive healthcare matters that require clinical attention depend solely on the COS' decisions. The PI Coordinator could more comfortably address changes if his or her position was not directly responsible to the COS. NIHCS management should consider placing the PI Office organizationally under the Director's Office.

A monitor needs to be developed for the *SureMed* dispensing system. The *SureMed* medication dispensing system is utilized by nurses and physicians for dispensing medications that physicians order after Pharmacy Service closes, and also for narcotic dispensing. However, inspectors observed that there was no follow-up mechanism to document the accuracy of medications that are dispensed through *SureMed* and the Medication Administration Record (MAR). Generally, there is no method to account for medication doses that clinicians dispense when the Pharmacy Service is closed. NIHCS managers should require that Pharmacy Service and Nursing Service managers develop

an interdisciplinary monitor that focuses on the accuracy of medications obtained from the *SureMed* system and on the accuracy of notations recorded on the MAR.

Medication errors appear underreported in the Patient Incident Reporting process. NIHCS data indicates that NIHCS has a low number of reported medication errors. During the period September 1998 to August 1999, the overall medication error rate ranged from a low of 0.003 percent to a high of only 0.01 percent of doses dispensed. To put it another way, the highest rate of medication errors reported was only 1 in 10,000 doses. Such a low incidence of medication errors would be unusual with the complexity of patients served and the "dual order" system in place at NIHCS.

The administration of medications at NIHCS will soon be managed with an electronic bar-coding process. (Although already received, problems with bar-coding software had forced a return to the vendor and, as of the end of our onsite visit, the facility was still awaiting receipt of the new software.) When available, and in operation, the bar-coding software will increase knowledge of errors in medication dosages, times, and other administration issues. NIHCS managers should emphasize the need for employees to report medication errors in order to provide a data base from which to learn how to prevent such errors from recurring. As bar-coding is implemented, managers should also ensure that reported errors are reviewed and acted upon to improve the safety and quality of patient care. NIHCS managers should review medication error reporting with employees, stressing a non-punitive approach towards identification and prevention of medication errors.

Recommendation No. 3

The NIHCS Director should take steps to address the above quality management and performance improvement issues.

VA Northern Indiana Health Care System Director Comment

Concur.

The Chief of Staff and the Performance Improvement Coordinator have reviewed the Peer review process.

- a. An outside reviewer conducted the additional review requested. The findings of the second peer review validated the review conducted by the NIHCS peer review process.
- b. The annual review of the Peer Review Committee cases found many of the changes in levels reflected system problems rather than practitioner issues. The Peer Review Committee will now clearly designate whether the level should be assigned to the

practitioner or referred for resolution of a system problem. This change was discussed in Medical Staff meeting.

c. The annual review of the Peer Review Committee is shared with the Chief of Staff and the Director so that an effective peer review process is in place.

Placing the PI Coordinator organizationally under the NIHCS Director will be fully evaluated. There is frequent communication between the PI Coordinator and the Director, Chief of Staff and the Associate Director on both clinical and administrative issues. The current organizational alignment has not resulted in any conflict of interest.

The need for a monitor to focus on the SureMed dispensing system has been placed on the agenda for the next Pharmacy and Therapeutics Committee meeting.

NIHCS agrees that there is a potential for under reporting of medication errors in the Patient Incident Reporting (PIR) process. A new patient safety reporting process is being developed that NIHCS will be implementing following training May 23-25. This simplified reporting mechanism should improve the overall reporting process. In addition, NIHCS feels that the implementation of the bar-code medication system should also improve the reporting process.

Office of Inspector General Comment

The NIHCS Director's comment and implementation plans are responsive to this recommendation and we consider this issue resolved, although we may follow-up on all planned actions until completion.

> Medication Policy, Availability, and Security

The Controlled Substances Policy does not address disposal of transdermal narcotic patches. Facility policy no. 119-4-97, which pertains to the disposal of controlled substances, lacked information regarding the disposal of transdermal narcotic patches, such as *Fentanyl*. The manufacturer of *Fentanyl* patches recommends folding the adhesive ends of the patch together and flushing the used patch down the toilet. Procedures for disposal of all narcotics need to be addressed in the facility policy. NIHCS managers should require the Pharmacy and Therapeutics (P&T) Committee to establish a procedure for the disposal of used transdermal narcotic patches and add that information to the Controlled Substances Policy.

There is inconsistency in available formulary medications. During interviews, clinicians reported frustration with the fact that not all VISN 11 facilities have formularies that are consistent with the VISN 11 formulary. For example, the Indianapolis VA Medical Center is a major referral facility for NIHCS. Clinicians to

whom we spoke related routine incidents in which patients returned to NIHCS from the Indianapolis VA where clinicians prescribed medications that are not available through the NIHCS Pharmacy Service, because they are not on the NIHCS Formulary. While the NIHCS pharmacy did carry certain other medications that could be substituted for the medications prescribed, such substitutions could also be problematic.

An example given by clinicians of a commonly encountered medication prescribed at the Indianapolis VA, but not available through the NIHCS pharmacy, is "amlodipine." The NIHCS pharmacy did not carry amlodipine, but did carry "felodipine" which may also be substituted for the treatment of disorders similar to those for which amlodipine is prescribed.³ However, differences do exist between the prescribed drug and the possible therapeutic substitute, for example in dosages available. Clinicians could prescribe the substitute medication, but this may lead to multiple problems, including patient non-compliance with medication regimens. Insuring patient compliance with medication regimens can sometimes be difficult, and the difficulties may increase if a patient perceives inconsistencies in the medications prescribed.

In the example cited above, the NIHCS clinician who treats a recently transferred patient from Indianapolis is faced with the question of whether or not to prescribe a substitute medication, with its attendant potential problems. The only other option available for the clinician would be to request, through the P&T Committee, that the NIHCS pharmacy dispense a "non-formulary medication." However, utilizing a non-formulary drug request for frequently prescribed medications is an inefficient use of a clinician's time.

The inconsistency of medication availability between facilities is problematic for both patients and clinicians and may result in disjointed care. To avoid this problem, NIHCS managers should require the P&T Committee to review available formulary medications to ensure they are consistent with the VISN 11 Formulary.

- (b)(5) Breaches in medication security warrant management review.** Medication security was inadequate in some areas of the medical center. Unauthorized employees could readily access a Marion campus ward medication room using [REDACTED]; and a medication refrigerator, located in the Marion campus [REDACTED], was found to be unlocked. Reviews on the Ft. Wayne campus revealed numerous incidents of unsecured medications on the inpatient units. Inspectors found outdated medications in a room across from the [REDACTED], even though the room is not designated as a medication room. In an office area (also not designated as a medication room), Inspectors found unsecured medications on top of an unattended medication cart.

³ Another example of this situation exists for the drug "atorvastatin" which Indianapolis physicians may prescribe, but which is not available in the NIHCS pharmacy. In this case, the potential substitute drug is "simvastatin" which the NIHCS pharmacy does carry.

- (b)(5) Inspectors found unsecured narcotics in an unlocked [REDACTED] refrigerator. VHA and standard drug management policy require narcotics to be secured under double-lock. In this particular instance, the small refrigerator was located in an open bay area of the [REDACTED] accessible to other employees and visitors, and was out of view of the responsible registered nurse (RN). The specially designed lockable drawer inside the refrigerator was also unlocked. The Acting Nurse Manager and the Charge Nurse were not aware that the medications, including narcotics, were not secured as required by local policy.
- (b)(5) There was a general lack of knowledge regarding the potential for theft and diversion of drugs, particularly by health care providers. All of the facility's "Code Blue" (crash) Carts were [REDACTED]; however, these [REDACTED] can be easily [REDACTED] without detection, and without other employees realizing that medications and supplies on Code Blue Carts may have been tampered with. It is current practice to utilize a [REDACTED] for these carts and to record the [REDACTED] when checking the cart for integrity.
- (b)(5) NIHCS managers should take several steps to improve medication security. They should review and limit [REDACTED] to medication rooms. They should also require clinical managers to review the facility policy regarding medication security and the disposal of outdated medications with employees. Managers should place additional emphasis on medication security during facility environmental rounds. Managers should also require narcotics inspectors to follow-up on unsecured medications, including narcotics, to ensure that policy is being followed. Finally, managers should provide education about "abuse of narcotics in the healthcare profession" to all clinical employees who have access to medications.

Recommendation No. 4

The NIHCS Director should direct that the above-described improvements be made with regard to medication security, policy, and availability.

VA Northern Indiana Health Care System Director Comment

Concur.

The NIHCS Controlled Substances Policy will be revised to ensure procedures for the disposal of all narcotics, including transdermal narcotic patches, are addressed.

The NIHCS Pharmacy and Therapeutic Committee will review and revise the formulary to ensure maximum consistency with the VISN 11 formulary and provide practitioners the flexibility necessary for appropriate continuum of patient care.

All medication areas including crash carts are being reviewed for appropriate security and upgraded as necessary. Inspections will be held on a regular basis. Training in medication security and narcotic abuse will be provided to all clinical employees and managers.

Office of Inspector General Comment

The NIHCS Director's comment and implementation plans are responsive to this recommendation and we consider this issue resolved, although we may follow-up on all planned actions until completion.

> Patient Care Services

Staffing issues must be thoroughly reviewed to ensure that patients receive adequate quality of care. Inspectors interviewed a number of employees, working in several different areas at both campuses, who expressed concerns and raised issues that pertain to the adequacy of staffing for direct patient care. The predominant focus of the concerns and issues pertained to a purportedly serious shortage of nursing staff. The primary staffing concerns focused on a general shortage of bedside clinical employees, coupled with reductions in support employees, which has further increased the workload on employees remaining on duty.

Many of the complaints focused on several employees that were limited in their duty status because of on-the-job injuries. Also, managers were reportedly unable to back-fill positions of some employees who were absent from duty for long periods of time due to illness or injury, thereby exacerbating the problems of a, reportedly, already under-staffed Nursing Service. Employees complained that they have to work overtime and compensatory time in order to meet patient care needs on a daily and shift-to-shift basis.

The employees whom we interviewed appeared to be genuinely dedicated to providing the best possible care, and they conveyed a deep concern that patient care was not being provided in keeping with their personal standards. These employees cited examples of problems due to inadequate staffing, such as: inadequate to non-existent documentation; inadequate to non-existent patient education; increased numbers of patient falls; and the inability to provide timely basic patient care and medication treatments. Many of the employees who expressed concerns about these issues worked in support services, but they based their concerns on perceptions that the limited numbers of nursing employees are unable to accommodate all of the needs that the current patient load presents.

At the time of our visit, many of the tasks and treatments that have historically been carried out by other clinical and administrative personnel were being done by supervisory

registered nurses (RNs). For example, supervisory RNs acted as phlebotomists,⁴ drawing blood for all patients in the hospital who need tests done during evening, night, weekend, and holiday hours. At the time of our visit, Pathology and Laboratory Service had vacant phlebotomist positions; however, managers had not filled these positions as the vacancies occurred. Thus, tasks that phlebotomists had formerly performed were required to be performed by other more highly paid professionals. (See also “Laboratory Staffing Could Be Enhanced” in the *Management Control Issues* section of this report.)

Many employees commented about how dedicated the workforce was, but they also spoke freely about their perceptions that clinical employees, particularly nurses, felt exhausted. Employees also described Patient Care Services as being “rushed” for respiratory care treatments and for other specialized care or testing. It was evident from inspectors’ direct observation on the nursing units and wards, and from a review of staffing time schedules, that the medical center had a limited number of employees available to provide for patient care needs.

Inspectors reviewed all of the staffing procedures in place for Patient Care Services, including: Patient Classification Reports to estimate patient care needs; Expert Staffing Methodologies Statistics; and the overall assignment of staff in accordance with the organizational plan. We concluded that clinical staffing in Nursing Service appeared to be too low to meet patient care demands. Supporting this view was the fact that more than 32 full-time employee equivalent (FTEE) nursing vacancies existed.

At the time of our review, NIHCS management had not given approval to recruit or hire nurses to fill the vacancies, nor had they authorized any reduction in programs or services in acknowledgement of the staffing shortage. When we discussed our findings with management, they responded that the vacancies could not be filled because of a budgetary shortfall.

NIHCS managers should ask the Veterans Health Administration’s Chief Consultant of the Nursing Strategic Healthcare Group to appoint an independent evaluation team of staffing experts with the mission of conducting an in-depth review of staffing for NIHCS patient care requirements. Based on the results of that evaluation, budgetary relief should be requested from VISN and Headquarters management to fill any direct patient care staffing deficit found.

Patient safety issues identified in Building 172 and Building 1 need to be addressed. Acute and chronic psychiatric patients on the Marion campus are provided care in Building 1 and Building 172. The ceilings in the sleeping areas of these buildings are not constructed of solid plaster. Instead, they have panels held in place by metal frames. The panels may be removed and patients could use the frames to attempt suicide or to harm

⁴ A phlebotomist is one who draws blood from patients for laboratory analysis.

others. Sprinkler heads in the patient showers and bathrooms are not recessed into the ceiling and are not of the "breakaway" type. Shower curtains are held up by metal shower hooks, which are attached to non-breakaway shower rods. Television mounts are also not of the breakaway type.

The hooks, sprinkler heads, and television mounts all represent potential instruments which patients could use for suicide attempts or as weapons. NIHCS managers should replace ceiling panels and metal frames in patient rooms with solid ceilings. Managers should also replace sprinkler heads in patient showers and bathrooms with recessed or breakaway sprinkler heads. Shower rods with metal shower hooks need to be replaced, and shower rods must be of the breakaway type. Managers should also ensure that breakaway television mounts are installed or that the currently existing mounts and television sets are removed from rooms.

Clinicians inconsistently screen for possible victims of abuse, and employee training regarding identification of victims of abuse is incomplete. The NIHCS policy regarding possible victims of abuse is comprehensive; however, Emergency Department (ED) and Outpatient Clinic employees' responses were inconsistent regarding their roles in identifying and intervening with possible abuse victims. Also, employees had widely varying amounts of training that pertained to the approach to, and treatment of, abuse victims. NIHCS managers should provide dedicated training for clinicians regarding victims of abuse, and should require employees to review the facility policy regarding possible victims of abuse. Clinical managers should also implement a monitor for screening of abuse victims in the ED and Outpatient Clinics.

NIHCS lacks guidelines on prevention counseling for sexually transmitted infections (STIs), and condoms are not available at either campus. A review of reportable communicable diseases from 1995 to March 2000 revealed 16 patients who had 2 or more infections that may have been sexually transmitted. Three patients were treated for gonorrhea or chlamydia within a 4-month period. We interviewed clinicians regarding STI prevention counseling, and obtained inconsistent information concerning the content of counseling and the employees who are responsible for STI prevention counseling. Managers need to develop guidelines or policy delineating the content of STI counseling and the responsibilities of all involved employees.

Although condoms are listed on the National VA Formulary, they are not available through the NIHCS Pharmacy Service, and condoms are not provided to patients as a method of birth control. The Chief Pharmacist indicated that providing condoms through the Pharmacy had been discussed in the past, with a decision being made that patients should obtain condoms from community sources. NIHCS managers should direct the P&T Committee to consider providing condoms through Pharmacy Service for patients who have clinical indications of a need for prophylactics.

NIHCS shuttle service requires utilization review and guideline development. NIHCS provides a shuttle service between the Marion and Ft. Wayne campuses, making four scheduled transports daily over the approximately 55-mile route. However, there are situations that need to be addressed in the provision of this service:

- Each shuttle van has a hospital radio with a range of only 10 miles, plus a cellular phone which is powered by the vehicle's battery and is permanently mounted on the vehicle floor. This configuration is unsatisfactory, since the driver must look away from the road to pick up the phone and, in the event of a vehicle battery failure, the phone would be inoperable. Thus, if the driver encounters problems of any kind, he may not be able to contact either of the NIHCS campuses or any other source of emergency assistance.
- Also reportedly, patients have ridden the shuttle in inappropriate attire, for example pajamas. Again, the shuttle driver told us that sweat clothes and jackets are available for patients if needed; however, the staff responsible for providing appropriate clothing may not be doing so.
- Finally, first aid kits were available on board the shuttles; however, drivers did not have training in cardiopulmonary resuscitation (CPR) or even in basic first aid.

NIHCS does not have a policy that pertains to shuttle services. NIHCS managers should develop written guidelines that pertain to shuttle operations. Managers should also ensure that:

- A "hands free" cellular phone, with separate battery backup, is installed in each shuttle to allow for safe, uninterrupted communication between shuttle drivers and staff at both campuses or sources of emergency assistance.
- Patients riding the shuttle are appropriately clothed.
- Shuttle drivers are trained in CPR and basic first aid.

Medical record documentation needs to be improved. We reviewed 46 patients' medical records, 42 using both the computerized records and paper copies and 4 medical records from the Mental Hygiene Clinic. Eight records (19 percent) did not contain problem lists, and 21 records (50 percent) had outdated or incomplete problem lists. Problem lists facilitate clinicians' rapid evaluation of patients, and must include all current physical and psychological problems. Thus, they should be updated regularly, and must be available in the medical record. NIHCS should consider including the problem list on the health summary, along with allergy information, invasive procedures, and current medications.

Documentation of patient teaching about new medications, test results, and procedures was lacking in 31 (74 percent) of the charts that we reviewed. Documentation of patient/family teaching needs to be available in the medical record. NIHCS managers should consider developing a patient education form on which clinicians could record all patient/family teaching, and that form should be easily identifiable and accessible.

Five (12 percent) of the records we reviewed did not have any interim care plans. Interim care plans should be available to all disciplines for the direction of patient care. Facility policy requires that interim care plans include physician orders and nursing interventions that are identified on the day of admission. NIHCS managers should direct Nursing Service to initiate interim care plans on all patients within 24 hours of admission.

We also reviewed an additional four medical records randomly chosen from the Mental Hygiene Clinic (MHC). Three of these four MHC records did not contain treatment plans. NIHCS managers should ensure that MHC clinicians develop patient treatment plans and update the plans on a regular basis. In addition, management should ensure that the plans are always available in the medical records.

Inspectors noted that NIHCS had multiple record systems in existence, which lends itself to the occurrence of documentation errors and inconsistency in the clinical setting. At both campuses inspectors found: the Computerized Patient Record System (CPRS); a hard copy chart system; and an accumulation of loose files. In addition, NIHCS had two methods for writing and transcribing physicians' orders. The non-staff physicians do not use the CPRS system for orders. Instead they write their orders in longhand. This dual system of physician ordering raises the potential for omissions and errors to occur.

Post Traumatic Stress Disorder (PTSD) treatments warrant review. Patients reported dissatisfaction with the lack of a structured PTSD treatment program, the lack of consistent and adequately trained clinicians, and the lack of space. Treatment specific to PTSD is limited to a weekly group session. The space allotted to the group is too small to comfortably accommodate the number of PTSD patients who attend. NIHCS managers should consider developing a dedicated PTSD clinical team, along with the development of a structured PTSD treatment program with measurable treatment goals, as well as providing sufficient space for PTSD treatment activities.

Patient confidentiality needs to be strengthened. Inspectors identified numerous infringements on patient confidentiality on both campuses. The clerk who supports the Former POW, Persian Gulf, Agent Orange, and Compensation and Pension (C&P) examinations is located at a desk in a busy waiting area. Limited privacy is available for patients in this setting.

Inspectors also found that unsecured patient records and information were located in areas that were readily accessible to the general public. For example, on the Marion

campus, chart carts were located in the Ambulatory Care waiting room, and patient information was found, without privacy covers, in chart holders outside examination rooms. The Ft. Wayne campus had multiple instances of unsecured patient records on wards, in clinics, and in specialty areas in the form of charts and single forms that were located on clipboards and in readily accessible file folders. The Muncie community based outpatient clinic (CBOC) had medical records stored in a wall unit, with patient names and social security numbers visible to the public. The inpatient units on both campuses had signs taped to patient room doors that contained patient information. Presently, patients who present to the Pharmacy Service at Ft. Wayne sign their name, date, and time on a clipboard that is located in an entryway to the Pharmacy. Pharmacists utilize the clipboard to provide medication counseling to patients in an orderly manner; however, the clipboard is left unattended at other times.

NIHCS managers should emphasize the need to maintain strict patient confidentiality and privacy of medical record information. They should also review the patient privacy issues that we discuss in this report, and correct noted deficiencies.

Patient Representative (PR) information needed to be more effectively communicated. The Patient Representative's picture is posted throughout both campuses. However, information that patients and family members need to contact the PR is not available with the picture. NIHCS managers should ensure that the PR's office location and telephone extension are added to the signage, below the PR's picture, at both campuses and at CBOCs.

Procedures for patients seeking a change in their primary care provider needed to be formalized. NIHCS clinicians and the PR described differences in the series of events entailed in processing patients' requests to change primary care providers. This is of particular concern in situations in which patients are seeking controlled substances and are not satisfied with their present primary care provider. Patients need written information that describes the process for requesting a change in primary care providers. Prompt feedback to involved clinicians needs to be provided when a change is requested and granted. NIHCS managers need to consider developing a policy to prescribe the procedures that need to be followed when a patient requests a new primary care provider.

Recommendation No. 5

The NIHCS Director should ensure that the above-described improvements are made in Patient Care Services.

VA Northern Indiana Health Care System Director Comment

Concur.

Staffing

While we will seek the recommended input from knowledgeable external reviewers, the Resource Management Committee is already reviewing staffing requests to ensure appropriate staffing for patient care. The Chief, Patient Care Support Services has developed a plan for patient care staffing that will serve as a basis for staffing decisions. Since the IG visit, recruitment has begun for many direct patient care vacant positions. When suitable applicants have been found the positions will be filled.

Safety

Modifications were made to the facility based upon the recommendations made during the IG visit. We have had several inspections, including a recent VISN-chartered focused review, to assist in providing a safe environment for patients. The Safety Committee is reviewing all of these recommendations and a plan of action is being developed. A 100-bed Acute Psychiatry facility is now nearing completion and is scheduled for activation in the fall of FY 2000. All of the safety features described in the narrative have been incorporated into the design and construction of this new facility.

Employee training regarding identification of abuse

NIHCS has a policy to screen patients for possible victims of abuse. We will reinforce our education and training efforts with the staff to ensure their understanding of the policy. A monitor will be developed to ensure compliance through the Medical Record Review Committee.

Guidelines for sexually transmitted infections

The Infection Control Committee and the Pharmacy and Therapeutics Committee will develop policy and guidelines related to sexually transmitted disease (STD) prevention counseling and the responsibility of involved clinical staff.

Physician and clinical staff role in the prevention of STD's will be based on the Center for Disease Control and Board of Health guidelines. Prevention counseling of STD will begin with education based on changing the sexual behaviors that place patients at risk, the means for reducing the risk for transmission, detection of asymptomatic and symptomatic STD's, and effective diagnosis, treatment, and evaluation of those who are infected. Condoms have been made available at both campuses and the medical staff has been informed to prescribe them for patients with suspected STD.

Prevention Counseling Guidelines will be drafted within the next thirty days and presented to Clinical Executive Board for review and approval.

Shuttle service

The cellular phones in the shuttles operate both off of the vehicle battery and their own internal battery and are installed to operate "hands free."

On occasion, patients have been transported in pajamas based on availability of sweat suits. Sweat suits have been purchased and are available in Ambulatory Care at both campuses. This item will be discussed at the next patient care meeting to remind staff to ensure patient is properly clothed throughout the seasons.

We will include the requirement of CPR and basic first aid in the shuttle driver duties and provide the training necessary to complete basic CPR.

Medical record documentation

The Clinical Application Coordinator presented the process and requirements for documenting the Problem List in the Computerized Patient Record System (CPRS) to the Medical Staff on May 5, 2000. An instruction manual will be given to the Medical Staff by June 5, 2000.

All NIHCS staff will utilize the Computerized Patient Record System for all documentation and orders. All non-staff (consultants and fee basis) physicians will utilize the CPRS for orders.

Post traumatic stress disorder (PTSD)

We are restructuring Mental Health Services and staff and will consider a dedicated PTSD team with the new structure.

Patient confidentiality

We have a policy on confidentiality and have reinforced it at all levels in the organization. The Information Management Committee is monitoring and evaluating when patient confidentiality is breached. Plans are under way to correct cited physical limitations.

Patient Representative

Pertinent information and point of contact will be added to the pictures of the Patient Representatives. Appropriate patient representative information also will be provided to our CBOCs.

Primary care provider

NIHCS will expand and communicate our procedure on how patients can request a change in their providers.

Office of Inspector General Comment

The NIHCS Director's comment and implementation plans are responsive to this recommendation and we consider this issue resolved, although we may follow-up on all planned actions until completion.

➤ **Employee Assistance and Training**

The Employee Assistance Program (EAP) warrants management review and enhancement. Most employees whom we interviewed were not aware of services available to them through the EAP. The individuals who direct EAP efforts were uncertain if a facility policy existed regarding the EAP. Employees who seek EAP assistance reported breaches of confidentiality and conflicts of interest with EAP employees. The EAP is not well publicized, nor is it discussed during Human Resources Management Service's new-employee orientation. Training was not offered for supervisors concerning the EAP or about ways to recognize and assist impaired employees. NIHCS managers should review and strengthen the EAP, should develop a plan to incorporate the EAP into the new-employee orientation, and should establish training for supervisors regarding the EAP and the recognition of impaired employees.

Chaplain Service and NHCUC team members would benefit from additional training. Reportedly, CPRS documentation of intervention by chaplains has been inconsistent due to varying levels of computer skills. Interviews with NHCUC interdisciplinary team members also revealed a gap in the level of training and in understanding of the Resident Assessment Instrument/Minimum Data Set (RAI/MDS) tool that is required by VHA.

It is necessary for all treatment team members to understand these patient assessment tools, beyond just their own assigned sections, in order to achieve accurate and useful data. NIHCS managers should provide chaplains additional CPRS training to enhance documentation of care in the electronic medical record. Managers should also consider providing RAI/MDS retraining for all NHCUC team members. This remedial training needs to be accomplished before completed assessments are forwarded for entry into the software.

Recommendation No. 6

The NIHCS Director should take action to enhance the EAP, and provide employees with needed training as outlined above.

VA Northern Indiana Health Care System Director Comment

Concur.

Employee Assistance Program

An all-employee bulletin is being drafted to raise the awareness of all NIHCS employees concerning the Employee Assistance Program (EAP) services. NIHCS written policies concerning the EAP will be reissued as well. These actions will be completed within 30 days.

Increased emphasis on EAP will be included in future NIHCS new employee orientation. A module geared specifically for supervisory staff is being developed and will be offered within 60 days at the NIHCS Supervisors Academy. Updated modules on the EAP will be offered in the same venue on an annual basis.

Chaplain and NHCU Team Training

Additional training in CPRS and Resident Assessment Instrument/Minimum Data Set (RAI/MDS) will be provided to all appropriate personnel.

Office of Inspector General Comment

The NIHCS Director's comment and implementation plans are responsive to this recommendation and we consider this issue resolved, although we may follow-up on all planned actions until completion.

Management Control Issues

Organizational Strengths

We concluded that the administrative activities reviewed were generally operating satisfactorily and management controls were generally effective. We found no problems or only minor deficiencies in the following areas:

- Staff of NIHCS are responsible for conducting compensation and pension examinations in connection with the adjudication of claims for VA benefits. Processing times and examination completeness are the two quality assurance measures in place for this program. Processing times for Fiscal Year 1999 averaged 27 days, which is well within the 35 days allowed by VA policy, and the "remand" rate (rate of examination reports returned because of deficiencies) was only .8 percent.
- Staff established a temporary lodging and care program for substance abuse patients at the Marion campus of NIHCS in compliance with VHA and local policy.
- Staffing for implementation and operation of VA's Decision Support System (DSS) was sufficient. Management fully supported implementation and use of DSS. All processing was completed timely, and plans were being made to train service-level managers and clinical staff to use the system. Management was aware that as implementation proceeds and more demands are placed on DSS staff in the future, staffing levels will need to be reassessed.

- Construction planning staff had developed a comprehensive process for the development, review, and approval of non-recurring maintenance and minor construction projects. Supporting documents adequately described and justified proposed projects. Staff considered alternatives and performed appropriate cost benefit analyses.
- NIHCS staff had established an effective equipment management program for emergency medical equipment, including defibrillators, ECG monitors, and respirators and ventilators. The equipment management program included written equipment testing procedures and a training program for users.
- Local policy for the control of non-expendable equipment was in line with VA policies. Adequate controls existed for loaned equipment. In addition, reports of survey substantiated a low loss rate and adequate follow-up on missing equipment.
- Patients who required special or emergency care at the Marion campus were properly referred to outside medical facilities. We found no evidence that Marion staff were treating patients who should have been referred elsewhere.
- NIHCS staff handle hazardous materials in accordance with VA policies. A Hazardous Materials and Waste Management Plan has been established. Employees who must be exposed to such substances have been identified and have been trained in their use and handling. Hazardous materials were inventoried and stored appropriately.
- Purchases of information technology (IT) equipment during Fiscal Year 1999 adhered to the special rules that apply to such purchases.
- Limited tests of the Government purchase card program revealed no deficiencies. We identified no inappropriate purchases or “split” purchases. NIHCS staff performed reconciliations and audits of credit card purchases properly and timely. In addition, the use of cash advances was proper.
- Staffing levels for rehabilitation medicine and recreation activities at the Marion campus were appropriate.
- In a limited review of mileage reimbursements to employees for official travel between the Ft. Wayne and Marion campuses, nothing came to our attention to indicate inappropriate payments.

Opportunities for Improvement

We identified opportunities to further improve operations in 11 areas. Specific aspects of those 11 areas that require greater management attention are discussed fully below.

> Administration of the South Bend Community Based Outpatient Clinic (CBOC) Contract Needed To Be Improved

The administration of a CBOC located in South Bend, IN needed to be improved in several ways. Deficiencies and inefficiencies occurred because the contract was flawed and because medical center and contractor staff did not adhere to certain provisions of the contract. Consequently, VA paid more per-visit for medical care than it expected, and NIHCS staff could not always assure that quality of care monitors were adhered to. Also, the contractor was billing Medicare for some VA patient visits for which VA was already paying.

In April 1998, NIHCS entered into a contract with a private health maintenance organization (HMO) to provide care for veteran CBOC patients by "enrolling" them in the existing HMO. At that time, the estimated annual cost of the contract was \$1.5 million, which was based on anticipated veteran enrollment levels for Fiscal Year 2000. The contract required that, for a set fee (or "premium") of \$36 a month per enrollee, the HMO would provide primary care for each veteran patient enrolled by NIHCS staff in the HMO. The contract was intended to have the HMO provide for the primary care needs of most of the South Bend area's veteran population. More complex care, mental health care, and diagnostic and therapeutic care not available through the HMO was to be provided by NIHCS. We reviewed the contract and interviewed NIHCS and HMO staff, and identified several issues that need to be resolved:

- NIHCS staff informed us that they had received complaints from patients indicating that their care was being billed to both VA and Medicare. Interviews with HMO staff revealed that they, indeed, did bill Medicare, under certain conditions, for treatment provided to enrolled veterans. According to HMO staff, these conditions were:
 - If the veteran patient was seen by an HMO physician who was not privileged by NIHCS.
 - If the veteran patient had been treated at least twice already in the program in a 12-month period.
 - If the veteran patient stated he wished to be treated as a Medicare patient.
 - If the veteran patient's primary care provider in the CBOC program was also his private care provider.
 - If the veteran patient was seen at an HMO site that was not one of the three specific sites identified in the contract.

Because VA had already paid the HMO, on a *per capita* basis, for enrolled veterans, we believe the HMO's practice of billing Medicare for certain individual outpatient visits constituted double billing of the United States Government.

- NIHCS staff reported that they could not always verify reported patient encounters at South Bend because HMO staff did not enter progress notes into the automated medical record through NIHCS' VISTA system, as required in the contract. We documented 153 occasions between October 1999 and February 2000 when HMO staff failed to input progress notes timely for a reported visit. Due to the lack of timely documentation of care provided by the HMO, NIHCS could not accurately measure demand for CBOC services in South Bend on a timely basis. In addition, NIHCS staff could not monitor the quality of care provided by HMO staff for those visits that did occur, but for which there were no progress notes.
- NIHCS staff failed to dis-enroll patients who did not report to the CBOC within a reasonable period of time⁵ after being enrolled. This was required by the contract. As a result, VA paid premiums to the HMO for patients who did not use the HMO's services.
- The CBOC's apparent per-visit cost was relatively high because of low workload. In Fiscal Year 1999, each visit to the CBOC cost VA approximately \$237, based on a projected annual cost of \$313,876⁶ and actual workload of only 1,322 visits. This occurred because patients for whom the medical center paid monthly enrollment fees did not use the CBOC to the extent originally anticipated when the contract was formulated and the *per capita* enrollment fee set. Some veterans enrolled in the CBOC continued to seek services at NIHCS, either exclusively or in conjunction with care provided at the CBOC, thus contributing to the low use rate.
- Some HMO practitioners were not privileged by NIHCS to provide care to veterans. This would not be a concern as long as enrolled veteran patients were not treated by these practitioners. However, as noted above, such treatment could have taken place, as identified when Medicare would have been billed if services were provided by non-VA-privileged practitioners. To insure that this cannot happen, the NIHCS Director should reach an agreement with HMO management that only VA-privileged practitioners continue to treat VA patients at HMO facilities. Further, NIHCS staff

⁵ *Although nothing in the contract language or other sources defined what was meant by "a reasonable period of time," NIHCS staff used 45 days as a rule of thumb. We found that they failed to apply that criterion in some cases.*

⁶ *We projected July, August, and September costs based on the first 9 months of Fiscal Year 1999. In addition, these were direct costs only. Support provided by NIHCS staff for contract administration and quality assurance monitoring represented additional, unquantified costs.*

should periodically monitor whether the HMO is complying with the agreement for the remainder of the contract.

We discussed the above conditions with medical center management and staff responsible for oversight of the South Bend CBOC. Management was aware of most of those issues and had addressed them by planning to allow the present contract to expire, without renewal, at the end of the current option year. It was NIHCS management's opinion that they needed the balance of the current option year in order to put into place another contractual agreement for a CBOC with a new provider. They reasoned that, if the HMO contract were terminated immediately, it would deprive the South Bend veteran population of local, VA-sponsored healthcare for several months.

This was the first CBOC in VA's healthcare system established by contract with an outside provider. Management characterized the contract as an experiment, and hindsight showed that some aspects of it were less than optimal, e.g., use of a capitation method for determining costs based on a projected workload that did not materialize. NIHCS management expects to use a per-visit payment method in a follow-on contract, more like a conventional fee basis payment system. In addition, it is likely that quality assurance concerns will be addressed differently in the new contract. We concur with both of these proposals.

Because NIHCS management was aware of problems associated with payment and quality control in the current South Bend CBOC contract and had plans to address both, we are not making any recommendations on those specific issues. However, we do recommend that the Director follow through on his plan to develop a new contract that addresses, at least, the above-described concerns. In addition, the Director should take action to dis-enroll veterans from the current contract, and any future contract, who have not sought treatment at the CBOC within a reasonable period of time. This will prevent the unnecessary payment of monthly fees to the contractor for veteran patients who are not using the CBOC's services.

(b)(5)

[REDACTED]

Recommendation No. 7

The NIHCS Director should take the following actions with respect to the HMO CBOC contract:

- a. Follow through on his declared intention to terminate the contract at the end of the current contract year.

- b. Avoid, in any replacement contract, the kinds of deficiencies in the HMO contract described above.
- c. Dis-enroll veterans from the current, and any future, contract who do not seek treatment within a reasonable period of time.
- d. Ensure that only VA-privileged practitioners treat veteran patients.

VA Northern Indiana Health Care System Director Comment

Concur.

- a. We will not exercise the final option year of the existing South Bend CBOC contract.
- b. We will develop a solicitation for a new South Bend CBOC contract that will address the deficiencies found in the OIG review of the current contract.
- c. Veterans will be dis-enrolled from the current, and any future, contract who do not seek treatment within a reasonable period of time. A monitor will be implemented for this specific purpose.
- d. An explicit agreement will be reached with the South Bend, IN, CBOC contractor that only VA-privileged practitioners will treat VA patients at their respective facilities. A monitor will be implemented to insure that the contractor is living up to this agreement for the remainder of the contract.

Office of Inspector General Comment

The NIHCS Director's comment and implementation plans are responsive to this recommendation and we consider this issue resolved, although we may follow-up on all planned actions until completion.

> Accountability and Security Over Controlled Substances Should Be Improved

VA facilities are required to maintain accountability of all controlled substances and to be in full compliance with Drug Enforcement Administration regulations. VA facilities are required to maintain perpetual inventories of all controlled substances. VA criteria also require an unannounced monthly narcotic inspection. For physical security, VA provides a detailed Design Guide for the security of controlled substances.

We identified several conditions related to accountability and security over controlled substances that, taken together, indicate an overall need for controls to be improved, as follows:

- Destruction of expired drugs was not conducted frequently enough.
- Expired controlled substances were kept for an extended period.
- Unannounced narcotics inspections were not conducted frequently enough.
- Unannounced narcotics inspections took too long to complete.
- A pharmacy intrusion alarm was not tested frequently enough.

Destruction of expired drugs did not occur frequently enough. VA policy requires that outdated or otherwise unusable controlled drugs be destroyed at least quarterly. Expired controlled drugs, if allowed to accumulate, become increasingly susceptible to pilferage. Drug destruction records showed that, at the Ft. Wayne campus, there was no destruction of expired drugs from July 1998 to January 2000, a period of 15 months. At the Marion campus, no destruction of drugs occurred in the third quarter of Fiscal Year 1999.

Reviews of narcotics inspection records from March 1999 through February 2000, revealed that inspections scheduled for June and July were not conducted at the Ft. Wayne campus. Inspections also took too long to complete, particularly at the Ft. Wayne campus. At Ft. Wayne, inspections typically took up to 4 days to complete. Ideally, inspections should be completed within 1 day or as close to 1 day as possible. An inspection conducted over an extended period makes accounting for drugs more difficult since there is likely to be some movement of drugs between locations, e.g., from the pharmacy to a ward. It also allows more time for staff at "downstream" locations to prepare for an inspection, thus negating one important control aspect of an "unannounced" inspection. Extended inspections also make it easier to move drugs improperly from an inspected area to an uninspected area for the purpose of concealing a shortage.

Reviews of alarm test records maintained by VA police staff showed that the pharmacy intrusion alarm at the Marion campus was not tested in 4 of the last 12 months. VA criteria require monthly alarm tests. From March 1999 through February 2000, the alarm was not tested in August, September, November, or February.

During our review, we called for and observed an unannounced narcotics inspection. During that inspection, we noted eight instances of drug dispensing documentation where clinical staff wasted drugs⁷ that were not properly witnessed. VA criteria require that when controlled drugs are wasted, the action itself of wasting the drug and the corresponding documentation must both be witnessed.

⁷ This occurs quite legitimately when only a portion of a unit-dose drug is administered to a patient. The unused portion is "wasted," or disposed of, typically, by pouring it into a toilet or other drain.

While the discrepancies we noted were diverse, both in nature and in location, we believe that taken together they indicate a need for a general review of medical center-wide controls over controlled substances. Controls need to be strengthened.

Recommendation No. 8

The NIHCS Director should strengthen controls over narcotics by ensuring the following actions:

- a. Monthly narcotics inspections at all locations every month and within as short a time frame as possible.
- b. Destruction of outdated drugs at least once every 3 months.
- c. Wasting of drugs that is properly supervised and witnessed.

VA Northern Indiana Health Care System Director Comment

Concur.

- a. Monthly narcotic inspections will be conducted.
- b. Destruction of outdated drugs will occur at least quarterly.
- c. A procedure will be published to outline the SOP for supervision and documentation of the wasting of drugs.

Office of Inspector General Comment

The NIHCS Director's comment and implementation plans are responsive to this recommendation and we consider this issue resolved, although we may follow-up on all planned actions until completion.

> A Scarce Medical Specialist Contract for Radiology Services May Not Be Needed

A scarce medical specialist contract to procure the services of a full-time radiologist at the Ft. Wayne campus may not be needed. In addition, time spent by the physician providing those services may be less than contracted for.

NIHCS staff entered into a scarce medical specialist contract with a private radiology group to provide one full time equivalent radiologist on a 5-day, Monday through Friday schedule. The contract also provided for emergency call-back for hours outside of the

regular tour at a billed rate of \$56 an hour. Total costs for the contract in Fiscal Year 1999 were \$397,000. However, information provided to us revealed that waiting times for radiologist services are sometimes protracted and that the physician contracted for is physically present at the facility for only about 4 hours a day during the regular, Monday through Friday, workweek.

An alternative to a scarce medical specialist contract for the Ft. Wayne campus may be available. A full-time radiologist is on staff at the Marion campus. Use of tele-radiology technology could make that radiologist's services available to the Ft. Wayne campus electronically. Based on a recent Inspector General audit that studied tele-radiology use in VA, we believe that the situation at this dual-site facility is particularly appropriate for an application of this kind. Given the relatively high cost of the radiologist contract at Ft. Wayne, the potential for use of tele-radiology should be explored.

Recommendation No. 9

The NIHCS Director should take the following actions with regard to radiologist support for the Ft. Wayne campus:

- a. Assure that the current contractor provides the number of staff hours provided for in the contract or, alternatively, amend the contract to reflect the number of hours actually provided.
- b. In cooperation with VISN management, evaluate the applicability of tele-radiology technology in NIHCS, in lieu of contracting for radiologist services.

VA Northern Indiana Health Care System Director Comment

Concur.

- a. The current contract for radiology services is under review for modification and monitoring of performance. Guidance for potential actions has been sought from VAHQ. NIHCS expects to develop a direction for contracted radiology services within 3 weeks.
- b. The potential for teleradiology services applicable to the Fort Wayne campus of NIHCS will be explored with VISN 11 management along with other means to obtain any necessary services.

Office of Inspector General Comment

The NIHCS Director's comment and implementation plans are responsive to this recommendation and we consider this issue resolved, although we may follow-up on all planned actions until completion.

➤ **Laboratory Service Staffing Could Be Enhanced**

Lack of a dedicated phlebotomist⁸ to draw blood specimens for Laboratory Service testing at the Ft. Wayne campus necessitates use of fee basis services and contributes to inefficiencies in the use of nursing staff. (See also the *Quality of Care* section of this report, under subtitle “Staffing issues must be thoroughly reviewed to ensure that patients receive adequate quality of care.”) Authorized staffing in Laboratory Service provides for 5 full time equivalent employee (FTEE) medical technologists, 1 FTEE medical technician, and 1 FTEE histo-pathology technician, for a total of 7 FTEEs. However, at the time of our review there were only 4 FTEE medical technologists on duty. This created an imbalance between staffing and workload demands.

In an attempt to address the workload demand, NIHCS management relied on a combination of fee basis phlebotomists, contract laboratory services, and use of otherwise reportedly scarce nursing staff to obtain patient specimens for laboratory testing. Estimated annual cost for fee basis phlebotomy was \$42,000, and the estimated annual cost for two laboratory contracts was about \$106,000. Thus, total measurable cost to augment laboratory staffing was about \$148,000 per year. Although the dollar cost of using nursing staff to supplement specimen drawing was unknown, we believe that staff efficiency and morale were reduced because of the existing nurse shortage.

Due to the amount of resources already expended to partially ameliorate the laboratory staffing shortage, at least 1 FTEE staff phlebotomist should be recruited. Hiring a dedicated phlebotomist should obviate the need for fee basis phlebotomy and should reduce reliance on relatively expensive, and scarce, nursing staff to draw blood specimens.

Recommendation No. 10

The NIHCS Director should explore the practicability of hiring 1 FTEE phlebotomist.

VA Northern Indiana Health Care System Director Comment

Concur.

We are currently recruiting for a medical technologist to provide “extended-hour” coverage in laboratory services, including phlebotomy. The Chief of Pathology and Laboratory Medicine will conduct a review of the total requirements for laboratory staffing by July 1, 2000.

⁸ *While medical technologists usually are qualified to perform phlebotomist duties, a fully qualified medical technologist is more expensive to employ than a phlebotomist who may lack other technologist credentials.*

Office of Inspector General Comment

The NIHCS Director's comment and implementation plans are responsive to this recommendation and we consider this issue resolved, although we may follow-up on all planned actions until completion.

> Established Procedures for Obtaining Informed Consent for Surgical Procedures Should Be Followed

Veterans Health Administration (VHA) policy requires that informed consents are obtained from patients before performing surgical procedures or other procedures that may entail significant discomfort or the risk of potential harm. If the patient is unable to provide informed consent, consent may be obtained from the patient's next of kin. In order of precedence, this may be from a spouse, an adult child, a parent, or an adult sibling. Finally, in emergent situations, the Chief of Staff may give consent on behalf of a patient who is unable to do so for him/her self and in the absence of any next-of-kin.

To determine if NIHCS staff properly obtained informed consents from patients undergoing surgical procedures, we reviewed a judgement sample of 19 surgical cases occurring in January 2000. We found that in one case, NIHCS staff obtained consent from a patient's nephew, even though his records showed that he had both a wife and an adult child, one or both of whom had previously given consent for procedures for this patient. While there may very well have been a valid reason to depart from VA policy, there was no reason offered in the medical record.

Recommendation No. 11

The NIHCS Director should ensure that informed consent is obtained from appropriate individuals and that responsible staff justify any exceptions to the established order of precedence in the medical record.

VA Northern Indiana Health Care System Director Comment

Concur.

An additional indicator has been added to the existing surgical monitoring for informed consent that reads, "Preferably, consent will be signed by the patient or the durable power of attorney/guardian of person as identified on the face sheet. Otherwise, next-of-kin will be sought in order of precedence."

Office of Inspector General Comment

The NIHCS Director's comment and implementation plans are responsive to this recommendation and we consider this issue resolved, although we may follow-up on all planned actions until completion.

➤ Oversight of the Contract Community Nursing Home (CCNH) Program Should be Strengthened

We reviewed the CCNH Program, including the CCNH inspection process, and overall administrative and clinical oversight of CCNHs. As part of NIHCS' oversight, a social worker and nurse alternate visits monthly to track the overall care provided to VA patients in CCNHs. However, despite these visits, the Resource Utilization Groupings-version III (RUGs-III) review was not consistently accomplished on CCNH patients. This review is used to evaluate the level of care appropriate for individual patients. Thus, NIHCS relied on un-validated CCNH data for decisions on continuing monthly contract rates.

Clinical managers should consider requesting PI data⁹ from CCNHs on a quarterly basis, and move toward completing Resident Assessment Instruments (RAIs) for all CCNH patients in order to monitor contract prices. An alternative would be to require the CCNHs to submit quarterly assessments of patients along with the corresponding RUGs-III levels. Also, all CCNH contracts need to be presented to NIHCS clinicians for approval.

VA criteria also prescribe that periodic inspections be conducted of CCNHs by qualified clinical and administrative staff to ensure that those facilities meet minimum standards for care of VA nursing home patients. Employees we spoke to indicated that the CCNH inspection process had changed from direct VA inspections in the past, to reviews of surveys performed by the State of Indiana. Although VA staff do make occasional, unannounced spot inspections of contract nursing home care facilities, NIHCS management relies primarily on the state inspection reports to monitor the CCNHs.

While VA criteria do allow for reliance on inspections by other Government agencies, reports of such inspections are to be thoroughly reviewed by qualified VA staff to determine if they identify any conditions that warrant intervention. However, at the time of our review, there was no established multi-disciplinary team, either for conducting nursing home inspections, or for reviewing reports of nursing home inspections conducted by the state. Only one VA employee, a social worker, reviewed these state

⁹ An example of PI data that can be requested from the CCNHs is the Health Care Financing Administration (HCFA) Report #672.

reports. He relied on his judgement alone to determine whether the state inspection reports revealed conditions that warranted VA intervention.

Because there are several specialized aspects to nursing home care, we believe that such decisions should be made collectively by a team of individuals from various clinical disciplines, e.g., nurses, physicians, therapists, and social workers. NIHCS management should also consider conducting unannounced CCNH visits to evaluate care during times when CCNH administrators are not on duty. The NIHCS Director should appoint a team of qualified professional staff for reviewing, and recommending action based on, state inspection reports of contract nursing homes, and for conducting VA inspections when warranted.

Recommendation No. 12

The NIHCS Director should improve the administration and oversight of contract community nursing homes in the areas discussed above.

VA Northern Indiana Health Care System Director Comment

Concur.

The Acting Chief, Extended Care and Rehabilitation will implement the following by June 2, 2000.

- a. An interdisciplinary team will be formed to evaluate the continuation of contracts.
- b. Obtain PI data on a quarterly basis.
- c. Conduct inspections or reviews of state-conducted inspection reports by using a multidisciplinary team to determine if intervention is required.

The inspections will be both announced and unannounced.

Office of Inspector General Comment

The NIHCS Director's comment and implementation plans are responsive to this recommendation and we consider this issue resolved, although we may follow-up on all planned actions until completion.

> Problems Associated with Implementation of the Generic Inventory Package for Control of Medical Supplies Should Be Resolved

Reported medical supply inventories in both the Supply Processing and Distribution (SPD) activity and the main warehouse were inaccurate because there was no effective system in place to control inventory. We tested inventory levels at the Ft. Wayne SPD activity and at the Marion warehouse. The results of our tests revealed wildly inaccurate inventory data in NIHCS' Generic Inventory Package (GIP) system.¹⁰ We found that, because of inaccuracies in the GIP system, important supply items needed for patient care and maintained in stock for issue were expired or near expiration. We also found that SPD and warehouse staff were forced to rely on experience and visual estimates, rather than on accurate data to determine when reordering was needed.

Although VA policy does not require the use of GIP, its use is encouraged by both VHA officials and officials in the Office of Acquisition and Materiel Management (OA&MM). In our experience, staff at most VA medical centers use GIP to manage medical supply inventories. At some facilities its use has been expanded to include housekeeping, engineering, prosthetics, and other kinds of common supplies.

As part of our preparation for this review, we requested that NIHCS staff provide us the "Days of Stock on Hand" report from their GIP system. Although they provided the report as requested, an accompanying note stated that inventory levels recorded in the report were inaccurate. In subsequent interviews, SPD and warehouse staff confirmed that the GIP data was unreliable. In addition, we conducted inventories of 10 randomly selected items in the Ft. Wayne SPD area and found that none of the reported inventory levels were correct.

Aside from forcing staff to rely on visual estimates to maintain appropriate stock levels, lack of accurate data on inventory levels can contribute to the undetected presence of expired stock. Of the 10 items in our sample, we observed one that was very near expiration. In addition, during our tour of SPD operations, we identified two other items, not in our sample, that had already expired. One of these two items had expired 15 months earlier, and one had expired 19 months earlier.

NIHCS management strongly supported the concept of automated inventory control, particularly the use of VA's GIP system. However, they complained that there were software problems in their GIP system that, despite or because of, numerous corrective "patches," had made the system unreliable. In particular, they cited a "patch" issued in September 1999 that has necessitated daily adjustments to inventory levels, which the medical center does not have sufficient staff to complete. Officials in VA's Office of Acquisition and Materiel Management informed us that they were not aware of any

¹⁰ GIP is an automated system used to control medical supply inventory.

complications of this type. However, they promised to contact staff at NIHCS to provide assistance in restoring GIP functionality. In the interim, and regardless of the outcome of resolving GIP software issues, some type of accurate perpetual inventory system for medical supplies is needed.

Recommendation No. 13

The NIHCS Director should put in place an accurate medical supplies inventory system.

VA Northern Indiana Health Care System Director Comment

Concur.

A comprehensive review of the NIHCS Generic Inventory Package (GIP) implementation procedures has been completed which confirmed the existence of a problem in the GIP software; however, it was also discovered that some of the local practice policies were found to compound that problem. New procedures have been developed and implemented that allow the GIP to perform as designed. The new procedures also provide NIHCS a "work-around" to the software problem until such time that it is fixed nationally. Correction to all SPD inventories is progressing and completion is expected within two weeks. The barcoding package extension of GIP has also been fully implemented, enabling its use at both campuses of NIHCS.

Office of Inspector General Comment

The NIHCS Director's comment and implementation plans are responsive to this recommendation and we consider this issue resolved, although we may follow-up on all planned actions until completion.

> Other Aspects of Supply Processing and Distribution Operations Should Be Improved

Using VA Handbook 7176, we evaluated several other aspects of SPD performance at the Ft. Wayne campus and identified four additional areas that require improvement.

- SPD staff reported to us that temperatures in the SPD operation at the Ft. Wayne campus have, on occasion exceeded 100 degrees. An employee reported fainting from the excessive heat on one occasion. The SPD handbook requires that temperatures be maintained between 65 and 72 degrees with humidity levels between 35 and 75 percent.
- We observed that sterile items bound for hospital nursing wards at the Ft. Wayne campus were transported on open carts. To prevent contamination, the SPD

handbook requires that sterile items be transported in closed carts. We observed several closed carts in SPD intended for transporting sterile supplies, but which were instead used only to store miscellaneous items.

- SPD staff reported to us that support furnished by Environmental Management Service staff was erratic. They also reported that heavy cleaning and recurring maintenance of walls and floors occurred only infrequently. We observed some areas in the Ft. Wayne SPD area that appeared in need of cleaning.
- Storage areas at the Ft. Wayne SPD were cluttered. Aisleways were also cluttered with an excessive number of delivery carts and crash carts.

Action should be taken to ensure that temperatures in the Ft. Wayne SPD are maintained within required parameters, and that sterile supplies are transported to wards in closed carts intended for that purpose. In addition, SPD space should be regularly cleaned and properly maintained, and clutter in SPD space should be reduced to a minimum.

Recommendation No. 14

The NIHCS Director should ensure that SPD operations are improved in the areas described above.

VA Northern Indiana Health Care System Director Comment

Concur.

Heat and humidity concerns are actively being remedied. A construction project has been awarded for air conditioning corrections including the SPD area, which will be completed this fall.

Sterile items are now being transported from the SPD area in closed carts.

The SPD bulk storage area is currently being reconfigured to allow proper space for the storage of carts without the clutter noted at the time of the review. This effort will be completed within 30 days.

A recurring schedule with the Environmental Management Department is being developed for heavy cleaning including maintenance of walls and floors and will be followed. This schedule will be completed within 14 days.

Office of Inspector General Comment

The NIHCS Director's comment and implementation plans are responsive to this recommendation and we consider this issue resolved, although we may follow-up on all planned actions until completion.

> Timeliness of Agent Cashier Audits and Controls Over Third Party Payer Checks Needed To Be Improved

We reviewed various aspects of Agent Cashier operations and identified two areas that needed improvement. Although our review accounted for all Agent Cashier funds, internal audits of these funds performed by NIHCS staff were not timely. In addition, some checks received from third party payers and sent from the NIHCS mailroom to the Agent Cashier were not properly controlled.

VA policy requires that NIHCS staff conduct audits of Agent Cashier funds at least every 90 days. We reviewed the timeliness of the last four audits performed at both the Ft. Wayne and Marion campuses. At Ft. Wayne, none of the last four audits were conducted within the required 90 days. Those audits ranged from 91 to 158 days apart. At Marion, two of the last four audits exceeded the 90-day requirement, ranging from 136 to 175 days apart.

The Agent Cashier at the Ft. Wayne campus was not receipting for third party payer checks delivered from the mailroom. Medical Care Collection Fund (MCCF) staff picked up third party payer checks from the Ft. Wayne mailroom and delivered them to the Agent Cashier for safekeeping pending their eventual processing by MCCF staff. However, the Agent Cashier did not sign receipting documents for these checks. Thus, there was no confirmation that such checks, recorded in mailroom records, were in the possession of the Agent Cashier. An internal audit, performed by NIHCS staff in October 1998, identified this as an internal control weakness. However, at the time of our review in March 2000, the practice continued.

Recommendation No. 15

The NIHCS Director should take action to ensure that internal audits of Agent Cashier funds are conducted timely, and that the Agent Cashier receipts-for checks held for processing by MCCF staff.

VA Northern Indiana Health Care System Director Comment

Concur.

The proper procedure for handling third party payer checks has been explained to all appropriate employees. A Fiscal Service Standard Operating Procedure (SOP) will follow the verbal instructions on handling of these important documents and will be published and distributed to appropriate staff by May 26, 2000. The procedure will include procedures for logging in all third party payer checks, delivering of all checks to the Agent Cashier within a timely manner, and having the receipt log signed by the Agent Cashier for each check.

Procedures for ensuring that agent cashier audits are accomplished timely have been developed. The Manager, Fiscal Support Services, will monitor the frequency of audits as a second line monitor to ensure that these reviews are conducted within the prescribed 90-day timeframes at both campuses.

Office of Inspector General Comment

The NIHCS Director's comment and implementation plans are responsive to this recommendation and we consider this issue resolved, although we may follow-up on all planned actions until completion.

> Access Authority Should Be Terminated Timely for Inactive Users of Information Technology Systems

We reviewed various aspects of information technology (IT) security. NIHCS has a complete and current IT contingency plan. Physical access to IT hardware, although not monitored by camera or card reader, is adequately limited by requiring users to pass two occupied offices to an inner door, which had a cipher lock.

However, our review identified an apparently large number of inactive IT system users. These were mostly non-NIHCS staff (students, contract staff, volunteers, VA Cemetery staff, VA Regional Office staff, and others) who, for legitimate reasons, had been given limited IT access at one time or another. Because such persons do not usually undergo regular out-processing procedures when their tenure ends or when their need for access ends, controls designed to terminate IT access do not catch them. IT staff took immediate action to delete 102 of these inactive users from IT system access.

Recommendation No. 16

The NIHCS Director should establish controls to timely terminate IT access for inactive users.

VA Northern Indiana Health Care System Director Comment

Concur.

A Standard Operating Procedure has been written to include the following:

- a. Any employee and/or user listed in the New Person File who has not been logged on to NIHCS system for 120 days will be terminated.
- b. Monthly, Information Resource Management Department will provide a list to the ISOs of Regional Offices in Indianapolis and Cleveland, and also to the contact persons at South Bend and Muncie CBOCs to determine whether users require continued access.
- c. Monthly, IRM will review all non-NIHCS users for continued access and forward the list to the appropriate ISO/contact person for comment and/or action.

Office of Inspector General Comment

The NIHCS Director's comment and implementation plans are responsive to this recommendation and we consider this issue resolved, although we may follow-up on all planned actions until completion.

➤ Drug Prescription Backlogs Need To Be Better Monitored

Pharmacy staff do not regularly review and report on outpatient mail-out prescriptions to determine if they are processed and dispatched within 7 working days as required by VA policy. VA Manual M-2, Part VII requires that pharmacy staff review outpatient mail-out prescriptions for backlogs on the first workday of each workweek. When backlogs exceed 7 days, pharmacy staff must submit a report to the facility Director that includes the age of the oldest prescription pending at the time of the report and a description of the circumstances that led to the backlog. If pharmacy staff need to submit such reports for four consecutive work-weeks, the facility Director must notify the VISN Director.

Pharmacy staff informed us that they do not notify NIHCS management when mail-out backlogs exceed the allowable time limit. At the time of our review a prescription mail-out backlog existed, comprised of a mix of prescriptions to be mailed from the NIHCS Pharmacy, and from the Consolidated Mail-Out Pharmacy (CMOP) located in Hines, IL. At least one prescription was 9 days old. In addition to customer service and quality of care issues, the Director cannot fulfill his reporting requirements to VISN management unless pharmacy staff routinely report on backlogs.

Recommendation No. 17

The NIHCS Director should ensure that mail-out prescription backlogs are monitored and that internal and external reporting requirements are met.

VA Northern Indiana Health Care System Director Comment

Concur.

Outpatient mail-out prescriptions will be reviewed in accordance with VA Regulations and the results reported to the Director to ensure VA policy and VISN requirements are met.

Office of Inspector General Comment

The NIHCS Director's comment and implementation plans are responsive to this recommendation and we consider this issue resolved, although we may follow-up on all planned actions until completion.

Fraud and Integrity Awareness

During the week of March 6 through 10, 2000, the Office of Investigations conducted four fraud and integrity briefings at the two main NIHCS campuses, Ft. Wayne and Marion. The presentations were well received by approximately 65 individuals from all services at NIHCS. The briefings included a lecture, a videotape presentation, and question and answer opportunities. Each session lasted approximately 60 minutes.

The presentations provided a history of the Office of the Inspector General (OIG), discussions of how fraud occurs, criminal case examples, and information to assist in preventing and reporting fraud. Specific case examples were used to alert the employees to how easily administrative safeguards against illegal acts could be circumvented.

Reporting Requirements

The attendees were strongly encouraged to report all types of fraud immediately to their direct supervisors or to the Inspector General Hotline Center at Washington, D.C. They were made aware of VA Manual MP-1, Part 1, Chapter 16 that specifies the responsibility of VA employees in reporting any wrongdoing. The OIG is heavily dependent upon VA employees to report suspected instances of fraud, waste, abuse, and improper medical care; for this reason, all contacts with the OIG to report such matters are handled confidentially.

The videotape presentation covered the same basic information, but contained real life scenarios. Attendees were provided with points of contact for the VA OIG and were encouraged to call and discuss any concerns about bringing a particular matter to the attention of the OIG.

Importance of Timeliness

It is important to report allegations promptly to the OIG. Many investigations rely heavily on witness testimony. The greater the time interval between the occurrence and an interview with the OIG, the greater the likelihood that witnesses will not recall the event in significant detail. Also, over time, documentation can be misplaced or destroyed. Finally, most Federal criminal statutes have a 5-year period of limitations.

Referrals to the Office of Investigations - Administrative Investigations Division

The Administrative Investigations Division investigates allegations of serious misconduct on the part of VA officials that are not criminal in nature. An example would be misuse of a Government-owned vehicle by a senior VA official.

Referrals to the Office of Investigations - Criminal Investigations Division

Upon receiving an allegation of criminal activity, the Office of Investigations, Criminal Investigations Division will assess the allegation and make a determination as to whether an official investigation will be initiated. Not all referrals are accepted. If the Office of Investigations decides to initiate an investigation, the matter is assigned to a case agent. If the investigation substantiates criminal activity, the matter is then referred to the Department of Justice (DOJ), usually the local US Attorney's Office. DOJ then determines whether it will accept the matter for prosecution. Not all cases referred to DOJ by the OIG are accepted. If DOJ accepts the case, either an indictment or a "criminal information" follows. These two vehicles are used to formally charge an individual with a crime. Following the issuance of an indictment or information, an accused individual either pleads guilty or goes to trial. If a guilty plea is entered or a person has been found guilty after trial, the final step in the criminal referral process is sentencing.

If the investigation only substantiates administrative wrongdoing, the matter is referred back to VA management, usually the medical center or regional office director, for action. Management, with the assistance of Human Resources Management and Regional Counsel staff, will then determine what administrative action to take, if any.

Areas of Interest for the Office of Investigations - Criminal Investigations Division

The Office of Investigations, Criminal Investigations Division, is responsible for conducting investigations of suspected criminal activity having some VA nexus. The range and types of investigations conducted by this office are very broad. VA is the second largest Federal department and it does a large volume of purchasing. Different types of procurement fraud include bid rigging, defective pricing, double or over billing, false claims, and violations of the Sherman Anti-Trust Act. Another area of interest is bribery of VA employees; this sometimes ties into procurement activities. Bribery of VA officials can also extend into the benefits area. Other benefits-related frauds include fiduciary fraud, compensation and pension fraud, loan origination fraud, and equity skimming. Healthcare-related crimes include homicide, theft and diversion of pharmaceuticals, illegal receipt of medical services, improper fee basis billings (medical and transportation), and conflicts of interest. Still other areas of interest include workers' compensation fraud, travel voucher fraud, and false statements by staff or beneficiaries.

**To report wrongdoing in VA programs and operations
call the Inspector General Hotline at (800) 488-8244.**

Summary of Inquiries Received

As part of the CAP process, we encourage patients and staff to come to OIG team members with any information that they may have dealing with fraud, waste, abuse, or improper medical care. During the week of our visit, we received inquiries on 99 issues from 41 individuals. Of the 41 individuals, 15 were anonymous, which limited our ability to follow-up on the information provided and to draw any conclusions about validity. The following, categorized into five general areas, summarizes the inquiries that we received.

- 35 inquiries reflected concerns over quality of care
- 32 inquiries alleged mismanagement of VA resources
- 16 inquiries were personnel-related
- 6 inquiries alleged minor criminal activities
- 10 other inquiries were of a miscellaneous nature

We noted that of the 99 issues raised by informants, 27 related in some fashion, directly or indirectly, to staffing issues. For instance, some informants who raised concerns over patient or staff safety, or of management of VA resources, tied their concerns to insufficient or inappropriate staffing. Medical center management was generally aware of such concerns regarding staffing and the implications of staffing patterns, and had been attempting to address staffing issues within their budgetary limitations.

We have closed all of the inquiries because: 1. medical center management appropriately addressed the issues; 2. there was insufficient information for us to pursue; 3. the issues were unfounded; or, 4. the issues fell outside the OIG's jurisdiction. In these latter cases, we referred the individuals to other appropriate offices, such as the General Counsel or the Office of Resolution Management.

In our opinion, there existed no pattern to these inquiries, other than those relating to staffing, that would cause us to recommend any particular action to medical center management or to cause us to pursue the issues further.

Cover Memorandum for
VA Northern Indiana Health Care System Director's Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 11, 2000

From: Director, VA Northern Indiana Health Care System (610)

Subj: Draft Report, VA Northern Indiana Health Care System, Fort Wayne and Marion, IN
Project No. 2000-1199-R4-221

To: Assistant Inspector General for Auditing (52)

1. In accordance with your letter of April 28, 2000, our comments to the recommendations from your draft report are attached.
2. The NIHCS Director concurs with all recommendations. Our implementation plans will be carried out in partnership with our employees and other NIHCS stakeholders.
3. If you have any questions, please contact me at 219-460-1310.

E/S/

Michael W. Murphy, Ph.D.

Attachment

The full text of the Director's comments to each recommendation has been inserted in the "Results and Recommendations" Section of the report, following each recommendation.

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This report will be available in the near future on the VA Office of Inspector General website at <http://www.va.gov/oig/52/reports/mainlist.htm>. *List of Available Reports.*

This report will remain on the OIG web site for 2 fiscal years after it is issued.

**Post-Hearing Questions
Concerning the June 1, 2000, Hearing**

**for
The Department of Veterans Affairs**

**from
The Honorable Terry Everett
Chairman, Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
U.S. House of Representatives**

Question 1. Is Marion realigning and clarifying the admission criteria and the delineation of clinical responsibilities for the Sub Acute Rehabilitation Program? If so, when will these tasks be completed?

Answer: Consistent with the recommendations in the VA Office of Inspector General Combined Assessment Program review, the VA Northern Indiana Health Care System has clarified the admission criteria and defined clinical responsibilities for the Sub Acute Rehabilitation Program. Specifically, the following actions have been completed:

- a) Delineation of patient's medical conditions that may not be manageable on the unit – The Rehabilitation Program's written Plan of Care delineates the conditions and reasons for transfer to acute care.
- b) Evaluation of the patient's problem list, previous diagnostic testing results, and rehabilitation potential by an interdisciplinary screening and admission process – An interdisciplinary team has been established to review referrals and recommend admissions. Patients requiring inpatient rehabilitation are admitted to the Nursing Home Care Unit using criteria appropriate for Nursing Home placement.
- c) A clear delineation of employee responsibilities for medical management of Sub Acute Rehabilitation Unit patients – A Primary Care Physician from NHCU has been designated as first contact to consult for medical complications developed after admission to the Sub Acute Rehabilitation Unit.

Question 2. Is Marion reviewing and updating the policy on the use of physical and chemical restraints? If so, when will these tasks be completed?

Answer: Yes. The new policy incorporates changes to meet the latest HCFA and JCAHO standards and is being circulated for staff concurrence. We expect to publish this during August 2000.

Question 3. Please state the corrective actions taken on each pharmaceutical management issue addressed in the VA OIG Combined Assessment Program review (CAP). Also, please state the administrative actions taken regarding all pharmaceutical and other medical personnel directly involved in breaches of medication security.

Answer: The OIG CAP recommendations addressed pharmacy issues pertaining to both campuses of VA NIHCS. The recommendations centered on the following main categories:

a) Controlled Substance Security

- 1) Physical security of areas, crash carts, SureMed, refrigerators, and storage rooms to include inspections, alarms, control of keys, and lock integrity for prevention of diversion and/or pilferage.
- 2) Control over timely destruction of expired drugs, wasting of unused narcotics, and disposal of used transdermal narcotic patches to prevent diversion and/or pilferage.
- 3) Monitors, inspections, education, and managerial oversight to ensure compliance with the "Controlled Substance Policy" that is currently under revision.

Corrective Action: A general NIHCS-wide review of policy, controls, security and destruction for controlled substances is underway. A discrepancy report to follow up on the appropriate dispensing of narcotics has been established for the SureMed Dispensing System. The key control policy has been reviewed and appropriate changes have been implemented. The room where the medication was found to be outdated has been cleared and medication is no longer stored there. Nursing is working with Pharmacy to ensure adherence to policy and secure medications including narcotics.

b) Mail Out Prescriptions - Mail out backlog exceeded allowable time limit.

Corrective Action: A monitor by Chief, Pharmacy Service, to identify unfilled prescriptions for action is now in place to ensure compliance with the standard. The backlog is currently operating within the standard of seven days.

c) Inconsistency of medication availability between facilities.

Corrective Action: Formulary changes to enhance availability of medications used by other facilities and streamlining the non-formulary drug prescription process have been implemented.

d) Lack of condom availability.

Corrective Action: Pharmacy Service now maintains condoms as a normal stocked item. Normal inventory control procedures will ensure re-ordering and continued availability.

- e) Medication errors underreported.

Corrective Action: Medication errors are reported through the patient safety incident reporting system (10-2633). Bar Code Medication Administration is operational throughout both campuses, which will help improve the reporting accuracy of medication errors.

- f) Administrative actions were not indicated for specific individuals during the investigation, implementation, and formal response phase to OIG recommendations because:
- 1) Recommendations from the OIG referred to general observations and problems concerning medication storage, outdated medications, disposal, and education. In no case did they recommend administrative disciplinary action be taken. NIHCS did not think that these incidents warranted administrative action.
 - 2) Emphasis has been placed on resolving system problems, policy shortcomings, monitors, inspection processes, and education. Managers are held responsible for making the necessary changes and reporting them to management.

Question 4. Please list all the patient safety issues in Buildings 1 and 172 identified in the CAP report and the date these issues were addressed and corrected.

Answer:

- a) **North Campus (Fort Wayne) Building 1**

- 1) NHCU, 5th floor has rooms with raised floors that represent a falling hazard for geriatric patients.

Corrective Action: The raised floors identified by the IG are presumed to be expansion joints, which are typical in design and construction for these buildings. These have not been identified in slip-trip-fall data as a fall hazard in any of our patient fall monitors. We will continue to monitor this through our facility Safety Committee.

- 2) Nurse-call dangling from the ceiling and hanging loose beside the patient beds.

Corrective Action: Nurse-call system repaired on July 12, 2000.

- 3) Oxygen tubing was running across the floors of patient rooms and in the hallway.

Corrective Action: The observed O2 tubing connected to the central oxygen system has been shortened and E size oxygen tanks are available for ambulatory patient use. An Environment of Care Inspection was conducted on June 27, 2000 with no finding of oxygen tubing on the floor. This will continue to be a monitor during future inspections.

- 4) Environmental maintenance closets and carts unattended, with unsecured chemicals was found during the walk-through.

Corrective Action: Staff has been re-instructed to secure chemicals at all times. An Environment of Care Inspection was conducted on June 2, 2000 with no finding of unsecured rooms or carts. This will continue to be a monitor during future inspections.

b) South Campus (Marion) Buildings 1 and 172

Ceiling in patient sleeping rooms are not constructed of solid plaster; sprinkler heads in patient showers and bathrooms are not recessed into the ceiling and are not the breakaway type; shower curtains are held up by metal shower hooks, which are attached to non-breakaway shower rods; and television mounts are not of the breakaway type.

Corrective Action: These issues are specific to the psychiatric care environment standards. All of the safety features described in the above statement have been incorporated into the design and construction of our new 100-Bed Psychiatric facility. Buildings 1 and 172 will not house psychiatric patients after September 2000.

Question 5. Please list the specific oversight improvements that have been established to correct the identified management and oversight shortcomings of the South Bend Community Outpatient Clinic. Also, please describe all administrative personnel actions taken on all VA officials with direct responsibility for these issues.

Answer:

- a) Amendments to the South Bend CBOC contract were issued referencing the timelines for patients to be seen.
- b) The Contractor is verifying veteran enrollment status prior to providing services as a CBOC patient.

- c) A Request for Proposal (RFP) will be issued this fall in support of a new contract for the South Bend CBOC. The new contract will address and correct any deficiencies and shortcomings of the current contract.
- d) NIHCS has discussed the credentialing of health care providers with the contractor. NIHCS has emphasized to the contractor that all of their practitioners who provide care to veterans need to be appropriately credentialed by VA.
- e) The NIHCS expanded formulary should greatly reduce the demand for non-formulary pharmaceuticals.
- f) VA Information Management staff is developing procedures to upload progress notes directly into VistA. Planned completion date is August 31, 2000.
- g) The contractor is developing a plan to schedule directly into the VistA system by August 31, 2000.
- h) The CBOC issues are considered primarily contractual in nature. Although the contract was reviewed for legal and technical sufficiency prior to award, it was developed early in the CBOC acquisition process with limited guidance available. No administrative personnel actions are warranted for any VA staff.

Question 6. Please respond in detail to the CAP report regarding the efficiency and cost benefit of Ft. Wayne's \$397,000 full-time radiology support contract.

The CAP report recommended the following:

- a) Assure that the current contractor provides the number of staff hours provided for in the contract or, alternatively, amend the contract to reflect the number of hours actually provided.
- b) In cooperation with VISN management, evaluate the applicability of tele-radiology technology in NIHCS, in lieu of contracting for radiologist services.

Answer: The following actions have been taken:

- a) The contract has been amended to clarify the number of hours of radiologist coverage actually provided.
- b) NIHCS is an active partner in the VISN 11 tele-radiology initiative. As the technology becomes available, NIHCS plans to make use of the capability and will make appropriate adjustments to the radiology support contract.

Question 7. Please list and explain all new management and oversight measures initiated as a result of the CAP report on the contract for the Community Nursing Home Program.

Answer:

- a) An interdisciplinary team will be formed to evaluate the continuation of contracts.

The Medical Staff Committee is now reviewing and recommending continuation for the contracts. Documentation of approval of continuation is provided in the Medical Staff Minutes.

- b) Obtain Performance Improvement (PI) Data on a quarterly basis.

At the present time, the Facility Quality Indicator Profile (FQIP) is reviewed prior to any renewed contracts. This information is also reviewed by the VA's Community Nursing Home social worker and nurse during regular monthly/bimonthly follow-up visits. Therefore, the data would also be reviewed at least quarterly.

- c) Conduct inspections or reviews of state-conducted inspection reports by using a multidisciplinary team to determine if intervention is required.

Nursing and Social Work Service conduct announced and unannounced site inspections. A multidisciplinary team of VA staff reviews state inspection reports.

Question 8: Please list current and the previous year's appointment backlog waiting times for all specialty care clinics in NIHCS.

Answer: The table below shows the number of days until the next appointment.

Clinic	FY99	FY00
Women's	128	30
Audiology	11	30
Cardiology	5	20
Dermatology	146	160
ENT	15	15
Oncology	6	6
Ophthalmology	122	4
Optometry	101	83
Orthopedics	15	37
Urology	203	102

NIHCS realizes that there are a number of specialty clinics that have average wait times that are longer than what is acceptable. To that end the NIHCS is using the Institute for Health Improvement (IHI) process to reduce the average wait time for those clinics. It is anticipated that the results of the IHI initiative will be realized in the coming months.

Question 9. Please describe any corrective actions that have been initiated to address the problems generated from the consolidation of laundry facilities at Battle Creek?

Answer: There has been, and continues to be, direct communication between NIHCS, the VISN 11 (VIP) Laundry Manager, responsible staff at Battle Creek and the Laundry Board of Directors on a regular and routine basis to ensure linen needs are being met.

The main issues involved were: patient clothing, proper processing of linen and receiving requested quotas on standard linens, OR scrubs and the timely return of employee uniforms. The processing and turnaround time of patient clothing has been more consistent during the past 90 days. NIHCS receives the daily quotas requested approximately 95% of the time. Items of linen not received one day are usually received on the next scheduled shipment. OR scrubs are now plentiful throughout the system, and use of paper scrubs is minimal.

Question 10. Please provide a chronology of all personnel actions relating to the consolidation of the NIHCS' Chief of Police position, to include periods of vacancy, buyouts, advertisement, recruitment and filling of this position.

Answer: In May 1995, the Police and Security Services for the Marion and Fort Wayne campuses were consolidated under one Service Chief, Ernie Marroni. In January 1996, the Chief of Police at the Fort Wayne Campus, retired on disability (Leonard, Daniel). Because the Police and Security Services of the two campuses were consolidated, this position was not filled. In February 2000, the Chief of Police and Security Service, Ernie Marroni, who was physically located at the Marion campus, accepted a buyout and retired. The buyout program was used by local management to reorganize the Chief position so that it could be based at the Fort Wayne campus, a non-commuting distance from Marion. The position previously vacated by Mr. Daniel is being used to fill this vacancy. This position is currently under recruitment.