



Office of Inspector General

REPORT OF FOLLOW-UP TO THE COMBINED ASSESSMENT PROGRAM REVIEW OF THE VA NORTHERN INDIANA HEALTH CARE SYSTEM FORT WAYNE AND MARION, INDIANA

Report No. 00-01199-129

Date: August 15, 2001

**Office of Inspector General
Washington DC 20420**

Office of Inspector General Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care and benefits services are 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 and regional offices on a cyclical basis. The purpose of CAP reviews are to:

- Evaluate how well the facility is accomplishing its mission of providing eligible veterans convenient access to high quality care.
- Determine if management controls ensure compliance with regulations and agency policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Conduct fraud and integrity awareness briefings for facility staff.

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

**To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244**

Memorandum to the Network Director, Veterans Integrated Service Network (VISN) 11

Report of Follow-Up to the Combined Assessment Program Review of the VA Northern Indiana Health Care System Fort Wayne and Marion, Indiana

1. The Office of Inspector General (OIG) conducted a follow-up review to evaluate management actions taken to implement the agreed upon recommendations made in our Combined Assessment Program (CAP) review of the Department of Veterans Affairs (VA) Northern Indiana Health Care System (NIHCS), Report No. 00-01199-72 dated May 25, 2000. Our onsite phase of the review was conducted from October 23 to 25, 2000. We reviewed agreed upon implementation actions taken by NIHCS management on the 17 recommendations made in our report.

2. We found that 12 of the 17 recommendations were implemented to include two of the six recommendations made for improvement of the quality of healthcare delivery. However, NIHCS management had not implemented four of the healthcare delivery recommendations, as follows:

- Studying the advantages of relocating the Sub-Acute Rehabilitation Unit from Marion to Fort Wayne, and of moving the Nursing Home Care Unit from Fort Wayne to Marion.
- Initiating action to improve the environment of care in the area of safety on geropsychiatric units, and to separate Nutrition and Food Service loading dock areas from Environmental Management Service functions.
- Improving certain aspects of medication security.
- Initiating action to improve patient and employee safety in three specific functional areas.

3. The follow-up review also found that NIHCS management had fully implemented 10 of the 11 recommendations relating to management control systems. However, NIHCS management had not implemented parts of one recommendation concerning the establishment of a new contract for the South Bend community-based outpatient clinic (CBOC). In addition, we identified one additional minor issue involving patient consent that management agreed to correct during our follow-up visit.

4. Based upon the results of our follow-up review, we recommended you:

- Ensure that the NIHCS management takes agreed upon actions to fully implement all quality of care recommendations that we found not implemented.
- Initiate aggressive efforts to put in place a new South Bend CBOC contract, and perform a review of the operation of the Muncie CBOC.

5. You provided acceptable comments and details of implementation actions for all recommendations in this report. Therefore, we consider all issues resolved but will follow up on implementation actions.

(Original signed by:)

RICHARD J. GRIFFIN
Inspector General

Table of Contents

	<u>Page</u>
Memorandum to the Network Director, Veterans Integrated Service Network (VISN) 11	i
Results and Recommendations	1
Follow-Up to the Combined Assessment Program Review	1
Appendices	
I. VISN 11 Director Comments	9
II. Final Report Distribution	11

Results and Recommendations

Follow-Up to the Combined Assessment Program Review

The following section describes the recommendations that were not implemented at the time of the follow-up review. In each case we have presented the unimplemented portion of the recommendation, as set forth in the CAP report, along with the NIHCS Director's comments and agreed upon implementation plans. We also discuss the results of our follow-up review for specific recommendations and in some cases we propose new corrective actions.

Quality of Care Recommendations Not Fully Implemented

Recommendation No. 1

The NIHCS Director should improve the provision of long-term care in certain areas as follows:

- b. Operations of the Sub-Acute Rehabilitation Unit could benefit if the unit were moved from Marion to Fort Wayne
- c. Long-term care would benefit if the Nursing Home Care Unit were consolidated to Marion.

NIHCS Director Comment

Concur.

- b. 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.
- c. 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.

Results of Follow-Up Review

Recommendation 1b — This recommendation was not implemented. There was no evidence that the NIHCS Director initiated a comprehensive review of the Sub-Acute Rehabilitation Unit, in cooperation with VISN 11, to determine the advantages and disadvantages of moving the unit from Marion to Fort Wayne.

Recommendation 1c — This recommendation was not implemented. There was no evidence that the NIHCS Director had completed a thorough review, in cooperation with the VISN 11 Service Line, of the benefits of consolidating all long-term care operations at Marion.

Recommendation No. 2

The NIHCS Director should take action to improve the facility treatment environment as follows:

- a. NIHCS managers should install barriers (e.g., Plexiglas) on counters and desk areas in psychiatric units to prevent patients from accessing employee workspace.
- c. Nutrition and Food Service and Environmental Management Service loading dock areas needed to be separated at Fort Wayne.

NIHCS Director Comment

Concur.

NIHCS is reviewing options for providing barriers at the Nurses Stations in B-172. NIHCS will conduct a review of community facilities' emergency departments 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 Nutrition and Food Service and Environmental Management Service 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.

Results of Follow-Up Review

Recommendation 2a — This recommendation was not implemented. Psychiatric patients at Marion were moved to a new building (Building 185). This move enabled NIHCS to improve and correct the safety issues cited in the original report. However, geropsychiatric patients remained hospitalized in Building 172 where safety concerns remained unresolved.

Recommendation 2c — This recommendation was not implemented. Necessary action was not taken to avoid cross contamination between food and waste on the Nutrition and

Food Service loading dock. Two large garbage containers remained at the end of the loading dock where employees placed trash. This was the same location where trash haulers picked up facility trash and where food was delivered. Nutrition and Food Service staff stated that outgoing trash and incoming food deliveries could use the same routes. However, one staff member explained that if food were being delivered, they would probably go out another door with their trash.

During the follow-up visit, we also observed that the Nutrition and Food Service food preparation areas were not clean. Walls, floors, and outside loading dock areas were dirty and had stains. There was a window inside the tray line area that had been removed, and peeling paint, rust, and dirt were in the frame of the removed window. There was an upper corner of a wall that had a hole in it where a pipe may have run through in the past.

Recommendation No. 4

The NIHCS Director should direct that the following improvements be made with regard to medication security, policy, and availability:

- c. Breaches in medication security warrant management review. NIHCS managers should take several steps to improve medication security.

NIHCS Director Comment

Concur.

- c. 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 narcotics abuse will be provided to all clinical employees and managers.

Results of Follow-Up Review

Recommendation 4c — This recommendation was not implemented. Although there was a new controlled substances policy that met part of the intent of this recommendation, there were other aspects of the recommendation that NIHCS management did not implement. The NIHCS Director informed us that a number of steps were taken to improve medication security. These included training for all pharmacy personnel, Registered Nurses, Licensed Practical Nurses, Student Nurse Technicians, physicians, and other clinicians with access to medications. The NIHCS Director offered a planned completion date as of August 2001. There was evidence to support that 75 healthcare professionals had completed this training.

During the follow-up review, we observed medication that was not secured. There was medication on top of a medication cart that was unattended in a hallway on the long-term care unit at Fort Wayne. Two medication cabinets in the Intensive Care Unit were unlocked, and the locks were missing. A nurse told us that they planned to get replacement locks.

In addition, there were grand master keys in the possession of staff who did not have need for entry into medication rooms. This was corrected during our review.

The generic locks for Code Blue crash carts were replaced with numbered locks. Although, this was an improvement from our initial CAP review, there was no accountability for the locks. For example, when a nurse performs the shift-to-shift check of the cart, documentation to verify the integrity of the cart needs to include the lock number along with the date, time, and signature of the person performing the check.

Recommendation No. 5

The NIHCS Director should ensure that the described improvements are made in Patient Care Services:

- b. NIHCS managers should correct patient safety issues identified in Building 172 and Building 1.
- c. 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, and implement a monitor for screening of abuse victims in the Emergency Department and Outpatient Clinics.
- e. NIHCS managers should develop guidelines that pertain to shuttle operations and shuttle drivers need to be trained in cardiopulmonary resuscitation (CPR) and basic first aid.

NIHCS Director Comment

Concur.

- b. Safety. Modifications were made to the facility based upon the recommendations made during the OIG 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 Fiscal Year 2000. All of the safety features described in the narrative have been incorporated into the design and construction of this new facility.

- c. 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.
- e. 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.” 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.

Results of Follow-Up Review

Recommendation 5b — This recommendation was not implemented. By September 22, 2000, all acute and chronic psychiatry patients had been moved to a new building at Marion (Building 185). However, one ward of geropsychiatry patients, clinically identified as “extended care patients,” remained in Building 172. Patient safety concerns need to be corrected for patients remaining in Building 172.

During the follow-up review, we noted two new safety concerns that need management attention in Building 185. First, each of the patient care units had four electric beds. These beds had electric cords, approximately 4 feet long, that could pose a risk to patients trying to harm themselves. The facility engineer agreed to install brackets to secure the cords to the wall, which will make them less accessible. Secondly, management was uncertain of the weight limit for the ceiling brackets that held shower curtains. NIHCS management told us they would determine the weight limit for the shower curtain ceiling brackets. If this information cannot be obtained, a tamper proof shower curtain mechanism needs to be installed in all shower areas in Building 185.

Recommendation 5c — This recommendation was not implemented. We reviewed the training video regarding victims of abuse. The content of the training film focused on adult protective services, emphasizing elder abuse; but, it did not provide information about domestic abuse of incapacitated or vulnerable adults.

Recommendation 5e — This recommendation was only partially implemented. Although shuttle drivers were trained in basic first aid, training records revealed they were not trained in CPR.

Management Control Systems Recommendation Not Implemented

Recommendation No. 7

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

- b. Avoid, in any replacement contract, the kinds of deficiencies in the contract described above.

NIHCS Director Comment

Concur.

- 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.

Results of Follow-Up Review

Recommendation 7b — This recommendation was not implemented. Management could not provide us with any evidence that they have been working on establishing a new South Bend CBOC contract. Thus, as of the date of this follow-up review, over 7 months from the date that we informed management of the problems at the South Bend CBOC, nothing had been done to implement a new contract.

At the end of March 2000, we agreed to NIHCS management's request for a 1-year period to perform the work necessary to initiate a new contract for the South Bend CBOC. This was done by invoking a third option year under provisions of the original contract. This contract was originally entered upon in April 1998 with an extension option year beginning April 1999 and extending through April 2000. We agreed to the third option year because the NIHCS Director maintained that it would take up to an additional year to put a new contract in place. The NIHCS Director further asserted that were NIHCS staff given less time to implement a new contract, service to veterans in the South Bend catchment area might be interrupted. In addition, he cited the need for assessments to be made of the needs of the patients in the primary catchment area of the CBOC and alternative methods of delivering outpatient care to the area were to be evaluated. We were informed that these measures were essential to ensure that a contract that better addressed the needs of the Veterans Health Administration (VHA) and its patients could be put in place. Because of the volume and complexity of work outlined by NIHCS management, we consented to a significantly extended period for facility management to implement our recommendation.

However, during the follow-up review we found that the facility was no nearer implementation of a new contract than it had been in March 2000, 7 months earlier. Although management and facility staff continued to assure us during the follow-up review that the contract would be terminated in April 2001, none of the work identified by NIHCS management as necessary for termination of the old contract and implementation of a new contract had been performed. In fact, interviews with

management and facility staff revealed that a contract specialist had not been assigned to begin the work necessary to identify specifications for a new contract.

We believe that the 7 months that elapsed would have been invaluable in taking just those actions outlined by NIHCS management in their implementation plans for this recommendation to ensure a better and more easily administered contract. Medical center procurement staff informed us that one reason they felt comfortable with delaying work on a new contract was that they had a much improved template at hand in the contract used to procure services for the newer Muncie CBOC.

However, our evaluation of the Muncie CBOC contract during the follow-up review revealed that it was also a capitation-based arrangement. The capitation funding structure of the South Bend contract was what led to several of the problems that we identified during the original CAP review. Therefore, the Muncie CBOC contract may be similarly flawed and should be reviewed.

Follow-Up Recommendations

Recommendation No. 1

That the Network Director, VISN 11 take action to ensure that NIHCS management fully implements recommendations 1b, 1c, 2a, 2c, 4c, 5b, 5c, and 5e.

Network Director Comments

Regarding your recommendation that the network ensure NIHCS management takes agreed upon actions to implement all quality of care recommendations, please be assured this has been done over the past year and will continue. Specifically, I personally visit NIHCS – most recently May 30-31. I have facilitated mediation efforts between facility management and labor officials to maximize effective working relationships, which are key to the ongoing success in delivering quality care. In addition, the Network Chief Financial Officer (CFO) is mentoring the new facility fiscal officer to ensure he is aware of critical financial management functions. The Network CFO also conducts quarterly site visits to network facilities to evaluate actual performance, correct deficiencies and conduct training, as needed. Other network staff, including the Chief Medical Officer (CMO) and Chief Operating Officer (COO) communicate with facility staff on a regular basis and visit the two campuses periodically, with a site visit planned for July.

(The full text of the VISN Director's comments appears in Appendix I.)

Office of Inspector General Comments

The VISN Director's comments and implementation plans are acceptable. We consider this issue resolved but will follow up on implementation actions.

Recommendation No. 2

That the Network Director, VISN 11 take action to:

- a. Initiate aggressive efforts to put in place a new South Bend CBOC contract that addresses the deficiencies identified during the original CAP review.
- b. Cause a review of the Muncie CBOC to determine if it suffers from problems similar to those found at the South Bend CBOC.

Network Director Comments

The South Bend CBOC contract was advertised this past winter, and was awarded to Medmark, Inc. in April 2001. The responsibility for the development of CBOC proposals and performance monitoring of operations is assigned to a member of my staff. This individual will continue to work with facility management to ensure the terms of the South Bend contract are met and that effective communications are maintained between VA and the contractor. Specific responses to the OIG report on South Bend clinic are being sent under separate cover from NIHCS, following my review and approval. This network has a comprehensive process to review and evaluate all CBOCs, including the Muncie CBOC, on a quarterly basis. This review process includes workload, costs, performance measures, and contract management.

(The full text of the VISN Director's comments appears in Appendix I.)

Office of Inspector General Comments

The VISN Director's comments and implementation plans are acceptable. We consider this issue resolved but will follow up on implementation actions.

VISN 11 Director Comments



M E M O R A N D U M

DATE: June 11, 2001
TO: Assistant Inspector General for Auditing (52)
FROM: Network Director (10N11)
RE: Follow-up of CAP Review

1. I have reviewed your May 31, 2001 correspondence and report regarding the October 2000 follow-up CAP review at Northern Indiana Healthcare System. Subsequent to that follow-up visit six months ago, network and facility managers have completed actions to address the recommendations of the original CAP review. Quarterly progress reports have been submitted documenting actions taken, and, as of the April 2001 update, the CAP report has been closed. Please reference the quarterly reports submitted in August and October 2000, January and April 2001, as well as the closeout letter dated May 2, 2001.

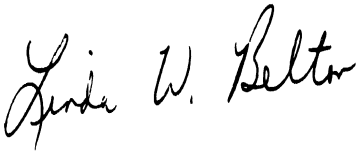
2. A number of clinical program reviews have been completed, with action plans currently being initiated to move the nursing home beds from Ft. Wayne to Marion and to close the limited number of acute medicine beds at Marion. Facility and network managers have initiated necessary notification to HQ officials, labor representatives, employees and key stakeholders. The review of sub-acute rehabilitation programs at the two campuses noted a number of programmatic improvements, but did not recommend significant change or closure at either campus. A review of inpatient surgery program at Ft. Wayne has just been completed, with the report due to the Network Chief Medical Officer in the next month. Other clinical and administrative program and process improvements are noted throughout the four enclosed quarterly follow-up reports.

3. Regarding your recommendation that the network ensure NIHCS management takes agreed upon actions to implement all quality of care recommendations, please be assured this has been done over the past year and will continue. Specifically, I personally visit NIHCS – most recently as May 30-31. I have facilitated mediation efforts between facility management and labor officials to maximize effective working relationships, which are key to the ongoing success in delivering quality care. In addition, the Network Chief Financial Officer (CFO) is mentoring the new facility fiscal officer to ensure he is aware of critical financial management functions. The Network CFO also conducts quarterly site visits to network facilities to evaluate actual performance, correct deficiencies and conduct training, as needed. Other network staff, including the Chief Medical Officer (CMO) and Chief Operating Officer (COO) communicate with facility staff on a regular basis and visit the two campuses periodically, with a site visit planned for July.

VISN 11 Director Comments
(Continued)

4. The South Bend CBOC contract was advertised this past winter, and was awarded to Medmark, Inc. in April 2001. The responsibility for the development of CBOC proposals and performance monitoring of operations is assigned to a member of my staff, Daniel Hendee, Health System Specialist. Mr. Hendee will continue to work with facility management to ensure the terms of the South Bend contract are met and that effective communications are maintained between VA and the contractor. Specific responses to the IG report on South Bend clinic are being sent under separate cover from NIHCS, following my review and approval. This network has a comprehensive process to review and evaluate all CBOCs, including the Muncie CBOC, on a quarterly basis. This review process includes workload, costs, performance measures and contract management.

5. If you or members of your staff have any questions please feel free to contact me at 734-930-5950 or Barbara McLelland, Chief Operating Officer, at 734-930-5996.



Linda W. Belton

Enclosures (5)

Final Report Distribution

VA DISTRIBUTION

Secretary
 Under Secretary for Health (105E)
 General Counsel (02)
 Assistant Secretary for Public and Intergovernmental Affairs (002)
 Acting Principal Deputy Assistant Secretary for Management (004)
 Acting Principal Deputy Assistant Secretary for Information and Technology (005)
 Principal Deputy Assistant Secretary for Policy and Planning (008)
 Deputy Assistant Secretary for Congressional Affairs (009C)
 Deputy Assistant Secretary for Public Affairs (80)
 Deputy Assistant Secretary for Acquisition and Materiel Management (90)
 Director, Management and Financial Reports Service (047GB2)
 Assistant Deputy Under Secretary for Health (10N)
 Health Care Information Registry (10M1)
 VHA Chief Information Officer (19)
 Veterans Integrated Service Network Director (10N11)
 Director, VA Northern Indiana Health Care System, Ft. Wayne and Marion, IN (610/00)

NON-VA DISTRIBUTION

Office of Management and Budget
 U.S. General Accounting Office
 Honorable Richard G. Lugar, United States Senate
 Honorable Evan Bayh, United States Senate
 Honorable Mark E. Souder, House of Representatives
 Honorable Steve Buyer, House of Representatives
 Chairman, Committee on Governmental Affairs, United States Senate
 Ranking Member, Committee on Governmental Affairs, United States Senate
 Chairman, Committee on Veterans' Affairs, United States Senate
 Ranking Member, Committee on Veterans' Affairs, United States Senate
 Chairman, Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, United States Senate
 Ranking Member, Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, United States Senate
 Chairman, Committee on Veterans' Affairs, House of Representatives
 Ranking Member, Committee on Veterans' Affairs, House of Representatives
 Chairman, Subcommittee on Benefits, Committee on Veterans' Affairs, House of Representatives

NON-VA DISTRIBUTION (CONTINUED)

Ranking Member, Subcommittee on Benefits, Committee on Veterans' Affairs, House of Representatives
Chairman, Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives
Ranking Member, Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives
Chairman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives
Ranking Member, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives
Chairman, Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, House of Representatives
Ranking Member, Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, House of Representatives
Staff Director, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

This report will be available in the near future on the VA Office of Audit web site 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.