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FROM THE MINNESOTA DEPARTMENT OF HEALTH

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**HEALTH DEPARTMENT RECOMMENDS
CONTINUED INVOLVEMENT OF HUMAN SERVICES DEPARTMENT
AND EFFORTS TO IMPROVE MANAGEMENT
AT MINNESOTA VETERANS HOME**

Sister Mary Madonna Ashton, Minnesota Commissioner of Health, has recommended that the Minnesota Veterans Home remain, at least temporarily, under the control of the state Department of Human Services (DHS).

A report prepared by the Commissioner recommends that a management team from Human Services remain at the Minneapolis facility until health and safety violations found during a July inspection of the facility are corrected, and "the health and safety of the residents can be assured."

The report also recommends that DHS begin the process of recruiting a new administrator for the facility, with "extensive experience in successfully operating large nursing home facilities."

The report cited lack of experience on the part of the previous administrator as one possible source of management problems at the Veterans Home.

With 346 licensed nursing home beds and 194 licensed board and care beds, the facility is one of the largest in the state, the report noted.

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The report also recommended that a mission statement be developed for the Veterans Home, describing the kinds of patients it will serve, and that a "case mix" system be used to help assess the needs of residents at the facility.

The case mix approach involves assigning residents to different categories, based on the amount of care they need. This information about patients can then be used to determine staffing requirements for the facility in a more effective manner.

The report further recommends that

- a management study of the facility, to be conducted by the state Department of Administration, be expanded to include the relationship between the Veterans Home and the Commissioner's Office at the State Department of Veteran's Affairs;
- the state Commissioner of Human Services set up a citizen Advisory Committee to oversee operation of the Veterans Home; and
- the State Legislature review budget allocations for the Veterans Home along with allocations for other state-run health care facilities -- rather than separately, as is now the case.

DHS assumed control of the Veterans Home from the Department of Veterans Affairs last month, at the request of Governor Rudy Perpich. At that time, inspectors from the Minnesota Department of Health (MDH) had issued correction orders for 36 new violations at the facility -- as well as finding uncorrected violations from previous inspections.

The Veterans Home has "a history of difficulty in maintaining compliance with regulatory standards" according to the report. The facility received a total of 119 correction orders from MDH between the beginning of 1981 and July 1987 --

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and was fined 20 times, during the same period, for failure to correct previous violations. The facility received 17 correction orders after its annual inspection in 1985, and 19 in 1986 -- compared with an average of 6.7 for facilities statewide during fiscal 1986.

State law would have required the Commissioner of Health to begin proceedings for the suspension or revocation of the facility's license after the July inspection -- for repeat violations of the same MDH rules -- if control of the facility had not been transferred to DHS.

The Commissioner's report found that there were a number of management-related problems at the facility -- including failure to adequately spell out the authority and responsibilities of key officials like the Commissioner and Deputy Commissioner of Veterans Affairs, and the Administrator of the Veterans Home. The facility also has a history of high turnover in top management positions, according to the report, and has made a practice of leaving mangement positions vacant for an extended period of time. That has sometimes made it necessary for managers to assume the responsibilities of more than one position, with limited knowledge of their added duties.

The position of Assistant Administrator, for instance, was vacant from August 1986 to May 1987. At another point, the facility was without a permanent Nursing Director for a period of seven months.

The facility had failed to develop formal policies and procedures in a number of key areas, according to the report -- leading to confusion about job responsibilities and supervisory

authority, and problems related to the quality of nursing care.

In particular, the facility had failed to adequately spell out the supervisory relationships between the Administrator and the Medical Director.

The Medical Director oversees physicians from the Veterans Administration Medical Center (VAMC), Minneapolis, who provide care at the facility under contract. The report praised the quality of care provided under the arrangement with VAMC, noting that "the medical coverage appears very good, and the residents have access to specialists, emergency care and hospitalization."

The report also noted a number of problems related to the organization and supervision of the facility's nursing staff -- including

- a lack of authority on the part of professional nurses to supervise nursing assistants;
- failure to provide adequate management and administrative support for the Nursing Director, in supervising the facility's staff of over 200 nursing personnel;
- use of nurses to perform non-nursing duties; and
- use of nursing home staff to cover for inadequate staffing levels at the facility's board and care unit, raising questions about the adequacy of staffing at the nursing home.

Finally, the report found that the facility has not always maintained effective in-house committees to deal with a variety of important policy issues -- as is the practice at other nursing homes -- and has failed to plan adequately to meet its personnel and human resource needs.

The Commissioner's report suggests that a final decision on continued DHS control of the facility should be delayed, until

final reports are available from a Blue Ribbon Commission being appointed by Governor Perpich to study the Veterans Home, and from the Department of Administration management study. Those reports are expected in February.

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