DEPARTMENT OF ADMINISTRATION

MANAGEMENT ANALYSIS DIVISION

Pursuant to 1987 Laws, ch 404
Section 55

MANAGEMENT STUDY

OF THE

MINNESOTA VETERANS HOMES

DEPARTMENT OF ADMINISTRATION
Management Analysis Division
February 1987

STATE OF MINNESOTA

Department of Administration

OFFICE OF THE COMMISSIONER

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200 Administration Building
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February 11, 1988

The Honorable Rudy Perpich
Governor
130 State Capitol Building

Patrick E. Flahaven
Secretary of the Senate
231 State Capitol Building

Edward A. Burdick
Chief Clerk
House of Representatives
211 State Capitol Building

Dear Gentlemen:

Pursuant to Laws of Minnesota 1987, Chapter 404, Section 55, the Department of Administration has studied the management and operations of the Minnesota Veterans Homes. The study was conducted by the department's Management Analysis Division with the cooperation of the Departments of Finance, Health, Human Services, Veterans Affairs, and the State Planning Agency.

The report provides an overview of the homes as well as findings and recommendations in the areas of mission and admission and discharge policies. Findings and recommendations regarding leadership, health care management, human resources management, and fiscal management are presented separately for the Minneapolis and Hastings homes. A concluding chapter addresses long-term care needs of Minnesota's veterans.

Sincerely,

Sandra J. Hale

Sandra J. Hale
Commissioner
Department of Administration

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INTRODUCTION

The 1987 Legislature directed the commissioner of administration to conduct a study of the management and operation of the Minnesota Veterans Homes in Minneapolis and Hastings. The commissioner delegated the legislative mandate to the Management Analysis Division of her department. The division's role in state government is to provide management consultation services to the legislature, the governor, state agency heads and state managers/supervisors. The division conducted an earlier study of the Minnesota Veterans Homes in 1980, also at the request of the legislature.

The purpose of this study is "to provide the legislature with an accurate assessment of the management of the home[s] and a comprehensive appraisal of any deficiencies or problems that need to be addressed." The intent of the legislature was to assure quality care and services and an enhanced quality of life for veterans in the homes.

Specifically, Minnesota Laws 1987, Chapter 404, Section 55, Subd. 2, mandated evaluation of the following:

1. The role and responsibilities of the governing body, administrator and management staff at each home (see "Leadership Patterns," p. 31, and "Hastings: Leadership Patterns," p. 137).

2. The relationships among the governing body, administrator and management staff at each home (see "Leadership Patterns," p. 31, and "Hastings: Leadership Patterns," p. 137).

3. The span of control and authority delegated to the management staff at each home (see "Leadership Patterns," p. 31, and "Hastings: Leadership Patterns," p. 137).

4. The effectiveness of the management practices at each home (see "Executive Summary" p. 5).

5. The direct-care and other support-personnel staffing patterns and assignments throughout all units in the homes (see "Human Resources Management," p. 97, and "Hastings: Human Resources Management," p. 150).

6. The admission criteria and practices (see "Admissions and Discharges," p. 23).

7. The assessment of the care and service needs of the residents (see "Health Care Management," p. 53, and "Hastings: Health Care Management," p. 140).

8. The utilization of state-operated veterans homes compared to the utilization of community-based and operated long-term care facilities for the veteran population (see "Veterans' Care Policy," p. 157).

9. The relationship of the home with the federal Veterans Administration regulatory programs (see "Background: External Relationships," p. 16).

10. The relationship between the federal regulatory programs and the state regulatory programs (see "Background: External Relationships," p. 16).

11. The programmatic and fiscal advantages or disadvantages of Medical Assistance certification for the veterans homes (see "Veterans' Care Policy," p. 157).

12. The utilization of a pre-admission screening program for the homes (see "Admissions and Discharges," p. 23).

13. Any other factors necessary for an accurate and complete assessment of the role, operation and management of the homes.

The legislature mandated completion of a report with specific findings and recommendations in the above areas by February 1, 1988.

Events subsequent to the 1987 legislative session have made the task more complex. During the period of the study (September 1987 through January 1988), the management and operations of the homes were in a state of change:

> On July 30, 1987, Governor Rudy Perpich ordered control of the homes temporarily transferred from the Minnesota Department of Veterans Affairs to the Minnesota Department of Human Services. This action followed an intensely critical inspection of the Minneapolis facility conducted by the Minnesota Department of Health.
>
> The administrator of the Minneapolis home resigned on August 13, 1987, and transferred to a position in Veterans Affairs' central office.
>
> The Minneapolis home's director of nursing was terminated by Human Services management on September 30, 1987. The assistant director of nursing was terminated the following day. In each instance, a primary reason cited for termination was failure to follow mandatory reporting procedures under the Vulnerable Adults Act.

On October 29, 1987, the Legislative Advisory Commission approved an emergency request to add 58 staff positions at the homes.

Although most new positions were filled, the Minneapolis home has not yet been able to hire a permanent administrator.

Human Services management revised the Minneapolis home's organizational structure and redefined reporting relationships within the nursing area.

In addition to shifting management responsibilities for the homes, Governor Perpich appointed a blue-ribbon commission to (1) review problems at the homes, (2) recommend administrative and managerial changes, and (3) assess the long-term care needs of Minnesota's veterans. (The formal charge to the commission is included as Appendix A.)

The lack of an existing stable management system to review and the creation of a parallel assessment process (the blue-ribbon commission) resulted in the following decisions regarding the content and scope of this report:

The report's assessment of management and operations at the homes focuses largely on the period of time when the homes were under the jurisdiction of Veterans Affairs, particularly the last several years prior to the transfer.

Attempts are made to note and discuss changes implemented by Human Services management, but most often these changes are too new to assess fairly. This report endorses many of those efforts in the interest of much-needed stability at the homes and because they are consistent with industry standards.

Because there is some overlap in the formal charges, it seemed prudent to coordinate efforts with the blue-ribbon commission.

This report focuses primarily on the operational level, while the commission report deals with broader policy issues.

It should be noted that the commission also was staffed by the Management Analysis Division and an interagency team which collected data and presented draft findings and recommendations.

The commission's recommendations are generally consistent with those which would have been reached by an independent Management Analysis Division assessment. Therefore, this report endorses the conclusions and recommendations of the commission on policy issues when appropriate.

The commission's primary recommendations are summarized below:

Develop a new mission emphasizing geriatric research and education.

Create a new agency with an independent board of directors to manage and operate the homes and veterans' health care programs.

Upgrade programs and services available to boarding care residents.

Fund Human Services' supplemental budget request for positions and capital improvements.

Integrate the homes into the mainstream of health care in the state through the use of pre-admission screening and the development of institutional and non-institutional alternatives.

EXECUTIVE SUMMARY

OVERALL MANAGEMENT EFFECTIVENESS

The following report explores in some detail management effectiveness issues at the Minnesota Veterans Homes. Conclusions are reached regarding management successes and failures in specific areas. However, broader conclusions regarding overall effectiveness are not drawn.

The purpose of this section is to provide the comprehensive perspective which would otherwise be missing. The data which supports these conclusions and recommendations is found throughout the rest of this report.

Conclusions

The Veterans Home in Minneapolis remains in a state of crisis. The Hastings facility has problems needing attention, but they are not of the magnitude or severity of those at the Minneapolis home.

Many of the most critical needs identified in the Management Analysis Division's 1980 report were not addressed prior to the governor's emergency reassignment of management responsibilities in July 1987.

Fundamental health care management systems had not been implemented by Veterans Affairs. Failure to develop basic systems (such as quality assurance reviews, mandatory reporting of potential abuse and neglect, and medication controls) placed the health and safety of the homes' residents -- particularly nursing care residents -- at risk.

Similarly, basic management systems unrelated to health care had not been implemented by Veterans Affairs. Ineffective supervision, poor communication, unclear roles and responsibilities, lack of accountability, and unmanaged conflict negatively affected residents and employees in Minneapolis. To a lesser degree, these issues also were found in Hastings.

Inadequate resources were one of many ongoing problems, but cannot begin to explain the ineffective management documented in this report.

Domiciliary (boarding care) residents have not been receiving the programs and services needed to promote rehabilitation and a return to community living.

Eligible veterans have earned the right to the highest quality health care. Under the auspices of Veterans Affairs, they were receiving some of the poorest health care in the state.

Under the management of Human Services, major deficiencies have been corrected and fundamental management and health care systems are being developed to prevent further deficiencies.

However, in its efforts to make necessary but radical changes, Human Services has employed a highly directive management style which has further alienated and demoralized an already beaten-down staff.

Neither Veterans Affairs nor Human Services is an appropriate choice to provide ongoing direction to the home. The next three to five years are likely to be the most difficult phase in the home's history. To change from a substandard facility on the verge of losing its license to a nationally-recognized center for geriatric teaching and research will require an absolute break from the past.

The new leadership will need a clear vision of the new mission, state-of-the-art health care expertise, and the ability to motivate the staff to work toward shared goals.

Recommendations

1. We endorse the blue-ribbon commission recommendation to work toward making the Veterans Home in Minneapolis a first-class geriatric research and teaching facility. This may seem farfetched, given the home's history, but we believe that enormous change is needed at the Minneapolis home and this would be one way of achieving that change.

2. We endorse the blue-ribbon commission recommendation to create a new independent agency to provide leadership through this difficult transition phase.

3. If the legislature chooses not to create the new agency recommended by the commission and returns the homes to the management of Veterans Affairs, we recommend either of the following options:

    a. The governor should replace the top management of Veterans Affairs. No effort should be made to develop the homes' research and teaching roles under Veterans Affairs management. All efforts should focus on making the homes adequate nursing and boarding care facilities.

b. The legislature should mandate that the state contract with a private health care facility management corporation and that Veterans Affairs management play no role in the operation of the homes.

METHODOLOGY

The Management Analysis Division consulting team assigned to the project included Kent Allin, Charlie Ball, Gail Dekker, Virginia Dodds, Elaine Hanson, Mirja Hanson, Sue Laxdal, Deb Lindlief, Dick Manthey and Georgie Peterson. The team worked on this project in collaboration with Terry Bock and Fred Grimm, the division's director and assistant director, respectively.

The team's work plan contained the following activities:

1. Review of previous studies and other relevant background materials (statutes, policies and procedures, budgets, position descriptions, etc.).

2. Ongoing formal and informal consultation with other government agencies, including the Minnesota Department of Employee Relations, the Minnesota Department of Finance, the Minnesota Department of Health, the Minnesota Department of Human Services, the State Planning Agency, the Minnesota Department of Veterans Affairs and the federal Veterans Administration.

3. Coordination of interagency staff assistance to the blue-ribbon commission.

4. Management and staff orientation sessions at the Minneapolis and Hastings homes.

5. Personal interviews with managers and staff at the two homes, and with external experts.

6. Group interviews with residents, family members and active volunteers at the two homes.

7. Surveys of staff attitudes and perceptions.

8. Surveys soliciting input from family members, volunteers and veterans service organizations.

9. Project-specific research and analysis, including a comprehensive assessment of the inspection histories of comparable facilities.

10. Management and staff data feedback and discussion sessions at the two homes and the Veterans Affairs and Human Services central offices.

11. Data synthesis and analysis by the team and the division leadership.

12. Pre-publication review of this report by experts in long-term health care management.

The study team's input from interested parties is detailed below:

Personal interviews were conducted with the top management of Veterans Affairs, current and past managers of the homes, and involved parties from the Departments of Finance, Health and Human Services.

All staff of the homes were invited to participate in one-to-one interviews with members of the study team.

The team ultimately conducted 127 personal interviews, which were broken into component statements and analyzed using an automated data base management system.

Group interviews elicited input from more than 30 residents, family members and volunteers. All residents were invited to attend the group interviews. Randomly selected family members and volunteers were invited.

The team also conducted two staff surveys. One (referred to in this report as the "staff mini-survey") asked open-ended questions about accomplishments, concerns and recommended actions. It elicited 95 responses from Minneapolis and 36 from Hastings. The second survey (the "staff mail survey") asked the staff to indicate their level of agreement or disagreement with a number of statements regarding management effectiveness. This survey, mailed to each employee's home, elicited 132 responses from Minneapolis and 22 from Hastings (see Staff Survey, Appendix B).

Additional mail surveys of target audiences generated 30 responses from family members (Appendix C), 15 responses from volunteers (Appendix D), and seven responses from veterans organizations (Appendix E).

The Management Analysis Division team wishes to sincerely thank everyone who contributed time, effort and ideas to this project. Special thanks go to the management and staff of the two homes and our colleagues who made this a truly interdepartmental effort.

CHAPTER 1: BACKGROUND

HISTORY

Century Overview

The Minnesota Veterans Home in Minneapolis is 100 years old. The home, known then as the State Soldiers' Home, was established by the legislature in 1887 as a home for honorably discharged veterans, their spouses and mothers who, for medical, social or economic reasons, needed assistance in living. The home operated under a board of trustees appointed by the governor, confirmed by the Senate and representing each of the state's congressional districts.

For its first 89 years, the home operated on a military model. As a semi-state agency, the home was administered by a commandant who was appointed by the board and served at its pleasure. All staff were appointed and their salaries set by the commandant with the board's approval.

The primary goal of the home was to provide room and board services. Medical care was limited and other rehabilitative programs were not provided. The commandant made weekly white-glove inspections of residents' rooms, and military rules of conduct applied to residents and staff. Neither the board, which exercised considerable control over admissions and daily operations, nor the commandant were trained in administration or health care. The commandant and trustees were appointed primarily on the basis of their service in the military or with state veterans' organizations. Although a medical clinic has existed since 1936 and the Department of Health Office of Survey and Compliance has Minnesota Veterans Home inspection records dating back to 1945, the home did not have the management and professional expertise and structure of a health care facility.

Since 1972, the home has formally changed to a health care model. In that year, the position of commandant was abolished and a person trained in health care administration was appointed as administrator of the home. In 1975, the authority over the operation of the home was transferred from the board of trustees to the commissioner of Veterans Affairs, with appropriate oversight and management responsibilities shared by the Departments of Employee Relations, Finance and Administration.

The need for health care services in the Minneapolis home has steadily increased, as nursing care beds have gradually outnumbered domiciliary beds over the last 20 years. In 1957, 84 percent of the home's 531 beds were licensed for domiciliary residents. In 1980, after the construction of two new nursing care facilities in 1972 and 1980, the Minneapolis home was licensed for 250 nursing and 290 domiciliary beds. Currently, 64 percent of the 540 Minneapolis home beds are licensed for nursing care.

In 1978, a former state hospital in Hastings was opened to provide domiciliary care to 150 to 200 residents. The Hastings home was operated as an extension of the home in Minneapolis until 1979, at which time it was established as a separate institution under the Department of Veterans Affairs. Both homes, however, remain under the operational responsibility and management of the Minneapolis home administrator.

Over the years, the Minneapolis and Hastings homes have developed unique identities. The geographic distance between the homes and the differences in their size and resident population have made them different in identity, character and management approach.

Two Decades of Intense Changes

Over the past 20 years, the homes and the issue of long-term care for veterans have been the subject of a number of reports. A few of the reports have been routine audits (e.g., the 1984 and 1985 legislative audits). Others were responses to a perception that there were serious problems at the homes (e.g., the 1980 Management Analysis Division study and the 1987 report by Health Commissioner Mary Madonna Ashton).

The homes have experienced a chronic shortage in staffing and resources. The Department of Veterans Affairs' biennial budget staffing requests for the homes have a history of not being fully funded by the legislature and governor.

> In Fiscal Years 1982-83, Veterans Affairs requested 42.5 permanent and 13 seasonal positions and received 28.
>
> In Fiscal Years 1984-85, there was an exception: Veterans Affairs requested 47.5 positions and received 53, as a result of opening the new nursing care Building 16.
>
> In Fiscal Years 1986-87, Veterans Affairs requested full funding of 14 positions held vacant due to underfunding, and requested additional funds for 11 new positions. They were granted seven positions.

In Fiscal Years 1988-89, Veterans Affairs requested 74 positions due to increased occupancy rates and collection efforts. The governor initially recommended granting 32 positions based on the projected balance in the homes' special revenue accounts. The Minnesota Department of Human Services and the Health Department re-reviewed the request in March 1987 and recommended granting 10 more positions. The legislature approved a total increase of 42 positions.

Staff shortages have been aggravated by reductions in the availability and use of resident workers.

The homes have had a high turnover in leadership. Four different administrators and three acting administrators have managed the Minneapolis home in the past seven years. Each administrator brought new management practices and, as a result, the management structures of the home have been in constant and major change since the early 1970s. Hastings has had six different on-site managers in the past 10 years.

Recent Events

The 1987 findings of the Health Department prompted the current focus and assessment on the Minnesota Veterans Homes.

The Health Department Office of Survey and Compliance routinely inspects nursing homes and boarding care homes. The Health Department's records show that 119 correction orders and 21 fine assessments have been issued to the Minneapolis facility as a result of inspections between 1981 and 1987. Compared to other comparable-size homes with a similar population, the Veterans Homes' performance has been poor (see Nursing Home Comparisons chart, Appendix F).

Annual VA inspections have consistently supported the findings of the Health Department inspections. (For details, see Health Care Management, p. 53.)

The Minneapolis home's recent regulatory history is as follows. In September 1986, the Health Department conducted an annual licensure survey of the home. The home was cited for 19 violations of health and safety standards. Reinspections of the facility in November 1986, March 1987 and April 1987 indicated that efforts were being made to correct the violations. However, violations remained and additional correction orders were issued.

As a result of the annual licensure survey of the home in July 1987, 35 new correction orders were issued. The commissioner of health notified the governor that her department was required under state law to begin disciplinary proceedings for suspension or revocation of the home's license for repeated violation of the same Health Department rules.

In response to the citations, on July 31, 1987, Governor Perpich issued an executive order temporarily transferring the management of the home to the Department of Human Services and continuing a moratorium begun in March 1987 on further admissions to the home until health violations were corrected. The objective of the Human Services on-site management team has been to make no radical changes in the mission or range of services, but to address basic resident needs in order to achieve and maintain compliance with Health Department and VA regulations.

Human Services has initiated changes in many areas, including reporting relationships in the personnel, purchasing and financial operations areas and restructuring in the nursing services area. A process is in place to hire a new administrator, although efforts have not been successful to date.

Staff shortages have been identified and documented through comparisons with other state nursing homes, observation of daily operations, completion of case-mix assessments, and independent consultant reviews. The Veterans Homes' budget and personnel planning did not take into consideration employee holiday, vacation and sick time. The shortage of positions has led to frequent use of overtime and intermittent staffing.

Fifty-eight new positions were requested and granted by the Legislative Advisory Commission in October 1987. An additional 26 positions are being requested from the 1988 Legislature. Aggressive hiring is in process to fill existing and new vacancies. The new positions assure ongoing care-level compliance with Health Department and VA regulations. The new nursing staff will bring the nursing hours per patient per day to the state average of 2.5. The new positions do not allow for major changes in the scope of services, programs or mission.

Human Services has decided to gradually and systematically begin admitting new residents in order to reduce a projected shortfall of $708,000 by the end of Fiscal Year 1988. Currently, they are admitting a few domiciliary residents into Building 9 on the Minneapolis campus and have plans to open up admissions into the nursing care unit in February 1988.

OVERVIEW OF THE HOMES

Mission

The mission of the homes, according to a formal mission statement of the Department of Veterans Affairs, includes the following components (see Appendix G for a complete statement):

1. Assure a maximum quality of life for eligible veterans and their spouses residing in the State of Minnesota.

2. Ensure that each resident has a structured environment and an individualized program to function at his/her highest level of physical, social and mental abilities and solicit participation from each resident in structuring his/her care.

3. Encourage the independence of each resident.

4. Render services in a professional and considerate manner, providing for the comfort and recognizing the human dignity of each individual."

Clientele

The homes are licensed to serve 740 residents. Minneapolis is licensed to serve 346 nursing care and 194 domiciliary residents. Hastings is licensed for 200 domiciliary residents.

As indicated by the demographics (see Demographics, Appendix H), the Veterans Homes' resident make-up is different from a typical nursing home population. The residents tend to be younger and predominantly male. Also, there are more residents in the Veterans Home who require minimal assistance with the activities of daily living.

The majority (68.3 percent) of the residents are veterans of World War I and II, and 11.2 percent served in Korea, 11.1 percent served in Vietnam, 6.2 percent served in peacetime and 2.1 percent are non-veterans. Almost two-thirds (63.8 percent) of the residents are from the Twin Cities seven-county metropolitan area.

Many residents choose the homes because of their veterans culture and their economic advantages, and because they provide an alternative to welfare subsidies.

Services Provided

The homes provide long-term care (primarily custodial), domiciliary care, terminal care, and certain types of treatment. The homes do not provide acute rehabilitation (physical, occupational and speech therapy), oxygen therapy, intravenous feeding and medication, or acute psychiatric intervention.

EXTERNAL RELATIONSHIPS

Governance Relationships

The Department of Veterans Affairs has been the official licensee of the homes. (Currently, Human Services holds the licensee responsibility.) The operating budget of the homes comprises about 80 percent of the Veterans Affairs budget. Other divisions include Veterans Benefits, Claims, Agent Orange, Administrative Services and Field Services.

According to the formal position description, the administrator of the homes reports to the commissioner and deputy commissioner of Veterans Affairs, but has principal responsibility for directing the operation of the Minneapolis and Hastings homes, including the development of goals, objectives, policies, procedures and strategic plans, human resource and fiscal management, health care management and public relations. In reality, the home operations have been co-managed by the commissioner, deputy commissioner and administrator.

Veterans Administration

The Veterans Homes have a close connection with the Veterans Administration. The VA provides operating and construction funds, provides medical care services to residents and conducts periodic inspections of the homes to monitor compliance with VA standards.

Per diem payments on behalf of eligible residents in Fiscal Year 1987 provided approximately $1,914,000 for nursing care ($17.05 per person per day) and $960,000 for domiciliary care ($7.30 per person per day).

Federal law authorizes a 65 percent participation rate in the construction and acquisition of new facilities. The VA has contributed $8 million toward construction at the homes. It is subject to a 20-year recapture.

The VA Medical Centers in Minneapolis and St. Cloud serve the residents of the homes on a daily basis. Many of the Veterans Homes' residents have been referred to the homes by the VA Medical Centers. Approximately $5,900,000 in medical care (roughly 1,200 inpatient visits and 9,000 outpatient visits) was provided to residents of the homes by the Minneapolis and St. Cloud Medical Centers during Fiscal Year 1987. Over the years, the cooperation between the facilities has increased to include contracts for physician services and sharing of equipment and expertise.

The Veterans Administration regulatory programs are directly tied to VA aid payments programs for state veterans homes.

Title 38 Code of Federal Regulations (CFR) 17.165 through 17.167 authorize the VA to make aid payments to states operating veterans homes subject to the provisions of 38 CFR 18.1 through 18.13. The VA Department of Medicine and Surgery Manual M-1, "Operations," Chapter 3, State Veterans Homes, Part I, "Medical Administration Activities" contains standards of care, policies and procedures for determining eligibility, reporting and vouchering, and auditing and inspecting state homes.

Compliance with regulatory program standards is a condition for both initiating and continuing federal aid payments to state veterans homes as well as to community nursing homes providing services to veterans by contractual agreement with the VA. Inspections may be carried out by VA personnel from the nearest regional VA medical center. The local VA health care facility director is responsible for VA regulation of the Minnesota Veterans Home.

VA standards require that the facility comply with applicable federal, state and local laws and regulations.

County Veterans Services

The County Veterans Service officers, under the general supervision of the commissioner of Veterans Affairs, provide information, referral, advocacy and screening services at the local level. There are 116 veterans service officers in Minnesota's 87 counties.

Veterans Organizations

Of the 500,000 veterans in the state, approximately half identify with groups such as the Veterans of Foreign Wars, the American Legion, Disabled American Veterans and others. The veterans organizations provide substantial support for the operation of the homes. A large portion of the program and recreation budget for the homes is provided by them.

The leadership of the Department of Veterans Affairs actively communicates and interacts with the veterans organizations in order to develop and maintain the organizations' support for the homes and other veteran-related needs.

State of Minnesota Long-term Care Programs

The Health Department Office of Survey and Compliance routinely inspects all nursing and boarding care homes in the state, including the Veterans Homes. Other than these inspections, the Minnesota Veterans Homes operate in relative isolation from the mainstream programs for long-term care in the State of Minnesota. Because of this, Veterans Homes' residents receive less than other elderly Minnesotans in both choice of health care options and quality of care. For example, veterans seeking admission to the homes do not participate in the state's pre-admission screening program which assesses a person's need for institutional care and which refers him/her to the most appropriate, less restrictive alternative.

CHAPTER 2: MISSION

Findings

Inspections records from the Health Department and the VA cite regulatory violations which are inconsistent with the homes' mission statement. For example, each resident has not had a "structured environment and an individualized program" allowing the individual to function at his/her highest level and services have not consistently been rendered "in a professional and considerate manner." (Details of the homes' inspection histories are documented throughout this report and in Appendix F.)

Much of the homes' mission statement paraphrases the statutory rights of all health care facility residents in Minnesota under the residents' Bill of Rights (Minnesota Statutes, Sections 144.651-144.652).

The homes have shifted from 100 percent domiciliary care to skilled nursing and domiciliary care since 1972, when the first nursing-care facility was built. In staff interviews, some staff felt that the shift from domiciliary care to nursing started many problems at the homes.

Confusion about the homes' mission was a common theme in staff interviews:

> Of 84 Minneapolis staff respondents who were asked if they were familiar with the mission of the home, 72 answered positively but did not necessarily agree on what the mission was. In Hastings, 9 of the 11 staff respondents indicated familiarity with the mission but had a variety of interpretations of it.
>
> Thirty-five percent of Hastings and 39.3 percent of Minneapolis staff survey respondents agreed with the statement, "We seem to change direction from one day to the next."
>
> Many staff felt that the mission of their work areas needed further clarification. Of Minneapolis staff survey respondents, 31.7 percent disagreed with the statement, "We have a clear understanding of our group's mission and priorities."
>
> Several staff (11 Minneapolis, 2 Hastings) expressed the need for the homes to determine whom the facility is going to serve, clarify the mission statement and redirect the programs to serve the needs of the target population of residents.

The Minneapolis staff have mixed feelings on how the home is accomplishing its mission. Of the Minneapolis staff who responded to the question of whether the home was meeting its mission, 20 felt it was, 29 said it was not and 20 said they did not know.

Resident care in the Minneapolis home is not consistently adequate, according to interviews, focus groups and surveys:

> Twenty-six of the 65 who answered the question, "Do residents generally receive adequate care and services?" felt that residents did not receive such care. (In Hastings, all but one respondent felt that care was adequate.) "Inadequate resident care" was ranked 12th in a list of 51 issues by the Minneapolis staff attending feedback sessions.
>
> The broad and difficult case mix was ranked fourth in a list of 51 staff issues on the Minneapolis campus. One staff member commented that the Veterans Home had moved too fast into the operation of a skilled nursing facility. Many agreed that there has been an influx of skilled nursing patients who require heavier care than in earlier years and that there is a substantial and growing group of younger residents with chemical dependency and mental illness care needs.
>
> Minneapolis staff, residents and family members indicated that, although there were a number of caring personnel, staff often showed poor attitudes toward residents.

Rehabilitative programming is not in place at Minneapolis or Hastings, particularly for the younger veterans in domiciliary care, according to interviews with staff and Human Services management. They felt that the homes were not good at motivating residents to return to society, and staff described the domiciliaries as "unmonitored college dormitories" and "three hots and a cot."

Conclusions

The mission statement of the homes is broad and leaves room for much interpretation. The mission does not drive the operations of the homes. Operations are driven by the need to respond to daily crises rather than by the mission or long-term strategies.

The mission of the homes is outdated, and does not reflect the Minneapolis home's transition into a skilled nursing care facility.

The Minnesota Veterans Homes are not meeting the primary objectives in their current mission statement. Regulatory evidence shows that the homes do not assure a "maximum quality of life" for residents. Even the mandatory provisions of the residents' Bill of Rights cited in the mission statement are not consistently enforced.

Many staff members are not aware of the homes' mission or have inconsistent views of it.

Recommendations

1. The governing body should endorse the new mission statement drafted by the governor's blue-ribbon commission. Management should then identify the client group to be served and practical long-term goals and objectives. There are many institutions which provide long-term health care services for the veteran. In order to maximize the quality and quantity of care for veterans, and avoid duplication of services, the mission of the homes needs to be determined in a system-wide context.

2. The homes should review and redesign management and operating systems in light of this new mission so that daily activities are consistent with the new directions. Strategies and changes instituted and/or begun by Human Services should be continued when possible in order to minimize needless change. The process of redesigning the systems should include all parties affected by the change: top management, staff, residents, family members and others.

3. Once the new systems are in place, the homes need to make an aggressive effort to communicate their clarified mission to their internal and external constituents as well as to the general public.

CHAPTER 3: ADMISSIONS AND DISCHARGES

THE ADMISSIONS PROCESS

Findings

Statutes Governing Admission to the Minnesota Veterans Homes

A person seeking admission to the nursing care or domiciliary care facility must comply with the eligibility requirements established under Minnesota Statutes, Sections 198.01, 198.03 and 198.022:

1. Veterans must have been discharged under conditions other than dishonorable.

2. Veterans who received bad-conduct or dishonorable discharges must be eligible for admission if the discharge is based on drug dependency or abuse.

3. Veterans must have served in a Minnesota regiment or have been credited to the state of Minnesota, or have been a resident of the state preceding the date of application for admission.

4. Veterans must have served on active duty for at least one day in time of war or else 181 consecutive days in peacetime.

5. All applicants for admission must be without adequate means of support and unable by reasons of wounds, disease, old age or infirmity to properly maintain themselves.

6. Any person eligible for admission except for the fact that the person has means of support may, at the discretion of the commissioner, be admitted to the home after agreeing to reimburse the home for expenses.

Additionally, under Minnesota Statutes, Section 198.022, spouses, surviving spouses and parents of eligible veterans may also be eligible for admission. They must be at least 55 years of age and residents of the state of Minnesota.

Management interviews disclosed that (1) there were 13 non-veterans in the Minneapolis facility in January 1988, (2) only a few are spouses residing with eligible veterans, and (3) although parents of veterans are eligible by statute, none have been admitted in recent years.

Minnesota Statutes, Section 198.06, requires the commissioner of Veterans Affairs to adopt administrative rules governing the admission, maintenance, conduct and discharge of residents of the Minnesota Veterans Homes.

The Department of Veterans Affairs has not promulgated the rules required. However, it had begun the first stages of the process in early 1986.

> The draft rule intended to provide additional guidance regarding priority admissions (those currently in a private residence or domiciliary setting) and those excluded from consideration (maternity cases, "disturbed mental residents," individuals with diseases which would endanger others, and individuals "for whom care cannot be provided in keeping with their known physical, mental or behavioral condition"). However, the language regarding those who would be excluded from admissions consideration was merely a repetition of the existing Health Department regulations for all nursing care and boarding care facilities.
>
> The rule also attempted to standardize resident fees.

Veterans Home Admission Policies

The 1980 Management Analysis Division study noted "considerable confusion regarding admission criteria and reasons for discharge," admissions which "do not occur systematically or according to any established procedures," and admission decisions "made on a unilateral basis and often without adequate medical/social data." The 1980 study recommended that "admission and discharge procedures and policies must be developed and implemented immediately."

A review of Veterans Homes' records and operational admission policies revealed that substantial efforts were made to comply with the Management Analysis Division recommendation in the early 1980s. Policies and procedures were drafted which identified (1) admission priorities, (2) persons who cannot be admitted and why, (3) a formal application process including screening for appropriate placement, and (4) an appeals process.

Staff interviews established that any formal application policies and procedures have been applied inconsistently or ignored in recent years.

A 1987 assessment by Human Services concluded that "candidates for admission must demonstrate medical justification" and "fulfill certain statutory eligibility requirements," but that "there is no real evidence of consistent and meaningful admissions policies or procedures within the Minnesota Veterans Home."

Veterans Home Admission Practices

In December 1987, there were 180 names on the waiting list for admission into the nursing care facility. The average age of individuals on the list was 73, the maximum age 97. There is no waiting list for domiciliary admissions.

Individuals entering the Veterans Homes are exempt from Minnesota's pre-admission screening requirements.

Staff and management interviews described the use of an admissions committee. Its composition has changed over time. Neither participants nor non-participants viewed it as an effective review process. Insufficient staff input and medical representation were a recurrent theme in interviews. One ramification cited was medically or behaviorally inappropriate admissions and questionable placement of residents within the facility.

Twenty-three staff interviews in Minneapolis suggested that application to the home has been a largely political process. Sixteen individuals chose the word "political" to describe the admissions process. (Six others -- over and above the 23 -- described the home in general as too "political.") Five others specifically cited the Veterans Affairs central office for what they perceived as inappropriate involvement in admissions. Staff and management also described pressure from veterans organizations, legislators and others. Several individuals claimed that a state senator had successfully pressured an admission in the spring of 1987 during a freeze on accepting new residents.

Family members in surveys and focus group discussions acknowledged use of political influence in placement of their spouses:

> "Waited over three years or more . . . I had help from a state rep (God bless him!)."
>
> "You had to have pull to get in. I had applied and they said it would be a two-year wait!! When I contacted people who knew people in the right places, he was admitted in four days!"

Hastings staff interviews also described political influence in the admissions process there.

Developments Under Human Services Management

Human Services withdrew Veterans Affairs' draft rules and has not issued alternative rules. Human Services has, however, begun to issue and reissue internal policies and procedures deemed appropriate. Among the topics addressed in recently released materials are the following:

* Veterans status for admission;
* Health conditions for admission;
* Priorities for admission to nursing care;
* Priorities for admission to domiciliary care;
* Applicants not viewed as admissible to the Veterans Homes;
* Urgency of care;
* Refusal of admission by applicant;
* Pre-admission interview;
* Facility capabilities;
* State agency requirements;
* Admission agreements;
* Discharge planning;
* Role and composition of admissions committee;
* Admission denial - appeal process; and
* Readmitting candidates who were discharged for failure to meet rules.

Conclusions

Minnesota's statutes contain exceptionally broad eligibility criteria for admission to the homes. The commissioner of Veterans Affairs has not promulgated the administrative rules required to set priorities within the eligible population.

The demand for nursing care beds by eligible individuals exceeds the number of beds available at the Veterans Homes. Absent clear medical, monetary or service-related criteria, admissions decisions have at times been made on the basis of political influence.

The admissions system has lacked legitimacy and integrity. It has met the needs of a minority of vocal or politically connected individuals at the expense of the larger group of medically needy veterans.

The Management Analysis Division shares the belief of the blue-ribbon commission that Minnesota's veterans have been unfairly denied the benefits of pre-admission screening. These include access to the full range of non-institutional alternatives and institutional placement at the most appropriate, least restrictive level of care.

Recommendations

1. The governing body should promulgate administrative rules regarding admissions as required under Minnesota Statutes, Section 198.06:

   These rules should define clear priorities for admission of eligible veterans consistent with defensible policy objectives.

   These rules should outline a process for application which includes an appropriate medical assessment and counseling on alternatives.

   These rules should spell out the rights of aggrieved applicants and include an appeal process to the administrator of the Minnesota Veterans Homes. That appeal should not be to the commissioner, in order to reduce the central office role in admissions.

2. The Minnesota Veterans Homes should develop internal admission procedures consistent with the rules and enforce them even-handedly. They should create a legitimate admissions review process involving a multidisciplinary committee which has the authority to resist political pressure.

3. We endorse the blue-ribbon commission recommendation that the Minnesota Legislature include applicants for admission to the Minnesota Veterans Homes in the pre-admission screening program.

THE DISCHARGE PROCESS

Findings

Human Services data shows that in 1986, the last full year of discharge data available, the Minneapolis facility (both nursing care and domiciliary) discharged 145 residents for the following reasons:

* Death 67 (46.2%)
* Independent living 40 (27.6%)
* Transferred to VA Medical Center 25 (17.2%)
* Transfer to other hospital 6 (4.1%)
* Other level of care 5 (3.4%)
* Transferred to Hastings Veterans Home 1 (.7%)
* Other 1 (.7%)

The average length of stay of the current residents in all facilities operated by the Minnesota Veterans Homes is 4.9 years from the date of their most recent admission, according to data supplied by Human Services. The median length of stay is 3.4 years, the maximum is 45 years, and the minimum is one month. (This is slightly longer than the average length of stay of Medical Assistance recipients in nursing care facilities in the state.)

Interviews and a review of the historical record suggest that, as with admissions, there have been no clear policies and procedures regarding resident discharges.

Following efforts to evict certain residents, Veterans Affairs was sued and a court order prohibited further involuntary discharges absent administrative rules. Therefore, the only discharges currently allowable at the Veterans Home are voluntary or medically necessary.

Both staff and residents expressed frustration over the moratorium on discharges. The predominant staff view was that some residents took advantage of the situation, knowing there would be no consequences for misconduct. Residents expressed anger that there were individuals who were refusing to pay for their care pending resolution of legal disputes.

A Human Services assessment from December 1987 concluded that "there has been no consistent criteria or methods for basing discharge decisions, outside of those for negative behavior," and that "when certain discharge policies were in effect, they were not enforced equally among the residents, by the staff, especially with regard to alcohol use/abuse."

Human Services also reported that "past Minnesota Veterans Home discharge policies have also been lacking in addressing such critical discharge elements as evaluating the potential capabilities of the resident, assessing the overall needs of the resident, assessing the alternate care needs of the resident, and formalizing a discharge planning process." Recent Veterans Administration inspections also cited the homes for lack of discharge planning.

As with admissions, the commissioner of Veterans Affairs was required by law to promulgate rules setting forth procedures for discharges. Veterans Affairs has not done so; however, it had begun the process. Its draft rules contained resident conduct and discharge policies in areas such as the following:

* leaving the grounds of the home without permission
* possession of contraband
* possession of liquor
* honoring financial obligations
* personal hygiene
* room cleanliness
* smoking
* private vehicles
* discharge planning
* advance notice of discharge to residents
* involuntary discharges
* due process rights of residents prior to involuntary discharges

Conclusions

The homes lack formal discharge rules and procedures:

Discharge criteria involving medical planning and assessment would decrease the high average length of stay at the homes and increase the likelihood of residents returning to independent living or other appropriate alternatives.

Administrative rules on resident conduct leading to discharge would protect both residents and staff. A formal system with criteria could provide due process to discharged residents while giving the homes the right to execute involuntary discharges with cause.

Recommendations

1. The governing body should promulgate administrative rules regarding discharges consistent with the Minnesota residents' Bill of Rights. It should then enforce them consistently and even-handedly.

2. These rules and resulting procedures should specify:

   * development of a discharge plan for every resident prior to discharge
   * criteria for voluntary discharge of residents admitted for rehabilitation or for short-term stays

* criteria for involuntary (disciplinary) discharges
* an appeal process to the administrator (which would be in addition to a resident's statutory right to "contest" a discharge to the area nursing home ombudsman)

The following chapters provide a comprehensive assessment of the Minneapolis home in the areas of leadership, health care management, human resources management and fiscal/material resource management.

The Health Department exposure of severe problems at the Minneapolis home lead to the emergency transfer of management to the Department of Human Services. Devoting the bulk of this report to the Minneapolis facility is consistent with its troubled history, the time the study team spent at the facility and our conclusion that the the home remains in a state of crisis.

CHAPTER 4. LEADERSHIP PATTERNS

Regarding leadership patterns, the legislature specifically asked that the study evaluate 1) the role and responsibilities of the governing body, administrator and management staff located at the Minneapolis home, 2) the relationships among the three parties and 3) the span and authority delegated to the management staff located at the home.

In general, the Management Analysis Division findings in this area confirm the conclusions made by Health Commissioner Mary Madonna Ashton in her "Report on the Minnesota Veterans Home in Minneapolis," submitted to the governor in August 1987. The commissioner's analysis of the major issues is used in this section as the framework for presenting the Management Analysis Division study results.

BACKGROUND ON POSITION DESCRIPTIONS

Commissioner: Minnesota Statutes, Chapter 196 spells out the duties and powers of the commissioner of Veterans Affairs. In addition to a list of formally prescribed duties, the commissioner is granted "powers as may be authorized and necessary" to manage the Department of Veterans Affairs and the Minnesota Veterans Homes in Minneapolis and Hastings.

Deputy Commissioner: Responsible for directing the department's legislative initiatives, property and building contracts, veterans organization contacts and the Field Operations Division. Also responsible for reviewing legislative bills which affect the veteran community, and reviewing and advising the commissioner on all fiscal and

personnel matters. At the commissioner's direction and control, the deputy may exercise all the powers of the commissioner and represent the department in all matters in the commissioner's absence.

Administrator: Responsible for all dimensions of the home's operation, including the development of goals, objectives, policies, procedures and strategic plans, human resource and fiscal management, health care delivery management and public relations.

TOP MANAGEMENT TURNOVER

Commissioner Ashton Conclusion:

"[There is a] history of frequent turnover in top management positions, and the extended coverage of vacant management positions by individuals with other full-time responsibilities.

"Turnover in the home's top management positions, including administrator, assistant administrator and director of nursing, has been frequent. For budgetary reasons, this frequent turnover was combined with the practice of holding positions vacant for extended periods of time and using management staff to cover two positions during 1986 and 1987.

"Since 1980, there have been four different administrators and several interim acting administrators in charge of the home.

"The assistant administrator position, which provides overall supervision for the indirect care areas (housekeeping, laundry, food service, transportation, grounds, physical plant, maintenance and powerhouse) was vacant from August 1986 to May 1987. During that time, the administrative management director covered the responsibilities of his own position (financial management, information services and personnel) as well as those of the assistant administrator. He had no background knowledge in these areas.

"The director of nursing position was also vacant for about seven months. During this time, the assistant director of nursing was responsible for functioning as the acting director of nursing as well as covering her position as a nursing supervisor on one of the nursing home floors.

"The combination of frequent turnover and doubling up on coverage of management positions has been disruptive to line supervisors in the direct and indirect care areas and has resulted, in some cases, in individuals supervising, for extended periods of time, areas in which they have insufficient or no expertise."

Findings

Many staff expressed frustration about the unstable leadership over the years, and ranked the issue of excessive management turnover as 17th in a list of 51 issues. Each administrator introduced new concepts, priorities and practices. One staff described the home's history as one of "many changes but no improvements." In interviews, staff stated that the turnover in leadership has resulted in a chronic lack of continuity in management and supervision.

The frequent changes in management are one reason the home has been placed on an annual, rather than biennial, Health Department inspection schedule.

Human Services placed a high priority on hiring qualified persons to fill the vacancies in the top management team and, as of January 1988, the Veterans Home has a new director of nursing, assistant administrator of care related services and a quality assurance director. As soon as a new administrator and two assistant directors of nursing are hired, the management team of the home will be in place.

Conclusions

The Management Analysis Division concurs with Commissioner Ashton's conclusion that there has been a frequent turnover in top management positions and extended coverage of vacant management positions by individuals with other full-time responsibilities.

The leadership changes have not been managed well and have had a negative, stressful impact on line staff.

Recommendations

1. The administrator position should be protected from frequent turnover and political interference. The Management Analysis Division endorses the blue-ribbon commission recommendation to structure the classification of the Veterans Home administrator position in the same way as administrator classifications at State Regional Treatment Centers: the position would be assigned to unclassified civil service, but with removal only for cause and with the right to a hearing.

2. Leadership transitions must be managed wisely. Line supervisors should be orientated to the new top management team. Reporting relationships should be defined in detail. Efforts should be made to consciously develop effective teamwork at the top management level and between them and their staffs. All employees need to be included in this process in order to encourage participation and ownership in the transition.

CHAIN OF COMMAND

Commissioner Ashton Conclusions:

"[There is a] lack of clearly defined lines of authority, responsibility and accountability among the commissioner of Veterans Affairs, the deputy commissioner and the administrator of the home.

"The relationships and lines of authority among the commissioner of Veterans Affairs, the deputy commissioner and the home administrator were not clearly defined. The extent of involvement of Veterans Affairs' central office in the management of the home appears to have contributed significantly to confusion about the administrator's authority and position.

"[There is an] organizational structure that limits the control of the administrator over certain key functions such as personnel and financial management.

"Under the Veterans Affairs organizational structure, the administrative management director reported directly to the deputy commissioner and commissioner. The administrative management director is responsible for the financial management and personnel functions of the home; thus, the authority of the home administrator over those critical functions was limited."

Findings

The chain of command problem is at least seven years old. In 1980, the Management Analysis Division found numerous problems with the delineation of roles and responsibilities, including the unclear relationships among departmental managers, the administrator and the assistant to the administrator at the Minneapolis home, as well as the connections between the commissioner and the home management. A recommendation was made in the report to clarify the administrative organization and delineate responsibilities.

During the current study, comments in many interviews pointed toward the negative effects of central office intervention in daily operations:

> Several interviews revealed examples of times when the administrator's decisions, actions and authority were undermined or bypassed by central office staff.
>
> In his capacity as budget director, the deputy commissioner personally worked on-site in assessing resource needs rather than delegating budget development to the administrator and home's management team. Some involved parties alleged that communication and planning regarding financial and other resources occurred directly between line staff and the deputy commissioner rather than through the administrator.
>
> The central office leadership was frequently involved in the decision-making regarding admission of residents (see "Admissions and Discharges," p. 23).
>
> Evidence in staff and management interviews suggests that the deputy commissioner and commissioner spent a substantial amount of their time dealing with the direct operational management of the homes. The job descriptions of both leaders do not specify any duties relating to the direct management of the homes. The home serves a very small percentage of the 500,000 veterans in the state. Time spent directly on the home operations is time away from serving the majority of the state's veterans.

The working relationships between the two homes have, to a degree, achieved the decentralization which was recommended by the Management Analysis Division in 1980.

> In management interviews, leaders indicated that, although the priorities at the Minneapolis home tend to overshadow time and energy spent on Hastings, the degree of independence between the two operations has been helpful.
>
> Many management and staff interviewees recommended that the two homes widen the independence by having a licensed administrator for the Hastings home who reports directly to the governing body rather than the Minneapolis administrator.

The Department of Human Services has shifted the reporting structure of the Administrative Services Division. Currently the Personnel and Staff Development Department, Financial Management Department and Information Systems Department report directly to the administrator. According to some individuals close to the change, the new relationship will require considerable problem-solving to become operational.

Conclusions

Management Analysis concurs with Commissioner Ashton's conclusion that there is a lack of clearly defined lines of authority, responsibility and accountability among the commissioner of Veterans Affairs, the deputy commissioner and the administrator of the home.

As a result of the unclear chain of command at the top management level, the line staff have experienced difficulty in effectively responding and relating to leadership and handling operational decision-making and problem-solving.

The Management Analysis Division concurs with Commissioner Ashton's conclusion that the personnel and financial management reporting relationships to the central office limited the administrator's authority and control. (See "Fiscal/Material Resource Management," p. 113 for more detailed conclusions and recommendations in this area.)

Recommendations

1. The responsibilities of the governing body and the administrator of the home should be clarified. As chief operating officer, the administrator needs to be the primary leader for the home, as spelled out in the current position description. The administrator should be held accountable for operating the facility according to the mission, goals and objectives of the home and within Health Department and VA standards.

2. The chain of command and organizational structure should be communicated to all staff so that employees understand the leadership structure and know how to effectively participated. As chief operating officer, the administrator needs to be the primary leader for the home, as spelled out in the current position description. The administrator should be held accountable for operating the facility according to the mission, goals and objectives of the home and within Health Department and VA standards.

2. The chain of command and organizational structure should be communicated to all staff so that employees understand the leadership structure and know how to effectively participatersonnel and nursing.

POLICIES AND PROCEDURES

Commissioner Ashton Conclusion:

"[There is an] overall lack of attention on the part of management to develop and implement formal policies and procedures, especially in the areas of administration, personnel and nursing.

"Review of the home's organization charts and position descriptions revealed discrepancies between reporting relationships as described on the position descriptions and in the organizational charts. Many of the position descriptions reviewed were incomplete or outdated. Several were missing items such as priorities, percent of time to be spent on various responsibilities, signatures of employees and supervisors, and dates.

"Deficiencies in the July 1987 correction orders included the lack of nursing policies and procedures regarding general nursing care and aseptic techniques.

"The lack of policies and procedures in the areas of administration, personnel and nursing points to the failure of top management to establish, enforce and require accountability for policies and procedures.

"The director of nursing and the assistant administrator are still relatively new to their positions. These managers need time to improve administrative procedures within the areas they supervise."

Findings

In 1980, the Management Analysis Division recommended that "top priority must be given to developing written policies and procedures for all of the homes' operations and be compiled into a manual for use by all staff." The study found that the existing manual was "a conglomeration of general policy statements, intra-home memos, handwritten notes and photocopied portions of manuals from other nursing homes." It was not sufficiently detailed to act as a guide to employees and did not pinpoint staff responsibilities. Hastings had no policy and procedures manual in 1980.

The current manual is in somewhat the same form, but a review of the contents revealed that substantial efforts had been made by several administrators to develop policies and procedures since 1980. Further work would have been needed to institutionalize the content of the manual. Interviews revealed a wide gap between written policy and actual practice.

Inconsistent policies and procedures were identified as a key issue in 30 staff interviews. The staff at the feedback sessions ranked this issue as 11th in importance in a listing of 51 Minneapolis home issues.

> Many staff were concerned about whether the existing policies and procedures were self-established Veterans Home work rules and not accepted universally in the industry.
>
> A majority of the comments specifically pointed to the lack of written rules and procedures for such things as isolation procedures, emergencies, chemical dependency and resident discharges.
>
> Policies and procedures were described by many staff to be constantly fluctuating. Consistent policies and procedures are not maintained from day to day, shift to shift, supervisor to supervisor, building to building, and floor to floor.
>
> In the staff mail survey, only 20.3 percent of the staff who responded agreed with the statement, "We have lots of good policies and procedures so we know what we are supposed to do." On the same survey, only 5.8 percent of the staff felt that the home keeps its policies and procedures up-to-date.

Human Services has hired a health care administration consultant to review, refine and operationalize the overall operative and administrative policies and procedures and to work with the departments and work units to develop department-specific policies and procedures.

As noted previously, Veterans Affairs had begun the process of statutory rulemaking for the home. However, the rules have been withdrawn by the management of Human Services.

Conclusions

The Management Analysis Division concurs with Commissioner Ashton's conclusion that there has been an overall lack of attention on the part of management to developing and implementing formal policies and procedures, especially in the area of administration, personnel and nursing.

The staff of the home experience inconsistency in the application and interpretation of policies and procedures. Although Human Services has begun the process of reviewing and revising the home's policies and procedures, there is a wide gap between the written materials and the operational practices of the home.

Recommendations

1. Continue with the ongoing Human Services effort to review, revise, clarify and add to the existing Veterans Affairs operations manual and complete the development of policies and procedures for all aspects of the home operations.

2. Institute an aggressive orientation and training program to communicate and train all staff in policies and procedures which affect their work areas and their ability to perform effectively on the job.

3. Expedite the rulemaking process for the home.

HEALTH CARE EXPERTISE

According to the commissioner's report, "The leadership of the Veterans Home has been weak in the area of professional management, which is essential to running a very large facility in today's complex health care environment. With 346 licensed nursing home beds and 194 licensed board and care beds, the Veterans Home in Minneapolis is one of the largest facilities in Minnesota. It has the fifth-largest number of licensed nursing home beds in the state and the fourth-largest number of licensed board and care beds."

The commissioner of Health found that the structure of the Veterans Home was missing many major systems considered fundamental to a health care facility. These system deficiencies are highlighted in this section but are described and evaluated in detail in "Health Care Management," p. 53.

1. Commissioner Ashton Conclusion: "[There is] a need for written clarification of the lines of responsibility, authority and accountability of the medical director and the physicians at the home. Although the medical coverage appears very good, and the residents have access to specialists, emergency care and hospitalization, the home has no position description for the medical director, and the contract with the Veterans Administration Medical Center is very vague." (Excerpt of Finding No. 6)

2. Commissioner Ashton Conclusion: "[There are] major problems in the nursing organizational structure, staffing patterns and level of staffing. There is a structure which limits the station professional nurses to direct or influence the provision of care given by non-professional human service technicians. [This structure has since been abolished by Human Services.] The director of nursing is responsible for all administrative tasks related to the management of more than 200 nursing personnel, with insufficient administrative assistance. There is a lack of administrative support on nursing stations. Nurses perform non-nursing duties and use nursing home staff to supplement inadequate staff levels in the domiciliary unit." (Excerpt of Finding No. 7)

3. Commissioner Ashton Conclusion: "[There is] a lack of effectively functioning committees in the areas of patient care, quality assurance, utilization review, pharmacy and infection control. Health Department nursing home licensing rules require a patient care committee. Quality assurance, utilization review, infection control and pharmacy committees customarily exist in nursing homes and are required under VA nursing home care standards." (Excerpt of Finding No. 8)

4. Commissioner Ashton Recommendation: "The Veterans Home [should] implement, as soon as possible, a case-mix system on a permanent basis." (Excerpt of Recommendation No. 4)

The case-mix system, in use by most facilities across the state, was not in place at the Veterans Home when the commissioner prepared her report. It has been instituted under Human Services management.

In addition to the major systems gaps, the commissioner was critical about the expertise and experience of the administrator in charge at the time of her report:

Commissioner Ashton Conclusion: "There is an administrator with very limited education and experience in the field of nursing home or health care administration. It does not appear that the administrator at the time of the 1986 and 1987 licensure surveys had sufficient educational background and experience in the field of health care administration to take on the tremendous responsibility of this position. He had the minimum requirement for a nursing home administrator's license. However, the Veterans Home was the only health care facility in which he had worked, and then only for three years prior to this appointment. The resignation of the administrator provides the opportunity to hire a new administrator with stronger credentials in nursing home administration." (Excerpt of Finding No. 3)

Findings

Review of inspection reports by both the Veterans Administration and the Health Department reveals that there has been a lack of accountability in the structures overseeing the health care practices. (See "Health Care Management," p. 53, for detailed findings and conclusions in this area.)

Human Services has used its knowledge of health care regulations and long-term care facility administration, plus consultants from other facilities, to quickly bring the home into minimal compliance with applicable regulations. Human Services management stated, however, that the recent efforts will not insure ongoing compliance and that the priority of the home for the next year needs to be maintaining its license."

Basic health care values are not deeply rooted in the staff of the home, according to staff and management interviews and a January 1988 report by the ombudsman who served at the home for three months prior to the report:

> Staff and management interviews reported that the professional opinions of health care staff were not given the appropriate weight in admissions committee deliberations.
>
> The ombudsman's report concluded that staff, particularly the human service technicians, do not have a basic understanding of the aging process and caring for those who are highly dependent or suffering from impaired mental abilities. (Additional findings and conclusions in this area can be found in "Health Care Management: Nursing Services," p. 55.)

Conclusions

The Management Analysis Division concurs with Commissioner Ashton's conclusions that the home does not have basic health care management systems in place and that the health care expertise of managers and supervisors has tended to be minimal.

Quality health care values have not been effectively modeled and communicated to the staff of the home. As a result, a large number of frontline staff do not provide care in a way that reflects understanding and compassion for residents.

Recommendations

1. Install the fundamental and required systems of a health care facility. (Specific recommendations are contained in "Health Care Management," p. 53.)

2. Complete the process of hiring a highly-qualified health care professional as administrator of the home.

3. Install safeguards which insure that the administrator and all management who are hired have top-notch credentials and experience for their positions.

4. Develop health-care-oriented values throughout the home through comprehensive worker orientation, ongoing training and enforced professional service standards for staff.

BASIC MANAGEMENT SYSTEMS

In general, the leadership of the home has failed to install basic management systems which assure efficient and effective operations.

Commissioner Ashton Conclusion:

"[There is a] management failure to recognize the patterns of serious deficiencies and address them with staff training, supervision, follow-through and accountability.

"The management staff appears to have focused on the details of specific incidents cited in the September 1986 and March/April 1987 correction orders, rather than recognizing the patterns of serious deficiencies and taking steps to ensure that they did not recur.

"At the end of every survey visit, Health Department survey staff meet with the management staff and supervisors of a facility to discuss deficiencies. The facility then receives written correction orders that describe what the deficiencies are and suggest ways to correct them. Veterans Home staff did not seem to recognize the seriousness of some of the deficiencies. For example, Health Department surveyors held an exit interview with Veterans Home management staff on September 11, 1986, to discuss the 19 deficiencies found in the September 8-11, 1986, survey, yet the Veterans Home management staff told the VA on September 26, 1986, that 'nothing major' came up during the state survey.

"Minnesota Department of Health survey staff and the consultants who reviewed the Minnesota Department of Health's regulatory record agree that management practices and policies relating to accountability of supervisors and line workers at the Veterans Home need to be re-evaluated and strengthened. Many of the system's problems reflect the absence of normally expected built-in accountability mechanisms."

Findings - Top Management Systems

Overall Attention to Management Systems

A majority of the 1980 Management Analysis Division recommendations have not been implemented. These include most of the recommendations involving basic management systems for delineating responsibilities, planning, human resource management and communication/decision-making.

Management Reporting

In March 1987, the governor requested weekly reports from the Department of Veterans Affairs to inform him of the status of correcting Health Department citations. The updates indicated that the corrections were well under way and the home was generally under control.

Planning Systems

In 1980, the Management Analysis Division found that top management had not developed comprehensive long-range plans for the homes and that top management and line managers do not prepare annual or monthly work plans. A recommendation was made to train all leaders in work plan development and institute the practice in the home. Interview data indicates that planning is not an ongoing activity at the home:

> Several staff interviews specifically recommended that the home set goals, do advanced planning and develop operational workplans.
>
> One common theme in the staff interviews was that workers perceived themselves to rarely be involved in operational decisions or planning.
>
> According to management interviews, the planning activity was reduced to the assessments and projections made during the budget development process.

Obtaining and Allocating Resources

The home has had a chronic shortage of human, financial and equipment resources.

A review of legislative appropriations history and interviews with leaders in Veterans Affairs, Human Services and Finance reveal that management has not been effective in obtaining essential resources and documenting basic needs. It has not been successful in using its networks of veterans organizations to insure that veterans receive their entitlement to the best health care available.

The chronic resource shortage has fostered an environment of "creatively" working within the limits. In interviews, past managers told of many "innovative" actions taken to do more with less. Examples included taking Central Office positions to create more direct care positions, consolidating fiscal personnel to allow more help in direct care and food services, splitting positions in order to have full coverage at all times, using a large pool of intermittent workers, using student workers in the summer to care for grounds and buying used vans.

In the staff mail survey, 60 percent of the respondents agreed with the statement, "The Department of Veterans Affairs could have run the home well if given enough budget and staff." However, in the compilation of all the interview data, approximately 85 percent of the comments were in the area of organizational and program structure and management systems. Only about 15 percent of the comments dealt specifically with staffing needs and operational resources.

Organizational Communication

The communication systems in the home are minimal and, even at best, tend to be one-way, from the top to the bottom. Many interviewees expressed dissatisfaction with the lack of information-sharing on the part of management as well as the lack of employee input in decision-making. ("Human Resources Management: Staff Teamwork," p. 106, has detailed findings and conclusions regarding staff/management communication.)

More than half the staff interviewees expressed concern about the lack of staff input into operational planning and decision-making. Specifically, staff felt they could contribute to the assessment of residents for admissions, suggest inservice training programs, provide information and ideas for work-area planning and participate in many other areas.

In the staff mail survey, only 5.7 percent agreed with the statement, "A lot of effort is made to ask for the thoughts and opinions of employees."

Instilling Values

Although interviews provided convincing evidence of a core of dedicated staff at the home, the training and orientation structures which instill and enforce service values are absent (see "Health Care Management: Staff/Resident Relations," p. 88).

Labor-Management Relations

The unions, particularly AFSCME, play a central role in supporting and caring for worker needs -- 81.5 percent of the home's employees belong to AFSCME. As several staff pointed out in interviews, the union has stepped in to replace a weak management. According to management interviews, many relatively informal work group issues are dealt with through formal labor and management channels. Communication between labor and management has not improved under Human Services.

Constituent Relations

Veterans organizations provide substantial services and funds to the homes each year. However, management has not always channeled that good will toward the best interests of the home. For example, donated refreshments are sometimes incompatible with residents' medical restrictions (e.g., angel food cake for diabetics and beer for alcoholics), and monetary contributions are often earmarked for specific uses and do not go toward things which are most badly needed. Several staff interviewees talked about the role of the veterans organizations as very important to the home, but were somewhat bothered by what one staff described as "vets groups throwing their weight around."

During the recent months when the Department of Human Services has been managing the home, the support of the veterans organization has decreased. According to staff interviews, this was especially apparent over the holiday season. Human Services has set up a veterans organization advisory committee to deal with the conflict and mediate between the home and the organizations.

The leadership of the Department of Veterans Affairs devotes a great deal of time and attention to maintaining communication and relationships with the veterans organizations. Management interviews stated that sometimes, in order to maximize support from veterans organizations, special admissions of residents and other favors were exchanged for maintaining good relations with the organizations.

Findings - Line Supervisory Systems

The 1980 Management Analysis Division found multiple problems with supervisory effectiveness. According to surveys and interviews, little has changed:

> Ineffective supervision was among the most common subjects addressed in staff interviews. Comments ranged from general evaluation of supervisors as poor to specific criticism about supervision in particular work areas.
>
> A dual supervision structure which put nursing floors under the authority of one nursing and one non-nursing supervisor caused multiple problems. (Further details are contained in "Health Care Management: Nursing Services," p. 55).
>
> The lack of consistent policies and procedures, high turnover in top management and the lack of basic management structures have resulted in an environment with little official order and few supervisory norms. Consequently, the style of supervisory leadership has depended primarily on the individual personality of the supervisor. A few exceptional individuals have excelled. Most others, lacking structures and support, have failed.

Conflict Management

As described in the "Teamwork" section of the Human Resources Management chapter, there is much defensive turf protection among work groups. The levels of hostility and blaming are often high, and interfere with resident care and cooperation across work units. Only 17 percent of the staff mail survey respondents agreed with the statement, "Supervisors cooperate with each other."

Leadership Competence and Integrity

In both staff and management interviews, serious doubts were raised regarding the competence of individual supervisors and department managers. The following are allegations which, although not witnessed by the Management Analysis Division team, were heard often enough to be considered credible:

> Individuals are verbally abusive with staff and residents.
>
> Sexual harassment charges have been filed against one individual.

Some supervisors were unaware of the Health Department regulations for their areas.

One individual reportedly will not speak to one of his workers.

One individual intimidated a Health Department inspector.

One individual mishandled his purchasing authority until it was removed.

One individual is perceived to be so difficult to work with that he is now a supervisor in name only; he supervises no one.

Only 33.6 percent of the staff mail survey respondents agreed with the statement, "I feel confident in my supervisor's leadership."

Health Care Supervision Skills

Interviews suggested that the supervisory experience for some has been mostly on the job, and many require more training in basic health care, operations and regulations, as well as leadership responsibility and skills.

Performance Evaluation

One interviewee described the performance evaluation process as "a joke" and another expressed concern about not receiving instructions and feedback from his/her supervisor. According to some staff interviews, the performance reviews mandated by the collective bargaining agreements are not conducted regularly and consistently for all employees. The lack of honest documentation on performance makes termination of incompetent or unproductive staff and supervisors very difficult.

Only 30.2 percent of the staff mail survey respondents agreed with the statement, "I receive feedback on how well I do on my job."

Delegation and Scheduling

Interviews and surveys revealed the perception among some staff that a significant number of employees are not carrying a fair share of the work. There are allegations that some supervisors exhibit favoritism in making assignments. Some supervisors have also been accused of sanctioning the misuse of overtime, sick leave and vacation time.

On the staff mail survey, only 26.4 percent of the respondents agreed with the statement, "The workload in my area is fairly distributed." Only 15 percent of the respondents disagreed that some employees are "on-the-job retired."

Communication and Problem-solving

Staff members report not receiving information from supervisors in a timely manner. This is especially true of direct care communications such as medications for residents and changes in patient conditions.

In the ombudsman's report of January 1988, it is stated, "Problem-solving at the supervisory level and/or care plan sessions do not appear to be effective nor is it carried through to the direct care of the resident. In the past, the nursing organizational structure has had limited authority to influence the direct care providers, the health service technicians. When problems occur, it has not been clear as to how to define the problem or where to seek assistance for a solution. Consequently, problem situations were left unidentified and therefore unaddressed, resulting in situations that could have been anticipated and/or averted."

Conclusions

The Management Analysis Division concurs with Commissioner Ashton's conclusion that there has been a management failure to recognize the patterns of serious deficiencies and address them with staff training, supervision, follow-through and accountability.

Specifically, the home has lacked basic management structures including a planning system at all levels, a dependable mechanism for assessing basic resource needs, and effective line supervision.

Relationships with the unions and veterans organizations need attention. The lines of authority and structures for interaction and decision-making are not clearly established. Sometimes health care needs of residents have become secondary to the priority of maintaining good relationships with veterans organizations.

Recommendations

1. Implement a comprehensive organization development program to create the needed management systems at the home. Include planning and decision-making systems, leadership development and a clear delineation of the chain of command from the administrator to the line staff.

2. Involve the staff closely in the design of these systems in order to foster their full cooperation in the implementation phase. The study team found during the interview process that staff are very knowledgeable about the issues and often have practical and innovative suggestions for improvements.

3. Institute an aggressive program to upgrade the competence and skills of line supervisors. Those who are not willing or able to be trained need to be fired or moved to other roles. The training needs to emphasize professional information and team management skills, with a particular emphasis on the development of "people" skills. See "Human Resources Management," p.97, for further recommendations on training.

4. Empower the administrator and top management by clarifying and delineating responsibilities and establishing team norms and practices. The team should develop a strategy for bridging the gap among them, line supervisors and staff.

5. Develop and install resident-oriented service values through training and orientation of all staff and develop structures which support the front-line care providers to give good service. The focus of leadership should be on serving those who serve the residents rather than seeing line staff as servants of the supervisor and managers.

6. Solicit the unions' assistance in the development and implementation of the transition plans for the home and work toward handling operational issues less formally within work teams.

7. Formalize the relationship with veterans organizations by creating systems for communication and decision-making between the home and the organizations, such as the VA Medical Center model for coordinating volunteer group resources with facility needs. Develop a mutual understanding focused on the need to see resident care as the priority value in planning and decision-making.

HUMAN RESOURCE STRUCTURES

Commissioner Ashton Conclusion:

"[There has been] insufficient management attention to planning human resource needs.

"A health care facility's employees are its most important resources. Minnesota Veterans Home management has not paid sufficient attention to planning human resource needs.

"Management concern about a projected shortfall in Fiscal Year 1987 resulted in keeping positions vacant, not allowing supervisors to hire temporary help to replace employees on extended medical leaves, and cutting resident work hours.

"Following the reinspection of the home in March 1987, Minnesota Department of Health and Department of Human Services staff did an analysis comparing staff levels at other state nursing homes, Ah-Gwah-Ching and Oak Terrace, and documented a shortage of staff assigned to housekeeping, maintenance, sanitation, dietary services and nursing at Minnesota Veterans Home.

"The Department of Human Services/Minnesota Department of Health analysis documented the need for an additional 10 positions beyond the 32 in the governor's budget for a total of 42 full-time equivalents. (The original Minnesota Veterans Home budget request for Fiscal Years 1988-89 included 72 additional staff. Because of insufficient demonstration of the need for the additional 72 staff positions by the Department of Veterans Affairs, the Department of Finance had reduced the request to 32 positions which were included in the governor's budget.)

"Numerous vacancies continue to exist in the current fiscal year. Some vacancies can be attributed to attrition and staff movement to new positions within the Minnesota Veterans Home. However, insufficient attention has been given to human resource planning which would ensure that vacancies are filled in a timely manner, temporary and emergency help are retained when necessary, and priorities are established when resources are limited."

Findings

Additional investigation disclosed that 32 positions were approved by the Department of Finance because that number could be paid for with the balance in Veterans Affairs' special revenue fund.

In general, most of the traditional activities of a human resources management system are inadequate at the home. The Human Resource Management Chapter of this report contains additional findings and conclusions in this area. The traditional activities are the following:

Staffing: Employment planning, Equal Employment Opportunity act implementation, recruitment, selection (hiring)

Development: Orientation, training and employee development programs, performance evaluation

Employment Relations: Worker participation in decision-making, career development, employee assistance, employee security, employee rights, labor relations

Compensation: Pay level and structure determination, individual pay and administration, benefits

Evaluation: Human resource information systems, evaluation and monitoring of all human resource activities

Although the Department of Employee Relations provides many good resources in all these areas, the home has not had an effective human resources management program to direct the activities and utilize the state services.

Conclusions

The Management Analysis Division concurs with Commissioner Ashton's conclusion that there has been insufficient management attention to planning human resource needs. However, "insufficient documentation" was not the sole reason that Veterans Affairs' budget request was reduced to 32 positions.

Recommendations

1. Design, staff and install a comprehensive human resources management program at the Minnesota Veterans Home, including the activities of staffing, training and development, compensation, employment relations and evaluation. See recommendations in the Human Resources Management chapter for further detail on this subject.

2. Make human resource management a top priority for the leadership team of the home.

CHAPTER 5: HEALTH CARE MANAGEMENT

The Minnesota Veterans Home in Minneapolis is licensed by the Minnesota Department of Health to provide nursing care for 346 patients and boarding care for 194 residents. The Minneapolis home is reimbursed by the federal Veterans Administration for providing this care to eligible veterans.

The care provided to residents of the Minnesota Veterans Home in Minneapolis is a multidisciplinary effort on the part of the many different departments/services described in this chapter, such as nursing services, physician services, social services, pharmacy services, rehabilitation services, volunteer services, dietary services and housekeeping services.

One important criterion used to assess a facility's ability to properly manage its health care component is its licensure and inspection history. The Minnesota Department of Health Office of Survey and Compliance routinely inspects nursing care homes and boarding care homes in accordance with applicable state statutes and regulations governing those facilities. Additionally, the Veterans Administration inspects facilities which have contracts to provide nursing care and domiciliary care to eligible veterans according to VA standards.

According to the commissioner of health's August 1987 report to the governor, the Minnesota Veterans Home in Minneapolis has a history of difficulty in maintaining compliance with applicable statutes and regulations governing nursing care and boarding care facilities. The report states that 119 correction orders were issued to the home from 1981 through 1987. Of the 119 correction orders, 71 were issued during the three most recent annual licensing surveys. Health Department records also show that 87 correction orders were issued to the home as a result of annual inspections conducted from 1977 through 1980.

Research conducted by the Management Analysis Division revealed that, in comparison to other similar facilities in the state, the Minnesota Veterans Home in Minneapolis has a poor regulatory history, with respect to the number of correction orders issued by the Health Department during licensing inspections.

The study team researched Health Department files to determine the number of correction orders issued to other similar nursing care and boarding care facilities in the state. The three most recent annual licensing inspections were studied for each facility. Research showed that the average number of correction orders issued to a sample of dual-licensed (nursing care and boarding care) facilities during annual inspections was 6.9, while the corresponding average for the Minneapolis home was 23.7. The average number of correction orders issued to a group of large nursing care homes during annual inspections was nine, while the corresponding average for the Minnesota Veterans Home in Minneapolis was 22.7 (violations applicable to the Minneapolis home's boarding care component were not included in this average).

The home's potential for fines (not actual fines assessed) based on correction orders issued during its three most recent licensing inspections was between $16,000 and $17,000. Corresponding averages for other facilities studied were $5,025 (dual-licensed) and $6,718 (nursing care). (Tables, methodology and a more detailed analysis are included in Appendix F.)

In addition to the unusually large number of correction orders issued to the Minneapolis home, there is concern among health care officials about repeated violations in the same areas and failure to correct items within designated time frames.

> Repeated violations over the years have been of a serious nature and include inadequate staff to meet the nursing needs of domiciliary residents, medications not administered as ordered by physician, inadequate assistance for residents with grooming and during mealtimes, inadequate supervision of residents who self-administer medications, unsanitary conditions in the dietary area, inappropriate handling of soiled linen, numerous housekeeping and physical plant deficiencies and violations of the Vulnerable Adults Act and Patient Bill of Rights.
>
> Analysis of VA inspection reports also shows that the home has a history of failing to meet VA standards for nursing care and domiciliary care. Many of the VA-noted deficiencies have been repeatedly cited by the VA, and directly correspond to deficiencies cited by the Health Department over the years.

Twenty-one fine assessments have been issued to the home by the Health Department from 1981 through 1987 for failing to correct deficiencies within specified time frames. The home is not subject to federal certification requirements for Medicaid and Medicare. Federally certified facilities are faced with losing a major source of funding if they fail to meet federal certification requirements, whereas the home has been subject only to Health Department fines. Although the VA has cited the home for not meeting its standards for nursing care and domiciliary care in recent years, it has not withdrawn per diem reimbursements from the home.

In addition to the home's regulatory history, interviews with health care advocates, management, staff, residents and family members also revealed that there are numerous problems related to health care management that must be addressed.

The specific nature of Health Department correction orders and VA-noted deficiencies, as well as the concerns of other health care officials/advocates, residents, family members, employees and the home's current management, will be discussed in the pertinent sections of this chapter.

NURSING SERVICES

Findings

Nursing services are provided for both nursing care and domiciliary residents, based on the level of care needed.

Table A on the next page shows the distribution of the Minneapolis home's residents based on the level of care needed as determined by the case-mix system. This system classifies residents according to their primary and secondary diagnosis and the total number of key activities of daily living in which they are considered to be dependent. Key activities of daily living are as follows:

* Dressing
* Grooming
* Bathing
* Eating
* Bed mobility
* Transferring
* Walking
* Toileting

Weighted scores are applied to the activities and a determination is made as to a resident's dependency. The scores are then classified into the following scheme:

Classification	Weighted score
A - Low dependence	1.00
B - Low dependence-behavior	1.30
C - Low dependence-special nursing	1.64
D - Medium dependence	1.95
E - Medium dependence-behavior	2.27
F - Medium dependence-special nursing	2.29
G - High dependence	2.56
H - High dependence-behavior	3.07
I - Very high dependence (eating)	3.25
J - High dependence-neurological impairment	3.53
K - High dependence-special nursing	4.12

TABLE A

DISTRIBUTION OF RESIDENTS OF
THE MINNEAPOLIS VETERANS HOME
Based on case-mix level of care
(as determined by 8/87 Q & R review)

Level of Care		Skilled Nursing Care Residents		Domiciliary Residents	
A		121		138	
B	Low dependence	26	(55%)	7	(100%)
C		25		1	
D		26		--	
E	Medium dependence	13	(15%)	--	
F		8		--	
G		19		--	
H		11		--	
I	High dependence	16	(30%)	--	
J		24		--	
K		26		--	
Total		315		146	
Average Index		1.99		1.01	

As Table A shows, nursing care patients require a much higher level of care than do domiciliary residents.

Nursing care patients may need assistance with activities of daily living, medications, and special nursing treatments such as catheterizations, tube feedings and wound treatments. Oxygen therapy and intravenous feeding and intravenous medication are not provided at the Minneapolis home.

Nursing services for domiciliary residents include supervision of residents who self-administer medications and supervision of activities of daily living. Staff also monitor residents to ensure they attend scheduled medical appointments. If residents are unable to self-administer medications, medications are then administered by nursing services staff.

Nursing services are concentrated in Buildings 16 and 17, which house the home's nursing care residents. Nursing care residents are placed in various units/floors within these buildings according to the level of care needed, with the most independent residents on the second floor of Building 17 and the heaviest care patients on the fourth floor of Building 17.

Nursing care residents are moved to different floors if their condition requires a different level of care. Similarly, domiciliary residents are moved to the appropriate nursing care buildings if they require a higher level of care.

Nursing services is by far the largest department at the home. The department will have a staff complement of 235 employees if management secures permanent funding for the emergency positions recently granted by the Legislative Advisory Commission. In recent years, nursing units were staffed by various combinations of the following positions:

<u>Licensed Staff</u>

Registered nurse supervisors
Registered nurses
Licensed practical nurses

<u>Unlicensed Staff</u>

Assistant group supervisors
Program assistants
Human services technicians (nursing assistants)

RN supervisors supervised licensed staff and assistant group supervisors supervised unlicensed staff. Both RN supervisors and assistant group supervisors reported to the director of nursing. The assistant group supervisor positions were eliminated as of January 15, 1988. All staff within a unit now report to RN supervisors.

A review of recent VA and Health Department inspection reports revealed that the home has been cited for many deficiencies related to nursing services:

The home was issued 35 correction orders by the Health Department in July 1987. Ten of those related to nursing care problems such as:

* inadequate general nursing procedures and aseptic techniques

* errors in the administering of medications

* lack of follow-up charting on identified medical problems

* medications and records left unattended

* failure to notify physician about an instance of projectile vomiting.

Nursing care problems cited by the VA during its October 1987 inspection were:

* overall objectives/goals of nursing not stated in policies

* lack of inservice training on patient care topics

* no documentation of rehabilitation in medical records

* no documentation of nutritional intake for some patients

* numerous charting errors concerning the administration of medications

Repeated problem areas cited by the Health Department and/or VA over the years have been:

* inadequate staffing to meet the nursing needs of domiciliary residents

* medications not being administered as ordered by physician

* inadequate supervision of domiciliary residents who self-administer their medications

* nonexistent or ineffective quality assurance, utilization review and infection control mechanisms

Interviews with health care officials/advocates and management revealed that, in their professional opinions, the nursing care provided at the home has not met standards of care provided in other nursing care facilities. One individual stated that the care is comparable to the bottom 25 percent of the care in private facilities throughout the state.

Staff who were interviewed seemed generally unaware of the seriousness of the home's regulatory history with respect to the quality of nursing care provided. When asked if residents received adequate care and services, 37 said "yes" and 26 said "no." Those who responded in the negative often cited the lack of time for social interaction with residents and the inability to provide "extras," as opposed to relating systemic problems such as medication errors and treatment procedures.

Family members contacted through a focus group and survey cited instances of medication errors, treatment errors and poor communication between nursing care staff. They generally felt a strong need to monitor the nursing care provided.

Staff interviews revealed that direct care employees were generally unaware of any policies or procedures which established systemwide standards for nursing care. Human Services management found previous policies and procedures in place to be inadequate. More than one employee stated that the quality of care depended on the employees working a given shift or the standards of the various supervisors. In a survey sent to family members, scores for the quality of care provided differed significantly, depending upon which floor the resident resided on (see Family Member Survey, Appendix C).

According to Human Services management, nursing care plans have tended to be vague and have lacked specific approaches to identified needs. Management reports that, in the past, the interdisciplinary care planning process was not seen as a priority. Employees lacked training on the care planning process and did not sufficiently relate care plans to their daily work. A report by the home's ombudsman states that "problem solving at the supervisory level and/or care plan session does not appear to be effective, nor is it carried through to the direct care of the resident."

State regulations and VA standards require that nursing homes have an active program of rehabilitation nursing care directed toward assisting each patient to achieve and maintain his highest level of self-care and independence by such measures as proper positioning of patients confined to their beds, making efforts to keep patients active and out of bed for

reasonable periods of time, bowel and bladder training programs and encouraging patients to achieve independence in the activities of daily living, transfer and ambulation. According to Human Services management, mechanisms for rehabilitation nursing have been weak and need much development.

The ombudsman's report also states that "those persons providing direct care do not appear to have a basic understanding of the aging process and caring for those who are highly dependent or [disoriented] as evidenced by excessive noise and activity levels, giving too many directives or instructions at one time, addressing the resident from the side or behind, pulling residents backwards in geri-chairs, spinning residents around in wheelchairs or changing directions too rapidly, leaving residents in geri-chairs for long periods of time and feeding residents too rapidly and not observing residents during the feeding process.

According to interviews with employees and management and Commissioner Ashton's recent report to the governor, consistent, strong floor supervision has been lacking within the nursing units.

> Many employees stated that problem employees were not monitored or disciplined and that supervisors were not accessible when problems or questions arose.
>
> Several of the employees interviewed did not trust the judgment and nursing skills of their supervisors.
>
> Human Services management also pointed out that the supervisory and nursing skills of some of the nursing supervisors and assistant group supervisors are not particularly strong, and stressed the importance of strong supervisors who could set positive examples for staff.
>
> Family members also saw a need for stronger floor supervision and cited cases of employees who did not attend to patient care needs.

The dual supervisory system within the nursing units has been cited as a problem by health care officials as well as by nursing care staff. Human services technicians (nursing aides) previously reported to assistant group supervisors who did not have nursing backgrounds, and licensed staff reported to RN supervisors. This limited the authority of nursing staff to direct the activities of human services technicians

and reportedly created a "rift" between licensed and unlicensed staff. Employees were especially frustrated about this situation because human services technicians, who are primarily responsible for assisting residents with activities of daily living (eating, toileting, etc.), spend the most time with residents and have valuable input about changes in resident conditions.

Staffing shortages have existed in the nursing services department.

A formal system for monitoring overall nursing hours and determining the appropriate ratio of direct care staff to residents for specific units did not exist until Human Services management implemented the case-mix system used by Minnesota's long-term care facilities to determine reimbursement rates based on the level of care provided. In early 1987, the home conducted a resident assessment using the RUG (Resource Utilization Groups) system developed in the State of New York. However, no long-term formal staffing plan was developed in conjunction with this assessment.

The home, in recent years, has had to pull nursing staff away from nursing care units to provide coverage in the domiciliary units due to repeated Health Department citations related to supervision of residents who self-administer medications. While these employees were not permanently assigned to the domiciliary, the time spent attending to the needs of these residents diluted the time spent in caring for nursing care residents.

Direct care staff have been pulled away from nursing care duties to restock linens and sort mail.

Employees voiced a major concern about being asked to work extra hours on a somewhat regular basis due to staff shortages and high rates of absenteeism.

There have been limited training opportunities for direct care staff.

The VA, for the past two years, has cited the home for insufficient inservice training for nursing personnel. Most other nursing homes have strong inservice training related to patient rights and care topics because it is required for purposes of federal certification.

Most employees, as well as family members, felt that the brief orientation for human services technicians who had not completed a certified nursing assistant program prior to their employment resulted in employees being placed on the floor before they were capable of handling basic duties.

Many nurses stated that they felt out of touch with basic standards or new approaches that exist in the health care community at large.

Some nurses were not aware of procedures to be used for residents returning from the VA Medical Center who required specialized treatments.

The home has had no formal internal mechanisms with which to monitor and assure quality care on an organizational level. The VA, in recent years, has cited the home for non-existent or ineffective committees on quality assurance, utilization review and infection control. Commissioner Ashton's report to the governor notes the absence of an effective patient care policy committee, which is required by state regulation (Minnesota Rules 4655.1400, Section G) in order to develop policies and procedures related to patient care.

Management has taken steps to address many of the problems related to nursing services:

A follow-up inspection conducted by the Health Department to determine compliance with the July 1987 correction orders found that all correction orders related to nursing care had been corrected or partially corrected and that management had conducted inservice training, developed policies and procedures, and created new systems to address some of the problem areas.

Veterans Affairs management obtained 24 additional direct care staff positions in its budget request for Fiscal Year 1988. The Legislative Advisory Committee recently approved Human Services' request for additional nursing staff positions. Management stresses that the staffing resources requested were those which would minimally be required to provide basic services and meet fundamental resident needs. Continued funding for these positions will be requested during the next legislative session.

Some of the nursing positions granted by the Legislative Advisory Commission have been used to permanently establish twenty-four-hour nursing services in the domiciliary units to address Health Department citations for inadequate supervision of these residents.

Management recently hired a quality assurance coordinator whose priorities will be care planning, monitoring compliance with federal and state requirements and ensuring quality care. As of December 23, 1987, a new quality assurance committee was created. Management is planning to implement effective utilization review, infection control and patient care policy committees.

The assistant group supervisor positions were eliminated and all nursing care staff now report to RN supervisors. The number of RN supervisor positions has been increased in order to provide better supervision of direct care staff.

Management has enlisted the services of a consultant to assist various departments with revising and/or creating policies and procedures. Nursing care policy and procedures manuals will be placed in all units.

Management will request funding for additional staff development positions during the next legislative session to expand training opportunities.

Management, in keeping with most nursing care facilities, will no longer hire human services technicians who have not completed certified nursing assistant programs.

Conclusions

Until recently, nursing care provided to residents has been consistently unacceptable.

In the absence of effectively functioning quality assurance mechanisms, it is difficult to truly assess the quality and effectiveness of care provided in areas not addressed by regulatory agencies.

There have been staff shortages which can account for some of the problems in this area.

The absence of strong floor supervision, standard policies and procedures, effective organizational structures, adequate training opportunities, formal quality assurance mechanisms and effective interdisciplinary care planning have been major contributors to the problems that have existed.

Recommendations

1. Management should proceed with plans to secure permanent funding during the next legislative session for the nursing positions recently granted by the Legislative Advisory Committee.

2. The director of nursing, in conjunction with the new quality assurance coordinator, should focus her efforts on meeting basic standards for patient care in accordance with state regulations, VA standards and industry-wide standards. This should be accomplished by:

   ensuring that policies, procedures and inservice training related to patient care are developed in accordance with the above-referenced standards, made available to all nursing personnel, and updated accordingly, and

   implementing internal monitoring mechanisms to ensure compliance with these standards in each nursing unit.

3. Management should guarantee strong floor supervision by:

   recruiting highly qualified and experienced individuals for RN supervisor positions, and

   adopting the "working" supervisor model, whereby RN supervisors focus on effective service delivery, monitoring patient care outcomes and providing clinical guidance to subordinates.

4. Management should continue to use the case-mix system to ensure adequate staffing levels and placement of residents consistent with the level of care needed.

5. Management should establish and/or strongly support effective committees on quality assurance, utilization review, infection control and patient care to assess quality of care on an organizational level and identify and correct specific problem areas. The creation of a quality assurance coordinator position is strongly endorsed.

6. In order to bridge the gap between licensed and unlicensed staff, management should provide training on teamwork. Such training should be provided for each nursing unit and should stress the common goals related to patient care that must be achieved in each nursing unit, the nature of the duties required of the various positions and how those duties are interrelated, and the necessity for teamwork and cooperation in order to achieve common goals.

7. Management should monitor and support interdisciplinary care planning conferences. Better communication between supervisory nursing personnel attending care planning conferences and those providing direct patient care should be accomplished by regular timely staff conferences. The conferences could be tape-recorded for those unable to attend.

8. Management should provide adequate inservice training for nursing personnel, with emphasis on rehabilitation nursing and gerontology, by using community educators with expertise in these fields and/or highly qualified employees within the home.

SOCIAL SERVICES/PROGRAMS/THERAPIES

Findings

One major issue which arose during staff interviews and in assessments of the home by health care officials was that the home has, by virtue of its broad mission and admissions policy, many subpopulations within its walls -- all with individual needs which require different levels of care and programs. Nursing care patients and domiciliary residents require different programs and levels of care. There are further distinctions within the domiciliary, where some residents need short-term rehabilitation or supportive after-care and others need more long-term health maintenance care.

Social Services

The responsibility for assessing, monitoring and providing for the psychosocial needs of the home's residents has fallen in large part to the home's social services department. Social workers act as case managers and periodically receive multidisciplinary input through care planning conferences.

Typical duties of social workers include completing admissions social service summaries and assessments, participating in quarterly care planning reviews with the treatment team, serving as liaison between residents and the community (families, outside providers, income maintenance programs and courts), conducting discharge planning services, and monitoring resident rights protection.

There is a growing concern among social services personnel and health care professionals that, given the large case loads social workers must handle, many domiciliary residents will become dependent on the home when, with the appropriate level of attention (e.g., discharge planning), they might be capable of functioning at a more independent level within the community.

The VA has twice noted that the ratio of social workers to residents is unacceptable. Ratios have normally been one social worker to 120-150 residents, while the VA recommends one to 60. According to a recent VA inspection report, psychosocial assessments were not present in all charts, progress notes were inadequate or non-existent and additional staff was needed to facilitate meaningful discharge planning and treatment goals.

A recent assessment of social services conducted by personnel from another Human Services facility noted that social service staffing in the domiciliary units was not sufficient to provide active and appropriate discharge planning services in addition to daily social service needs of residents.

Interviews with health care advocates concerning the nature of ombudsmen's services over the years revealed that the home has sometimes been dependent upon ombudsmen for routine tasks that would ordinarily be performed by social services staff. Advocates saw a need for training on advocacy, ethics and availability of community resources.

The Human Services assessment also found that "case load size dictates that care plans and most interventions with residents are superficial and, at times, irrelevant to clinical needs." In addition to recommending additional social worker positions, the report also recommended the creation of a social services aide position to handle the large amount of clerical functions now being performed by social workers, who need to spend more time on counseling and meaningful discharge planning.

The assessment notes that "sound social work principles are carried out to the best of the staff's ability given the high case load size. Without exception, the social work staff have, to some extent incredibly, maintained a caring attitude toward residents and an enthusiasm about providing quality services."

Veterans Affairs management requested two additional social worker positions during its Fiscal Year 1988 budget request, but was denied funding for these positions. Human Services management recently converted one of the abolished assistant group supervisor positions into a senior social worker position. It will request additional social services positions during the next legislative session.

Programs

Mental Illness Component

According to a case-mix assessment conducted in the home in August 1987, approximately 38 percent of the home's residents have some type of mental illness diagnosis.

An assessment of the home conducted by the Human Services Mental Health Division notes that "persons with mental illness often require assistance and programming to meet basic needs in: housing, employment, medication management, transportation, psychosocial rehabilitation, independent living skills, crisis assistance, assistance in applying for benefits, development, identification and monitoring of living arrangements, client outreach and case management."

According to the above assessment, VA inspection reports and staff interviews, the needs of mentally ill residents have not been appropriately assessed, monitored, served or case managed.

The home has not had a psychologist or psychiatrist on its staff.

Admissions personnel have not had access to mental health providers/consultants or current clinical assessments when making decisions regarding the appropriateness of placement.

The VA has noted that there are no clinical mental health professionals on the home's staff to conduct clinical assessments either during the admissions process or on an ongoing basis. Similarly, an assessment conducted by the Human Services Mental Health Division revealed that "residents may or may not have clinical assessment data prior to admission," and that assessments done after admission were conducted by a bachelor's-level social worker, which "is not enough."

The home does not participate in pre-admission screening. The absence of any formal pre-admissions link with outside mental health providers could result in the inappropriate placement of individuals who might be better served by community programs or higher levels of care.

Once admitted, ongoing assessment, monitoring and treatment of mentally ill residents are conducted by employees with no clinical mental health background/training, and with inadequate access to mental health professionals.

Staff interviews revealed that many employees feel ill-equipped to monitor and serve the needs of these residents, especially in crisis situations, in view of the fact that they have little or no training in mental health and/or the effects of psychotropic medications.

The Human Services assessment noted that case managers had no access to clinical supervision or consultation with mental health professionals and that there was no consistent procedure between the VA Medical Center and the home for making treatment decisions, including crisis intervention.

The VA, as well as employees, saw a need for a psychiatrist and/or clinical psychologist on staff to conduct ongoing assessments and provide consultation to staff. Nurses with mental health backgrounds were also recommended.

Management recently secured a psychologist III (clinical psychologist) position which will come under the direction of the assistant administrator for care-related services. This may help to address the need for clinical assessments and guidance of social workers. The proposed contract with the VA Medical Center for physician services also provides for a .5 full-time-equivalent psychiatrist, who, according to management, would work closely with the clinical psychologist.

Chemical Dependency Component

Twenty-three percent of the Minneapolis home's residents have a diagnosis related to chemical dependency. According to staff, many of these residents have been resistant to traditional forms of treatment.

The Minneapolis home employs two chemical dependency counselors who participate in care planning, conduct interventions and make referrals to various community treatment programs. AA meetings and support groups are held two days a week. According to Human Services management, more one-on-one interaction between chemical dependency counselors and residents is needed to keep residents involved in treatment.

Residents in need of in-patient treatment for chemical dependency are normally transferred to outside health care providers, primarily the VA Medical Center. Outpatient chemical dependency referrals to community programs have also been made.

Neither the Hastings nor Minneapolis home have licensed programs for the active treatment of chemical dependency. The Hastings home has an AA-based program with strong emphasis on relapse prevention. Residents who enter the Serenity Program reside in a segregated 30-bed unit and sign a contract which requires attendance at AA meetings and support groups. The Minneapolis home has no equivalent to the Serenity Program.

The majority of employees interviewed had no formal training in chemical dependency or enabling behaviors. Employees are confused about the home's mission with respect to treatment of residents who are chemically dependent, and see no real "program" in existence to provide supportive after-care for these residents.

Of considerable concern to staff and outside health care experts/agencies is the unmonitored availability of alcohol in the home.

> The home has an unmonitored vending machine from which beer can be purchased. The machine is open from 1 p.m. to 10:30 p.m. and consumption is normally 20 to 22 cases a week. Current management reports that receipts from the beer machine are approximately $1,000 a month at 50 cents a can.
>
> Veterans groups occasionally sponsor activities where alcohol is provided. Veterans Affairs management states that these functions were monitored by staff. However, staff interviews indicate this was not always the case.

The home has not had clear policies to address the provision of alcohol by volunteer groups or monitoring access to alcohol in the home. The unmonitored availability of alcohol in the home is viewed by staff and health care professionals as detrimental to the interests of chemically dependent residents who need to live in a supportive chemically-free environment and residents who have health conditions which are negatively affected by alcohol. Employees and management cited instances of residents being intoxicated. In one of the instances cited, the home had to call 911 because an intoxicated resident's blood pressure rose to a dangerous level. Interviews also revealed that employees do not always report residents who abuse chemicals in the home.

The VA strongly recommended that access to alcohol be monitored and managed. Many employees feel there is a need to eliminate the availability of alcohol in order to provide quality health care consistent with community standards, given the home's chemically dependent population. Others recognize that some of the home's residents can responsibly engage in social drinking without negative effects to their health.

The Hastings home had a beer machine and reduced consumption from 30 to 5 or 6 cases a week by limiting the types of beer offered, limiting the hours the machine is open, and introducing more non-alcoholic beers. The machine was recently closed down in accordance with a VA recommendation calling for a drug-free environment.

In accordance with the VA's recommendation, management is reviewing and revising policies and procedures related to chemical dependency and exploring mechanisms for monitoring the availability of alcohol.

Alzheimer's Residents

Residents with Alzheimer's disease and other forms of dementia constitute another subpopulation within the home.

No formal program to deal with the special needs of these patients has existed, although a number of the Alzheimer's residents are placed within a specific unit in Building 16. Staff interviews revealed that the home's decision to care for these patients was not accompanied by any type of program planning or specialized training for employees who are responsible for the direct care needs of these patients.

Although the home employs program assistants in this unit (as well as other units), they do little by way of specialized programming for Alzheimer's residents and spend the majority of their time attending to the more basic needs of patients.

Employees who work closely with these patients expressed frustration with management policies and decisions, which they feel are based on limited knowledge about the special needs of Alzheimer's patients.

Examples cited were:

> The decision to house Alzheimer's residents, who have a tendency to wander, in Building 16, which sits on a steep embankment near the river. Current management recently extended the fence that runs along this embankment.
>
> Installation of an alarm system in Building 16, which aggravates the residents. Building 16 was designed, and first used, for domiciliary care. Its doors cannot be observed from the nursing station. State regulation requires that all doors not visible from the nursing station have alarms. The state fire code prohibits doors which lock from the inside unless special waivers are granted.
>
> Abiding by the standard practice of reducing direct care staff on the evening shift, when Alzheimer's residents experience the "sundown effect," whereby they grow more agitated and difficult to handle. Current management notes that it recently added more positions to this shift.

As of January 1988, management created a position for an Alzheimer's program director who will report to the director of nursing. This individual will review past activities and establish a committee to participate in the development of the program.

Therapies

The home's rehabilitation therapy unit is staffed by a director and therapists who provide corrective and recreational therapy services and coordinate the work therapy program.

Corrective therapy encompasses some of the same modalities as rehabilitation nursing, in that some of the typical activities include walking, range of motion, etc. It is viewed by current management to be more a form of recreation and exercise than a structured therapy. Corrective therapy is used only within the VA system. Management reports that the VA is considering discontinuing its use. It has been used primarily for younger veterans with psychiatric problems who learn how to exercise to relieve stress.

Recreational therapy normally takes place in large groups, as opposed to individualized or small group activities. Typical activities might include mental stimulation through games, socialization groups, outings to picnics, baseball games and restaurants. Recreational therapy receives substantial financial support from veterans groups who sponsor and participate in some of the activities. Family members and residents who were contacted were generally pleased with the activities offered, some considering them to be one of the strongest features of the home.

The unit also coordinates the work therapy program which enables the residents to work within the home.

There are several concerns about the therapies offered at the home:

Acute rehabilitation therapy, such as physical therapy, occupational therapy and speech therapy, is not provided. Residents who require physical therapy are transported to the VA Medical Center. Current management stresses that these therapies are standard, necessary services in comparable nursing home facilities throughout the state.

Recent VA inspections have found the ratio of therapists to patients to be unacceptable. Ratios have normally been 1:100+, while the VA recommends 1:60. The VA noted that the home's population had tripled in the past 10 years while the home's complement of corrective therapists had remained at its original level. The VA also noted that there was limited corrective therapy for domiciliary residents to address issues of physical fitness and self-image.

The VA recently noted that "individualized functional needs are not assessed as need develops if not presently on the therapy roster. Those needs encountered due to age and progressive disabilities are 1) adaptive equipment and 2) retaining functional level with maintenance therapy before restorative therapy is needed." The VA recommended additional rehabilitation staff, specifically occupational therapists, to provide adaptive equipment assessments and training, and activities of daily living training.

Most recreational activities take place in large group settings. Staff see a need for more one-on-one activities, and are receptive to using volunteers. Current management also sees a need for more structured small group participative activities, as opposed to large group observational activities. Residents and family members see a need for more participation in activities and feel that the home's non-ambulatory residents are excluded from many of the large group outings.

The number of hours of resident work at the home has declined from 148,000 in Fiscal Year 1984 to 64,000 in Fiscal Year 1987. The home has been criticized by the Health Department in recent years for overreliance on resident workers to perform duties that should be assigned to regular staff. Documentation regarding the therapeutic value of this type of work had been lacking. The VA recommended that the work therapy program take on a more vocational role in order to enhance the quality of life and facilitate discharge planning goals. Staff is also receptive to refocusing this program and has suggested that vocational training and job placement services be added.

Human Services management plans to request additional rehabilitation therapist positions to bring therapist/resident ratios in line with VA recommendations. The rehabilitation program will be assessed to determine the need for physical, occupational and speech therapies at the home as well as to measure the ability of the current therapies to meet individual needs of domiciliary and nursing care residents.

Conclusions

Programs and/or services to meet the specialized needs of a diverse resident population have been inadequate.

This can be attributed to many factors:

The home's broad mission statement has not clearly defined which specific groups can be best served by the home and whether its efforts should be aimed at short-term acute rehabilitation, supportive after-care or more long-term health maintenance care, especially with reference to domiciliary residents.

The lack of effective assessment and screening mechanisms during the admissions process has meant residents' needs have not been adequately defined and appropriate placement of residents has not been ensured.

Unacceptable staff-to-resident ratios in areas most responsible for the monitoring and rehabilitation of residents have led to superficial discharge planning, care planning and intervention.

The absence of staff with professional backgrounds in areas related to specialized needs of residents (mental health, Alzheimer's, etc.) and limited financial resources have limited the home's ability to develop specific programs in these areas and to provide guidance to staff who work with these residents on a regular basis.

Recommendations

1. Management should proceed with plans to request additional positions in the areas of social services and rehabilitation therapy consistent with VA guidelines for appropriate staff/resident ratios in order to ensure more individualized treatment goals and discharge planning.

2. Management should proceed with plans for adding an Alzheimer's program coordinator, clinical psychologist and psychiatrist (see "Health Care Management: Physician Services," p. 75) to its staff. Management should make certain that these individuals are available to provide consultation and training to staff who deal with residents on a daily basis.

3. Management should participate in formal pre-admissions screening to ensure that community-based alternatives for treatment have been exhausted and residents are appropriately placed within the home. Management should provide training for social services personnel in the areas of advocacy and community resources in order to maximize ongoing use of community-based alternatives for treatment.

4. Mental health assessment services or diagnostic and evaluation services, including a professional determination of the nature of the resident's problems, factors contributing to them, and the assets and resources available to meet individual needs, should be conducted prior to admission and monitored by mental health professionals.

5. Given the large number of residents who have an alcohol-related diagnosis, all applicants for admission should receive a chemical-dependency assessment as part of the admission screening process, which should include a personal interview and the use of a chemical abuse instrument.

6. Management should assess the rehabilitation therapy program to determine whether currently offered therapies meet the individualized needs of residents, and if there is need for more acute rehabilitation therapies, such as physical, occupational and speech therapies, as offered in other similar facilities.

7. Management should provide staff with training in chemical dependency and enabling behaviors, mental illness and Alzheimer's/dementia.

8. Management should create policies and procedures to address the provision and consumption of alcohol.

   Policies addressing the consumption of alcohol must distinguish between residents who are not negatively affected by responsible consumption of alcohol, and those who, by virtue of their diagnosis, should abstain from the consumption of alcohol.

   Policies addressing the provision of alcohol should state that alcohol can be provided only at planned social events which are staffed by social services and/or nursing personnel. Such personnel must then enforce policies relating to the consumption of alcohol.

9. Before making major programmatic changes, management, in conjunction with the Hastings home, the VA and other outside providers, must review its role and mission with respect to the levels and types of services/programs offered, based upon the needs of the veteran population it serves, the effectiveness of its currently offered services and/or programs and the effectiveness and availability of the services/programs that exist in the community at large.

PHYSICIAN SERVICES

Findings

Prior to January 1986, physician services for the Minneapolis home were provided by one full-time physician who was employed by the Minneapolis home and reported to the administrator.

In January 1986, the home's physician died unexpectedly. Physician services were then provided by two VA Medical Center physicians on an emergency basis in absence of a formal contract. Physicians were directly reimbursed by the state on an hourly basis. As of July 1, 1986, the Minneapolis home formally contracted with the VA Medical Center for a medical director and 1.65 full-time-equivalent physicians. Personnel remained under the direction of the VA Medical Center, which was reimbursed by the home for physician services.

The home also contracts for dental, optometry and podiatry services. In addition to these services, residents have access to specialists, emergency care and hospitalization, primarily through the VA Medical Center.

Various sources report that, prior to the utilization of VA Medical Center doctors, medical services were less than optimal:

A quality assurance review conducted by the Department of Health in 1980 noted the following deficiencies:

insufficient use of and poor coordination with the VA Medical Center;

lack of medical diagnoses status, complete progress notes and lab work in charts reviewed;

unspecific diet orders;

no procedures for monitoring diabetics.

Staff interviews conducted during the Management Analysis Division study revealed that before January 1986, coordination of patient care with the VA Medical Center was especially poor and that the relationship between the home and the VA Medical Center could be described as antagonistic. It was not uncommon for residents to be sent to the VA Medical Center without appropriate documentation and to experience difficulties in being admitted or treated.

Staff, management and residents report that medical services have improved since January 1986 as a direct result of contracting with the VA Medical Center for physician services:

Both staff and residents acknowledge the importance of using physicians who are familiar with the VA "bureaucracy," and feel that the improved relationship between the two parties has resulted in better patient care. The home recently established a computer link to the VA Medical Center which will improve access to lab and X-ray data.

Interviews revealed that licensed staff and management find the new physicians to be more thorough and aggressive in their treatment of residents, as evidenced by the increasing number of physicians orders being generated.

Current management finds the quality of primary care provided by the current physicians to be first rate and applauds the medical director for putting in numerous uncompensated hours in order to establish the new physician services.

There are some concerns related to current physician services:

Management reports that the medical director has made a concerted effort to perform the duties normally delegated to a medical director. However, the role and duties of medical director have never been formalized, in terms of a written position description. This is of some concern to management because the current medical director does not plan to continue in that role and management cannot ensure that future medical directors will perform the duties that are required for this position, in absence of a contract and position description.

According to the October 1987 VA inspection report, the medical director did not attend interdisciplinary meetings, psychiatric consultation was not available, and data concerning psychiatric assessment and communication with mental health providers regarding follow-up treatment was inadequate.

Current management has noted that there are a number of patients who have been on psychotropic drugs for many years without having appropriate psychiatric assessments to determine continued need for medications and/or current dosages.

The contract for VA Medical Center physician services expired December 31, 1987. Based upon its assessment of services needed, management is negotiating a new contract which will:

enable the medical director to take on a stronger advisory role, with respect to the administrator;

expand and formally define the duties of the medical director to include participation in formal mechanisms to assure quality care, including committees on quality assurance, utilization review, patient care, pharmacy, and infection control;

expand physician services from the current 1.65 full-time-equivalent to 2 full-time-equivalent physicians and a .5 full-time-equivalent psychiatrist.

VA Medical Center physician services, as defined in the new contract, have recently been endorsed by the blue-ribbon commission appointed by the governor to study the home and long-term health care issues related to veterans.

There are also concerns about physician services being provided by specialists within the VA Medical Center itself. A January 1988 report by the ombudsman who recently served at the Minneapolis home notes the following problems:

"Residents have been known to wait unreasonably long periods of time (two to three hours) for scheduled appointments. It is not unusual for a resident to spend an entire day at the center. The center does not provide a noon meal unless the resident is diabetic.

Residents state that they have no way of knowing if they will see the same doctor at each appointment, nor do they always know the doctor's name.

Some residents report that information regarding justification for a test or results of tests have been refused them.

Residents have been known to be scheduled for treatment of a non-existent problem, e.g., an appointment to have a hearing aid checked. The resident did not have a hearing aid and never did."

According to the report, these problems violate sections of the residents' Bill of Rights pertaining to courteous treatment, appropriate health care, physician's identity, information about treatment and continuity of care.

Conclusions

Medical services for residents of the Minneapolis home have improved in recent years as a result of contracting with the VA Medical Center for physician services.

Problems still exist with respect to coordination with the VA Medical Center and physician services provided in that facility.

There is a need for the medical director to take a strong role in implementing and monitoring formal quality mechanisms, such as committees for quality assurance, utilization review, patient care, pharmacy and infection control, given the home's unsuccessful efforts in these areas.

The absence of a staff psychiatrist has meant that the needs of some residents, especially those on psychotropic medications, have not been adequately served.

Recommendations

1. Management should continue to contract with the VA Medical Center for physician services and should proceed with negotiating a new contract which will expand services to provide for psychiatric consultation and formally define the role of medical director.

2. The Management Analysis Division endorses a recent recommendation made by the ombudsman who served in the home which states, "Communication with appropriate persons at the VA Medical Center should be established in order to ensure the quality of care and guarantee the Resident Bill of Rights for the Minnesota Veterans Home residents. The administrator should direct the quality assurance committee to pursue this task or appoint an ad hoc committee for this purpose."

PHARMACY SERVICES

Findings

The pharmacy is currently staffed by three registered pharmacists, two pharmacy technicians and a resident assistant.

The Department of Veterans Affairs had requested additional staff for the pharmacy in accordance with recent VA inspections. One of the three registered pharmacist positions was newly allocated in August 1987. However, this position was merely used to replace the services of an intermittent pharmacist.

According to the October 1987 VA inspection report, 400 residents at both homes receive medications through a seven-day unit dose system, and 350 through a 30-day self-medication system. Each resident has a medication profile which is accurate, updated on a regular basis, and used to check for duplications, drug interactions and correct dosage.

The VA recommends that pharmacists fill 10 to 12 prescriptions per hour. In March 1987, the home's pharmacists averaged 25 prescriptions per hour.

The pharmacy has been repeatedly cited by the VA for its inability to provide consultation services to staff, make rounds and review individual charts for drug utilization, and establish a pharmacy committee and formal drug utilization review program. The VA noted that a drug utilization review by a pharmacist is not only beneficial to patients (by decreasing the average number of prescriptions per patient) but can also prove to be a very cost-effective measure. According to the inspection report, these deficiencies were attributed to staff shortages and could be remedied by the addition of another pharmacist.

Interviews with current management personnel indicate that management is aware of the significance of the above-cited deficiencies. Management stresses that drug utilization reviews and pharmacy committees are standard features in nursing homes because they are required for purposes of federal certification. Management also sees a need for the pharmacy to monitor individual drug routines and periodically inspect the medication distribution systems in the various nursing units.

The home has failed to meet VA requirements for controlled access to drugs because one of the pharmacy doors remained unlocked during regular hours. Current management has recently corrected this problem.

Staff report there are excellent working relationships within the pharmacy, with employees working together to achieve common goals. Many manual tasks have now been automated. Staff and residents generally did not voice complaints regarding pharmacy services during interviews.

Conclusions

The pharmacy appears to be a well-functioning unit with respect to patient profiling and basic drug delivery.

Staffing levels have prevented this unit from implementing standard mechanisms to effectively monitor and assure quality patient care and drug utilization.

Recommendations

1. Management should staff the pharmacy at needed levels or contract with an outside provider to ensure that the following tasks can be performed in addition to basic drug delivery services:

   clinical drug utilization reviews

   periodic monitoring and inspection of individual patient drug routines and medication distribution systems within the various nursing units

   evaluation of medication errors and medication error rates

   establishment of an effective pharmacy committee.

VOLUNTEER SERVICES

Findings

The Minnesota Veterans Home in Minneapolis has a full-time volunteer services director, who serves as liaison between the home and the community to recruit volunteers and solicit funding for various projects and activities. The director of recreational therapy also maintains contact with volunteers and community groups.

At the request of Governor Perpich, an assessment of the volunteer program was conducted by the Department of Administration Office On Volunteer Services in order to offer program development assistance. Some of the findings related to structural issues were:

Informal volunteer programs have been preferred over formally structured programs.

No formal and separate budget exists for the volunteer program.

Policies and procedures related to volunteer involvement do exist, yet have not been implemented consistently nor clearly understood throughout the home.

An intensive staff training program on how to plan for and work with volunteers has not yet been introduced.

The home enjoys a strong relationship with veterans organizations in the state and its volunteers are, for the most part, members of these groups. Veterans organizations contribute time and money to both of the Minnesota Veterans Homes. According to Veterans Affairs, the homes received approximately $155,000 in cash contributions from veterans groups during Fiscal Year 1987. Corresponding figures for donated goods and volunteer labor were not available. Interviews with the Minneapolis home's current management and employees revealed that these groups normally offer their services on their own accord, as opposed to an orchestrated recruitment effort on the part of the volunteer services coordinator.

Employees see a necessity for maintaining this strong relationship with veterans groups, which they consider to be instrumental in funding projects, donating goods and sponsoring many group activities for the home's residents. Some note that residents really enjoy interacting with

volunteers who are veterans. At the same time, some employees see the home's dependence on veterans groups for volunteer services as detrimental, in that it allows these groups to exert inappropriate influence over the home's operations. It was also reported that some of these groups withdrew their services after the home was placed under the Department of Human Services.

Employee interviews revealed that employees are not satisfied with the volunteer services now being provided. Staff see a crucial need for recruitment of individual volunteers to work in the home and/or interact with residents on a one-to-one basis. This has been a repeated problem area and was noted in the Management Analysis Division's 1980 study of the home. Employees interviewed were generally not aware of any volunteers who ever filled these roles on a regular basis. Suggested volunteer tasks were letter writing, escorting residents to the VA Medical Center, delivering mail, feeding residents, visiting, etc.

Family members and residents also noted that many of the home's non-ambulatory residents were unable to attend group activities and that volunteers could fill this void by visiting with or escorting residents.

Volunteers of the home generally rated the volunteer services program very highly (see Volunteer Survey, Appendix D), but noted some of the following concerns and suggestions:

> "Allow the volunteer coordinator to actively recruit volunteers without the interference of politics."
>
> "Long-term volunteers are not receptive to new volunteers and don't include them in some activities."
>
> "Little effort was made to pair me up with residents and get a constructive program going . . . I was left to flounder while someone was trying to decide what I could do . . ."
>
> "Encourage supervisors to properly utilize volunteer skills to enhance the programs as well as the daily lives of residents."

During a focus group held for volunteers of the Minnesota Veterans Homes, one volunteer of the Hastings home mentioned that some veterans groups prefer volunteering at the Hastings home because they are treated better by staff. Others cited a strong need for a formal committee comprised of the home's department heads and members of veterans groups to communicate the day-to-day needs of the home and coordinate the activities of volunteers to meet those needs.

Conclusions

The Minneapolis home is highly dependent on veterans groups who, for the most part, regularly offer their services on their own accord. Most volunteer services are sponsored by groups and provided in large group settings.

The volunteer services program has not been successful in recruiting individual volunteers to work in the home or engage in one-to-one or small group activities with residents, nor has it been successful in recruiting individuals or groups who are not connected with veterans organizations.

These services are essential in light of staffing patterns, the reduction of resident workers and the need for the home's residents to engage in meaningful social interaction.

Recommendations

1. Management should establish a formal budget for the volunteer services program and provide adequate funding for volunteer expense reimbursement, marketing and recruiting, volunteer recognition and training for staff.

2. Management should provide a training program for supervisory staff on how to plan for and work with volunteers, which should include methods for volunteer needs assessment.

3. Management should establish a formal centralized mechanism for assessing the needs of the home, communicating the needs to the community, recruiting and coordinating volunteers to meet those needs, and evaluating and recognizing volunteers. Management could create a committee for this purpose which would include the home's volunteer services coordinator, representatives from various departments within the home, volunteers and residents. A marketing and/or volunteer services consultant could be secured to provide initial advice and assistance to the committee, which would meet regularly in order to develop and/or revise:

   tools for assessing the needs of the home on a regular basis such as surveys or forms filled out by supervisors in various units and submitted to the volunteer services coordinator,

   strategies for communicating the needs to the community and recruiting volunteers, which might include public service announcements, brochures, etc.,

methods for coordinating, evaluating and recognizing volunteers, and

budgets needed to carry out these functions.

4. The volunteer services program should focus its efforts on:

   The recruitment and training of individual volunteers to work within the home and/or participate in one-to-one or small group activities with residents. Such training should include coverage of the residents' Bill of Rights and Vulnerable Adults Act which apply to volunteers as well as employees.

   Expanding the home's volunteer base beyond the core of veterans groups which regularly volunteer their services.

   Management should establish clear goals and timetables for achieving these tasks and make appropriate staffing changes if they are not achieved within a reasonable time frame.

INDIRECT SERVICES

Findings

Review of VA and Health Department inspection reports for recent years indicates there have been many repeated violations and deficiencies related to housekeeping and dietary services.

Housekeeping Services

Housekeeping deficiencies have related to the need for more frequent and thorough cleaning in numerous areas, inappropriate storage of cleaning materials, strong urine odors, inadequate supply of clean linens, and inappropriate handling of clean and dirty linen.

Staff and family members voiced concerns about housekeeping services:

> Cleanliness of the home was an issue which arose during employee interviews. Typical comments of employees were, "Housekeeping is atrocious," and, "The home is a filthy, dirty place."

Family members felt that resident rooms were not thoroughly cleaned and had, on occasion, spotted accumulations of urine and food on wheelchairs and in common areas. In a survey sent to family members which asked them to rate services on a scale of 1 (poor) to 5 (excellent), cleanliness of rooms was rated at 2.9 and cleanliness of common areas at 3.4.

Employee interviews, as well as input from family members, revealed that the home was frequently short of clean linen supplies. In some cases, residents went without sheets. If towels were not available, pillow cases were used to dry patients. Instances of residents' personal clothing being lost in the laundry were also noted.

An assessment of housekeeping services recently conducted by personnel from another Department of Human Services facility noted that housekeeping was now at an unacceptable level. The report referenced the difficulty in the upkeep of some of the home's furnishings, particularly carpeting and heavily-used lounge areas. According to the assessment, services could be improved by reorganizing the unit to provide for better accountability and coverage, training employees on regulatory requirements, monitoring employee activities, and soliciting input from the executive housekeeper regarding furnishings purchased for the home.

Housekeeping staff expressed concern about the unit's staffing levels, which dictated that a janitor clean 50 patient rooms in an eight-hour shift and 100 patient rooms if the other janitor on the floor called in sick. The Department of Human Services assessment noted that each janitor was responsible for maintaining more than 15,000 square feet and recommended additional staff be added. A recent VA inspection also noted an insufficient number of trained personnel to maintain a safe, clean and orderly environment.

Dietary Services

Dietary deficiencies cited by the Health Department related to unsanitary conditions in the food service area, storage and transportation of food under unsanitary conditions, numerous unsanitary practices of food services staff, absence of ongoing nutritional assessments in treatment plans, and absence of recipes adjusted to yields appropriate for the size of the home.

An assessment of the dietary services conducted by a Department of Human Services consultant in August 1987 found that basic sanitation was in serious jeopardy and that the home was not providing meal service which minimally met basic sanitation, coordinated presentation and basic nutritional requirements of individual clients. According to the report, many of the Health Department correction orders issued in July 1987 had not been appropriately addressed. This was attributed to ineffective direction and supervision of employees who appeared to be unaware of the importance of regulatory compliance.

The home's kitchen was not designed to provide tray service to the large number of residents it now serves. Commissioner Ashton's report to the governor noted that "the design of the food service area does present problems with timely service, storage and sanitation." The VA also noted that overcrowding in the kitchen placed sanitation at a risk.

The food services area has relied heavily on resident workers and their numbers are decreasing. The current staff complement is far below that of other comparable Human Services facilities. The VA recommended additional staff for this area.

There was concern among staff, family members and residents about inadequate food distribution, especially to residents of Building 16, who must wait for food to be delivered by van from Building 17. Food was often cold upon arrival. (Building 16 used to house domiciliary residents, but was later converted to a nursing care unit.)

Family members and residents voiced no major complaints about food quality. There was some concern about the large amount of processed meats being served. In the Question-and-Answer section of Human Services' newsletter, residents' concerns about food quality have been raised. Management has responded by encouraging residents to attend monthly meetings with the dietary director.

There is some evidence which suggests that indirect services may be improving:

> The majority of the July 1987 correction orders cited in these indirect services areas have been corrected, according to a September 1987 Health Department follow-up inspection.

Veterans Affairs management was successful in obtaining 13 additional positions for housekeeping and food services for Fiscal Year 1988. Nine additional positions will be requested by Human Services during the next legislative session.

A clinical dietician now directs the dietary department. According to Commissioner Ashton's report, "This will help address deficiencies relating to sanitation and therapeutic diets." The September 1987 Health Department follow-up inspection report noted that the new dietary director had implemented detailed cleaning schedules and that staff had been trained, with frequent monitoring for follow-through.

The home received $1.5 million from the 1987 Legislature for a combined kitchen and storage warehouse construction project and management is currently studying various options for improving food services.

Much of the carpeting in direct care areas has been replaced with tile floors which are easier to maintain and clean.

Family members, staff and residents report that the food has been better and the home has been cleaner in recent months.

Conclusion

Until very recently, indirect services consistently had been unacceptable and had not met minimal state and VA guidelines for a clean and sanitary environment for residents.

Additional staff for both areas has been recommended by the VA and in assessments conducted by personnel from other Human Services facilities, and will help to address some of the noted deficiencies.

Many of the deficiencies (e.g., unsanitary food-handling techniques, improper storage of cleaning supplies) can be attributed to poor supervision and limited knowledge of regulatory standards, as opposed to staff shortages.

Recommendations

1. Management should proceed with its efforts to secure additional staffing so that staffing levels are in accordance with VA recommendations and are comparable to those of similar Human Services facilities.

2. Management should place emphasis on meeting Health Department and VA standards related to housekeeping and dietary services. This could be accomplished by supervisors:

   providing training on applicable regulatory requirements;

   establishing mechanisms to regularly monitor tasks delegated to employees;

   conducting periodic inspections to assure compliance with regulatory requirements.

3. Management should take necessary steps to expand housekeeping services in the dietary area, given the number of deficiencies related to unsanitary conditions.

4. Management should consult the executive housekeeper when making purchasing decisions involving furnishings and equipment for the home.

5. Management should meet with the executive housekeeper to determine the cause of clean linen shortages and devise a plan of action to eliminate the problem.

STAFF/RESIDENT RELATIONS

Findings

Applicable statutes and regulations which specifically address resident and staff interactions and relationships are the Bill of Rights for patients and residents of health care facilities, the Vulnerable Adults Act, and pertinent sections of federal Veterans Administration regulations and standards regarding quality of life in facilities providing care for veterans.

In addition to statutes and regulations, the Veterans Home in Minneapolis has written policies and procedures governing resident and staff interactions and conduct. The home's philosophy and mission statement encourage resident and family participation in care planning and specify that "care will be rendered in a professional and considerate manner providing for the comfort and recognizing the human dignity of each individual."

VA standards for nursing and domiciliary care require an active resident council with elected officers which meets regularly and communicates with management concerning the needs and concerns of residents. Additionally, the Bill of Rights gives residents, as well as their family members, a right to participate in care planning and to voice grievances.

The home has both a resident and family council.

Family members interviewed felt the family council served as an effective tool for voicing concerns to the home's management. Some council members said the management of the home was much more receptive to family concerns than those of other facilities they had come in contact with.

As assessment of the home recently conducted by personnel from another Human Services facility noted that the resident council is a viable organ which functions in an autonomous fashion and frequently reports directly to the administrator. However, a recent report by the ombudsman who served in the home indicates a need for a strengthened resident council. A resident council developer from the Alliance for Health Care Consumers was recently working with resident council members to strengthen leadership and membership among participants.

The VA, in a recent inspection report, recommended that separate resident councils be developed for nursing care and boarding care residents, given the differing needs and concerns of these residents. According to a recent Human Services newsletter, separate 12-member groups are now being developed for each living unit within the home.

An agreement between Human Services and the Board on Aging provided for the services of an ombudsman at the home from September 2, 1987, through December 23, 1987. Residents supported having an ombudsman at the home and hoped this arrangement could be continued. Interviews with health care advocates revealed there is a need to continue the on-site services of an ombudsman. However, advocates feel the home's employees and residents could grow too dependent upon an ombudsman if this service was provided on a full-time basis. It has been recommended that on-site ombudsman services be secured on a half-time basis consistent with the other Human Services nursing homes which have half-time employees serving as advocates.

Both residents and family members felt a need for improvement in communication between the home's line staff and residents/families concerning resident care.

Family members said they were not routinely notified about resident injuries, or changes in medications, treatments and conditions affecting the resident. Many felt that direct care staff, including physicians, were not always accessible (see Family Member Survey, Appendix C).

Some family members felt that resident care planning was conducted on a haphazard basis and that families were not routinely notified about quarterly care planning conferences.

The VA, in its September 1986 inspection, noted that patient and family participation in quarterly care planning conferences needed to be improved.

Some family members felt resident concerns related to the care provided were ignored by employees, who treated non-ambulatory residents as if they all had a low level of mental functioning.

In recent months, Human Services management has placed considerable emphasis on the Vulnerable Adults Act, which prohibits abuse or neglect of vulnerable patients or residents, for a number of reasons:

The home has been cited by the Health Department in the past for failing to consistently identify patient vulnerabilities and include vulnerable adult prevention plans in patients' records.

Based on personal observation of resident and staff interactions, Human Services management felt there was a need to clarify and stress the Vulnerable Adults Act.

In September 1987, an instance of sexual abuse occurred, involving two of the home's residents. During the investigation of this incident, it was learned that staff had reported, since July 1987, that a male resident was sexually abusing a female resident. No action was taken by superiors to remedy the situation or to report the incidents to the Health Department, as required by the Vulnerable Adults Act, until September 1987, when the last instance of abuse occurred and was reported directly to the home's administrator.

With this in mind, Human Services management, along with representatives from the Health Department and the Board on Aging, conducted mandatory employee training sessions on the Vulnerable Adults Act soon after it assumed management of the home.

When the study team conducted staff interviews in October 1987, employees were asked about their level of familiarity with the home's policies and procedures concerning the Vulnerable Adults Act.

Many employees stated they did not receive any training about the act under Veterans Affairs management. Only 24 of 69 employees who were interviewed said they became familiar with the Vulnerable Adults Act when Veterans Affairs managed the home. Many of these employees did not recall specifics and mentioned that coverage of the Vulnerable Adults Act and the residents' Bill of Rights during orientation was brief and sometimes vague.

Many employees attended the recent mandatory training sessions and had a good understanding of the Vulnerable Adults Act. However, due to scheduling conflicts or inability to leave work stations, some employees did not attend the training sessions. Many who did were uncertain about the definition of "vulnerable" and what constitutes "abuse" or "neglect."

Some employees thought they could no longer engage in friendly social interaction with residents for fear it would be construed as abuse.

Employees were not certain what to do in cases where they perceived the act to come in conflict with other care requirements (e.g., you can't force a patient to receive treatment or eat meals, but it may be considered neglect if you don't).

Most employees were familiar with internal Vulnerable Adults Act reporting procedures, but not all of the employees interviewed knew they had a right to contact external agencies if they were not satisfied with internal mechanisms and outcomes.

Additionally, employees felt they were now "overreporting" incidents internally, due to confusion over what constituted abuse or neglect as defined by the Vulnerable Adults Act.

Employee interviews revealed that employees expressed a perceived value of caring for and interacting with residents, often calling this the most satisfying aspect of their job.

When employees were asked about the most frustrating aspects of their jobs, many in direct care felt there were limited opportunities for meaningful one-on-one care and social interaction with residents. Some attributed this to time constraints and shift and floor rotation schedules.

The study team learned of some employees who went out of their way to give residents special care, such as hunting down a suit of clothing for a resident to wear on his birthday, making special arrangements for family visits and parties, and serving as volunteers on resident outings beyond normal work hours.

Many employees hoped the home could maintain and foster a "homey," personalized environment in spite of its being a licensed health care facility.

However, other evidence suggests that not all employees treat residents with the respect and dignity that are emphasized in the home's mission statement and required by law.

The home was cited by the Health Department in September 1986 and again in July 1987 for violations of the residents' Bill of Rights section requiring courteous and respectful treatment of residents.

Health care advocates feel the home has a poor record of staff and resident relations. A recent report by the home's ombudsman notes the following problems:

> "Residents generally complain about the poor attitudes of human services technicians (nursing aides). Specifically, these persons convey a feeling that residents "owe" them something for providing care. Poor work habits such as extended breaks and lunch hours, rough handling and improper lifting techniques, disagreeable dispositions and open criticism of the home are issues that have been repeatedly submitted to the ombudsman.
>
> Specific complaints regarding unusually long periods of time (15 to 20 minutes) before call lights are answered are common. Residents state that human services technicians are often found in the hallways discussing their own social lives.
>
> There is a continued frustration among residents about to whom to complain and the lack of response when issuing a complaint through the staff. Some residents fear retaliation.
>
> A vast array of casual clothing does not contribute to either the professional "tone" or professional behavior in resident care. Female human service technicians have been observed wearing mini-skirts.

> Both males and females frequently wear T-shirts with inappropriate messages bonded on them, sandals, tank tops, unsuitable jewelry and clothing that often does not appear to be clean. Identification of the worker is often accomplished by writing one's name on micropore tape and applying it to clothing."

A human services technician at the home was fired in December 1987 and three other employees disciplined in connection with the alleged physical abuse of a 103-year-old resident. According to Human Services management, the results of an internal investigation revealed that, after the resident struck the human services technician, the employee used excessive physical force against the resident, who was already in restraints, and did not let go of the resident until a registered nurse physically intervened. Management of the home recently noted another instance of two employees pinning down a resident one evening in order to shave him.

Family members, residents and employees interviewed by the study team also cited several instances of rude and abusive behavior on the part of employees and felt that the home should be much more selective in its hiring practices, especially with references to human services technicians.

Theft of residents' money, personal belongings and mail by staff was also a major concern of family members and residents interviewed.

> According to a recent Human Services newsletter, theft continues to be a primary focus of the resident council.
>
> Ratings in a survey sent to family members indicate that theft is a problem (see Family Member Survey, Appendix C). One family member mentioned that her spouse put his money in his pillow case at night for safe keeping.

Employees felt that many of the home's residents were combative and difficult to care for and that management, with its recent emphasis on the Vulnerable Adults Act and residents rights, had not acknowledged the fact that residents are sometimes abusive to staff.

The home's policies addressing resident conduct specify that "residents shall conduct themselves in a manner not injurious or offensive to themselves, other residents, or staff persons." According to home policy, infractions of these rules can result in disciplinary action and/or discharge. Additionally, the admissions policy precludes the admission of an individual who has serious and/or consistent behavorial problems which make him/her a danger to himself or others.

Many employees felt these policies were not routinely followed.

> Staff cited examples of difficult residents being readmitted to the home in recent years over the objection of staff after they had previously been discharged for unacceptable behavior.
>
> Due to a court order prohibiting the home from further involuntary discharges in absence of administrative rules, the staff sees no real incentives for residents to control their behavior.

There are no support mechanisms in place for staff who deal with difficult residents on a regular basis. When employees were asked about the home's training needs, many cited a need for training on how to handle difficult, uncooperative residents.

Interviews with current management revealed that employees are to rely on supervisors when they are unable to handle a difficult resident. However, a recent report by the ombudsman who served at the home states that "coping with volatile, uncooperative and manipulative residents and lack of ability to diffuse an argument are ever-present problems" and "problem-solving at the supervisory level and/or care plan session does not appear to be effective."

Conclusions

The home appears to have an effective family council for addressing the concerns of residents and family members directly to the home's management, and is currently taking steps to strengthen the resident council.

Interaction between the home's front-line staff and residents/families is not acceptable. Serious instances of abuse of residents continue to be reported. Families are not routinely contacted about resident care. Many employees reportedly behave and dress in an unprofessional manner.

Despite the fact that Human Services management has made solid efforts to stress the importance of residents' rights and the Vulnerable Adults Act, considerable confusion still exists among staff with respect to laws, regulations and policies in these areas.

Employees find it difficult to work with uncooperative and abusive residents on a daily basis in the absence of training which would provide coping and intervention strategies.

Recommendations

1. Training sessions and written policies and procedures covering the Vulnerable Adults Act and Patient Bill of Rights should be revised to better illustrate what specific types of behaviors constitute abuse, neglect and other types of infractions. Trainers should encourage staff to ask questions and participate in the training by role-playing. An employee's right to contact external agencies regarding Vulnerable Adults Act infractions should be stressed.

2. In conjunction with training on the Vulnerable Adults Act and residents' Bill of Rights, management should provide training on therapeutic intervention and containment techniques used for handling difficult or combative residents.

3. Management should instruct supervisors to devise systems to more closely monitor staff interaction with residents and take appropriate disciplinary measures when residents are not treated with respect and dignity, especially with reference to theft of residents' money and personal articles.

4. Management should meet with employee unions to discuss the possibility of direct care employees wearing uniforms or clothing consistent with those worn in other professional health care facilities. One suggestion would be loose-fitting smocks. Proper name tags should be required for all employees.

5. Management should make necessary arrangements with the Board on Aging to secure the on-site services of an ombudsman on a half-time basis.

6. Nursing management should develop a system whereby families are routinely and promptly notified about injuries, significant changes in treatments and/or conditions, and quarterly care planning conferences.

7. Management should take steps to ensure that policies regarding readmission, discharge and resident conduct are strictly adhered to with respect to intentional inappropriate behavior on the part of residents.

STAFFING PATTERNS

Findings

Staffing Levels

The 1987 Legislature approved allocation of 42 new positions for the Veterans Home in Minneapolis at the beginning of last year.

In September 1987, the Department of Human Services prepared a Legislative Advisory Commission request for 84 new positions to be allocated to the homes, 58 in 1987 and 26 in 1988. Seventy-six would go to Minneapolis, eight to Hastings. In developing this requests, Human Services considered only basic services required to meet fundamental resident needs and to meet VA and Health Department standards. The staffing resources requested were those which would minimally be required regardless of the future direction of the homes. Emergency funding of 58 positions was approved in October 1987. Human Services will request the 1988 Legislature to permanently fund those positions and add 26 positions for the homes.

Following is an illustration from Human Services of the staffing levels of the Veterans Home in Minneapolis prior to and after the request for 84 additional positions:

MINNEAPOLIS VETERANS HOME
STAFF-TO-RESIDENT RATIOS
BEFORE AND AFTER REQUEST FOR 84 NEW POSITIONS

Staff	Before Request	After Request (if approved)
Nursing	179/540 .332	235/540 .435
Dietary	34/540 .063	38/540 .070
Housekeeping/Laundry/ Maintenance	41/540 .076	50/540 .093
Social Services/ Psychological	5.5/540 .010	9.5/540 .018

Recreation Therapy/ Rehabilitation	10/540 .019	12/540 .022
Chemical Dependency Services	2/540 .004	2/540 .004

Even with the addition of these new and proposed positions for the homes, overall staff-to-resident ratios will not be considered high compared with the position complements of the other state-managed nursing homes. The following illustration from Human Services compares the Minneapolis Veterans Home positions and case-mix to those of the state nursing homes Ah-Gwah-Ching and Oak Terrace:

Staff	Minneapolis Veterans Home (1.63)	Ah-Gwah-Ching (1.95)	Oak Terrace (2.34)
Nursing	235/540 .435	157.5/296 .532	173/297 .583
Dietary	38/540 .070	34/296 .115	39.4/297 .133
Housekeeping/Laundry/ Maintenance	50/540 .093	49/296 .166	38/297 .128
Social Services/ Psychological	9.5/540 .018	8/296 .027	6/297 .020
Recreation Therapy/ Rehabilitation	12/540 .022	16/296 .054	8.5/297 .029
Chemical Dependency Services	2/540 .004	11/296 .037	N/A

The 84 new positions, if permanently funded, will be allocated as follows in both facilities of the Veterans Homes:

Position	Minneapolis	Hastings
Nursing	56	3
Housekeeping	5	3
Dietary	4	
Maintenance	4	(1 shared)
Social Services	4	(1 shared)
Recreation Therapy	2	1
Staff Development	1	1
TOTAL POSITIONS	76	8

The Health Department requires a minimum of two nursing hours per resident per day in nursing care. Implementation of the case-mix assessment has assisted Human Services in developing accurate staffing needs. The staff added since the Legislative Advisory Commission request by Human Services will bring nursing hours per resident per day to the state average of 2.5 in nursing care.

It is difficult for the Minneapolis home to recruit registered nurses due to the nursing shortage and the home's reputation. According to staff interviews, registered nurses are not paid as much to work at the home as they receive in some other health care environments. The facility cannot compete with private industry in providing perks (e.g., promises of day shift only, no weekend work, extra financial benefits, etc.) for recruitment purposes.

Employee interviews indicated the workload in personnel is overwhelming. A contributing factor to the large workload is the frequent employee turnover at the home. There has also been a recent significant turnover in the personnel office.

Support staff members in interviews and feedback sessions repeatedly claimed there were staff shortages in their areas.

> All the personnel staff interviewed cited a "frustrating" and "overwhelming" workload and said that past requests for clerical help in this unit were either denied or ignored.
>
> The home has only one secretary to handle all administrative matters, including the work generated by an administrator and two assistant administrators. The creation of the word-processing unit shifted some of the workload from the secretary; however, she has acquired other responsibilities. She also sorts mail and provides at least two hours of switchboard relief every day.
>
> Maintenance staff have repeatedly said they need to have another carpenter and painter to handle the current work levels.

Staff in all support areas said in interviews and feedback sessions that, historically, their needs have not been taken seriously. Besides their staffing needs, their equipment, supply and work environment needs were continually underestimated or disregarded.

Staff interviews indicated shifting resources to direct care because of critical Health Department surveys has caused problems in program management and indirect care. In addition, reduced resident worker staff has also caused staff shortages in these areas.

Calculations made by Veterans Affairs to estimate staffing needs did not consider lost time due to workers' compensation claims, leaves of absences of any kind, the time involved in filling vacant positions (or anything else relating to turnover), actual use of sick leave, or the annual leave usage of long-time employees who earn more than four hours of leave per pay period.

Staff Use

Many staff expressed concern regarding overtime. During feedback sessions with staff, several concerns were again raised in this area. Interviews indicate staff are burned-out due to overtime on a constant basis. Overtime is necessary because of staff shortages and scheduling problems.

Many employees find it necessary to use sick leave to recuperate from constant overtime. These absences create overtime for other employees. Ten interview respondents were critical of sick leave use/abuse at the home.

Some employees in the staff feedback sessions indicated rotational staffing schedules and float positions have a negative impact on resident care. Participants in the resident focus group indicated that schedules have not allowed for consistent staff assignment. There are some advantages to rotating (e.g., staff are not consistently assigned to difficult residents); however, some employees would like to be assigned to a specific group of residents.

Staffing recommendations by Human Services have been made on the assumption that licensed nursing staff would be relieved of non-nursing duties. Staff interviews indicate this is a crucial area in establishing quality care for residents.

Minnesota Rule 3900.0400, Subparagraph 13 defines an intermittent employee as "...an employee who works an irregular and uncertain schedule which alternately begins, ceases and begins again as the needs of the agency require." In the past, intermittent and part-time employees were often regularly scheduled to work part-time hours to provide adequate staff coverage. Currently, Human Services is limiting use of intermittent employees. Use of intermittent employees has dropped from 30 to 40 shifts per pay period to six or less per pay period.

Conclusions

Crisis management has dictated staffing assignment and reassignment. Long-term planning for staffing needs has been minimal and/or inaccurate.

Human Services has addressed many of the critical issues surrounding staffing; however, proposed levels support existing programs and services only.

Scheduling problems, including excessive rotation of assignments and inappropriate use of intermittent employees, have negatively affected staff morale and quality of care.

Recommendations

Staffing Levels

1. Permanent staffing requests made by Human Services were those minimally required for fundamental resident needs, and should be approved as soon as possible.

2. Case-mix assessment should continue on a permanent basis, to allow more accurate comparison of Veterans Homes resident needs and staffing levels with those of other nursing homes and boarding care homes in the future.

3. The management team should look carefully at making the Veterans Home more attractive to registered nurses. This may require some innovative thinking to encourage candidates to apply. The Department of Employee Relations could assist management in developing ideas conducive to recruitment.

4. Management should assess the staffing needs of the personnel office. The Veterans Home should have knowledgeable personnel staff to provide adequate service to its employees.

5. When the mission of the home is changed, management should determine the affect that change will have on staffing levels.

Staff Use

1. Use of overtime should be limited. Staffing needs should be addressed to prevent overuse in the future. Other options should be explored to increase staff involvement in establishing assignment procedures. A goal of reduced overtime should be increased attendance.

2. Use of ward secretaries and support staff should be increased. Use of volunteers to assist direct care staff with some tasks (e.g., escorting residents to the VA Medical Center) should be investigated.

3. Staffing needs should be assessed with regard to use of intermittent employees. Intermittent positions should be used only as a pool to assist schedule coverage in emergency situations.

EMPLOYEE TRAINING

Findings

Inservice Training and Orientation

Staff members reported various areas where they would benefit from training, including general orientation, basic resident care and management techniques, internal policies and procedures, and management and supervisory training. Of the staff participating in the employee mail survey, only 24.8 percent indicated satisfaction with the training currently received.

Staff indicated a need for further training in Vulnerable Adults Act policies and procedures. Most employees are more familiar with the act's reporting procedures since the recent training by Human Services; however, many are still unsure about their responsibilities under the act. Although Vulnerable Adults Act training attendance was mandatory, several staff members said they did not attend and have no knowledge of the act.

Although Department of Employee Relations policies and procedures require minimum training for certification in state supervisory positions, many interviewees stated that several supervisors are not knowledgeable in personnel policies and procedures, union contract requirements and employee management techniques.

Staff interviews and feedback indicate orientation for human services technicians is incomplete. Some staff believe human services technicians are unqualified to be working with residents after an orientation consisting of a three-day classroom session and seven days of training on the floor. In addition, family members participating in both focus groups and surveys requested additional training for human services technicians.

Nurses and nursing supervisors are not given separate orientation. While general orientation sessions cover administrative policies relevant to all employees, these sessions do not necessarily address the material needed by nursing staff. Orientation is not adequately supplemented by on-the-job training. The VA has cited the Veterans Homes twice in the past year for insufficient training for nursing staff.

Some staff interviews indicate that past requests for specific inservice training have been ignored. One staff member requested specialized training and never received any response to the request. Requests for off-site training have been ignored in the past.

Training has not addressed individual staff development needs. Training for stress management, career renewal or other subjects outside the nursing field has not been provided or endorsed. At this point; however, most employees rate work-related training to be more important than general development.

Fourteen staff members interviewed indicated that adult learning techniques have not been utilized for inservice training sessions. The trainers/experts presenting material have not been well versed in their topics. Past training styles have been primarily in a lecture format.

Twenty-six staff members interviewed referred to specific training needs. In addition to the areas outlined above, many staff requested training in the following: AIDS, Alzheimer's disease, CPR, drug identification and use, chemical dependency, mental illness, behavior modification, geriatric issues and emergency procedures.

Training Resources

Adequate resources have not been devoted to training. The home currently has only one inservice training director for 350 employees. The Department of Human Services has provided some inservice training; but, according to Veterans Affairs, only $95 of the Fiscal Year 1988 appropriation of $5,000 has been spent.

No consistent effort has been made to bring in community resources. Outside organizations have not been approached with any regularity regarding training provision. Requests made for training from other state agencies are infrequent.

Staffing levels do not provide for training time. Staff interviews indicate employees are reluctant to leave their specific units understaffed in order to attend inservice training. Even mandatory training efforts have been unattended by some areas because of staffing schedules and personal priorities.

The 1980 Management Analysis Division study recommended that "the primary objectives of the training director be to: a) Develop a comprehensive staff assessment of training needs, b) Develop an appropriate curriculum for staff development, and c) Design a data collection system for the purpose of evaluation of both staff skills and staff development activities." The areas of general orientation, individual resident assessment, individual program planning, basic resident care/management techniques, health safety and first aid and manager training were to be included in an overall staff development curriculum. Few of these recommendations have been implemented since 1980.

Conclusions

Little progress has been made in the area of training since the 1980 assessment. Significant improvements will be needed for the home to stabilize systems for adequate care.

Recommendations

Inservice Training and Orientation

1. A training-interests and need survey should be conducted to assess the kinds of training that all the staff or various work groups need and want. Department heads should be surveyed to determine the needs of each work area. The results of the two surveys should be correlated to develop a comprehensive training plan. Individual preferences should not be substituted for managerial discretion, to assure that staff members' skills are consistent with agency needs and regulatory requirements.

2. Management should make a strong commitment to staff development. Staff members should work with their supervisors to draft a personal training and development plan which would identify the work-related areas they wish to pursue and any known resources that could address these interests. An adequate staff development program designed for all existing and new employees, with specific curricula emphasis matched to job function, is a critical element for organizational change.

3. Vulnerable Adults Act training should be clarified for all employees. Methods such as role-playing, videotaping simulated Vulnerable Adults Act incidents, and group feedback should be developed to assist employees in identifying Vulnerable Adults Act incidents. Mandatory attendance at this training should be a part of the performance standards for all positions at the homes. See the "Health Care Management: Staff/Resident Relations," p. 88, for more recommendations in this area.

4. Orientation for direct care staff (human services technicians, program assistants, licensed practical nurses and registered nurses) should be increased and improved. The orientation program should have two primary outcomes: 1) imparting specific work-related competencies and skills for each type of direct care staff and 2) developing teamwork values and norms among staff. The orientation program should be an effective combination of joint and separate sessions for human services technicians, program assistants, licensed practical nurses and registered nurses.

5. All supervisors should be trained in general supervisory techniques and decision-making, sexual harassment, and fiscal, personnel and other administrative responsibilities. In addition, supervisory training specific to nursing care staff management should be provided. Training in this area should be a part of performance standards for all supervisory positions.

6. Participants should evaluate each completed training session to determine if that session is meeting staff needs. Soon after the course has been completed, the supervisors of the participants should evaluate the impact and benefits of that training in their work area.

Training Resources

1. Management should devote resources to training needs. The Department of Human Services' request for two additional positions in this area should be approved. Management should continue to direct attention to staff development. Expansion of the staff development function at the homes is a fundamental building block to maintaining compliance with Health Department and VA regulations.

2. Management team members should encourage all employees to enhance their skills by participating in on-site and off-site training opportunities. Many organizations could be contacted to provide both types of training at minimal or no cost.

3. Staffing levels should be adequate to allow all employees to participate in training. Training time should be taken into consideration when creating staff schedules. Training sessions should be repeated on all shifts. In addition, management should follow-up with staff who do not attend mandatory training.

STAFF TEAMWORK

Findings

Staff and management interviews indicated that open and honest sharing of information has not been the norm at the home. Information distribution methods are not consistent. In both the survey and focus group, family members indicated poor communication among staff. Many of the same communication problems were cited in the 1980 Management Analysis Division study, such as infrequent use of formal channels of communication and weak horizontal communication between staff in different work units.

The Department of Human Services has established a newsletter to convey information concerning the transition of the home. In the past, the newsletter printed articles to inform employees about this study, the search for a new administrator, the Governor's Blue Ribbon Commission on the Minnesota Veterans Homes and several other subjects.

Staff interviews indicate that management has little respect for employee input, ignoring or otherwise not responding to employee suggestions. The employee mail survey establishes that only 5.7 percent of the staff responding were satisfied with employee input under Veterans Affairs. There has been little improvement in this area under Human Services, with only 15.3 percent of the employees satisfied in this area.

Staff schedules and the physical structure of the working environment do not facilitate meetings or joint group time. In addition, the turnover among staff along with the floating and rotational schedules preclude teamwork within work areas.

Many employees feel alienated from the organization and feel little sense of personal responsibility for its success. There is considerable peer support for a culture of complaining, where a lot of personal energy goes into verbalizing the ills of the organization but where little direct action is taken to do anything beyond complaining.

Staff interviews direct attention to conflicts among work areas, staff members and supervisors. Of the employees interviewed, 33 percent specifically mentioned this area. Participants indicate that different floors, shifts and supervisors often advocate different policies and procedures for their work areas.

Dissatisfaction with the amount of cooperation between supervisors was displayed by 43.8 percent of the staff survey respondents.

Many of the staff indicated that an attitude of "us versus them" exists. Employee interviews indicated a large rift exists between management and staff.

The management team at the home has created an environment of subcultures among staff, with employees supporting different team members and their policies. Human Services has changed this environment somewhat; however, they have not improved direct communication to line staff. This has hampered some of the improvements Human Services has endeavored to implement. Staff attending feedback sessions indicated that they have become disenchanted with the current management team and its policies, defining their management style as "management by intimidation."

Conclusions

In reviewing all of the sources of data, it is clear that communication issues are not being dealt with effectively and that unmanaged conflicts are inhibiting the success of the organization and adversely affecting morale.

Recommendations

1. Management needs to establish the value of open and honest communication in the organization and to model effective communication techniques for the home. Methods for modeling these values and techniques include regular, announced meetings with groups other than the supervisors, use of memos and internal newsletters as communication vehicles, and one-to-one communication with employees at their work stations.

   To assist in establishing new communication norms, a communicators' group should be formed with one or more representatives from each work area. This group would be responsible for the following:

a. Reviewing policies on information routing and monitoring routing procedures.

b. Providing a vehicle for fast distribution of important information (e.g., a telephone tree).

c. Establishing an employee newsletter, if interest exists. Such a newsletter might include articles on the work and successes of the home and/or work areas, updates on procedures, and items that address the social and morale issues of the home staff.

Information should routinely be shared with the widest appropriate audience. Current practices leave too many employees cut off from information which has a direct or indirect impact on their work performance or sense of involvement and commitment. Review of communication effectiveness should take place on a regular basis. Focus groups or simple, standardized surveys are potential means of doing so.

2. Management should commit the Veterans Home to a policy of soliciting affected employee input prior to any final decision-making regarding major policies or other significant concerns. This is not intended to give veto power to affected groups but to insure a legitimate opportunity for input.

3. Forums should be established for regular sharing of knowledge and techniques among staff. These might be incorporated into staff meetings or could occur at some regular interval as round-table discussions. Staff and management should set some ground rules for participation to assure that each group's agenda is met. Obvious examples of useful forum themes might include client communication, staff training or implementation of some aspects of this report. Orientation sessions should include a description of forums and should encourage new-employee participation.

4. Conflicts between work areas and staff should be resolved by use of written agreements or internal contracts which specify terms of interaction and by use of work groups to address issues which cut across department lines. Consideration should be given to involving the work areas in a structured conflict-resolution workshop where objective facilitators lead the groups through discussions of the perceptions, expectations and interdependencies among the areas. Safe, structured opportunities need to be created to confront trust issues which may be undermining teamwork and productivity.

5. Management should establish and communicate expectations for the number and frequency of meetings which departments and work areas should hold. Formal agendas and minutes should be required for these meetings and employees at all levels should have the right to submit agenda items. Allowing more flexibility would be appropriate after particular work areas have demonstrated their ability to communicate effectively through regular meetings.

WORKING ENVIRONMENT

Findings

Employee Morale

Staff morale is low. Forty employee interviews specifically referred to the issue of poor morale. A Department of Employee Relations survey conducted in conjunction with the 1980 Management Analysis Division study and interviews with supervisors during that study also indicated low staff morale at the home. Participants in employee feedback sessions ranked low morale as the highest priority out of 51 issues.

The recent negative publicity has adversely affected employee morale. Some staff are embarrassed to tell others where they are employed. The employee mail survey indicated that 33 percent of the staff do not look forward to coming to work.

The environment at the home has encouraged a lack of trust in working relationships. Many employees have developed a self-serving attitude. Level of pay has become the sole incentive for employment for many staff. The starting pay at the home for human services technicians is $7.37 and for licensed practical nurses $9.58. According to an assessment conducted for the governor's blue-ribbon commission, starting pay in private facilities is considerably lower.

In the past, management turnover created unstable working conditions with constant changes in policies and procedures. The family member focus group established this as a cause for poor morale.

The work environment has encouraged lower performance standards and a negative attitude in staff. Some staff members are comfortable with lowered performance. Others have become chronic complainers, dissatisfied with any change. These employees make work for other staff increasingly difficult.

Staff interviews indicated that several of the residents exhibit difficult behavior, causing the working environment for employees to be extremely stressful. The "Staff/Resident Relations" section of this report provides more detailed information concerning this area.

Rewards and Recognition

Lack of an adequate system for rewards and recognition was raised as an issue in several interviews and in the employee mail survey. Respondents to the employee mail survey indicated that only 16.3 percent under the Department of Veterans Affairs and 16.1 percent under the Department of Human Services believe their work units are praised for doing good work.

Many employees do not believe achievement awards have been handled appropriately. No clear criteria for awards have been made available to eligible staff. In the past, distribution of achievement awards resulted in grievances being filed by union representatives. A review of current collective bargaining agreements showed that the Minnesota Association of Professional Employees, Middle Management Association and Minnesota Nurses Association have specific provisions for achievement awards. The bargaining agreement for the American Federation of State, County, and Municipal Employees does not provide for achievement awards to be given to its members.

Employees believe that non-monetary recognition is also extremely important and that lack of such recognition is seriously undermining staff morale.

Conclusions

Morale has remained a critical problem since the 1980 Management Analysis Division study.

Morale problems are in part attributable to the perception that there is nothing to be gained from superior work.

The Veterans Home lacks adequate rewards and recognition for employees who have excelled despite the management and morale problems.

Recommendations

Employee Morale

1. Management should improve staff morale by consciously adopting a more participative management approach. Interested employees should have the opportunity to be involved in decision-making regarding the operations of their work group.

2. Management should develop and implement plans for resolving staff dissatisfaction and improving staff morale. Staff support groups should be created to alleviate stress within the nursing care environment. The State Employee Assistance Program could help develop support groups and recommend other resources for assistance activities. Staff should be encouraged to participate in these groups.

Rewards and Recognition

1. Management should initiate a highly visible rewards and recognition program for the home and allocate the funds needed for its success. Employees may find it motivating to receive tangible recognition such as informal notes, notice in an agency publication, work site visits, symbolic gestures (lunch, flowers, balloons, etc.), planned activities, awards and certificates.

   Very different things motivate different people. Intrinsic rewards relating to job satisfaction will have to be considered along with the more tangible ones in order to meet the needs of the staff meriting attention for good and improving performance.

   Interested employees should have opportunities for involvement in the planning and implementation of the program. Successful programs in other agencies should be reviewed for their applicability in this context, but involved staff should not feel obligated to duplicate someone else's program. The working group should be encouraged to develop a range of activities to meet differing individual needs.

2. Clear selection of achievement award criteria should be developed and publicized. Nomination by one's peers should be permitted. Every effort should be made to legitimize the process and to use it solely as a means of rewarding superior performance.

In addition, the overall rewards and recognition strategy should include some system for formal non-financial awards to those individuals who are not contractually eligible for monetary achievement awards.

3. The creation of a formal rewards and recognition program should not be seen as the full solution to the problem. Informal approaches should be used as well. Everyone at the home can take some personal responsibility for providing informal recognition to deserving co-workers. Such simple gestures as a note of thanks from a colleague can be meaningful.

CHAPTER 7: FISCAL/MATERIAL RESOURCE MANAGEMENT

FINANCIAL MANAGEMENT

This chapter begins with a report on the progress of the Minnesota Veterans Homes and the Department of Veterans Affairs in implementing the recommendations of the 1980 Management Analysis Division report and the 1985 Legislative Auditor's report, the most recent of three reports made on the homes by the auditor in this decade.

Although both the Legislative Auditor and the Management Analysis Division found significant problems in 1980, in 1985 the Legislative Auditor reported that Veterans Affairs had established controls and procedures to address many of the conditions discovered earlier.

History

In 1980, the Management Analysis Division and the Legislative Auditor each conducted an audit of the Department of Veterans Affairs and the veterans homes. Both studies found very serious problems with the financial management practices of the homes and the Veterans Affairs central office. The first Management Analysis Division recommendation endorsed the Legislative Auditor's findings and urged Veterans Affairs to correct all cited deficiencies by January 1, 1982.

The Legislative Auditor conducted a second audit in 1984 and found serious ongoing problems then, as well. As a result, the auditor felt it necessary to perform a "follow-up audit" in 1985. The 1985 report summarized the problems discovered during the 1984 audit:

> "[There were] significant internal control weaknesses which subjected [the homes] to an abnormally high risk of errors and irregularities. Due to their pervasiveness, the weaknesses were characterized into four general internal control areas: segregation of incompatible functions, safeguarding of assets, records management and written procedures."

The purpose of the 1985 follow-up audit was to measure the department's and the homes' success in implementing the 1984 audit recommendations. The auditors said of Veterans Affairs' progress:

"Recognizing the enormity of the task, we were pleased with the degree of implementation to date. Improvements have been made in all areas. Incompatible functions have been adequately segregated and no further recommendations [in this area] are necessary. The other general internal control areas have been significantly improved."

Status Report - Management Analysis Division Study

This section provides an item-by-item status report of the 1980 Management Analysis Division recommendations. Some material may be discussed more appropriately in the next section, which looks at the status of the 1985 Legislative Auditor's follow-up audit recommendations.

1980 Management Analysis Division Recommendation 1:

"The study team endorses the finding and recommendations of the Legislative Auditor in his report of March 21, 1980, on the Minneapolis Veterans Home. The department's administrative management director should draft a detailed plan and timetable to correct all legislative audit-cited deficiencies by January 1, 1982."

Findings

The 1980 Management Analysis Division study cited both the legislative audit and its own investigations to show that there were system-wide problems with Veterans Affairs' financial practices, including lack of necessary financial controls, lack of verification procedures, overpayments to contract providers, veterans and employees, lack of documentation and consequent inability to audit resident accounts, pharmacy records and payroll.

The 1984 legislative audit found many of the same deficiencies, because 1980 recommendations were not implemented or were only partially implemented. For that reason, they informed Veterans Affairs that they would conduct a follow-up audit in 1985.

In the summer of 1980, Veterans Affairs hired an administrative management director to focus on the financial practices of the agency. During that summer, Veterans Affairs and Management Analysis Division staff met to discuss the administrative management director's job description and relation to the central office and the homes. Both Veterans Affairs and the Management Analysis Division agreed to the following procedures and timetables for transferring control of the homes' business office to the new administrator:

The administrative management director would report directly to the commissioner and supervise the present central office accounting staff.

The Minneapolis accounting and business office staff would remain at the Minneapolis home. The director would directly supervise the Minneapolis accounting and business office staff during the transition to a new administrator. The commissioner would meet with the administrative management director and the homes' administrator every six months to determine when supervision of the staff would be returned to the administrator. The transition would not exceed 12 months. At the end of the transition, the director would have responsibilities similar to those outlined below for Hastings.

The director would provide technical and professional support and have only indirect supervisory responsibility for the Hastings accounting and business office staff.

The director's position description would reflect that 50 percent of the transition time would be spent at the Minneapolis home and 50 percent in the central office, handling department-wide fiscal and administrative matters.

The agreement "reflects the belief that financial responsibilities of the homes should remain with the homes' management so that program, fiscal and administrative concerns are tied," Veterans Affairs and Management Analysis stated.

Veterans Affairs reports that the administrator took charge of the homes' business office in 1981 as stipulated. But after the second critical legislative audit in 1984, the central office responded by creating the "consolidated accounting system." In this system, three division units were combined into a central operation with duties segregated by function: accounts payable, accounts receivable and purchasing and inventory. While this unit was located at the Minneapolis home, it was supervised from the central office in St. Paul, not by the home administrator.

Under this system, Veterans Affairs corrected many of the problems cited by the Legislative Auditor in his 1984 report.

1980 Management Analysis Division Recommendation 2:

"The administrative management director should develop position descriptions defining the authorities and responsibilities of each staff member under his supervision, develop written policies and procedures and train staff accordingly."

Findings

At the time of the changeover to the consolidated accounting system in 1984, personnel were moved from the central office and Hastings to the Minneapolis home. Position descriptions were written and policies and procedures were designed to delineate the staff's new tasks.

Veterans Affairs reported, and the Finance Department concurred, that these changes resulted in a "near-perfect" record for prompt payment of bills, improved collections and increased use of socially and economically disadvantaged vendors.

Veterans Affairs also developed a continuity plan for the accounts payable and purchasing units in case a key staff member was absent. No continuity plan was developed for the accounts receivable unit, because it was not required by the Legislative Auditor.

In the fall of 1987, Veterans Affairs worked with the Department of Employee Relations to review and revise central office job descriptions, which included central office business personnel.

One area where the system has not worked well, however, is in training. Staff members interviewed for this study in the fall of 1987 claimed that training in the business office has been inadequate, and, in particular, training and oversight of the supervisors have not been effective under the consolidated accounting system.

More critical, however, is the fact that this system keeps the home administrator weak and dependent on the central office for information. It also allows the central office to intervene too readily in the daily operations of the homes, undermining the administrator's authority. Health Commissioner Ashton cited "a lack of clearly defined lines of authority, responsibility and accountability among the commissioner of Veterans Affairs, the deputy commissioner and the administrator of the home" as the first finding of her August 1987 report to the governor. In fact, the

administrator does not have control over his budget. He cannot effectively delegate budget or staffing decisions to subordinates, nor does he have any way to hold them accountable for their decisions. Staff interviews confirmed that administrators continually called the central office for permission to make purchases, because they did not have that authority themselves.

Both the 1980 Management Analysis Division study and the 1987 Health Department study pointed out the shortcomings of such an arrangement and recommended that the home administrator have authority over business office functions.

1980 Management Analysis Division Recommendation 3:

"Responsibility for budgeting and fiscal management of the department should be decentralized."

Findings

The 1980 Management Analysis Division study found that supervisors at the homes were not informed of their units' budgets and, consequently, felt no responsibility for their units' fiscal condition. The study team felt that all managers must be held responsible for the financial affairs of their units, and must be involved in the planning and budget preparation.

The Veterans Affairs central office began to implement this process while preparing a budget request for the 1986-87 biennium, five years after it was recommended by the Management Analysis Division. A form was sent to all supervisors on which to enumerate their budget needs. Then each request was reviewed by the administrator, administrative management director and deputy commissioner and formulated into a final budget request.

For the 1988-89 biennium, the process was changed slightly. Supervisors filled out their initial budget requests, and no restrictions were placed on the requests at this stage. Then the administrator and central office staff met with the supervisors to go over the rationale for their requests, answer questions, and offer feedback before formulating the final department budget request.

The business office at the home sends supervisors periodic reports on year-to-date expenditures and available funds. They have also conducted two annual inservice training sessions to teach managers and supervisors how to use the reports they receive, along with information on purchasing and budget adjustment procedures.

1980 Management Analysis Division Recommendation 4:

"The Minnesota Veterans Homes must develop and implement a reporting system which accurately identifies revenues and costs and which is useful for decision-making by both top management and line managers."

Findings

The Management Analysis Division found that the homes and the central office lacked a comprehensive and useful fiscal reporting system. For instance, some reports lacked detail, some were based on bills paid rather than expenses incurred, and some were based on "guesses" as to how staff allocated their time between programs.

The Veterans Affairs reporting system did not utilize the Statewide Accounting System effectively. The reports that Veterans Affairs received from the Finance Department did not provide useful information to managers, because they did not reflect the current organizational structure -- a common problem, according to Finance personnel. In any case, the managers were not trained to read the reports.

Since then, Veterans Affairs has worked with the Finance Department to design and implement a new financial reporting system tied into the Statewide Accounting System. This process, begun in 1985, was in place for the 1986-87 biennium. Managers and supervisors now have accurate, detailed reports on their budgets and expenditures. They also receive training, as reported above, in reading the reports.

1980 Management Analysis Division Recommendation 5:

"The Department of Veterans Affairs should attempt to recover overpayments made by the Minneapolis home to its contract dentist, podiatrist and ophthalmologist. The homes must develop and implement immediately a system to monitor all payments on service contracts to prevent duplicate and overpayments and to ensure the quality of service provided."

Findings

In 1980, both the Management Analysis Division team and the Legislative Auditor found extensive overpayments for contracted services, in the range of $1,000 to $8,000, because no one monitored hours or verified invoices against timesheets or contracts.

Veterans Affairs reported in 1987 that all overpayments cited by the Legislative Auditor have been resolved. They have also put a system in place to monitor medical services contract vendors' hours.

The only exception is with the Veterans Administration, which provides physician coverage. Since Human Services took over the management of the homes, it has been negotiating a new contract for physician services with the VA, and anticipates it will be in place by March 1, 1988.

1980 Management Analysis Division Recommendation 6:

"The Minnesota Veterans Homes must reduce per diem costs of domiciliary care at Hastings and of nursing care at Minneapolis so that costs are no higher than those in the community for similar levels of care."

Findings

The 1980 Management Analysis Division study compared the per diem costs of nursing and domiciliary care to community facilities. It was found that domiciliary care in Hastings and nursing care in Minneapolis were more expensive than in the average statewide community, while domiciliary care costs in Minneapolis were lower. In addition, costs for domiciliary care in Hastings and nursing care in Minneapolis were rising at a rate faster than the statewide averages for both nonprofit and for-profit community facilities.

Veterans Affairs reported that nursing care cost in 1987 was $76.71 per day for the Veterans Home and $64.30 per day in the community. The reason for this difference is that the homes provide services not usually provided by private nursing facilities, such as physicians, dentists and ophthalmologists, corrective therapy and transportation for off-site treatment. (The actual rates charged to nursing care residents at the Veterans Home during 1987 were $54.38 per day. Rates differ from cost figures because rates are set on a retrospective rather than prospective basis.)

1980 Management Analysis Division Recommendation 7:

"The Minnesota Veterans Homes must reduce state costs at Hastings to a level equivalent to that at Minneapolis."

Findings

The state spent more to operate the Hastings facility for three reasons, according to the 1980 Management Analysis Division study:

1. A low occupancy rate: The 1980 study found that Hastings was staffed for 200 residents, but that the home's daily population had never been greater than 160 residents.

2. High per diem costs: Per diem costs were affected by the low population, but also by the large medical and support staff, according to VA standards, and an older physical plant, which is more costly to operate. Most significant, however, was the fact that many employees were at the top of their pay scales.

3. The way the Veterans Homes are funded: Both the VA and the individual residents contribute to the cost of their care at the homes, but their contributions are fixed amounts. The state is thus compelled to make up the difference. In addition, the VA pays a higher per diem rate for nursing residents than for domiciliary residents. It may have been that domiciliary costs in Minneapolis were under-reported and absorbed somewhat by the higher VA nursing per diem rate.

Since August 15, 1987, there has also been a moratorium on Hastings admissions, and the census had fallen to 144 on February 1, 1988. For the last several years, however, the census has been close to the maximum of 200 residents.

In addition, since 1984, consolidation of staff in the personnel and business offices has lowered Hastings' costs.

Veterans Affairs reported in 1987 that domiciliary operating per diems were $33.60 in Minneapolis and $33.18 in Hastings.

1980 Management Analysis Division Recommendation 8:

"The Minnesota Veterans Homes should seek Medicare/Medicaid [Medical Assistance] certification of portions of the homes so that Medicare/Medicaid payments can be used to reimburse the cost of care for peacetime veterans and non-veteran residents. As an alternative, the homes should consider placing non-veterans and peacetime veterans in certified community facilities."

Findings

The intention of this recommendation was to reduce the state's cost by increasing the federal government's share. Veterans Affairs has examined, but never formally sought, Medical Assistance certification for the Veterans Homes.

One objection Veterans Affairs has raised is that Medical Assistance certification would lower the veterans' personal needs allowance to $40 from the current $85 per month plus 5 percent of the balance of remaining income.

A second concern for Veterans Affairs is that veterans groups are loath to accept programs perceived as "welfare." Veterans have a strong sense that veterans benefits have been earned as a result of military service, unlike welfare programs, which are seen as unearned.

Of the 346 nursing care beds at the Minneapolis home, only 13 are filled by non-veterans or peacetime veterans who are ineligible for VA pensions. Unless the statute permitting admission of peacetime veterans and veterans' spouses and parents is changed; however, this issue will remain unchanged.

In 1983, the Health Department did a courtesy study at the request of the Department of Veterans Affairs to determine whether the veterans homes would be eligible for federal certification for Medical Assistance reimbursement. In a letter to the commissioner of Veterans Affairs, the Health Department explained that the homes would have to make many changes to be certified. These included providing or contracting for laboratory, radiological and audiological services, for physical, occupational and speech therapies and for a qualified social service consultant; establishing written procedures covering varied items from laundry operation to physician services; and setting up monitoring committees such as a pharmaceutical services committee.

There is great overlap between state and federal regulations, but there are also significant differences. Some of the differences are simply different ways to reach the same desired end. For example, one way the state attempts to ensure quality care is to require that nursing homes provide two hours of nursing care per patient per day. The federal government; however, focuses on the qualifications of the staff, requiring a registered nurse to be on duty seven days a week.

While not meeting federal standards does not imply that the homes were providing a deficient level of care, the life-safety violations cited by VA inspectors and continuing Health Department citations would have prevented the homes from being federally certified.

The domiciliary beds are probably not eligible for Medical Assistance certification, because rules prohibit Medical Assistance payments to people between the ages of 21 and 65 in "institutions for mental diseases." Because of the age of the domiciliary residents and the percentage with a mental illness diagnosis, it is not likely domiciliary beds would be eligible for Medical Assistance certification.

A further complicating factor is that the state has put a moratorium on the certification of new Medical Assistance beds, and in fact, there is a moratorium on licensing any new nursing home beds (Minnesota Statutes, Section 144A.071). There is an exception to that statute which says the commissioner of Health, in coordination with the commissioner of Human Services, may "certify or license new beds in a new facility that is to be operated by the commissioner of Veterans Affairs or when the costs of constructing and operating the new beds are to be reimbursed by the commissioner of Veterans Affairs or the United States Veterans Administration."

But this exception would not permit the homes to seek Medical Assistance certification without permission from the legislature, because the language in the exception refers to new facilities, not existing ones. In addition, the new facility must be operated by the commissioner of Veterans Affairs, which would preclude a new agency's seeking Medical Assistance certification without legislative approval.

It is also possible that Congress will approve a General Accounting Office recommendation which will permit the Veterans Administration to reduce VA pension payments to veterans in medical assistance-certified facilities in order to stop dual federal payments. This would greatly reduce the anticipated state savings.

For further discussion and recommendations, see "Medical Assistance Certification" in Chapter 9.

1980 Management Analysis Division Recommendation 9:

"The Minnesota Veterans Homes must develop comprehensive written policies, guidelines and procedures for determining individual maintenance charges and exceptions from the established rate schedule. Written notifications of changes in maintenance charges should be sent to residents in advance, and a formal mechanism by which residents can appeal decisions on maintenance charges should be established."

Findings

Minnesota law requires contracts describing maintenance charges for residents, to be signed by the commissioner of Veterans Affairs and all residents who are able to contribute to the cost of their care. The 1980 study team found that there were no such contracts in resident files.

Nor did they find written policies or procedures for determining maintenance charges or exceptions to them. There was no definition of gross or net income, no policy on using a resident's net worth in determining maintenance charges, and no single person with the responsibility of determining maintenance charges. The result was great disparity and inconsistency in resident maintenance charges. Residents typically received very short notice of changes in their maintenance charges, and the homes had no appeals process for residents who disagreed with the new charges.

Veterans Affairs reports that they have developed standard procedures for determining maintenance charges and notices of rate changes are now distributed to each resident with a minimum of 30 days' notice. These changes were implemented after the 1984 legislative audit.

Veterans Affairs has also drafted rules regarding Veterans Home admissions, resident conduct, fees, appeals and discharges. These have been approved by the Attorney General's Office. Human Services; however, has not pursued promulgation of these rules for several reasons:

1. Inconsistency. Human Services personnel said that the drafted rules are sometimes inconsistent with other rules governing the homes.

2. Scope. Human Services feels that some of the issues addressed by these rules now fall within the mandate of the Governor's Blue Ribbon Commission. Promulgation should wait until the commission completes its work.

3. Time. Unlike Veterans Affairs, Human Services considers these rules controversial. Promulgation of controversial rules can take many months, perhaps longer than Human Services will oversee operation of the homes.

The lack of rules has led a few residents to avoid paying maintenance charges. They cannot be discharged, because there are no rules supporting such an action. One resident has even brought suit against the Minneapolis home over this issue.

1980 Management Analysis Division Recommendation 10:

"The Minnesota Veterans Homes should revise the current rate schedule so that personal income exemptions are increased, no resident is charged more than the cost of his or her care and financial incentives are given to younger residents to return to the community."

Findings

The 1980 Management Analysis Division study team found that some residents did indeed pay more than the cost of their care, because there was no cap on resident payments. In effect, some residents were subsidizing other residents' care.

Another concern was the effect that unlimited maintenance charges had on a younger resident's ability to save money to successfully re-enter the community. There was a built-in disincentive in the rate structure that kept residents from saving money toward, for example, rent and utility deposits, since the more they earned, the more they paid the homes.

Veterans Affairs reports that a revised rate schedule was implemented by July 1984 so that no resident is charged more than the cost of care. Rates are reviewed every six months.

The personal needs allowance has been increased. Now residents with income from any source retain the first $85 of their monthly income. They are expected to contribute 95 percent of all income above $85 per month toward the cost of their care, and they retain the other 5 percent. Once they have fully met the cost of their care, they keep 100 percent of any remaining income.

Although domiciliary residents who work outside the homes are expected to apply their wages toward the cost of their care, those who are resident workers are not expected to use those wages to pay for maintenance costs.

Status Report - Legislative Follow-up Audit

Recommendations of the Legislative Auditor's 1985 follow-up audit and Veterans Affairs' report on implementation of these recommendations follows.

1985 Legislative Audit Recommendation 1:

"The Minnesota Veterans Home in Hastings should use an over/short account in the store and canteen areas."

Veterans Affairs reported that this recommendation was implemented by July 31, 1985.

1985 Legislative Audit Recommendation 2:

"The Minnesota Veterans Home in Hastings should maintain documentation showing that receipts are reconciled to the Statewide Accounting reports."

Veterans Affairs reported reconciliation of all receipts and deposits, implemented by June 30, 1985.

1985 Legislative Audit Recommendation 3:

"The Minnesota Veterans Home in Hastings should reconcile all receipts to either the Statewide Accounting Receipts by Deposit or Receipts by Appropriation report on a timely basis."

Veterans Affairs reported monthly reconciliation of all dedicated accounts, usually by the 15th of each month. This recommendation was implemented by June 30, 1985.

1985 Legislative Audit Recommendation 4:

"The Minnesota Veterans Home in Minneapolis should work with the State Board of Investment and the Department of Finance to verify the accurate investment balance for its social welfare account."

Veterans Affairs reported that proper account balances had been identified and that transfers and final reconciliation of all investments were completed by August 31, 1985.

1985 Legislative Audit Recommendation 5:

"The Minnesota Veterans Home in Minneapolis should reconcile the residents' account cards balance to the total social welfare assets."

Veterans Affairs reported that all accounts were reconciled by June 30, 1985.

1985 Legislative Audit Recommendation 6:

"A daily listing of all receipts should be completed by the cashier's unit at the Minnesota Veterans Home in Minneapolis."

Veterans Affairs reported that this recommendation was implemented by September 1, 1985.

1985 Legislative Audit Recommendation 7:

"Procedures should be developed and distributed for the following areas:

1) **processing of the VA reimbursement checks by the cashier's unit;**

2) **balancing the resident and maintenance account cards to the respective control card;**

3) **using the VA Estate Limitation when calculating the maintenance fees;**

4) **documenting the specific steps to be performed when completing the federal reimbursement reports;**

5) **calculating the two hours of nursing care per patient per 24 hours ratio."**

Veterans Affairs said they have developed policies to deal with all these items except the last, which was developed by the home administrator and the director of nursing. It exists in writing, but it is not known how well it has been followed.

1985 Legislative Audit Recommendation 8:

"The Minnesota Veterans Home Minneapolis business office should take special care to ensure that the ending inventory is accurate on the quarterly financial statements."

Veterans Affairs reported that the recommendation was implemented by June 30, 1985.

1985 Legislative Audit Recommendations 9 and 10 did not apply to the Minnesota Veterans Homes.

1985 Legislative Audit Recommendation 11:

"The Department of Veterans Affairs should conduct a complete physical inventory of fixed assets and update the listing accordingly."

Veterans Affairs reported that this is an ongoing process, but that continuous progress is being made. Some items have yet to be written off and others added. Staff from the homes and central office met most recently on January 12, 1988, to verify and correct inventory lists.

1985 Legislative Audit Recommendations 12 and 13 did not apply to the Veterans Homes.

1985 Legislative Audit Recommendation 14:

"The Department of Veterans Affairs should contact the Attorney General's Office to ensure that the payroll overpayments are satisfactorily resolved either through collection or write-off."

Veterans Affairs reported that this has been implemented.

Conclusions

The Department of Veterans Affairs, after the 1984 legislative audit, made conscientious and thorough attempts to implement the recommendations of the auditors.

Because the accounting office at the home did not report to the home administrator, the central office was too involved in the daily operations. This undermined the authority of the home's administrator.

In the past, the homes have lacked adequate contracts with contract service providers. It is necessary to have contracts with all outside service providers to ensure that services are of sufficient quality and quantity to meet the homes' needs.

The homes still lack rules regarding resident conduct, rights, obligations, fees, discharges and appeals. A few residents are taking advantage of this situation by refusing to pay maintenance charges.

Recommendations

1. The Office of the Legislative Auditor should conduct a financial audit of the Department of Veterans Affairs and the Minnesota Veterans Homes to ensure that the controls, policies and procedures recommended in previous audits are being maintained. Veterans Affairs and the homes should continue their attempts to follow the recommendations of the Legislative Auditor.

2. The homes should establish the position of business manager, who should supervise the work of the homes' accounts-payable, accounts-receivable, and purchasing and inventory sections. The business manager should report directly to the homes' administrator. This recommendation is consistent with those of the 1980 Management Analysis Division study and the 1987 Ashton Report to the Governor.

It is necessary for the home administrator to have authority over his/her business office, so that he/she can be held fully accountable for the homes' operations.

3. Management should sign an explicit contract with the VA Medical Center for physician coverage and set up a system to monitor and verify such coverage at the homes to ensure that payments for services are made according to contract. Contracts and systems to monitor the services provided by any new outside staff, such as a psychiatrist, should be put in place before they begin work at the homes.

4. When permanent management of the homes has been decided, the new management team should promulgate rules regarding resident conduct, fees, discharges and appeals. Rules should be comprehensive, consistent and clear. Residents, their families and staff members should be made fully aware of both their own and the homes' obligations.

5. Management should conduct a complete inventory of fixed assets and update the listing accordingly.

MATERIAL RESOURCE MANAGEMENT

The remainder of this chapter addresses the physical plant, vehicle and equipment needs and information systems usage at the Minneapolis home.

Physical Plant

Findings

Many older buildings are in use on the Minneapolis campus. Four buildings are 94 to 98 years old. One houses 18 to 25 residents. Another is leased to a chemical dependency treatment program. The others are a maintenance shop and the administration building. Building 6 (81 years old) houses 109 residents. Building 9 (51 years old) houses 65 residents. Building 15 (29 years old) is used for activities/auditorium. The nursing facilities are 7 and 15 years old and house 232 and 83 residents, respectively. Three buildings are closed and ready for demolition.

VA inspectors have expressed concern about the safety of the older buildings, particularly Building 6, built in 1906, and Building 9, built in 1936. These buildings are used for domiciliary residents.

A VA inspector found that Building 6 fire escapes were very rusty and recommended that they be tested for structural strength or replaced. They were tested on December 30, 1987, and passed. They will be sandblasted and painted when the weather allows.

VA inspectors have also cited the home for numerous electrical code violations, from exposed wires in junction boxes, missing outlet covers and frayed electrical cords to dangerous use of extension cords and multiple outlets. The Human Services management team reports that these problems were corrected by December 31, 1987.

Building 16, used for Alzheimer's patients, is on a cliff and near several open dumps on the home grounds. Human Services extended a previously-built fence farther along the cliff from the building when they began managing the home.

The security system in Building 16 is a buzzer that sounds when people do not successfully activate the bypass system. A notice on all outside doors informs anyone entering that they have 30 seconds once inside the building to bypass the alarm system. Anyone leaving the building must punch a number code to bypass the alarm. Staff, family members and alert patients know the code number.

> Health Department regulations require an auditory alarm system when nursing stations are not in sight of the doors. Because Building 16 was originally built as a domiciliary unit, not a nursing unit, there is no space to put nursing stations by the doors. Staff cannot tell if someone is missing without conducting a roll call of all patients. The staff has requested that doors be locked, but this does not meet Health Department regulations.
>
> The buzzer system has caused the staff much frustration. Persons entering the building sometimes do not read the notice on the door and accidentally activate the alarm. Staff and family members sometimes forget to punch in the code number before leaving, which also triggers the alarm. Sometimes the alarm sounds for no apparent reason.

Health Department inspectors cited both older and newer buildings on the Minneapolis campus for poor repair:

* burned-out exit lights
* kitchen flooring that was difficult to sanitize and needed to be replaced
* buckling floors
* stained and burned carpets

* missing window screens
* rotted window ledges
* crumbling steps
* peeling exterior paint on building trim
* peeling interior paint on walls and ceilings in public rooms, corridors and resident rooms
* crumbling mortar between bricks
* holes in interior walls

According to the current home management team, many of these items have been repaired.

The Health Department also cited the home for nonfunctioning plumbing. For example, in Building 9, used for domiciliary care, the first- and second-floor men's restrooms had shower faucets that had not functioned "for days," leaving the third-floor shower the only one available for residents. The water fountain in the corrective therapy room in Building 16 had apparently not worked in some time.

The Health Department cited the Minneapolis home for nonfunctioning exhaust ventilation in the majority of service rooms in Building 17. This has reportedly been corrected.

Several maintenance people have cited instances when fire alarms in Buildings 6, 9 and 17 have not functioned properly, and sometimes have been turned off for days at a time as a result.

An industrial hygienist with the VA cited the home on October 21, 1987, for not having an industrial waste discharge permit required by the Metropolitan Waste Control Commission. Nor does the home have an air emission facility permit from the Minnesota Pollution Control Agency. This was not cited as corrected in the report from the home to the VA on December 31, 1987.

This same inspector noted exposed asbestos in the mechanical rooms of Buildings 6 and 9. He also pointed out that other areas should be tested for compliance with OSHA regulations concerning employee exposure to asbestos, especially the tunnels between the buildings.

During the same inspection, asbestos respirators were found to be worn or defective and staff members did not know how to use them properly.

The VA inspectors found that the serving area where trays are assembled for non-ambulatory residents is totally inadequate to be efficient. Food gets cold and there is danger of bacterial growth from food sitting out too long.

The kitchen is too small for the food preparation equipment and freezers necessary to serve such a large population. Although food service is in Building 17, which was built in 1980, the facility is wholly inadequate to meet residents' needs.

The dry-storage area is too crowded as well, since stores are stacked too high to meet fire code requirements. This is in the process of being corrected.

The dietician does not have an office within a reasonable distance from the food service areas.

The administrative support staff do not have space for record storage and supplies.

The pharmacy was cited by VA inspectors for its small, inconvenient space, and because one of its doors was not locked during regular business hours.

Interviews with staff brought up complaints about the location of their work areas. For example, the paint shop is in a former garage; it is cold and damp and has mice and a leaky roof.

Maintenance people at the feedback session complained that inspectors were holding the home to more strenuous building codes than the law required -- that the home was being cited for violations of the code for new construction, not for existing buildings.

Both inspectors and maintenance staff noted how long it took to get maintenance requests taken care of. A maintenance worker described four routine maintenance requests he filed on the 11th of one month, and the first was not fixed until the 29th of the following month.

The home has no long-term facility management plan.

In Fiscal Year 1988, the Veterans Homes have received $240,500 for repairs and betterments, and the governor is recommending another $425,000 for Fiscal Year 1989 for repairs and replacements.

By December 31, 1987, the Human Services management team at the Veterans Home reported to Thomas Mullon, director of the VA Medical Center, that they had corrected the life-safety deficiencies cited in VA inspection reports during their October 1987 inspection.

The VA has agreed to conduct engineering studies to assess the long-term viability of the aging buildings.

Conclusions

Both Health Department and Veterans Administration inspections have cited the Minneapolis home for many building code violations and poor maintenance, which often affect the health and safety of residents and staff. These have included criticisms of the electrical systems, structural disrepair, exposure to asbestos and improper waste disposal.

Part of the problem has been the understaffing that has already been cited. In addition, the maintenance staff has not had adequate equipment or space to work in.

The legislature and the governor have not adequately funded the home's budget requests.

Space, even in newer buildings, is sometimes inadequate to perform needed tasks.

Management inattention to physical plant needs has affected resident and staff morale.

The security system in Building 16 currently meets Health Department requirements, yet is complicated and makes work for the staff.

Recommendations

1. Management should fund maintenance adequately and house staff and supplies adequately.

2. Management should work with supervisors and staff to reduce all regulations to a checklist so that maintenance staff can be sure that the facility is in compliance with the relevant codes.

3. Management should draw up a preventive maintenance schedule and determine who is responsible for implementing it and supervising the work.

4. Management should design a comprehensive, workable system for ensuring that repairs are completed in a timely fashion to guarantee the health and safety of residents and staff.

5. Following the VA engineering studies, management should develop a comprehensive facility-management plan. The plan should address capital investment needs, space allocations and plant maintenance.

Vehicles and Equipment

Findings

Vehicles and equipment were two of the largest sources of staff complaints in the material resource management areas. Equipment at the home was described as jury-rigged, too hard to fix, dangerous to use and never meant for its present use. Vehicles were a particular source of frustration.

Staff in interviews told of having to use second-hand or worse than second-hand equipment for the home. An example was circa-1950 hospital beds sent to the home with guardrails for another type of bed.

Used equipment is sometimes delivered to the home without instructions for assembly or safe use.

Staff find the vehicles difficult and dangerous to operate.

In January 1988, an ombudsman for older Minnesotans from the Minnesota Board on Aging found that, while the vehicles have restraints for wheelchairs, there are no restraints for wheelchair occupants or their special equipment, such as walkers or crutches. Some wheelchair restraints were frayed.

The ombudsman cited the vehicles for lack of repair and cleanliness. Transportation staff said that the vehicles need continuous repair. They are old, circa 1979.

There is no preventive maintenance plan for equipment and vehicles, only "emergency maintenance."

Vehicles continue to be used even under dangerous conditions. One driver told of seeing a tire with exposed cords on a van which carried residents. It took four days after he filled out a maintenance request before the tire was replaced.

The garage cannot house all the home's vehicles.

Conclusions

Equipment needs have been neglected.

Poor equipment and haphazard repair of equipment have threatened the health and safety of residents and staff.

Poor-quality and outdated equipment has created additional work for staff.

Recommendations

1. The legislature should fund equipment needs adequately, specifically Human Services' equipment funding request to the 1988 legislature.

2. The home should require the maintenance and transportation departments to develop a preventive maintenance program for equipment and vehicles. Staff should be assigned to carry it out.

3. Management should cut red tape to expedite maintenance and transportation requests.

Information Systems

Findings

An informations systems director was hired in the spring of 1986. He supervises a staff of four.

Automated systems now include word processing, pharmacy records, accounts receivable, the resident census and data base.

Personnel records are automated and on the Department of Employee Relations system.

Accounts payable are on the Statewide Accounting System.

Information systems office recommendations to the home administrator were sometimes not considered. In particular, the administrator and director of nursing refused to approve the purchase of case-mix software in the spring of 1987.

The software includes case-mix, pharmacy and care planning pieces. Human Services personnel have expressed concern about the care planning piece, but find the other pieces useful and appropriate.

Conclusion

Automation is new to the Veterans Homes, but this is an area where the homes have made progress.

The information systems office functions well, although there has sometimes been a lack of coordination and communication between this office and the home administrator, and between this office and users of automated systems.

Recommendations

1. Management should assess additional information system needs and develop a comprehensive plan in this area.

2. When a new software or hardware purchase is considered, the information services director should meet with users to discuss and evaluate the usefulness of the proposed purchase.

CHAPTER 8: HASTINGS VETERANS HOME

The staff and management of the Hastings Veterans Home expressed the belief that their problems were less severe than those in the Minneapolis facility. They felt that a management assessment which did not carefully distinguish between the two facilities would be unfair to the Hastings home. One individual characterized the relationship with Minneapolis as "guilt by association."

The Management Analysis Division team agrees that problems in the Hastings home are much less severe than those in Minneapolis, and that the two homes are best viewed as individual operations and environments. Consequently, this report contains a separate chapter on the Hastings home. It is a less detailed assessment which attempts to highlight some of the similarities and differences between the two homes.

LEADERSHIP PATTERNS

Findings

Hastings and Minneapolis share one licensed administrator. Management turnover in Minneapolis has, therefore, affected Hastings. The administrator has been available to Hastings' on-site management for consultation, but has not played a major role in day-to-day operations there.

Hastings has had six on-site managers since opening in 1978.

Most recently, actual on-site management has been provided by an assistant group supervisor who started at the home in August 1985. (His position was reallocated to a group supervisor classification in the summer of 1987.) He is in the process of fulfilling the educational requirements needed for certification as a nursing home administrator. (For purposes of this report, he will be referred to as the supervisor.)

Surveys and interviews showed that the supervisor is respected by the staff and residents:

> Nine employees commented on having a very good "administrator" in the staff mini-survey assessment of accomplishments.
>
> Staff identified the supervisor as having a "hands-on" management style. Several individuals cited instances where he became directly involved in the work (pouring concrete, rearranging food storage). This was not presented as interference, but as a willingness to pitch in as needed.

Some staff members stated that the supervisor has not been granted the necessary authority to be fully effective in his role. Political interference was selected as the fifth of 31 priority issues by a group of staff, residents and volunteers. The central office, the veterans service organizations and the county veterans service officers were all mentioned as having inappropriate levels of influence in daily operations.

Staff interviews and surveys expressed mixed views regarding leadership effectiveness of the management team:

Some suggested that supervisors and employees share opinions and work more as a team than their counterparts in Minneapolis.

However, roughly equal numbers commented on problems with undefined leadership, lack of communication and lack of cooperative interaction between levels and departments. These were ranked as the second (tie), fourth and 10th of 31 possible priorities for the home at a feedback session involving staff, residents and management.

Responses to the staff mail survey showed a similar split in opinions regarding supervisory effectiveness. In response to the statement, "I feel confident in my supervisor's leadership," 42.9 percent agreed or strongly agreed, while an equal 42.9 percent disagreed or strongly disagreed.

However, only 18.2 percent of the staff mail survey respondents agreed or strongly agreed that "supervisors cooperate with each other." Only 13.6 percent felt that communication between work groups is satisfactory.

Information from interviews suggested that some supervisors refuse to speak to each other and that some supervisors may not assign work effectively. While many staff reported a staff shortage, one individual reported having little to do.

The most recent VA inspection (October 1987) found that Hastings only partially met the standard for "input from all services to management by regular meetings and systematic review of the domiciliary program" and concluded that "more department head meetings are needed."

As in Minneapolis, policies and procedures have not been developed and communicated for all areas:

On the staff mail survey, only 19 percent of the respondents agreed or strongly agreed that the home "keeps its policies and procedures up-to-date."

Only 14.3 percent of the respondents believed that "changes in policies and procedures are clearly communicated to all those involved or affected," and only 5 percent felt that "changes in priority are promptly communicated."

The most recent VA inspection also identified problems with policies and procedures and concluded that they "require updating and rewriting."

The Management Analysis Division team heard a number of explanations for why informal leadership systems have been reasonably effective in Hastings:

* The size of the facility;
* Its more homogeneous resident population;
* The informality inherent in boarding care, in contrast to nursing care;
* The positive role model provided by its supervisor;
* Its relationship with the community of Hastings; and
* The "small-town values" of its work force.

Conclusions

Hastings shares some problems with Minneapolis: mission clarity, communication between individuals and departments, and policies and procedures.

The problems have not been as disabling in the Hastings environment. The explanations for why informal leadership works better in Hastings are convincing.

However, failure to address the problems will perpetuate conflicting goals, limit team effectiveness and promote less than fully effective resident services. Addressing the problem areas will benefit the home without sacrificing its strengths or identity.

Recommendations

1. The Management Analysis Division endorses the blue-ribbon commission's recommendation that there be a licensed administrator at Hastings. However, that recommendation should not be enforced until the current supervisor is eligible for licensure.

2. The role and authority of the Hastings administrator should be similar to that of the Minneapolis administrator. As recommended by the blue-ribbon commission, he or she should report directly to the governing body.

3. A top priority for the administrator should be to articulate and sell the new Hastings Veterans Home mission, as defined by the blue-ribbon commission and the governing body, to the staff and other interested parties. The mission's effect on the work of individuals should be described clearly so that all employees see the connection between their particular work assignments and the broader goals of the home.

4. Another top priority for the administrator should be the definition of roles, reporting relationships and responsibilities of supervisors and lead workers. He or she should set clear expectations for all members of the supervisory team and should be as directive as necessary to ensure that supervisors are meeting the home's needs. If necessary to ensure results consistent with needs, the administrator should require supervisors to adhere to strict work plans with measurable criteria for assessing outcomes.

5. The Management Analysis Division endorses the VA recommendations for more department head meetings and updated policies and procedures.

HEALTH CARE MANAGEMENT

Findings

The Minnesota Veterans Home in Hastings is licensed by the state to provide boarding care for a bed capacity of 200 and is subject to periodic inspections by the Health Department to assure compliance with regulations governing boarding care facilities. Because the home is reimbursed by the Veterans Administration for providing domiciliary care to eligible veterans, it is also subject to annual VA inspections.

Boarding care facilities are required to provide only personal and custodial care and related services. Examples of personal or custodial care and related services are board, room, laundry, supervision over medications and activities of daily living (bathing, eating, etc.), and a program of activities and supervision required by persons incapable of properly caring for themselves.

The care provided for the home's residents is an interdisciplinary effort on the part of licensed nurses, social workers, chemical dependency counselors, recreational/corrective therapists, volunteers and support services staff.

The home has contracts for physician, dental and optometrist services. Residents who require specialists, hospitalization or inpatient chemical dependency or psychiatric treatment are sent to outside providers, primarily the VA Medical Center. Pharmacy services are initially provided by the medical center pharmacy and refilled by the pharmacy at the Minneapolis home.

Analysis of recent VA and Health Department inspection reports, as well as interviews with health care officials, indicates that the Hastings home does not share the same regulatory history as does the Minneapolis home. Hastings has not had a large number of violations nor does it have a serious pattern of repeated violations or failure to correct violations within designated time frames that equals the Minneapolis home. Correction orders issued to Hastings are not as widespread as those issued to Minneapolis -- due in part to its being a smaller facility, having a smaller and better managed staff, and not having a nursing home component.

Nursing/Physician Services

Residents and family members contacted felt the quality of care provided by the nursing staff and physician was very good. The nursing staff was described as competent and caring by both groups. Scores and comments on a survey sent to family members were much more positive than those of Minneapolis family members, who voiced numerous complaints (see Family Member Survey, Appendix C).

Nursing services are provided by a staff of nine licensed nurses who reportedly have good working relationships with one another. The unit has not experienced the supervisory, communication and coordination problems that have existed in the Minneapolis home's nursing unit.

Staff interviews and/or inspection reports noted some of the following concerns related to nursing or medical care:

> The home was cited by the Health Department in September 1985 and again in September 1987 for not adequately addressing the poor hygiene of some of its residents. Interviews revealed that staff sometimes feel ill-equipped to deal with uncooperative residents who refuse to bathe and see no negative consequences in place for residents who don't cooperate after being confronted by the home's interdisciplinary care team.

The home was recently cited by the Health Department for insufficient monitoring of and documentation on residents who self-administer medications. Interviews revealed that medications are administered by nursing staff for approximately 40 residents, while the remaining residents self-administer their medications.

Recent VA inspection reports reveal that nursing care plans were found to be brief, nonspecific and incomplete, and were not included in interdisciplinary care plans. The VA recommended inservice training on care plans. Interviews revealed that input from nursing staff has sometimes been excluded from interdisciplinary processes, especially with reference to admissions and discharges. Staff feel that greater nursing input during the admissions process would allow for more appropriate placement of residents within the home. Staff report that efforts are under way to address these issues. The nursing supervisor has provided training on care plans, and interdisciplinary care planning procedures have been changed to allow for more nursing input and more individualized planning.

The VA cited the home in October 1987 for lack of inservice training for nursing staff. The home has had to rely on staff development personnel at the Minneapolis home, which has also been cited for this deficiency. Management will request funding for two additional staff development positions during the next legislative session, one of which will be allocated to the Hastings home.

The VA has cited the home in recent years for ineffective or nonexistent programs on quality assurance, utilization review and infection control. Interviews revealed that staff are eager to begin these programs but must wait for these programs to first be initiated at the Minneapolis home in order for efforts to be coordinated.

Staffing levels within the nursing unit have also been a concern at the Hastings home.

> The VA, in September 1986, found that nursing staffing levels were adequate for normal domiciliary residents, but were inadequate for unstable medical or psychiatric residents who were leaving hospitals "quicker and sicker." Interviews revealed that nursing staff have sometimes had to care for residents who recently returned from surgery and required temporary nursing procedures or assistance with walking or dressing, but, due to the temporary

nature of their conditions, did not require nursing home care. Employees felt that additional staff would help to address the needs of these residents, as well as improve the ability of staff to more closely monitor residents with respect to hygiene and/or self-administration of medications.

One of the 24 nursing positions obtained by Veterans Affairs for Fiscal Year 1988 was transferred to the Hastings home. Human Services management will request permanent funding for additional positions during the next legislative session. Interviews revealed that, with the addition of the new staff, the nursing supervisor has been able to organize nurses into teams with one nurse for 50 residents. This reportedly has allowed nurses to more effectively monitor residents to address problems with hygiene and self-medication.

Psychosocial Issues and Care

As is true in the Minneapolis home, many of the concerns related to the treatment and rehabilitation of residents at the Hastings home revolve around the home's vague and broad mission and admissions policies. Staff interviews revealed that there are many subpopulations within the home which require different levels of care. Staff are unsure about which target groups they are supposed to be serving and how they can best serve them. In a survey sent to employees of the home, none of the 22 respondents agreed with the statement, "The goals and objectives of the home are clearly defined and reviewed regularly."

According to Human Services management, 177 or 91.7 percent of Hastings residents are diagnosed as having a mental disorder, of which 142 or 80.2 percent have an alcohol-related diagnosis.

Staff see a further distinction between older stabilized residents who might require long-term supervision and younger residents who sometimes require more supportive aftercare and rehabilitation. Some employees believe that residents could be better served if the home, in conjunction with the Minneapolis home and the VA domiciliary in St. Cloud, targeted its resources toward a specific group of residents based upon the type and level of care needed.

Many of the employees interviewed were concerned about residents becoming dependent on the home when, with the appropriate level of attention and services, they might ordinarily be capable of returning to community living. One

employee stated that the current system, which lacks clear goals and expectations, enables some to become dependent on the home and to lose work habits and coping skills they formerly possessed.

In a focus group held for residents of the Hastings home, residents disagreed about their responsibility to take part in rehabilitation efforts. Some felt they had a right to room and board with minimal interference, while others proclaimed, "This is not a place to vegetate!"

The home is not licensed to provide active treatment programs for chemical dependency or mental illness. Most residents who require this type of treatment must go to outside providers.

According to the VA and an assessment done by the Human Services Mental Health Division, the home has not had adequate access to mental health professionals to assess and monitor the needs of some residents and provide consultation to social workers and other employees. Human Services management secured funding for a clinical psychologist who will be shared by both homes and provide consultation to staff. Management will request permanent funding for this position during the next legislative session.

The home has a 30-bed unit for residents who enter the home after receiving active community-based treatment for chemical dependency. The Serenity Program is a supportive AA-based program with a strong emphasis on relapse prevention. Residents are required to sign a contract agreeing to the expectations of the program, which include attendance at two support-group and two AA-group meetings every week.

Staff interviews revealed that chemically-dependent residents may not receive an adequate level of supportive after-care.

> The home offers one support group for the general population in addition to the AA meetings that are held. One chemical dependency counselor is available for individual counseling. Residents in the general population are not required to attend these meetings. Some feel that the Serenity Program should be expanded to include a continuum of care, but note that an additional chemical dependency counselor would be needed.
>
> Until recently, the home had a vending machine from which beer could be purchased. Additionally, veterans groups provide alcohol during some of the activities they sponsor. Interviews with staff revealed that many of the home's chemically dependent residents suffer relapses and

that some staff are more likely than others to report chemical use. During its most recent inspection, the VA noted that "alcohol availability severely jeopardizes the health of this community." It was recommended that the Hastings home become a drug-free environment, given its chemically dependent population. In accordance with this recommendation, management recently closed down the beer machine.

There are also concerns related to social services, recreational activities and other rehabilitation efforts.

According to a recent VA inspection report, not all records had psychosocial assessments. The results of social services rendered were not in charts. Resident charts did not reflect discharge planning and follow-through. The ratio of social workers to residents is 1:100, while the VA recommends 1:60. Similarly, an assessment of the social services unit conducted by Human Services personnel found that "case-load size dictates that care plans and most interventions with residents are superficial and at times irrelevant to the clinical needs of the residents."

Although the home has a work therapy program that enables residents to work within the home, both residents and staff saw a need for more vocational training and outside job placement services for residents. It was reported that many of the residents lack specialized skills that would enable them to earn enough money to support themselves in the community. Others noted a need for improved transportation between the home and the cities, where there are more employment opportunities.

The home was cited by the Health Department in 1985 for insufficient personnel for the activities program. This was found to be corrected during the most recent state survey. However, a recent VA inspection report notes that written care plans regarding activities were not in all records, goals were not clearly defined, patient compliance was not checked, rehabilitation evaluations were not in charts, and more frequent review and follow-up were needed.

Residents contacted enjoyed the activities offered at the home but felt that residents should be urged to participate in more activities. Staff interviews revealed that some residents don't participate in any activities.

Volunteers sponsor many of the group activities for the home's residents.

The Hastings home is dependent on veterans organizations for its volunteer services as is the Minneapolis home. When the home was transferred to Human Services, approximately 10 of the 22 volunteers who worked in the home on a regular basis transferred their services to the VA Medical Center.

Unlike at the Minneapolis home, staff interviews did not reveal a crucial need for more individual volunteers to interact with the home's residents on a one-on-one basis. Given that the Hastings home does not have a nursing home component, group activities had reportedly worked well.

A focus group was held at Hastings for volunteers of both homes, but only Hastings volunteers attended. One volunteer mentioned that some veterans groups prefer to volunteer at the Hastings home because they are treated very well by staff. Another saw a need for a more formal mechanism to recruit volunteers and coordinate their activities.

Indirect Services

Housekeeping staff provide services to the home's residents by cleaning the entire facility, coordinating the ordering and distribution of laundry with the home's laundry contractor and maintaining a center for donated clothing.

Interviews with residents and employees did not reveal complaints regarding the cleanliness of the home or the coordination of laundry services. Residents mentioned that the home was much cleaner in recent months.

Recent VA and Health Department inspection reports note a need for improved housekeeping services in several areas. Deficiencies noted were not as widespread as those at the Minneapolis home. The VA recommended that three additional housekeeping employees be hired to address housekeeping concerns. Human Services management will request permanent funding for additional staff during the next legislative session.

An assessment of housekeeping services conducted by personnel from another Human Services facility also noted deficiencies relating to housekeeping and said that these could be addressed by hiring three additional employees, purchasing

equipment for carpet cleaning, providing inservice training on certain procedures, developing regular schedules for cleaning miscellaneous items such as window sills, pipes, etc., and expanding housekeeping services in the dietary area. The assessment also recommended that the unit's building services supervisor be upgraded to an executive housekeeper in accordance with the duties she was performing, and that the building services supervisor position be maintained to allow for improved supervision.

Dietary staff provide meal service for residents of the home as well as for residents of the detox center and halfway house located on the home's grounds.

Residents contacted did not voice major complaints about food services. A September 1986 VA inspection report notes that food was attractive, portions were adequate, dietary supervisors tried to accommodate individual preferences of residents, dietary staff personally knew of residents who were on special diets, and residents' comments on food service were favorable. An assessment conducted by personnel from another Human Services facility also found that the receipt, storage, preparation and presentation of food were very good.

Deficiencies noted by the Health Department were not as widespread as those issued to the Minneapolis home.

> The home was cited by the Health Department in September 1985 and again in September 1986 because the food provided during the "cracker barrels" sponsored by veterans groups was not consistent with the therapeutic diets of some of the home's residents. The inspection report noted that staff had been encouraging groups to bring in fruits rather than cheese and crackers and had also attempted to obtain a physician's order which would allow these residents to attend "cracker barrels."
>
> The Health Department cited the home in September 1987 for unsanitary conditions and procedures in the dietary area. However, the deficiencies were not nearly as severe as those cited at the Minneapolis home. The report notes that deficiencies could be addressed by inservice training on sanitary procedures and by monitoring food sanitation on an ongoing basis.

An assessment conducted by personnel from another Human Services facility noted that most deficiencies were related to contractor errors and not to dietary staff. The report states that the dietary area should not have major Health Department deficiencies. There were plans under way to expand housekeeping services to the area. Dietary supervisors and staff seemed able and willing to make corrections.

Resident/Staff Relations

The home has not been cited by the Health Department during its two most recent licensing surveys for violations of the residents' Bill of Rights or the Vulnerable Adults Act. There is a functioning resident council as required by VA standards for domiciliary care. Residents contacted stated that they received timely information regarding resident rights. Residents hoped the recent emphasis Human Services management has placed on the Vulnerable Adults Act would not result in condescending attitudes on the part of Hastings staff.

Interviews with staff, residents and health care officials revealed that a "small-town" caring attitude permeates the home. Residents felt they were treated with respect by a caring staff with minimal interference unless warranted. Residents reported sharing a close relationship with the home's "administrator," who reportedly has kept in close contact with residents during all of the recent changes the homes have undergone. The home's size and long-term staff allow for more personalized care. One resident mentioned he asked for an aspirin one night and a nurse asked him how his headache was the following day.

Unlike the Minneapolis home, theft of money and personal articles was not a concern of residents and family members contacted. On a survey sent to family members, Hastings family members agreed with the statement, "The personal articles of residents are free from theft," whereas Minneapolis family members strongly disagreed with this statement. Theft was a major concern discussed during a focus group for Minneapolis residents but was not mentioned during the Hastings focus group. Overall scores and comments on a family member survey section pertaining to resident/staff relations were much more positive then those of Minneapolis family members.

When Human Services assumed temporary management of the homes, it provided for the on-site services of an ombudsman to address issues of residents' rights and resident/staff relations. The ombudsman recently issued a report which listed numerous problems at the Minneapolis home and stated that "extensive casework at Hastings did not appear to be necessary."

Conclusions

Nursing and medical care for the home's residents has been consistently less problematic than that of the Minneapolis home, as evidenced by regulatory history and the positive accounts of residents, family members and staff. This has been attributed to a more stable and caring staff, absence of supervisory problems and other issues which accompany a large nursing staff, and a level of care less demanding than the care necessary in a nursing home setting. Deficiencies related to resident hygiene and self-administration of medications and to care planning have started to be addressed with additional staffing, inservice training and the organization of nursing teams. Improved coordination with the VA Medical Center is needed.

Many of the problems that plague the Minneapolis home, with respect to the perceived failure of adequately addressing the rehabilitative and psychosocial needs of residents, exist in the Hastings home as well. A broad mission and admissions policy have allowed for resident subpopulations with different levels of needs -- some of which cannot be met, absent the structured programs and additional staffing that would be needed for a more supportive level of aftercare, especially for residents with diagnoses related to mental illness and chemical dependency.

Dietary and housekeeping services drew positive comments from staff, residents and family members. Regulatory deficiencies related to these services are minor in comparison with those issued to the Minneapolis home.

By all reports, interaction between the home's staff and residents has been consistently positive, and can be considered one of the home's strongest attributes.

Recommendations

1. Management should request permanent funding for positions requested to meet VA- and Health Department-related deficiencies in the areas of nursing services, psychological services, social services, staff development and housekeeping services.

2. Management should immediately schedule a meeting with VA Medical Center psychiatric and pharmacy personnel to develop a strategy which would ensure the provision of adequate psychiatric follow-up documentation and timely pharmacy services.

3. In accordance with a recent VA recommendation, management should prohibit the provision of alcohol within the home by:

   continuing to provide only non-alcoholic beverages in the home's vending machine, and

   prohibiting the provision of alcohol during activities sponsored by volunteer groups.

4. Management, in conjunction with the volunteer services coordinator, should establish a formal mechanism for assessing the needs of the home, communicating the needs to the community and recruiting and coordinating volunteers to meet those needs. Special emphasis should be placed on expanding the home's volunteer base beyond the veterans groups that regularly offer their services.

5. Before implementing major programmatic changes, management, in conjunction with the Minneapolis home, the VA Medical Center and other community-based providers, should better define its mission with respect to the levels and types of services/programs that should be offered based on the needs of the veteran population it serves, the effectiveness of its currently offered services and/or programs and the effectiveness and availability of the services/programs that exist in the community at large.

HUMAN RESOURCES MANAGEMENT

Staffing Patterns

Findings

Most of the staffing issues at the Hastings home have been addressed by Human Services in its request to the Legislative Advisory Commission. See "Human Resources Management: Staffing Patterns," p. 97, for more details on staffing levels.

Employee mail survey respondents are equally divided on whether the new positions added by the Legislative Advisory Commission will meet the home's needs for the near future. Staff interviews indicated concern regarding staff shortages in nursing, dietary, housekeeping and maintenance. In addition, the resident population has created a greater need for social services, chemical dependency counseling and psychological services.

Resident workers have been used to supplement staff in indirect care. These workers do not always permanently reside at the home and may not be consistent in their attention to quality work and/or work attendance.

Issues surrounding overtime and overwhelming workload do not exist at the home. Although some teamwork issues among staff members exist, only 9.1 percent of the respondents to the employee mail survey indicated that they cannot accomplish their assigned work on a shift.

Changes in the mission of the Hastings home may affect staffing needs. In the past, the home has been a boarding care facility with inadequate staff to provide meaningful rehabilitation programs.

Conclusions

Although the Hastings home has not faced severe staff shortages, any enhancement of services and programs will require a reassessment of staffing needs.

Recommendations

1. Staffing requests made by the Department of Human Services should be approved. If the mission of the Hastings home is altered, management should re-evaluate staffing needs.

2. Where necessary, resident workers should be replaced with civil service staff to ensure appropriate staffing levels. Reliance on resident workers as a substitute for permanent staff should be reduced. Policies and procedures should be established in this area.

Employee Training

Findings

Employee training at the Hastings Veterans Home has been virtually non-existent. Staff could attend training at the Minneapolis home, but were not encouraged to do so. Although the resident population is somewhat different from that at the

Minneapolis home, staff interviews indicated many of the same concerns (i.e., type of training needed, amount of training received, management attention to training needs, etc.) regarding training areas. Only the staff at Hastings specifically referred to the lack of ambulance and paramedic training for transportation unit drivers. Other findings in this area echo those of the Minneapolis home found in "Human Resources Management: Employee Training," p. 102.

Conclusions

Conclusions are identical to the conclusions regarding employee training at the Minneapolis facility, found in "Human Resources Management: Employee Training," p. 102.

Recommendations

Recommendations are also identical to those for the Minneapolis facility, found in the same reference.

Staff Teamwork

Findings

Both staff interviews and the employee survey indicated that cooperation and communication among staff is widespread. A familial environment has been created by both staff and residents.

However, some areas of poor cooperation and communication among staff, work areas and management do exist. Employee mail survey respondents indicated:

> Under the Department of Human Services, 4.8 percent agreed that conflicts are solved by talking and negotiating; 23.8 percent agreed under the Department of Veterans Affairs.
>
> Under the Department of Human Services, 19 percent disagreed that meetings are well planned, well run and productive; under the Department of Veterans Affairs, 23.8 percent disagreed.
>
> Under the Department of Human Services, 33.3 percent disagreed that a lot of effort is made to ask for the thoughts and opinions of employees; 28.6 percent disagreed under the Department of Veterans Affairs.

Resident and volunteer focus group participants indicated that staff cooperation and respect are an overall strength of the home. Participants were very positive about staff involvement in all areas.

Conclusions

Cooperation and communication problems do exist within the Hastings home. Informal systems do not necessarily address all staff needs in this area.

Recommendations

1. Formal communication policies should be established. Consideration should be given to recommendations made for the Minneapolis home in this area.

2. Resolution of conflicts between work areas should be made as soon as possible. Staff should be involved in developing specific terms of interaction. Written agreements among work areas, outlining roles and responsibilities, should be created to deal with confusion between departments.

3. Policies and procedures should be formalized to define authorities and responsibilities of each department. Staff participation in creation of formal written material is critical. Focus groups should be established to assist in development of formal policies and procedures in all work areas.

Working Environment

Findings

Morale at the Hastings home is generally very good. The employee mail survey indicated that the majority of employees look forward to coming to work. This is vastly different from the negative outlook at the Minneapolis Veterans Home.

Staff feel ownership toward their work and have a sense of pride in what they do. Respondents in the employee mail survey indicated that 59.1 percent believe their work unit values quality of work over deadlines. Many of the employees worked at the Hastings facility when it was a state hospital and have identified for a long time with the facility and the quality of care provided there.

Recent publicity at the Hastings home regarding the percentage of the resident population diagnosed as having some type of mental illness has negatively affected both staff and residents. Concern over the effect this publicity had on the public image of the home was expressed in the resident focus group.

The employee survey indicated that 54.5 percent of the respondents feel their work group gets adequate feedback from clients on services provided. However, 23.8 percent of the respondents to the employee mail survey indicated that their work unit is not praised by the Department of Human Services for doing good work. Slightly more, 28.6 percent, of the respondents said their work unit was not praised when they were under the Department of Veterans Affairs.

Conclusions

The working environment at the Hastings home is better than at the Minneapolis home.

The Hastings home lacks a formal rewards and recognition system. The informal system only partially meets the needs for recognition.

Recommendations

1. A formal rewards and recognition program should be established. Policies and procedures for this program should be developed by a focus group composed of both staff and management. Consideration should be given to criteria for both formal achievement awards for eligible employees and non-financial awards for those individuals not contractually eligible for monetary awards. Additional recommendations in this area can be found in the "Human Resources Management: Working Environment," p. 109.

FISCAL/MATERIAL RESOURCE MANAGEMENT

Findings

The Minneapolis home provides centralized fiscal, personnel, and purchasing services to Hastings. See "Fiscal/Material Resource Management," p. 113, for additional details on centralized services.

The VA's annual fiscal audit of Hastings was conducted on October 13 and 14, 1987. It discovered only one minor discrepancy.

As in Minneapolis, the Hastings campus includes older buildings. Building 23 has 155 beds and is 71 years old. Its addition is 36 years old. Building 25 is 68 years old and has 45 beds.

Upgrading of the physical plant was the most-mentioned accomplishment in the staff mini-survey. Improvements were noted in the kitchen and dining room, front lobby, Buildings 23 and 24, and the gym.

A new state law effective July 1, 1989, prohibits relicensing rooms with more than four boarding care beds. Hastings has eight rooms with eight beds and a few rooms with five beds. The supervisor indicated that subdividing rooms is not architecturally feasible, and that the new law will reduce the home's licensed capacity to about 165 beds.

Interviews raised staff concerns in the following areas:

Need for a private break space for employees, preferably with a microwave oven and refrigerator;

Physical plant and vehicle repairs and the need for a preventive maintenance program;

The use of second-hand equipment from Minneapolis and the sense that Hastings' needs are a low priority;

Availability of parts and supplies for routine upkeep and maintenance;

Asbestos safety; and

Boiler status and safety.

Independent testing confirmed that there are asbestos hazards on the campus. Management reports that inservice training on asbestos safety has begun and that a plan is being developed for "encapsulating" the areas of risk.

The Health Department survey team noted a number of physical plant problems in its September 1987 inspection, involving exhaust ventilation systems, damaged or rusty toilet stalls, holes in doors, and missing globes for light fixtures. The specific problems were resolved by the time the Health Department did its follow-up inspection.

An October 1987 VA inspection raised several industrial hygiene and fire safety concerns. Five of nine safety standards were rated as "not met." Three of three physical environment standards were rated as "partially met." Management reports that the VA is satisfied with progress made to date on these issues. A formal reinspection is due in April 1988.

Conclusions

The Hastings facility has not had sufficient control over its fiscal and material resource management.

Physical plant improvements are a major accomplishment for the home. However, staff and inspection concerns regarding aging buildings, maintenance and safety need to be addressed on an ongoing basis.

Recommendations

1. As recommended by the blue-ribbon commission, the Hastings home should become an individual institution with its own operating budget. It should share common services in fiscal, personnel or other areas only when it is feasible and economically beneficial.

2. As recommended for Minneapolis, management should develop and implement a facility management plan.

3. As recommended by the Health Department, the home should "develop and disseminate . . . a formal reporting mechanism with an inspection and monitoring program to ensure that [physical plant] problems . . . are identified and corrected on a timely basis."

4. Management should continue to give priority attention to asbestos hazard issues.

5. The home should also develop a preventative maintenance plan to prolong the life of equipment and vehicles.

CHAPTER 9: VETERANS' CARE POLICY

LONG-TERM CARE TRENDS

This chapter relates to the current and projected use of veterans homes and community alternatives and to the appropriateness of seeking Medical Assistance certification. Information has been provided by the State Planning Agency and the departments of Veterans Affairs, Human Services, Health and Finance.

Current Utilization of Long-term Care Facilities

According to the Department of Human Services, 9 percent of Minnesota's elderly population is in nursing homes, compared with a national average of 5 percent. This rate is in part a result of the high number of nursing home beds per 1,000 persons over 65 and in part a result of the high number of people over age 85. Minnesota ranked third in the nation in 1982 with 85 beds per thousand elderly, compared with a national average of 55 beds per thousand elderly.

Minnesota has 44,999 licensed nursing care beds and 4,734 licensed boarding care beds at this time. The average statewide occupancy rate for nursing homes was 93.5 percent during 1986, with a resultant total of approximately 42,074 nursing care residents in the state.

Although veterans make up 17 percent of the total elderly population in the state, a 1982 Veterans Affairs study determined that veterans represent only 7.3 percent of private nursing home residents. This is primarily because most veterans are male and are thus more likely to have a living spouse to provide informal care. The majority of community nursing home residents are female.

At any one time, an average of 308 Minnesota veterans are residing in community nursing homes through the VA's contract nursing home care program. The Minneapolis VA Medical Center contracted with 127 nursing care facilities in the state for such services during Fiscal Year 1987.

Currently, the Minnesota Veterans Homes in Minneapolis and Hastings have a combined capacity of 346 nursing care beds and 394 domiciliary care beds. As of January 1, 1988, 315 individuals resided in the nursing care unit and 319 individuals resided in the domiciliary units.

The State Planning Agency estimates that 3,071 veterans are cared for in Minnesota nursing homes, and that 1,700 receive Medical Assistance. The Minnesota Veterans Home in Minneapolis has 346 licensed nursing care beds and therefore serves approximately 8.9 percent of veterans in need of nursing care.

Cost of Care

Unlike rates in other state-operated and community-based long-term care facilities, the Minnesota Veterans Homes' rates have been set on a retrospective basis and have not included additional staffing and indirect and property-related costs associated with operation. Costs for new or increased operations are not realized until they have been incorporated into the rate base and included in revised rates, which can take up to six months. Effective January 1, 1988, daily rates for nursing care at the Minneapolis home were $59.

If the Minnesota Veterans Homes set rates prospectively, taking into account both the cost of additional staff (42 approved by the legislature for Fiscal Year 1988 and 58 approved by the Legislative Advisory Commission) and capitol costs (property acquisition and debt service), the Department of Finance estimates that the daily rate for nursing care at the Minneapolis home would be $85.49. (This figure will be higher if Human Services' request for additional staff beyond the 58 granted by the Legislative Advisory Commission is granted during the next legislative session.)

According to research conducted by the State Planning Agency, the corresponding average daily rate for an individual on Medical Assistance in a community nursing home is estimated to be $69.02.

The data below shows how payment for nursing care at the Minnesota Veterans Home and community nursing homes would be distributed among several contributors:

Resident Contribution: It is estimated that the average resident contribution would cover approximately 50 percent of the daily cost of nursing care at the Minnesota Veterans Home in Minneapolis, or $42.75. According to the Department of Human Services, the average Medical Assistance recipient in a community nursing home contributes approximately 48.8 percent of the daily rate for care.

Federal VA Contribution: The VA is expected to raise its nursing care per diem to $20.35 for Fiscal Year 1988. However, VA per diems are not provided for the homes' non-veteran residents or for residents who miss days as a result of hospitalization. Veterans Affairs estimates that the VA would contribute $18.81 (or 22 percent of $85.49) toward the average resident's daily cost of care, as opposed to the maximum per diem of $20.35.

State General Fund Contribution: When projected resident ($42.75) and VA ($18.81) contributions are subtracted from the projected daily rate for nursing care at the Veterans Homes ($85.49), the projected state contribution would be $23.93, or 28 percent of the cost of care. For Medical Assistance recipients in community nursing homes, the state contribution is estimated to be $15.81 per resident, or 23 percent of the cost of care, with the federal government contributing $20.14 and the county contributing $1.69.

COMPARISON OF ESTIMATED COSTS FOR NURSING CARE

Contribution Source	MN Veterans Homes*	Community Home **
Resident contribution	$42.75	$31.38
Federal VA per diem	18.81	---
State general fund	23.93	---
Federal share of Medical Assistance	---	20.14
State share of Medical Assistance	---	15.81
County share of Medical Assistance	---	1.69
TOTAL	$85.49	$69.02

*Estimated figures provided by State Finance and Veterans Affairs
**Estimated figures provided by State Planning

Assuming that rates were set prospectively, the state would pay approximately $8.12 more per day ($2,964 a year) in nursing care costs for a resident in the Minneapolis Veterans Home than it would for a resident receiving Medical Assistance in a community nursing home. Based on the veterans home's average census of 333 nursing care residents for Fiscal Year 1987, the state would pay $987,012 more per year in nursing care costs for residents of the Minnesota Veterans Home than it would pay if these residents were residing in community nursing homes and receiving Medical Assistance.

However, the U.S. General Accounting Office issued a recommendation to Congress in July 1987 to reduce VA pensions to residents in Medical Assistance-supported nursing homes. VA pensions and Social Security are the primary sources of income for veteran residents. If this change takes place, the amount residents contribute toward their care in community nursing homes would be reduced and, as a result, the state contribution toward their nursing care costs could be increased.

While much attention has been focused on the cost of nursing care at the Minnesota Veterans Homes, the majority of the homes' beds are licensed for boarding (domiciliary) care. For Fiscal Year 1987, the percentage of Minnesota Veterans Homes boarding care costs covered by the state was more than twice the percentage of its contribution for nursing care costs.

It is not easy to make a comparison between the rates charged for boarding care at the Minnesota Veterans Homes and those charged by other boarding care facilities throughout the state. A boarding care facility with a resident profile similar to that of the Minnesota Veterans Homes (i.e., high incidence of chemical dependency and mental illness) would be classified by the federal government as an institution for mental disorders. Because those institutions are not eligible for funding under Medical Assistance, the Department of Human Services has no information about their rate structure.

According to the Department of Human Services, the average daily rate for care at boarding care facilities certified for Medical Assistance was $38.85 as of November 1987. Medical Assistance covers 75 percent of that cost ($28.96), and the remainder is covered by the resident. Corresponding projected prospective daily rates for boarding care at the Minnesota Veterans Homes are $37.44 (Hastings) and $41.88 (Minneapolis).

Demographic Trends/Projected Needs

Nationwide, the population of individuals aged 85+ is rapidly increasing.

Minnesota's elderly population (persons 65 and older) is growing rapidly and will continue to grow for the next 25 to 35 years.

Minnesotans are long lived. The state ranks second in the nation with an average lifetime of 76.15 years. From 1985 to 2000, the number of Minnesotans 85 and older is projected to grow by 51 percent.

Persons 85 and older are the most long-term care dependent. More than one-third of persons in Minnesota over age 85 were in nursing homes in 1980, compared with 5 percent between the ages of 65 and 84.

The veterans population is aging. Elderly veterans will comprise an increasing share of all veterans into the next century.

Elderly veterans comprise about 17 percent of Minnesota's elderly population. As World War II veterans reach retirement age, the proportion of veterans in the elderly population will increase to almost 23 per cent by the year 2000.

The primary users of nursing care beds in the state are and will continue to be women over age 75. While the number of beds needed by veterans will increase through the year 2000, at no time will veterans constitute more than 23 percent of all Minnesotans who need nursing care.

In 25 to 30 years, the "baby boom" generation of the late 1940s through the 1960s will begin to reach retirement age and will dramatically inflate both the proportion and numbers of the elderly. However, state demographer and VA population projections indicate that, after the year 2000, elderly veterans will make up a decreasing proportion of this expanding elderly population.

The following trends are important to note when one considers that most long-term care has been provided by the "informal support system," family and friends of the elderly or disabled.

> Family size is shrinking. More couples are having fewer or no children. It has been estimated that half the nation's families have no children under age 18 living at home. Smaller family size could have a serious impact on the availability of adult children to care for an elderly parent in the future.
>
> The numbers of women working have continued to grow steadily, and women are returning to work sooner after having children. More than half of mothers in the nation who have babies return to work before the child's first birthday. Older women, too, are joining the work force in increasing numbers, particularly women age 45 to 64.

As more families become dependent upon two incomes and fewer women opt for full-time homemaking, the availability of at-home caregivers will diminish. The informal support system will be strained to adapt to the increasing care needs of the elderly population and the financial realities of the caregivers.

A state moratorium on nursing home beds was put in place in 1983 and extended in 1985 in order to control the rapid growth of nursing homes in Minnesota and to place an emphasis on alternatives to institutionalization for the elderly.

The moratorium does not apply to new beds in a new facility that is to be operated by the commissioner of Veterans Affairs or when the costs of constructing and operating the new beds are to be reimbursed by the VA. Several communities have expressed interest in constructing veterans nursing homes or in using existing facilities as veterans homes.

Federal law authorizes a 65 percent participation rate in the construction or acquisition of new facilities for veteran care.

However, federal matching funds are subject to recapture if facilities are not used as veterans homes for 20 years after the date of their construction. Further, adding new nursing care beds for veterans would affect other long-term care facilities forced to abide by the moratorium.

In addition to the moratorium on nursing home beds, in 1982 the state developed the pre-admission screening and alternative care grants program to provide alternative care services for elderly persons at risk of nursing home placement.

All persons seeking admission to Medical Assistance-certified nursing homes must be screened by a pre-admission screening team. Alternative Care Grant funds are available for eligible applicants who choose to remain at home.

In 1987, 24 percent of persons seeking nursing home placement were deterred from institutionalization and placed in the community with home care services.

Alternative care services cost an average of $375 per month, compared with an average nursing home cost of $1,620 per month. Human Services estimates that the state saved $14.5 million through alternative programs in Fiscal Year 1987.

Community care emphasizes the importance of remaining at home and independent for as long as possible. Alternatives to institutionalization are growing more popular and more options are steadily being developed.

Conclusions

Currently, the vast majority of elderly veterans in need of institutionalized nursing care are residing in community-based nursing care facilities throughout the state. Only 8.9 percent of elderly veterans in the state in need of nursing care receive such care at the Minnesota Veterans Home in Minneapolis.

The number of elderly persons requiring nursing care in Minnesota will continue to increase. The primary users of nursing home beds are, and will continue to be, women over the age of 75.

Alternatives to institutional nursing care provide veterans with a wide range of medical and program services and allow veterans to remain in their own communities near family and friends.

The demand for nursing care beds for elderly veterans will steadily increase and reach its peak by the year 2000, but will decline thereafter.

Newly constructed veterans facilities are exempt from the current moratorium on nursing home beds. However, demographic trends for elderly veterans in the state do not support the continued full use of new veterans facilities beyond the year 2000.

State costs for nursing and boarding care will likely be greater for veterans in the Minnesota Veterans Home than for veterans receiving Medical Assistance in other community facilities.

Recommendations

1. The Management Analysis Division endorses the blue-ribbon commission recommendation that long-term care planning for veterans be done in the context of statewide long-term care planning. The veterans-related exceptions in state law should not be used to defeat overall state strategies for reducing institutionalization and developing less restrictive alternatives.

2. The state should not construct or convert new veterans facilities at this time. Consideration of new facilities should not occur prior to the following:

   a. Development of a statewide long-term strategy for institutional health care.

   b. Development of the full range of non-institutional services for veterans in their home communities.

   c. Reduction of state costs in veterans facilities to approximate the cost of community care with Medical Assistance.

   d. Development of 20-year plans for any proposed projects using VA construction or conversion funds. These plans should assess the impact of the new beds on the larger health care system and indicate how the need for veterans beds in the affected community will extend beyond the immediate need created by the demographic bulge of aging World War II veterans.

MEDICAL ASSISTANCE CERTIFICATION

Background

The 1980 Management Analysis Division report recommended seeking Medical Assistance certification for the Minnesota Veterans Home.

A subsequent study by Veterans Affairs concluded that Medical Assistance certification would yield a cost savings to the state. However, because certification would decrease the personal needs allowance of residents and the opposition of veterans' organizations was expected to be "very troublesome and time-consuming," Veterans Affairs recommended against certification.

Veterans Affairs did, however, develop a strategy for increasing reimbursements (and decreasing state costs) by identifying additional benefits for which residents are eligible (pensions, Social Security, etc.).

Veterans Affairs data suggests that total reimbursements increased from a low of 69 percent in Fiscal Year 1984 to more than 80 percent in Fiscal Year 1986.

The draft rules proposed by Veterans Affairs would have required residents to apply for all benefits to which they are entitled. Under existing law, residents are not obligated to apply for benefits which would decrease state costs for their care.

Federal regulations preclude Medical Assistance payments to states for persons between the ages of 21 and 65 in "institutions for mental diseases." Given the diagnoses of the domiciliary residents in the two homes, the domiciliary units would not be eligible for Medical Assistance certification and reimbursement.

Additional background can be found in "Fiscal/Material Resource Management: Financial Management," p. 113, (Recommendation 8).

Ramifications for Residents and Families

Medical Assistance generally requires larger financial contributions from residents and families:

Under Medical Assistance, the personal needs allowance for residents would be reduced to $40 per month. The personal needs allowance is now $85 per month, plus 5 percent of the remainder of the resident's income. (The rule proposed by Veterans Affairs would have restricted the allowance to a flat $3 per day.)

The community, or non-home-resident, spouse of a Medical Assistance recipient must contribute to the cost of care if his or her net monthly income exceeds $647. A community spouse of a Medical Assistance recipient must also make a one-time contribution of assets equal to one-third the amount exceeding $10,000. A community spouse of a resident at the Minnesota Veterans Home is not required to make any contribution to the cost of care.

On the other hand, residents of the Minnesota Veterans Home must spend down their assets to $2,500, while Medical Assistance recipients can keep up to $3,000. (However, Medical Assistance counts some assets -- cash-surrender value of life insurance and a $1,000 burial account -- which the Veterans Home does not.)

Ramifications for Units of Government

Both Veterans Affairs and the Department of Finance have assessed the fiscal impact of Medical Assistance certification:

Finance has determined that, using a prospective rate-setting method, the state could save up to $1.7 million annually with Medical Assistance certification; Veterans Affairs calculated that amount at $1.79 million.

Counties pay a share of the costs of Medical Assistance. Estimated annual county costs range from $123,000 (Department of Veterans Affairs) to $145,000 (Management Analysis Division calculation based upon data supplied by the State Planning Agency and the Department of Finance). With 72.2 percent of Minneapolis home residents from metropolitan area counties, roughly $104,690 of the $145,000 would be borne by those counties.

The U.S. General Accounting Office recommended to Congress in July 1987 that VA pensions be reduced for Medical Assistance-supported nursing home residents. The General Accounting Office argued that states were the primary beneficiaries of a system which allowed receipt of two sizeable federal contributions to the cost of nursing care for the same recipient. No formal action has been taken on this recommendation.

Veterans Affairs calculated that, if this change is approved, the savings to the state through Medical Assistance certification would be reduced to $304,000 while the cost to counties would increase to $283,000 (a net savings to state and county governments of only $21,000).

Conclusions

Inequities exist between veterans in community nursing homes receiving Medical Assistance and those in the Minnesota Veterans Homes, particularly with respect to spousal support.

The state could realize significant savings by seeking Medical Assistance certification for the Minnesota Veterans Home if the federal government does not act on the General Accounting Office recommendation to eliminate the dual federal contribution.

Recommendations

1. The 1988 Legislature should ensure a greater degree of equity between veterans at the Minnesota Veterans Homes and veterans and non-veterans elsewhere with respect to spousal support. The legislature should also require residents to apply for all financial aid for which they are eligible, as proposed in the Veterans Affairs draft rules.

2. The governing body should reassess the financial advantages of Medical Assistance certification after the following have occurred:

   a. Equitable spousal contributions are being received, thus increasing the level of private pay and decreasing the level of state support.

   b. Residents are receiving all VA, Social Security or other pensions or benefits to which they are entitled, and are applying this support to their cost of care.

   c. The federal government's position on dual eligibility for Medical Assistance and VA pensions is known.

APPENDICES

Appendix A

CHARGE FOR THE GOVERNOR'S BLUE RIBBON COMMISSION

To develop a blueprint that will address the health care and related needs of disabled and elderly veterans and eligible family members into the next century.

Toward this goal the Commission will:

* Study current and past operating problems affecting the quality of care provided by the Minnesota Veterans' Homes to determine the underlying causes.

* Review the results and recommendations of the legislatively mandated study of the homes. (Minnesota Laws 1987, Chapter 404, Section 55, Subd. 2.) In light of the report of the State Health Commissioner to the Governor, dated August 27, 1987, it is assumed that this study will be expanded to cover Recommendation No. 5.

* Collect and assess data on long-term health care needs of Minnesota veterans and their families.

* Review alternative administrative and policy actions to provide improved quality health care for veterans and their families.

* Recommend to the Governor administrative and managerial changes to assure the highest quality of care at the Minnesota Veterans' Homes.

* Recommend policy alternatives to address the long-term health care needs of Minnesota veterans and their families.

Appendix B

MINNEAPOLIS VETERANS HOME
EMPLOYEE REACTION SURVEY ANALYSIS

" Favorable" means that the respondent answered the question with a reply considered complimentary of the work environment; conversely, "unfavorable" means that the respondent's reply can be considered critical of the work environment.

	FAVORABLE	UNFAVORABLE	NET FAVORABLE (+++)/UNFAVORABLE (---)
The Dept. of Veterans Affairs could have run the home well if given enough budget and staff.	60.0%	20.8%	++++++++++++++++++++++++++++++
Coworkers feel free to express their opinions even though they may disagree with one another.	53.8%	15.4%	++++++++++++++++++++++++++++
My supervisor is often unfair with employees.	50.0%	19.5%	++++++++++++++++++++++
Our work group gets feedback on how our clients (residents and families) feel about our services.	46.9%	16.4%	++++++++++++++++++++++
Our work group is able to clearly measure the results of its work.	45.7%	15.5%	++++++++++++++++++++++
My work unit values quality of work over deadlines.	45.6%	26.4%	+++++++++++++++
Our work group has difficulty working with other units in the home.	38.0%	23.3%	++++++++++++
The staffing levels proposed by the DHS (54 new positions in Mpls & 4 new positions in Hastings) will meet our needs for the near future.	35.9%	24.2%	++++++++
Our procedures are too "by-the-book" and don't show concern for residents' needs.	30.5%	20.3%	+++++++
I feel confident in the leadership of the Dept. of Human Services.	23.1%	23.1%	.
I feel confident in my supervisor's leadership.	33.6%	34.4%	.
I feel confident in the leadership of the Dept. of Veterans Affairs.	29.5%	31.8%	-
Key people are usually available when needed and willing to help.	27.7%	33.1%	----

MINNEAPOLIS VETERANS HOME
EMPLOYEE REACTION SURVEY ANALYSIS

" Favorable" means that the respondent answered the question with a reply considered complimentary of the work environment; conversely, "unfavorable" means that the respondent's reply can be considered critical of the work environment.

	FAVORABLE	UNFAVORABLE	NET FAVORABLE (+++)/UNFAVORABLE (---)
I receive feedback on how well I do my job.	30.2%	35.7%	----
Employees in the home work efficiently.	21.4%	29.0%	-----
I can finish the work I'm supposed to do on my shift.	31.3%	39.1%	-----
I get the training I need to perform my work and improve my job skills.	24.8%	38.0%	---------
The workload in my work area is fairly distributed.	26.4%	40.3%	----------
We have lots of good policies and procedures so we know what we are supposed to do.	20.3%	41.4%	----------
Supervisors cooperate with each other.	17.2%	43.8%	----------
Some people at the home are "on-the-job retired."	15.0%	51.2%	----------
Communication between the work groups is unsatisfactory and needs improvement.	9.9%	58.8%	----------

	VETERANS AFFAIRS		HUMAN SERVICES		NET FAVORABLE (+++)/UNFAVORABLE (---)
	FAVORABLE	UNFAVORABLE	FAVORABLE	UNFAVORABLE	(TOP BAR = DVA / BOTTOM BAR = DHS)
Employees share their opinions with supervisors or management.	33.6%	25.4%	32.0%	23.0%	++++++ ++++++
I look forward to coming to work.	32.3%	33.1%	25.0%	33.1%	. ------
We have a clear understanding of our work group's mission and priorities.	25.8%	31.7%	25.6%	25.6%	---- .
Supervisors and top management are too controlling and fail to let employees use their own good judgment.	16.3%	35.8%	24.4%	24.4%	---------- .

MINNEAPOLIS VETERANS HOME
EMPLOYEE REACTION SURVEY ANALYSIS

" Favorable" means that the respondent answered the question with a reply considered complimentary of the work environment; conversely, "unfavorable" means that the respondent's reply can be considered critical of the work environment.

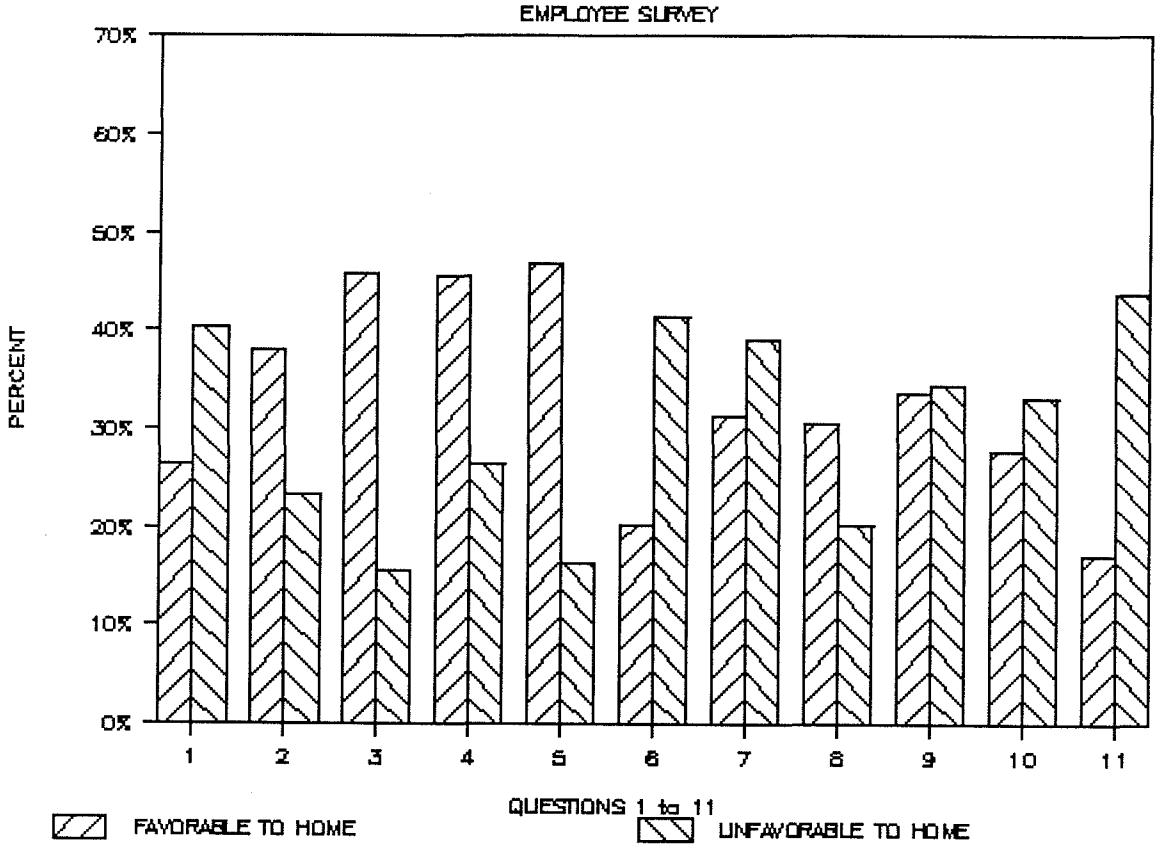
	FAVORABLE	UNFAVORABLE	FAVORABLE	UNFAVORABLE	NET FAVORABLE (+++)/UNFAVORABLE (---)
The leaders of this home have a sense of the real problems facing us.	19.7%	43.4%	28.6%	31.7%	----------
We seem to change direction from one day to the next.	13.1%	39.3%	17.7%	33.1%	----------
Conflicts here are solved by talking and negotiating.	11.6%	41.3%	19.2%	28.3%	----------
My work unit is praised for doing good work.	16.3%	48.0%	16.1%	42.0%	----------
Decisions here are timely and based on good information.	9.9%	43.8%	21.3%	26.2%	----------
The goals and objectives of the home are clearly defined and reviewed regularly.	9.9%	46.3%	13.2%	32.2%	----------
My work unit has access to top management and they value our input.	17.1%	54.5%	21.8%	40.3%	----------
Changes in priority are promptly communicated.	9.2%	47.1%	17.2%	40.2%	----------
I receive the information I need for my job in a timely manner.	10.7%	48.8%	13.9%	36.9%	----------
Meetings are well planned, well run, and productive.	10.0%	53.3%	17.4%	38.0%	----------
The home is able to see problems and changes coming and prepare for them.	7.3%	50.8%	15.7%	28.9%	----------
Changes in policies and procedures are clearly communicated to all those involved or affected.	8.9%	52.8%	19.5%	43.1%	----------
The home keeps its policies and procedures up-to-date.	5.8%	55.4%	15.1%	31.1%	----------

MINNEAPOLIS VETERANS HOME
EMPLOYEE REACTION SURVEY ANALYSIS

" Favorable" means that the respondent answered the question with a reply considered complimentary of the work environment; conversely, "unfavorable" means that the respondent's reply can be considered critical of the work environment.

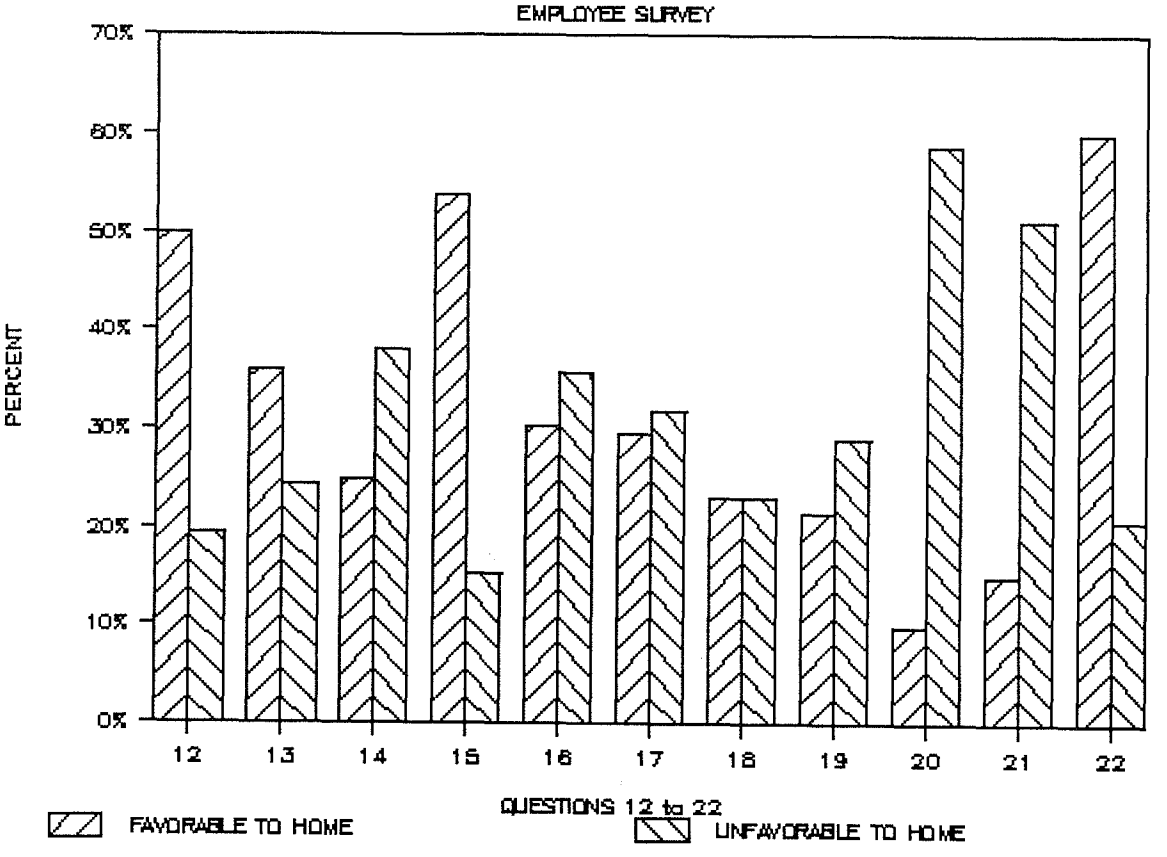
	FAVORABLE	UNFAVORABLE	FAVORABLE	UNFAVORABLE	NET FAVORABLE (+++)/UNFAVORABLE (---)
A lot of effort is made to ask for the thoughts and opinions of employees.	5.7%	64.2%	15.3%	46.8%	

MINNEAPOLIS VETERANS HOME



1. The workload in my work area is fairly distributed.
2. Our work group has difficulty working with other units in the Home.
3. Our work group is able to clearly measure the results of its work.
4. My work unit values quality of work over deadlines.
5. Our work group gets feedback on how our clients (residents and families) feel about our services.
6. We have lots of good policies and procedures so we know what we are supposed to do.
7. I can finish the work I'm supposed to do on my shift.
8. Our procedures are too "by-the-book" and don't show concern for residents' needs.
9. I feel confident in my supervisor's leadership.
10. Key people are usually available when needed and willing to help.
11. Supervisors cooperate with each other.

MINNEAPOLIS VETERANS HOME



12. My supervisor is often unfair with employees.

13. The staffing levels proposed by the DHS (54 new positions in Mpls & 4 new positions in Hastings) will meet our needs for the near future.

14. I get the training I need to perform my work and improve my job skills.

15. Coworkers feel free to express their opinions even though they may disagree with one another.

16. I receive feedback on how well I do my job.

17. I feel confident in the leadership of the Dept. of Veterans Affairs.

18. I feel confident in the leadership of the Dept.of Human Services.

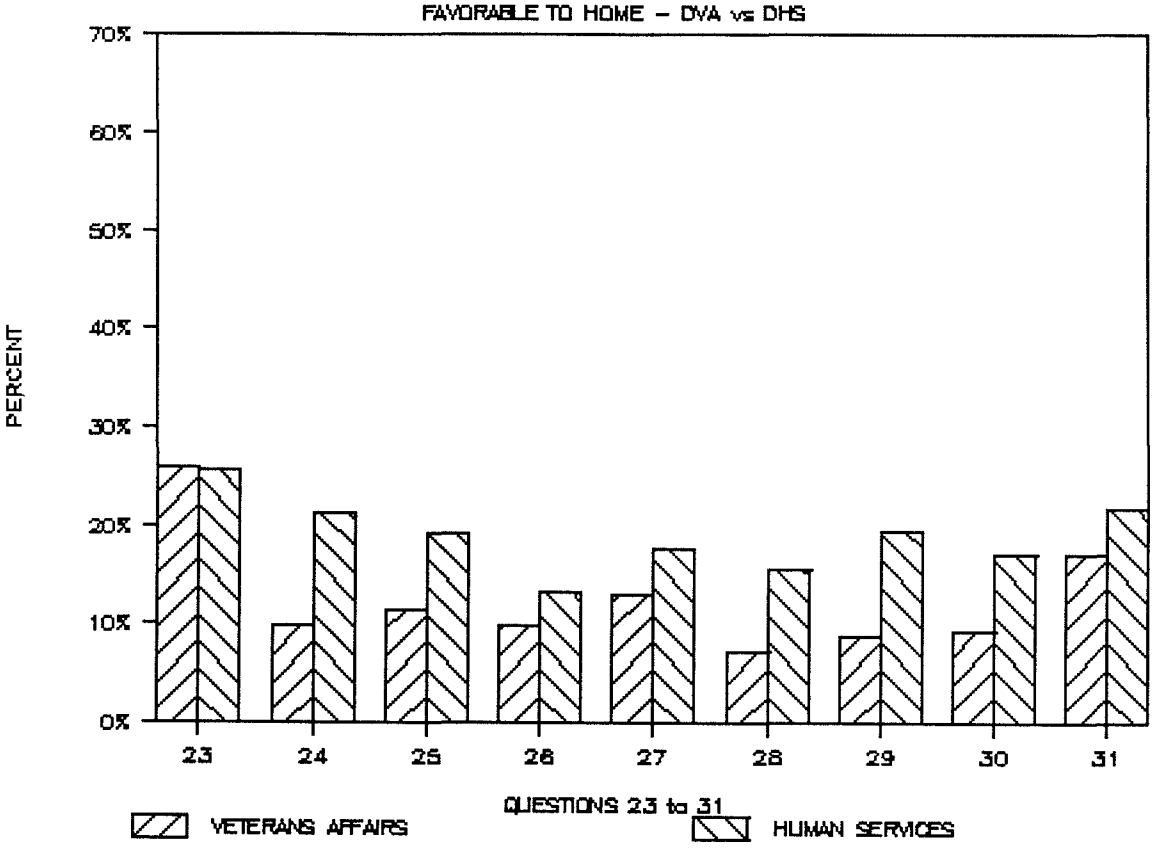
19. Employees in the Home work efficiently.

20. Communication between the work groups is unsatisfactory and needs improvement.

21. Some people at the Home are "on-the-job retired".

22. The Dept. of Veterans Affairs could have run the Home well if given enough budget and staff.

MINNEAPOLIS VETERANS HOME



23. We have a clear understanding of our work group's mission and priorities.

24. Decisions here are timely and based on good information.

25. Conflicts here are solved by talking and negotiating.

26. The goals and objectives of the home are clearly defined and reviewed regularly.

27. We seem to change direction from one day to the next.

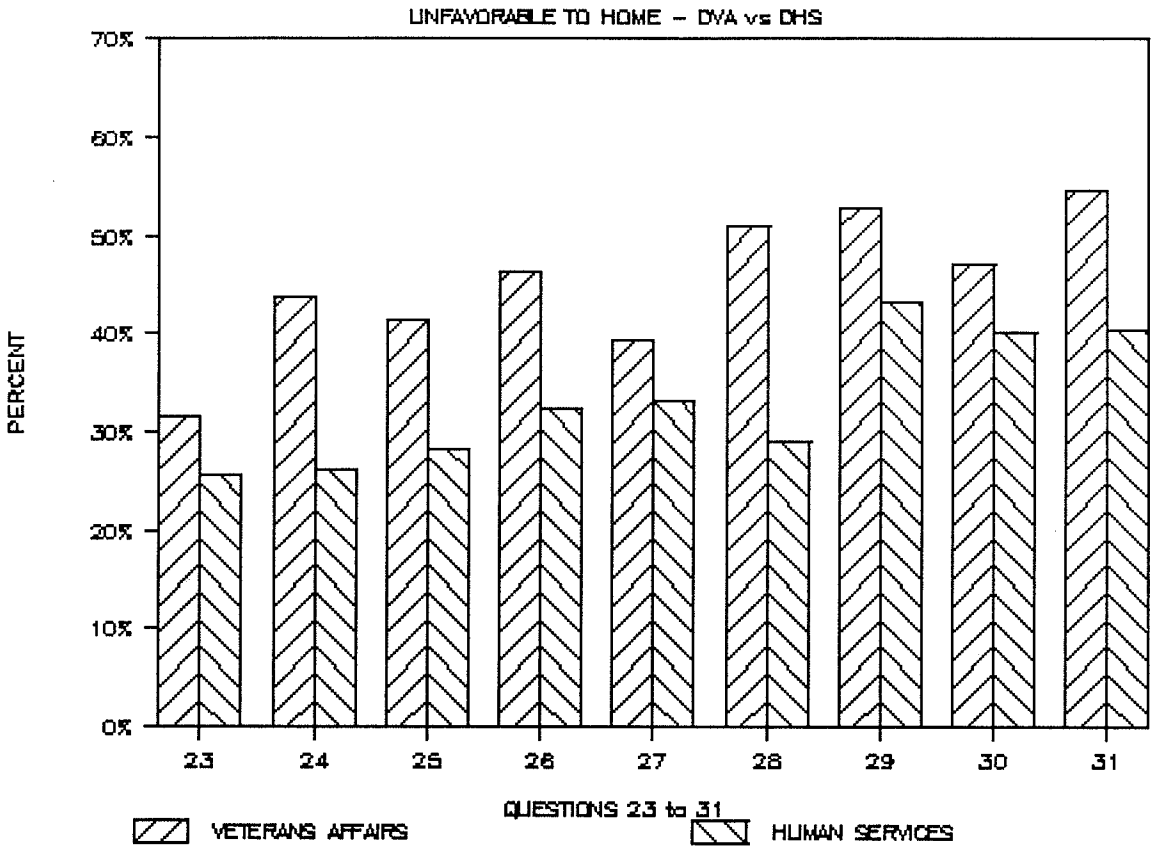
28. The Home is able to see problems and changes coming and prepare for them.

29. Changes in policies and procedures are clearly communicated to all those involved or affected.

30. Changes in priority are promptly communicated.

31. My work unit has access to top management and they value our input.

MINNEAPOLIS VETERANS HOME



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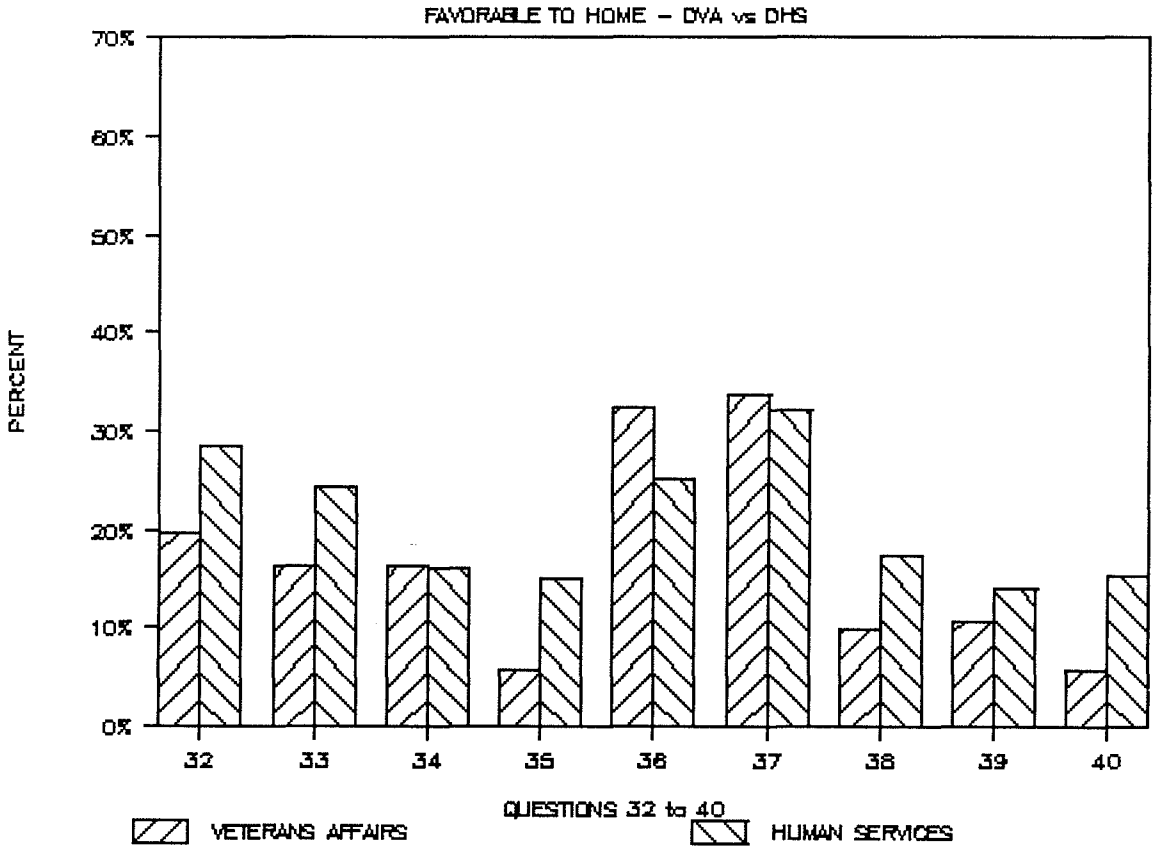

32. The leaders of this Home have a sense of the real problems facing us.

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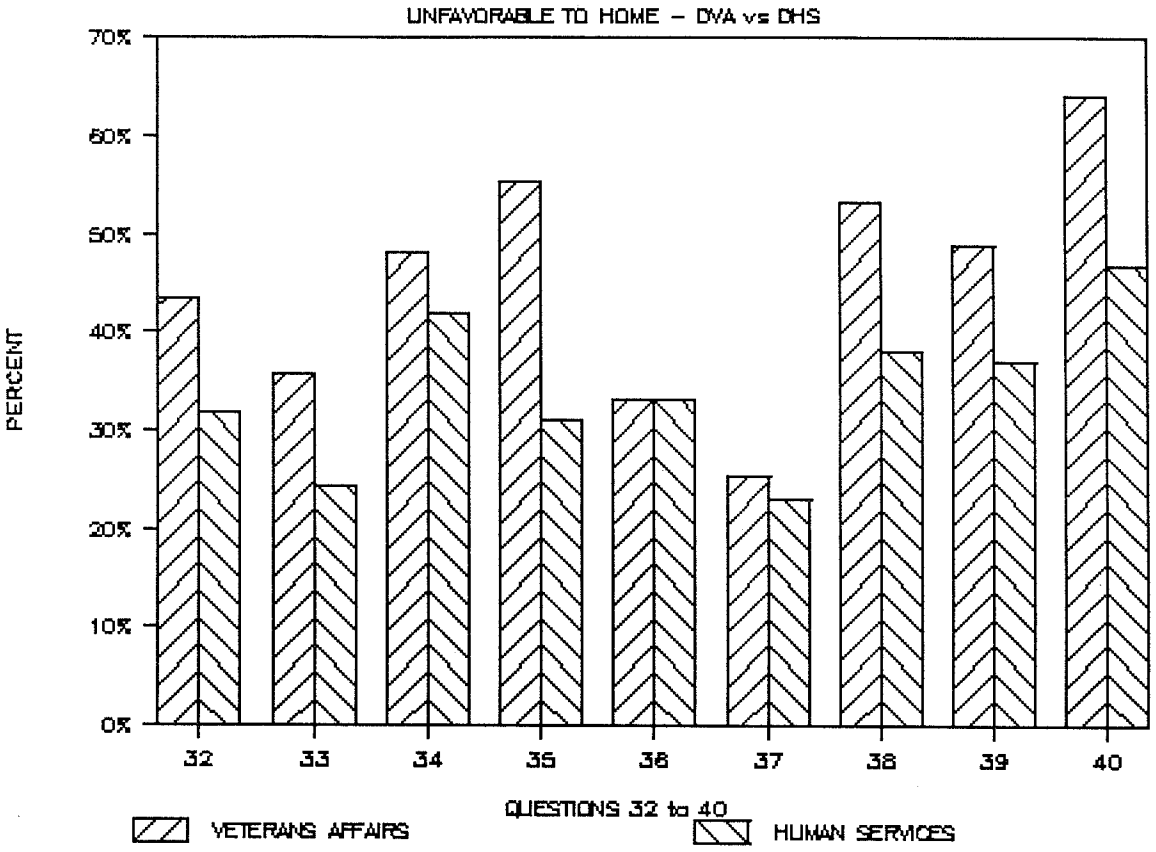
MINNEAPOLIS VETERANS HOME



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MINNEAPOLIS HOME

EMPLOYEE SURVEY (RAW COUNT)

QUESTION NUMBER	NUMBER OF 1's,2's etc 1	2	3	4	5	6	7	NO ANSWER	TOTAL ANSWERS	1 & 2 %	6 & 7 %	RECORD CHECK	OVERALL AVERAGE
1	4	30	16	7	20	23	29	3	129	26.4%	40.3%	132	4.504
2	13	17	17	22	11	38	11	3	129	23.3%	38.0%	132	4.233
3	15	44	17	19	14	15	5	3	129	45.7%	15.5%	132	3.295
4	17	40	11	13	11	17	16	7	125	45.6%	26.4%	132	3.608
5	24	36	17	16	14	13	8	4	128	46.9%	16.4%	132	3.242
6	11	15	12	18	19	20	33	4	128	20.3%	41.4%	132	4.648
7	14	26	10	11	17	21	29	4	128	31.3%	39.1%	132	4.328
8	18	8	13	27	23	21	18	4	128	20.3%	30.5%	132	4.281
9	18	25	9	21	11	13	31	4	128	33.6%	34.4%	132	4.133
10	9	27	15	17	19	19	24	2	130	27.7%	33.1%	132	4.254
11	5	17	10	25	15	20	36	4	128	17.2%	43.8%	132	4.813
12	17	8	11	21	7	38	26	4	128	19.5%	50.0%	132	4.648
13	12	34	15	28	8	15	16	4	128	35.9%	24.2%	132	3.742
14	6	26	13	16	19	18	31	3	129	24.8%	38.0%	132	4.504
15	21	49	17	11	12	9	11	2	130	53.8%	15.4%	132	3.115
16	13	26	18	16	10	20	26	3	129	30.2%	35.7%	132	4.147
17	14	24	7	37	6	8	33	3	129	29.5%	31.8%	132	4.186
18	12	18	9	51	10	11	19	2	130	23.1%	23.1%	132	4.062
19	6	22	25	18	22	20	18	1	131	21.4%	29.0%	132	4.221
20	49	28	20	14	7	8	5	1	131	58.8%	9.9%	132	2.588
21	40	25	19	23	1	12	7	5	127	51.2%	15.0%	132	2.874
22	53	25	3	13	9	7	20	2	130	60.0%	20.8%	132	3.008
23 V	15	16	20	21	10	15	23	12	120	25.8%	31.7%	132	4.100
24 V	6	6	18	27	11	21	32	11	121	9.9%	43.8%	132	4.835
25 V	6	8	16	28	13	21	29	11	121	11.6%	41.3%	132	4.760
26 V	4	8	14	24	15	18	38	11	121	9.9%	46.3%	132	5.017
27 V	29	19	17	29	12	8	8	10	122	39.3%	13.1%	132	3.262
28 V	3	6	6	25	21	21	42	8	124	7.3%	50.8%	132	5.306
29 V	2	9	11	20	16	21	44	9	123	8.9%	52.8%	132	5.260
30 V	2	9	6	27	19	17	39	13	119	9.2%	47.1%	132	5.176
31 V	7	14	7	17	11	25	42	9	123	17.1%	54.5%	132	5.065
32 V	8	16	13	17	15	14	39	10	122	19.7%	43.4%	132	4.746
33 V	27	17	12	24	23	10	10	9	123	35.8%	16.3%	132	3.561
34 V	6	14	17	15	12	20	39	9	123	16.3%	48.0%	132	4.862
35 V	1	6	6	23	18	20	47	11	121	5.8%	55.4%	132	5.471
36 V	16	24	12	24	7	9	32	8	124	32.3%	33.1%	132	4.105
37 V	12	29	23	16	11	10	21	10	122	33.6%	25.4%	132	3.811
38 V	2	10	12	23	9	26	38	12	120	10.0%	53.3%	132	5.142
39 V	6	7	11	24	14	21	38	11	121	10.7%	48.8%	132	5.050
40 V	0	7	13	16	8	22	57	9	123	5.7%	64.2%	132	5.593
23 H	12	19	23	29	7	16	15	11	121	25.6%	25.6%	132	3.893
24 H	6	20	18	32	14	14	18	10	122	21.3%	26.2%	132	4.164
25 H	5	18	17	33	13	12	22	12	120	19.2%	28.3%	132	4.292
26 H	3	13	17	31	18	16	23	11	121	13.2%	32.2%	132	4.554
27 H	21	20	14	36	11	17	5	8	124	33.1%	17.7%	132	3.540
28 H	6	13	12	39	16	16	19	11	121	15.7%	28.9%	132	4.405

MINNEAPOLIS HOME

EMPLOYEE SURVEY (RAW COUNT)

QUESTION NUMBER	NUMBER OF 1's,2's etc 1	2	3	4	5	6	7	NO ANSWER	TOTAL ANSWERS	1 & 2 %	6 & 7 %	RECORD CHECK	OVERALL AVERAGE
29 H	6	18	15	15	16	16	37	9	123	19.5%	43.1%	132	4.732
30 H	5	16	16	25	11	17	32	10	122	17.2%	40.2%	132	4.639
31 H	10	17	15	22	10	20	30	8	124	21.8%	40.3%	132	4.492
32 H	13	23	14	27	9	14	26	6	126	28.6%	31.7%	132	4.127
33 H	19	11	9	34	20	15	15	9	123	24.4%	24.4%	132	4.057
34 H	4	14	10	20	17	15	32	10	112	16.1%	42.0%	122	4.830
35 H	5	13	22	31	11	20	17	13	119	15.1%	31.1%	132	4.328
36 H	10	21	15	29	8	13	28	8	124	25.0%	33.1%	132	4.250
37 H	12	27	30	18	7	10	18	10	122	32.0%	23.0%	132	3.680
38 H	8	13	20	22	12	16	30	11	121	17.4%	38.0%	132	4.529
39 H	5	12	18	26	16	15	30	10	122	13.9%	36.9%	132	4.648
40 H	8	11	18	16	13	16	42	8	124	15.3%	46.8%	132	4.863

HASTINGS VETERANS HOME
EMPLOYEE REACTION SURVEY ANALYSIS

"Favorable" means that the respondent answered the question with a reply considered complimentary of the work environment; conversely, "unfavorable" means that the respondent's reply can be considered critical of the work environment.

	FAVORABLE	UNFAVORABLE	NET FAVORABLE (+++) / UNFAVORABLE (---)
My work unit values quality of work over deadlines.	59.1%	0.0%	++
Our procedures are too "by-the-book" and don't show concern for residents' needs.	57.1%	4.8%	++
I can finish the work I'm supposed to do on my shift.	59.1%	9.1%	++++++++++++++++++++++++++++++++++++
Our work group gets feedback on how our clients (residents and families) feel about our services.	59.1%	18.2%	++++++++++++++++++++++++++++++
Our work group is able to clearly measure the results of its work.	50.0%	13.6%	++++++++++++++++++++++++++
I receive feedback on how well I do my job.	54.5%	18.2%	++++++++++++++++++++++++++++
My supervisor is often unfair with employees.	50.0%	22.7%	++++++++++++++++++++
Our work group has difficulty working with other units in the Home.	40.9%	18.2%	++++++++++++++++
The Dept. of Veterans Affairs could have run the home well if given enough budget and staff.	50.0%	27.3%	++++++++++++++++
I get the training I need to perform my work and improve my job skills.	45.5%	31.8%	++++++++++
Coworkers feel free to express their opinions even though they may disagree with one another.	45.5%	31.8%	++++++++++
I feel confident in the leadership of the Dept. of Veterans Affairs.	45.5%	40.9%	+++
Employees in the home work efficiently.	18.2%	13.6%	+++

HASTINGS VETERANS HOME
EMPLOYEE REACTION SURVEY ANALYSIS

"Favorable" means that the respondent answered the question with a reply considered complimentary of the work environment; conversely, "unfavorable" means that the respondent's reply can be considered critical of the work environment.

	FAVORABLE	UNFAVORABLE	NET FAVORABLE (+++) / UNFAVORABLE (---)
The staffing levels proposed by the DHS (54 new positions in Mpls & 4 new positions in Hastings) will meet our needs for the near future.	27.3%	27.3%	.
I feel confident in my supervisor's leadership.	42.9%	42.9%	.
Key people are usually available when needed and willing to help.	36.4%	36.4%	.
The workload in my work area is fairly distributed.	27.3%	31.8%	---
I feel confident in the leadership of the Dept. of Human Services.	4.5%	31.8%	----------
Supervisors cooperate with each other.	18.2%	50.0%	----------
We have lots of good policies and procedures so we know what we are supposed to do.	18.2%	54.5%	----------
Communication between the work groups is unsatisfactory and needs improvement.	13.6%	50.0%	----------
Some people at the home are "on-the-job retired."	4.5%	40.9%	----------

	VETERANS AFFAIRS		HUMAN SERVICES		NET FAVORABLE (+++) / UNFAVORABLE (---)
	FAVORABLE	UNFAVORABLE	FAVORABLE	UNFAVORABLE	(TOP BAR = DVA / BOTTOM BAR = DHS)
I look forward to coming to work.	61.9%	9.5%	47.6%	9.5%	++ ++++++++++++++++++++++++++++
Employees share their opinions with supervisors or management.	60.0%	10.0%	30.0%	10.0%	++ ++++++++++++++
Supervisors and top management are too controlling and fail to let employees use their own good judgment.	38.1%	19.0%	14.3%	23.8%	++++++++++++++ -------

HASTINGS VETERANS HOME
EMPLOYEE REACTION SURVEY ANALYSIS

"Favorable" means that the respondent answered the question with a reply considered complimentary of the work environment; conversely, "unfavorable" means that the respondent's reply can be considered critical of the work environment.

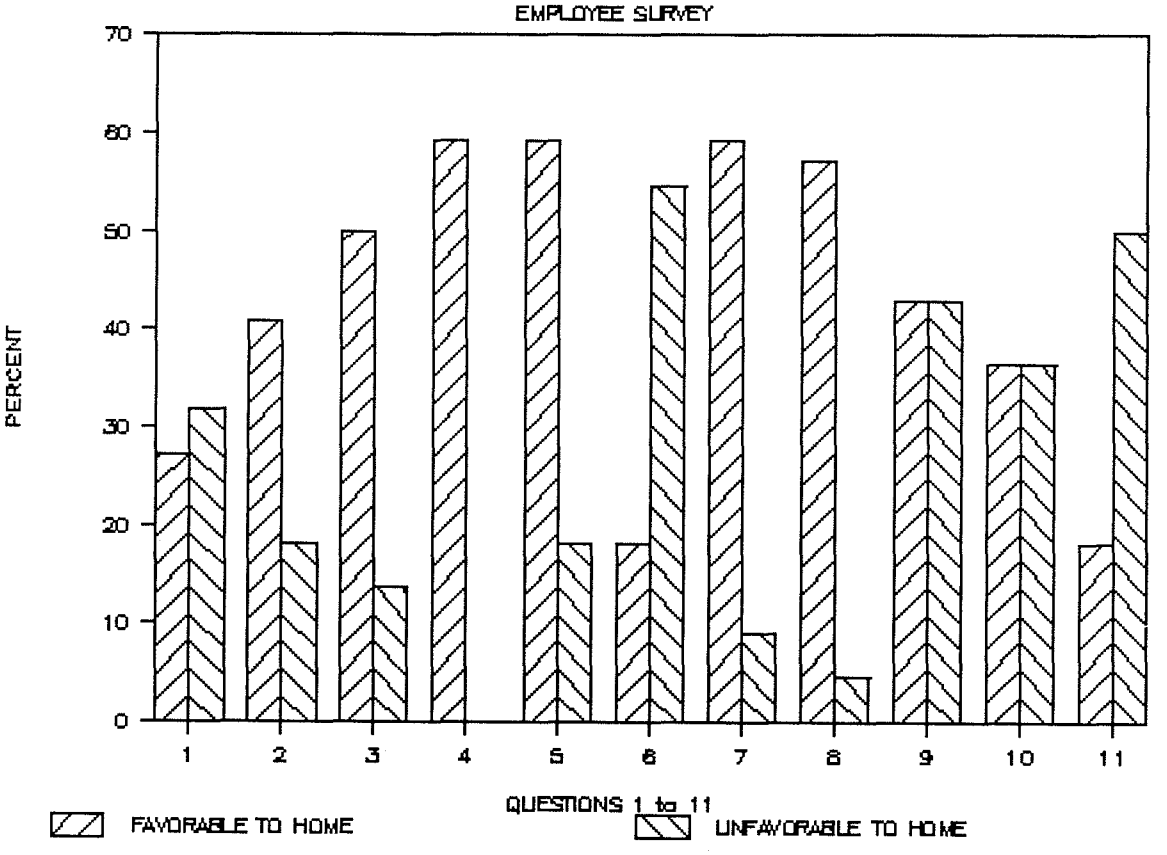
	FAVORABLE	UNFAVORABLE	FAVORABLE	UNFAVORABLE	NET FAVORABLE (+++) / UNFAVORABLE (---)
The leaders of this home have a sense of the real problems facing us.	33.3%	19.0%	19.0%	23.8%	++++++++++ ---
I receive the information I need for my job in a timely manner.	38.1%	23.8%	23.8%	28.6%	++++++++++ ---
We have a clear understanding of our work group's mission and priorities.	42.9%	28.6%	14.3%	42.9%	++++++++++ ----------
My work unit has access to top management and they value our input.	33.3%	23.8%	23.8%	19.0%	+++++++ +++
Conflicts here are solved by talking and negotiating.	23.8%	19.0%	4.8%	19.0%	+++ ----------
My work unit is praised for doing good work.	28.6%	28.6%	14.3%	23.8%	. -------
Meetings are well planned, well run, and productive.	19.0%	23.8%	9.5%	19.0%	--- -------
Decisions here are timely and based on good information.	20.0%	25.0%	4.8%	28.6%	--- ----------
A lot of effort is made to ask for the thoughts and opinions of employees.	23.8%	28.6%	14.3%	33.3%	--- ----------
We seem to change direction from one day to the next.	20.0%	35.0%	10.0%	25.0%	---------- ----------
The goals and objectives of the home are clearly defined and reviewed regularly.	19.0%	38.1%	0.0%	42.9%	---------- ----------
The home keeps its policies and procedures up-to-date.	19.0%	38.1%	19.0%	23.8%	---------- ---
Changes in policies and procedures are clearly communicated to all those involved or affected.	14.3%	38.1%	14.3%	33.3%	---------- ----------

HASTINGS VETERANS HOME
EMPLOYEE REACTION SURVEY ANALYSIS

"Favorable" means that the respondent answered the question with a reply considered complimentary of the work environment; conversely, "unfavorable" means that the respondent's reply can be considered critical of the work environment.

	FAVORABLE	UNFAVORABLE	FAVORABLE	UNFAVORABLE	NET FAVORABLE (+++) / UNFAVORABLE (---)
The home is able to see problems and changes coming and prepare for them.	10.0%	35.0%	5.0%	30.0%	----------
Changes in priority are promptly communicated.	5.0%	40.0%	5.0%	25.0%	----------

HASTINGS VETERANS HOME



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3. Our work group is able to clearly measure the results of its work.
4. My work unit values quality of work over deadlines.
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6. We have lots of good policies and procedures so we know what we are supposed to do.
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8. Our procedures are too "by-the-book" and don't show concern for residents' needs.
9. I feel confident in my supervisor's leadership.
10. Key people are usually available when needed and willing to help.
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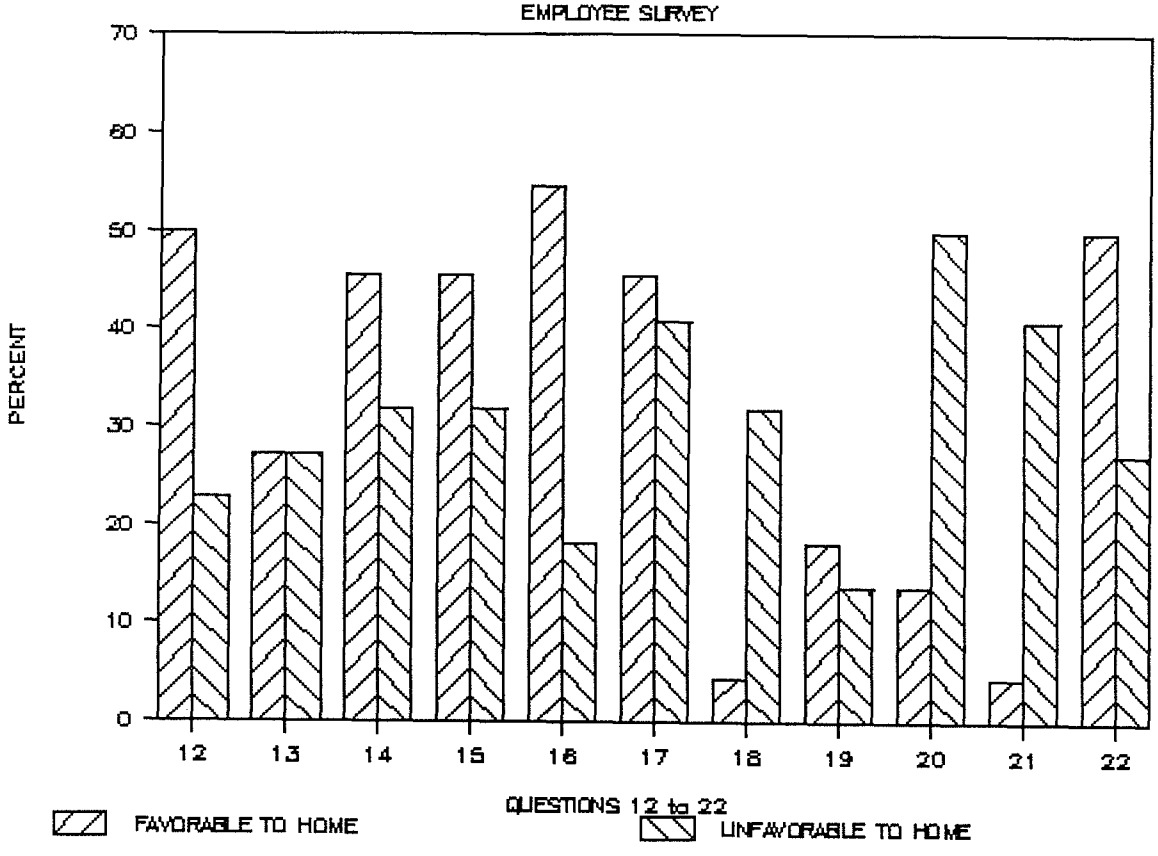
HASTINGS VETERANS HOME



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17. I feel confident in the leadership of the Dept. of Veterans Affairs.

18. I feel confident in the leadership of the Dept.of Human Services.

19. Employees in the Home work efficiently.

20. Communication between the work groups is unsatisfactory and needs improvement.

21. Some people at the Home are "on-the-job retired".

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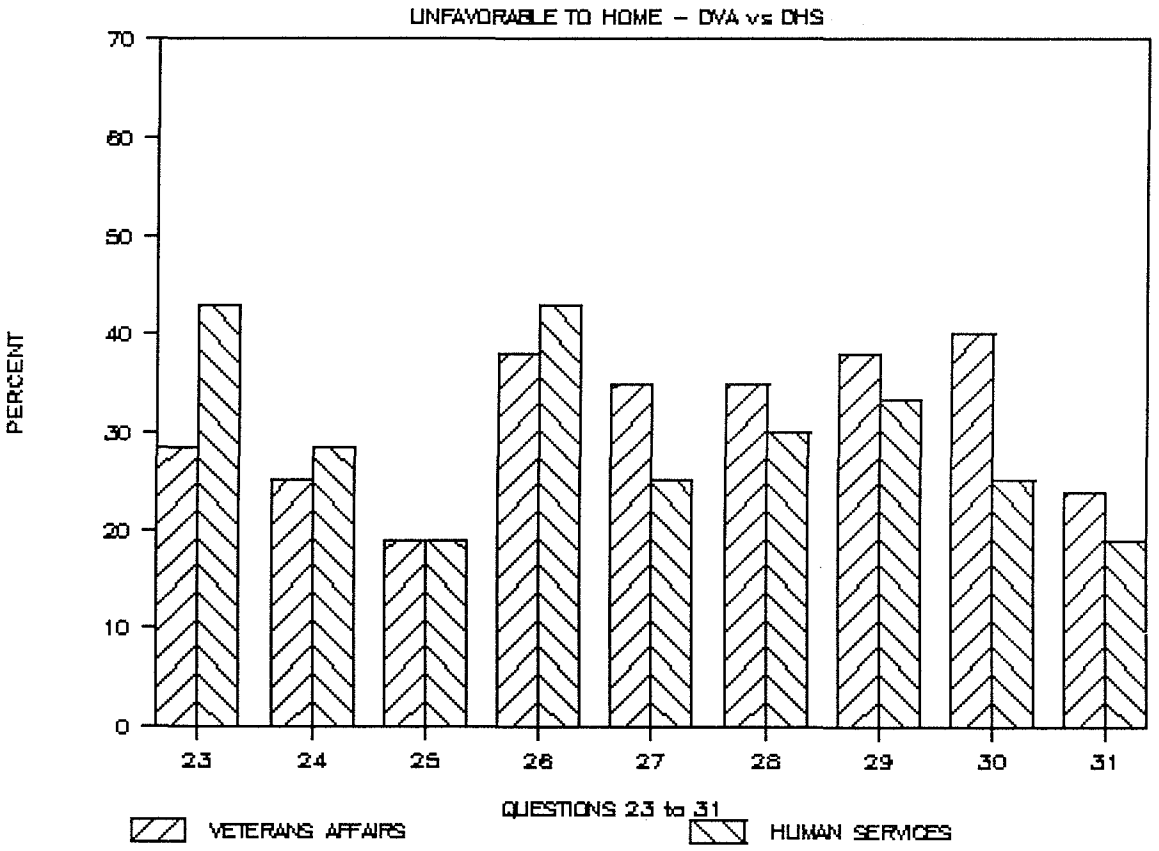
HASTINGS VETERANS HOME



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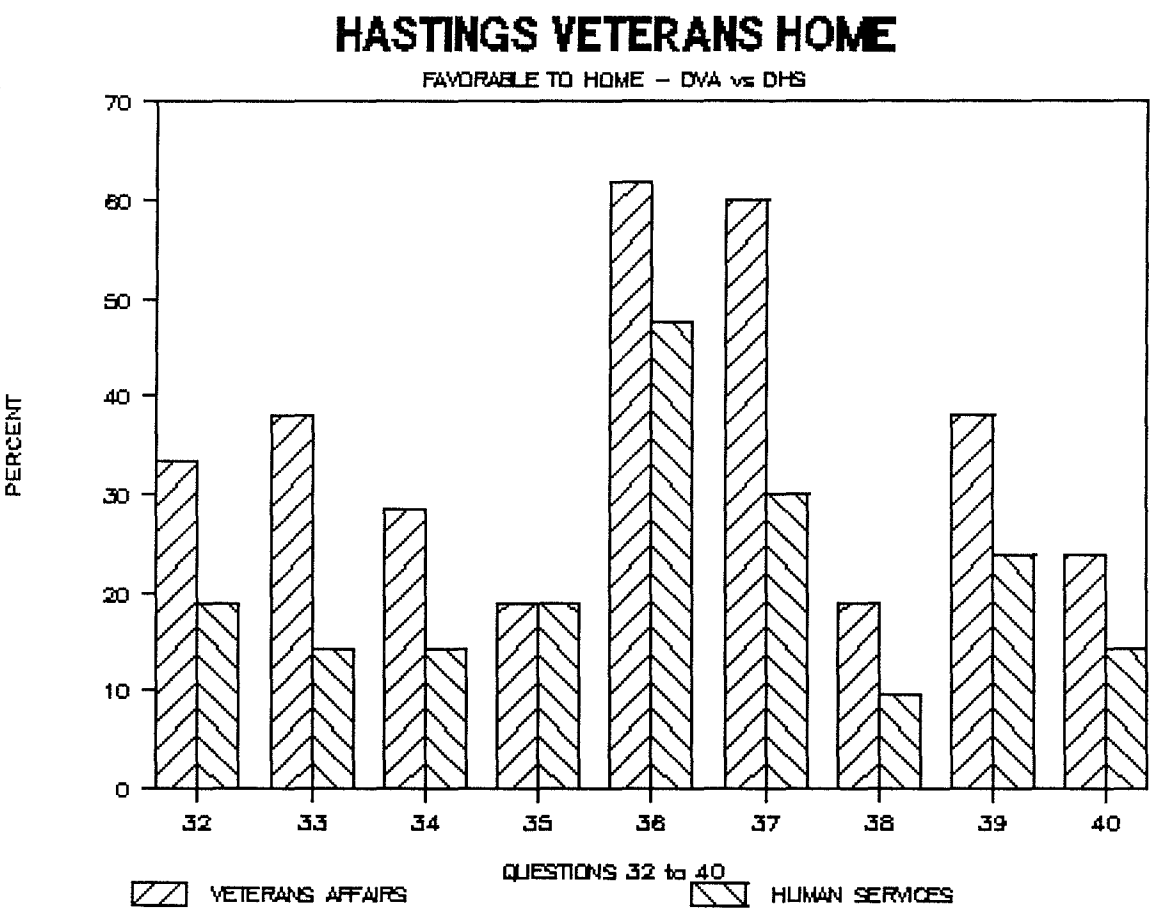
30. Changes in priority are promptly communicated.

31. My work unit has access to top management and they value our input.



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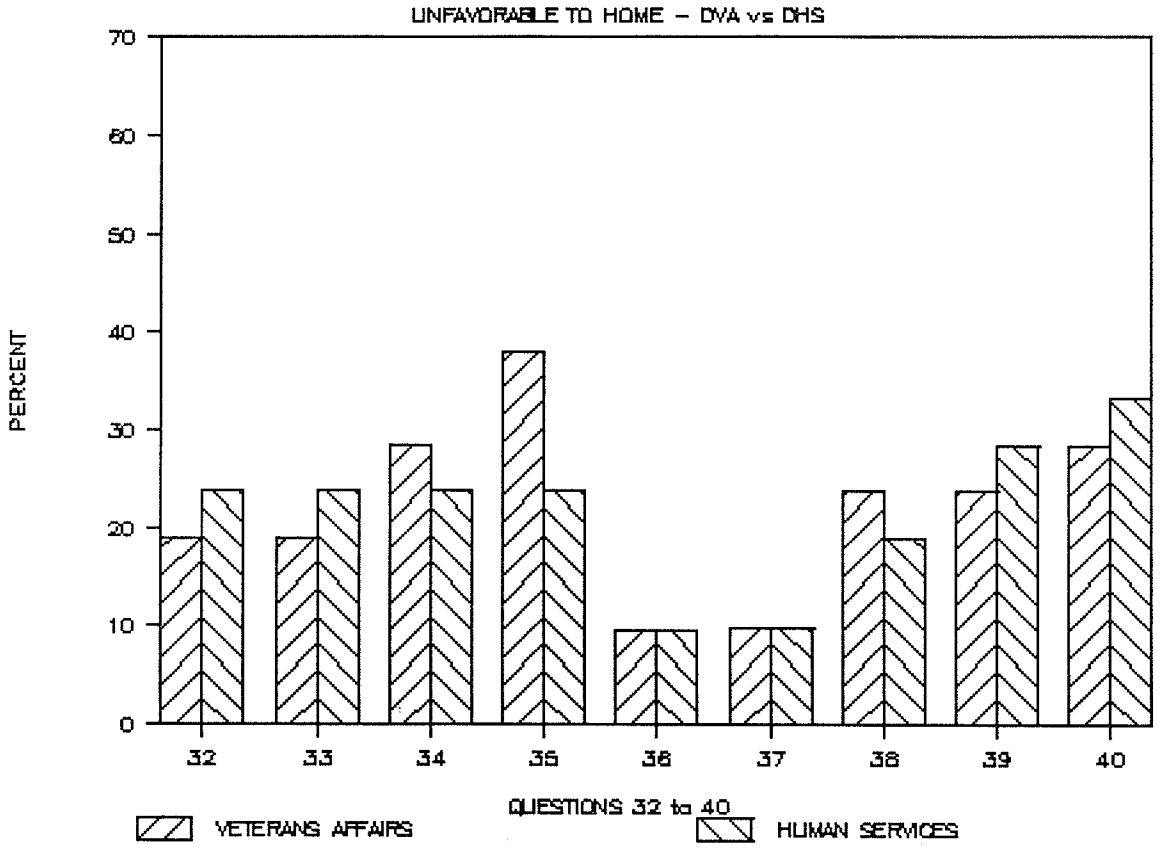
HASTINGS VETERANS HOME



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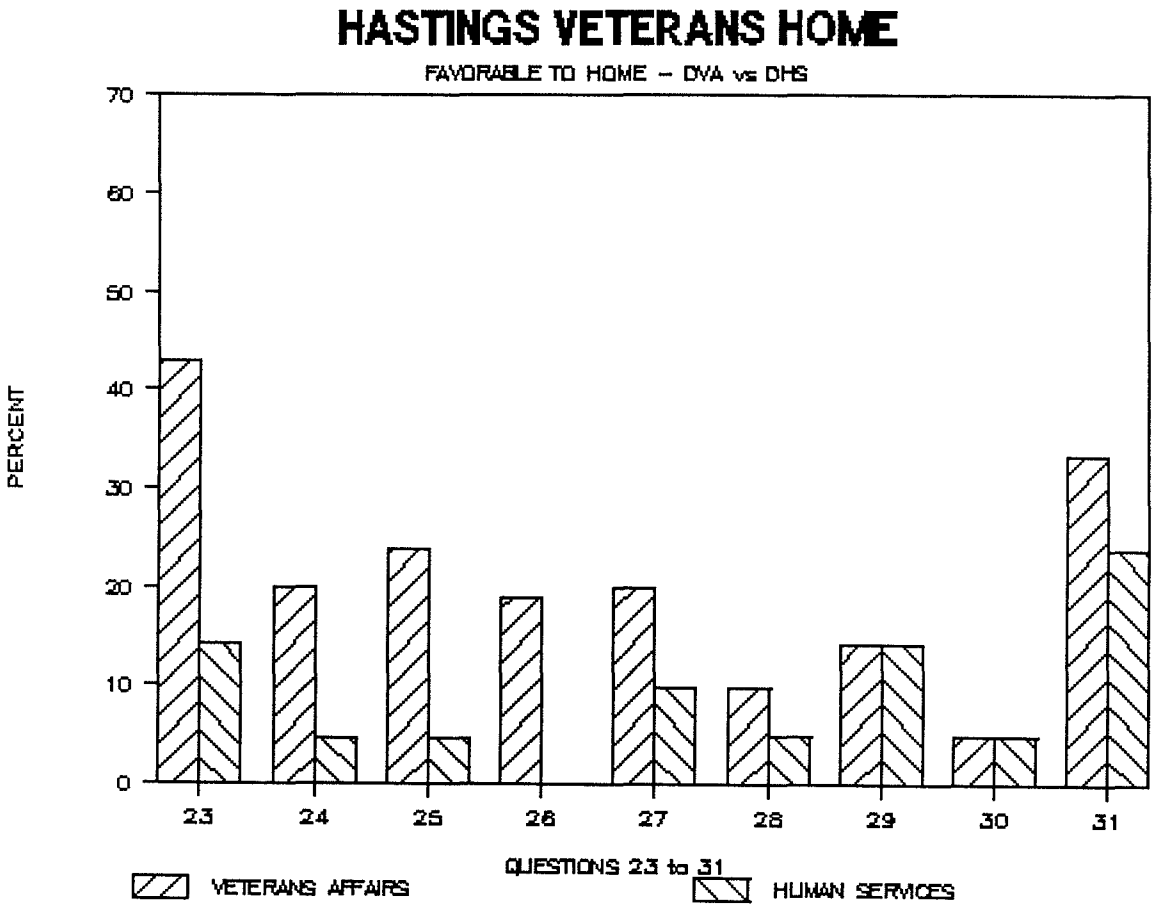
HASTINGS HOME

EMPLOYEE SURVEY (RAW COUNT)

QUESTION NUMBER	NUMBER OF 1's,2's etc 1	2	3	4	5	6	7	NO ANSWER	TOTAL ANSWERS	1 & 2 %	6 & 7 %	RECORD CHECK	OVERALL AVERAGE
1	3	3	3	3	3	4	3	0	22	27.3	31.8	22	4.091
2	1	3	3	3	3	6	3	0	22	18.2	40.9	22	4.545
3	5	6	3	4	1	2	1	0	22	50.0	13.6	22	3.000
4	2	11	1	5	3	0	0	0	22	59.1	0.0	22	2.818
5	3	10	2	0	3	2	2	0	22	59.1	18.2	22	3.182
6	1	3	2	2	2	6	6	0	22	18.2	54.5	22	4.955
7	3	10	0	2	5	1	1	0	22	59.1	9.1	22	3.136
8	0	1	1	5	2	3	9	1	21	4.8	57.1	22	5.524
9	5	4	0	2	1	5	4	1	21	42.9	42.9	22	4.000
10	2	6	1	2	3	4	4	0	22	36.4	36.4	22	4.182
11	1	3	0	3	4	5	6	0	22	18.2	50.0	22	5.045
12	4	1	0	4	2	4	7	0	22	22.7	50.0	22	4.773
13	3	3	2	5	3	3	3	0	22	27.3	27.3	22	4.045
14	3	7	1	3	1	6	1	0	22	45.5	31.8	22	3.636
15	1	9	4	0	1	5	2	0	22	45.5	31.8	22	3.636
16	3	9	1	2	3	3	1	0	22	54.5	18.2	22	3.273
17	8	2	1	1	1	4	5	0	22	45.5	40.9	22	3.773
18	1	0	2	8	4	2	5	0	22	4.5	31.8	22	4.818
19	2	2	4	7	4	0	3	0	22	18.2	13.6	22	3.955
20	8	3	3	1	4	1	2	0	22	50.0	13.6	22	3.045
21	6	3	3	7	2	1	0	0	22	40.9	4.5	22	2.955
22	8	3	0	4	1	2	4	0	22	50.0	27.3	22	3.409
23 V	4	5	2	2	2	2	4	1	21	42.9	28.6	22	3.714
24 V	2	2	3	6	2	1	4	2	20	20.0	25.0	22	4.150
25 V	1	4	5	4	3	3	1	1	21	23.8	19.0	22	3.810
26 V	1	3	2	3	4	3	5	1	21	19.0	38.1	22	4.667
27 V	3	4	4	2	3	4	0	2	20	35.0	20.0	22	3.500
28 V	1	1	3	1	7	3	4	2	20	10.0	35.0	22	4.850
29 V	2	1	3	1	6	2	6	1	21	14.3	38.1	22	4.810
30 V	0	1	3	4	4	2	6	2	20	5.0	40.0	22	5.050
31 V	2	5	4	4	1	1	4	1	21	33.3	23.8	22	3.762
32 V	2	5	4	3	3	0	4	1	21	33.3	19.0	22	3.762
33 V	3	3	1	5	3	4	2	1	21	28.6	28.6	22	4.048
34 V	2	4	3	5	1	3	3	1	21	28.6	28.6	22	3.952
35 V	1	3	2	2	5	4	4	1	21	19.0	38.1	22	4.667
36 V	7	6	4	2	0	0	2	1	21	61.9	9.5	22	2.524
37 V	3	9	1	4	1	0	2	2	20	60.0	10.0	22	2.950
38 V	2	2	2	5	5	2	3	1	21	19.0	23.8	22	4.286
39 V	1	7	4	1	3	3	2	1	21	38.1	23.8	22	3.714
40 V	2	3	3	4	3	3	3	1	21	23.8	28.6	22	4.143
23 H	1	2	1	5	3	4	5	1	21	14.3	42.9	22	4.857
24 H	0	1	0	10	4	3	3	1	21	4.8	28.6	22	4.810
25 H	1	0	2	10	4	3	1	1	21	4.8	19.0	22	4.381
26 H	0	0	2	6	4	3	6	1	21	0.0	42.9	22	5.238
27 H	2	3	2	7	4	2	0	2	20	25.0	10.0	22	3.700
28 H	0	1	2	7	4	5	1	2	20	5.0	30.0	22	4.650
29 H	1	2	2	4	5	2	5	1	21	14.3	33.3	22	4.714



23. We have a clear understanding of our work group's mission and priorities.

24. Decisions here are timely and based on good information.

25. Conflicts here are solved by talking and negotiating.

26. The goals and objectives of the home are clearly defined and reviewed regularly.

27. We seem to change direction from one day to the next.

28. The Home is able to see problems and changes coming and prepare for them.

29. Changes in policies and procedures are clearly communicated to all those involved or affected.

30. Changes in priority are promptly communicated.

31. My work unit has access to top management and they value our input.

HASTINGS HOME

EMPLOYEE SURVEY (RAW COUNT)

QUESTION NUMBER	NUMBER OF 1's,2's etc 1	2	3	4	5	6	7	NO ANSWER	TOTAL ANSWERS	1 & 2 %	6 & 7 %	RECORD CHECK	OVERALL AVERAGE
30 H	0	1	3	7	4	2	3	2	20	5.0	25.0	22	4.600
31 H	1	4	3	6	3	1	3	1	21	23.8	19.0	22	4.000
32 H	2	2	1	9	2	2	3	1	21	19.0	23.8	22	4.190
33 H	2	3	0	10	3	3	0	1	21	23.8	14.3	22	3.857
34 H	3	0	2	10	1	2	3	1	21	14.3	23.8	22	4.143
35 H	1	3	2	6	4	3	2	1	21	19.0	23.8	22	4.238
36 H	6	4	2	5	2	1	1	1	21	47.6	9.5	22	3.000
37 H	2	4	1	8	3	1	1	2	20	30.0	10.0	22	3.650
38 H	0	2	2	10	3	2	2	1	21	9.5	19.0	22	4.333
39 H	1	4	2	6	2	4	2	1	21	23.8	28.6	22	4.143
40 H	1	2	1	8	2	3	4	1	21	14.3	33.3	22	4.571

EMPLOYEE SURVEY

READ EACH OF THE FOLLOWING STATEMENTS CAREFULLY !
Indicate your level of agreement with the statements by circling the appropriate number on the 7-point scale.

AGREE STRONGLY = 1	DEFINITION of WORK GROUP :
AGREE = 2	
AGREE SLIGHTLY = 3	You, your direct supervisor,
NEUTRAL = 4	and others who report to your
DISAGREE SLIGHTLY = 5	direct supervisor.
DISAGREE = 6	
DISAGREE STRONGLY = 7	

SECTION A - THESE STATEMENTS FOCUS PRIMARILY ON THE WORK GROUP OR INDIVIDUAL LEVEL.

1	The workload in my work area is fairly distributed.	1 2 3 4 5 6 7
2	Our work group has difficulty working with other units in the Home.	1 2 3 4 5 6 7
3	Our work group is able to clearly measure the results of its work.	1 2 3 4 5 6 7
4	My work unit values quality of work over deadlines.	1 2 3 4 5 6 7
5	Our work group gets feedback on how our clients (residents and families) feel about our services.	1 2 3 4 5 6 7
6	We have lots of good policies and procedures so we know what we are supposed to do.	1 2 3 4 5 6 7
7	I can finish the work I'm supposed to do on my shift.	1 2 3 4 5 6 7
8	Our procedures are too "by-the -book" and don't show concern for residents' needs.	1 2 3 4 5 6 7
9	I feel confident in my supervisor's leadership.	1 2 3 4 5 6 7
10	Key people are usually available when needed and willing to help.	1 2 3 4 5 6 7
11	Supervisors cooperate with each other.	1 2 3 4 5 6 7
12	My supervisor is often unfair with employees.	1 2 3 4 5 6 7

13	The staffing levels proposed by the DHS (54 new positions in Mpls & 4 new positions in Hastings) will meet our needs for the near future.	1 2 3 4 5 6 7
14	I get the training I need to perform my work and improve my job skills.	1 2 3 4 5 6 7
15	Coworkers feel free to express their opinions even though they may disagree with one another.	1 2 3 4 5 6 7
16	I receive feedback on how well I do my job.	1 2 3 4 5 6 7
17	I feel confident in the leadership of the Dept. of Veterans Affairs.	1 2 3 4 5 6 7
18	I feel confident in the leadership of the Dept.of Human Services.	1 2 3 4 5 6 7
19	Employees in the Home work efficiently.	1 2 3 4 5 6 7
20	Communication between the work groups is unsatisfactory and needs improvement.	1 2 3 4 5 6 7
21	Some people at the Home are "on-the-job retired".	1 2 3 4 5 6 7
22	The Dept. of Veterans Affairs could have run the Home well if given enough budget and staff.	1 2 3 4 5 6 7

SECTION B - THESE STATEMENTS RELATE TO BROAD MANAGEMENT ISSUES. PLEASE RESPOND BY CIRCLING THE APPROPRIATE NUMBER IN EACH COLUMN WITH RESPECT TO THE MANAGEMENT OF THE HOME UNDER EACH AGENCY.

		VETS AFFAIRS	HUMAN SERVICES
23	We have a clear understanding of our work group's mission and priorities.	1 2 3 4 5 6 7	1 2 3 4 5 6 7
24	Decisions here are timely and based on good information.	1 2 3 4 5 6 7	1 2 3 4 5 6 7
25	Conflicts here are solved by talking and negotiating.	1 2 3 4 5 6 7	1 2 3 4 5 6 7
26	The goals and objectives of the home are clearly defined and reviewed regularly.	1 2 3 4 5 6 7	1 2 3 4 5 6 7

		VETS AFFAIRS	HUMAN SVCS.
27	We seem to change direction from one day to the next.	1 2 3 4 5 6 7	1 2 3 4 5 6 7
28	The Home is able to see problems and changes coming and prepare for them.	1 2 3 4 5 6 7	1 2 3 4 5 6 7
29	Changes in policies and procedures are clearly communicated to all those involved or affected.	1 2 3 4 5 6 7	1 2 3 4 5 6 7
30	Changes in priority are promptly communicated.	1 2 3 4 5 6 7	1 2 3 4 5 6 7
31	My work unit has access to top management and they value our input.	1 2 3 4 5 6 7	1 2 3 4 5 6 7
32	The leaders of this Home have a sense of the real problems facing us.	1 2 3 4 5 6 7	1 2 3 4 5 6 7
33	Supervisors and top management are too controlling and fail to let employees use their own good judgment.	1 2 3 4 5 6 7	1 2 3 4 5 6 7
34	My work unit is praised for doing good work.	1 2 3 4 5 6 7	1 2 3 4 5 6 7
35	The Home keeps its policies and procedures up-to-date.	1 2 3 4 5 6 7	1 2 3 4 5 6 7
36	I look forward to coming to work.	1 2 3 4 5 6 7	1 2 3 4 5 6 7
37	Employees share their opinions with supervisors or management.	1 2 3 4 5 6 7	1 2 3 4 5 6 7
38	Meetings are well planned, well run, and productive.	1 2 3 4 5 6 7	1 2 3 4 5 6 7
39	I receive the information I need for my job in a timely manner.	1 2 3 4 5 6 7	1 2 3 4 5 6 7
40	A lot of effort is made to ask for the thoughts and opinions of employees.	1 2 3 4 5 6 7	1 2 3 4 5 6 7

PLEASE TURN OVER.

Please provide the information requested below to assist us in evaluating the survey results. Our statistics will not be used in a way that would reveal an individual's identity.

Length of employment with Dept. of Veterans Affairs.

_____ Less than 2 years
_____ 2 to 5 years
_____ more than 5 years

Current work location

_____ Minneapolis
_____ Hastings

Current work group name _____

(e.g. "Social Services" or "Nursing Bldg.17/4")

Current job title _____

(e.g. "HST II " or "RN Supervisor")

Work shift

_____ Days
_____ Evenings
_____ Nights

Appendix C

MINNESOTA VETERANS HOME
---Family Member Survey Data---

		MVH MPLS	MVH HASTINGS
Method for selection of family members		Random sample of family council members	Random sample of residents' files for significant other listed
Surveys mailed 11/24/87		30	30
Undeliverable		1	1
Surveys delivered		29	29
Surveys returned to Management Analysis			
	Building/Floor		
	Bldg 16	4	
	Bldg 17, 3rd Floor	8	
	Bldg 17, 4th Floor	6	
	Undetermined	1	
		19	11
Response Rate		66%	38%

MVH FAMILY MEMBER SURVEY RESULTS

Reason(s) you or your family member chose MVH

	Undetermined	16	17-3	17-4	Mpls Total	MVH Hastings
Affordability		4	8	5	17 (89.4%)	5 (45.4%)
Location	1	2	3	3	9 (47.4%)	1 (9.1%)
Quality of Care		2	3	5	10 (52.6%)	2 (18.2%)
Veteran Population		1	4	2	7 (36.8%)	5 (45.4%)
Other		1	1	1	3 (15.8%)	1 (9.1%)

If you had the opportunity and means to place your family member in a private facility, would you do so?

	Undetermined	16	17-3	17-4	Mpls Total	MVH Hastings
Yes	0	0	2	0	2 (10.6%)	0
No	1	4	6	6	17 (89.4%)	10 (90.9%)
No response	0	0	0	0	0	1 (9.1%)

Another public facility?

	Undetermined	16	17-3	17-4	Mpls Total	MVH Hastings
Yes	0	0	1	0	1 (5.3%)	0
No	1	3	7	6	17 (89.4%)	9 (81.8%)
No response	0	1	0	0	1 (5.3%)	2 (18.2%)

MVH FAMILY MEMBER SURVEY RESULTS

Rating of MVH Operations
Scale=1 (poor) to 5 (excellent)
Ratings shown are averages for campus, building or floor
Number in ( ) represents number of respondents

MEDICAL CARE/STAFF

	MVH	MINNEAPOLIS				
Physicians	Undetermined	16	17-3	17-4	Mpls Total	MVH Hastings
Knowledge/Skills/Performance	3.0 (1)	4.0 (1)	3.5 (6)	4.8 (5)	3.8 (13)	3.8 (4)
Accessibility	1.0 (1)	2.0 (1)	2.8 (8)	4.8 (5)	2.7 (15)	3.8 (4)
Attitude Towards Residents	1.0 (1)	2.5 (2)	3.2 (5)	4.8 (5)	2.9 (13)	4.0 (4)
Nurses						
Knowledge/Skills/Performance	3.0 (1)	3.8 (4)	3.9 (7)	4.6 (5)	3.8 (17)	4.0 (4)
Accessibility	1.0 (1)	3.3 (4)	4.0 (8)	4.6 (5)	3.7 (18)	4.0 (4)
Attitude Towards Residents	1.0 (1)	3.3 (4)	3.7 (7)	4.6 (5)	3.2 (17)	4.0 (4)
HSTs						
Knowledge/Skills/Performance	1.0 (1)	3.3 (4)	2.9 (7)	4.0 (5)	2.8 (17)	NA
Accessibility	1.0 (1)	2.8 (4)	3.0 (8)	4.0 (5)	2.7 (18)	NA
Attitude Towards Residents	1.0 (1)	3.1 (4)	3.1 (7)	4.2 (5)	2.9 (17)	NA

MVH FAMILY MEMBER SURVEY RESULTS

Rating of MVH Operations

Scale=1 (poor) to 5 (excellent)
Ratings shown are averages for campus, building or floor
Number in ( ) represents number of respondents

MEDICAL CARE/STAFF

	MVH	MINNEAPOLIS				
	Undetermined	16	17-3	17-4	Mpls Total	MVH Hastings
Communication between medical care staff regarding resident care	3.0 (1)	3.5 (4)	3.4 (7)	4.2 (5)	3.5 (17)	4.0 (5)
Communication between medical care staff and family regarding resident care	1.0 (1)	3.0 (4)	2.9 (8)	4.4 (5)	2.8 (18)	4.0 (5)
Ability of medical staff to coordinate resident care with outside health care providers	5.0 (1)	1.7 (3)	4.0 (8)	4.6 (5)	3.8 (17)	4.0 (5)
Overall medical care received by residents	3.0 (1)	3.0 (4)	3.8 (8)	4.5 (6)	3.6 (19)	4.0 (5)

FAMILY MEMBER SURVEY
MEDICAL CARE/STAFF

MINNEAPOLIS		HASTINGS	
Strengths	Weaknesses	Strengths	Weaknesses
o Some feel medical care is better than at other homes	o Need to examine staff structure in terms of HST supervision	o Quick, efficient care	
o Some HSTs kind,cooperative, attentive to residents' needs--residents treated like a family	o Some HSTs have attitude problems that impede adequate resident care	o Concerned and caring staff	
o Staff generally competent and supportive when families "feel down"	o Resident care inadequate and/or inconsistent (monitoring of meds, medication & eating schedules, toileting frequency, shaving, general hygiene)	o Careful administration of medications	
o Care plan conferences a valuable learning experience for the family	o Poor communication between staff itself and between staff, family, and VAMC regarding changes in meds/treatments, notification of families, transfer to VAMC, special treatment procedures		
	o HSTs need additional training		
	o Staff don't wear uniforms--difficult to identify		
	o Some employees inconsiderate--fail to greet families and residents, use abusive language with residents		

Note: Most positive comments came from 17-4 family members.

MVH FAMILY MEMBER SURVEY RESULTS

Rating of MVH Operations
Scale=1 (poor) to 5 (excellent)
Ratings shown are averages for campus, building or floor
Number in ( ) represents number of respondents

INDIRECT CARE

	MVH	MINNEAPOLIS				
	Undetermined	16	17-3	17-4	Mpls Total	MVH Hastings
Food						
Quality	1.0 (1)	3.0 (2)	3.0 (8)	4.5 (4)	2.9 (15)	4.4 (7)
Quantity	5.0 (1)	3.5 (2)	3.5 (8)	4.5 (4)	4.1 (15)	4.7 (7)
Variety	5 0 (1)	3.0 (2)	3.1 (8)	4.5 (4)	3.9 (15)	4.4 (7)
Transportation for:						
Ambulatory	5.0 (1)	----(0)	5.0 (4)	4.7 (4)	4.9 (9)	4.4 (5)
Non-ambulatory	5.0 (1)	3.5 (2)	4.2 (6)	4.7 (3)	4.4 (12)	4.5 (2)
Maintenance of Buildings/Grounds	3.0 (1)	3.5 (4)	3.6 (8)	4.2 (6)	3.6 (19)	4.4 (5)
Housekeeping:						
Rooms	1.0 (1)	4.3 (3)	2.3 (7)	4.0 (6)	2.9 (17)	3.2 (6)
Common Areas	3.0 (1)	3.7 (3)	2.7 (7)	4.2 (6)	3.4 (17)	4.0 (6)

FAMILY MEMBER SURVEY
INDIRECT CARE

MINNEAPOLIS

Strengths

- Extra efforts made by 17-4 staff and housekeeping staff for special meals, parties
- Dietician extremely cooperative re: changes and answering questions
- Transportation to special events is excellent
- Each resident has private or semi-private room
- "Lovely park-like grounds...vegetable gardens for residents"

Weaknesses

- Missing clothes, shortage of linen
- Rooms not dusted or thoroughly vacuumed. Bathrooms not cleaned on daily basis
- Urine, food in common areas and on wheelchairs
- Food very often raw
- No transportation to outside medical appointments other than VAMC
- Better supervision of housekeeping staff needed

HASTINGS

Strengths

- "Meals good, tasty and well prepared" even for semi-soft diets

Weaknesses

- More emphasis needed on personal hygiene of residents
- Brother's room very dirty

MVH FAMILY MEMBER SURVEY RESULTS

Rating of MVH Operations
Scale=1 (poor) to 5 (excellent)
Ratings shown are averages for campus, building or floor
Number in ( ) represents number of respondents

RECREATIONAL ACTIVITIES/SOCIAL PROGRAMS

	M V H	M I N N E A P O L I S				
	Undetermined	16	17-3	17-4	Mpls Total	MVH Hastings
Counseling						
Spiritual	5.0 (1)	----(0)	4.4 (7)	5.0 (1)	4.8 (9)	3.6 (5)
Chemical Dependency	----(0)	----(0)	----(0)	----(0)	----(0)	4.0 (6)
Recreational Activities						
Quality	5.0 (1)	5.0 (1)	4.3 (6)	4.5 (2)	4.7 (10)	3.8 (5)
Quantity	3.0 (1)	5.0 (1)	3.8 (6)	4.5 (2)	4.1 (10)	3.6 (5)
Participation	5.0 (1)	5.0 (1)	3.7 (7)	5.0 (1)	4.7 (10)	3.0 (5)
Rehabilitation Program						
Quality	5.0 (1)	3.0 (1)	3.8 (6)	4.7 (3)	4.1 (11)	3.4 (7)
Quantity	5.0 (1)	3.0 (1)	3.5 (6)	4.7 (3)	4.1 (11)	3.2 (6)
Participation	5.0 (1)	4.0 (1)	3.4 (5)	4.5 (2)	4.2 (9)	2.8 (6)

FAMILY MEMBER SURVEY
RECREATIONAL ACTIVITIES/SOCIAL SERVICES

MINNEAPOLIS

Strengths	Weaknesses
o Family council	o Physical therapy not consistent
o Resident loves therapy--therapists do great job under difficult circumstances	o No one available to wheel residents down to chapel services and activities on 1st floor (17)
o Many, many excellent activities--MVH seems more concerned about residents than other nursing homes	o Chaplain "stretched too thin"
o Chaplain helpful and friendly	o Encourage residents to participate more
	o What are the duties and responsibilities of social workers?

HASTINGS

Strengths	Weaknesses
o Swimming	
o Outside entertainment from vets organizations	
o Resident given leadership role--fosters rehabilitation	
o Involvement in A.A.	

MVH FAMILY MEMBER SURVEY RESULTS

Rating of MVH Operations
Scale= 1 (strongly disagree) to 5 (strongly agree)
Ratings shown are averages for campus, building or floor
Number in ( ) represents number of respondents

RESIDENT RIGHTS

	M V H	M I N N E A P O L I S				
	Undetermined	16	17-3	17-4	Mpls Total	MVH Hastings
Staff respects residents' right to privacy	5.0 (1)	4.7 (3)	3.8 (8)	4.5 (6)	4.5 (18)	4.6 (5)
Staff treats residents with respect and dignity	3.0 (1)	3.8 (4)	3.1 (8)	4.5 (6)	3.6 (19)	4.6 (7)
Personal articles of residents are free from theft	1.0 (1)	2.5 (4)	1.4 (7)	4.2 (6)	2.3 (18)	4.4 (5)
Residents are free from physical harm by staff or other residents	2.0 (1)	2.5 (2)	3.4 (8)	4.5 (4)	3.1 (15)	4.8 (5)
Staff and management listen to resident/family concerns and respond in a positive fashion without retaliation	3.0 (1)	3.7 (3)	3.5 (8)	4.7 (6)	3.7 (18)	4.8 (6)

FAMILY MEMBER SURVEY
RESIDENT RIGHTS

MINNEAPOLIS		HASTINGS	
Strengths	Weaknesses	Strengths	Weaknesses
o Some residents treated with respect and dignity	o Theft an ongoing problem (money, personal belongings, resident mail)	o No reason for elderly residents to be on guard or feel threatened	
o Staff and former administrator extremely receptive to family concerns--worked well with family council--moreso than other homes	o Wandering residents a problem in Bldg. 16		
	o Residents sometimes treated in dehumanizing manner, talked down to (e.g., wheelchair=no mind)		
	o Resident concerns/needs ignored--some staff feel MVH is warehouse for terminally ill		
	o Retaliation by staff when concerns expressed to management		
	o Some staff appear to be abusive--some residents frightened		

Note: No weaknesses listed from 17-4 family members

FAMILY MEMBER SURVEY
ADMISSIONS PROCESS

MINNEAPOLIS		HASTINGS	
Strengths	Weaknesses	Strengths	Weaknesses
o Sensitivity on the part of staff (social workers, nurses)	o Political pull gets some applicants in sooner than others	o Well coordinated with VAMCs	
o Interviews/orientation brief, organized, efficient	o Insufficient information provided about activities and services for residents	o Done very quickly without problems	
	o Long wait for nursing care	o Lots of assistance given	
	o 4-hour wait before room ready for resident		

FAMILY MEMBER SURVEY
ADDITIONAL CONCERNS

MINNEAPOLIS

- Create Alzheimer's support group for families
- Create stroke support group for patients under 70
- Visitors' lounges for each floor
- Smoking areas away from eating areas
- Continue to care for Alzheimer's residents at Minneapolis
- More staff
- Return MVH to DVA but remove politics
- Pleased with care compared to other homes--overreaction to MVH problems
- Recruit more volunteers to assist staff
- Better screening of staff
- Get employees who care--some have the attitude that "residents don't pay their way"

HASTINGS

- Good job--great place to live
- Thankful for good care, food, entertainment--resident would like to stay for the "rest of his life"
- "Please don't close Hastings"

Note: No negative concerns voiced by 17-4 family members

MANAGEMENT ANALYSIS DIVISION
SURVEY FOR FAMILY MEMBERS OF RESIDENTS OF
THE MINNESOTA VETERANS HOMES

PERSONAL DATA

1. Your relationship to family member : _____

2. Family member currently resides in:

   ____ MN Veterans Home - Mpls (Bldg _____ Floor/Unit _____)
   ____ MN Veterans Home - Hastings

3. Family member's dates of residence at MN Veterans Home:

   From:_____ to _____

4. Family member is:

   ___ambulatory (capable of walking)
   ___non-ambulatory

5. Have you visited your family member at the Veterans Home? ___Yes ___No

   If yes: Date of last visit _____
   Frequency of visits _____(per year)

6. What is the most important reason you or your family member chose the MN Veterans Home?

   ____affordability
   ____location
   ____quality of care
   ____veteran resident population
   ____other _____

7. If you had the opportunity and means to place your family member in a private nursing home/residential facility, would you do so?

   ___Yes ___No

   Another public facility? ___Yes ___No

8. What do you recall about the admissions process? (How long did it take, who was involved, etc.)

OPERATIONS OF THE MN VETERANS HOME

In this section, you are asked to rate specific aspects regarding the major areas of operations at the MN Veterans Homes. Additionally, a space is provided at the end of each major area in order to obtain your input about the strengths and weaknesses you perceive in these areas.

A. MEDICAL CARE/STAFF	Poor				Excellent	Don't Know
Physicians						
Knowledge/Skills/Performance	1	2	3	4	5	____
Accessibility	1	2	3	4	5	____
Attitude towards residents	1	2	3	4	5	____
Nurses (LPNs, RNs)						
Knowledge/Skills/Performance	1	2	3	4	5	____
Accessibility	1	2	3	4	5	____
Attitude towards residents	1	2	3	4	5	____
HSTs (Nurses Aides - Mpls Home Only)						
Knowledge/Skills/Performance	1	2	3	4	5	____
Accessibility	1	2	3	4	5	____
Attitude towards residents	1	2	3	4	5	____
Communication between medical care staff members regarding resident care (medications, treatments, etc.)	1	2	3	4	5	____
Communication between medical care staff and resident/family regarding resident care	1	2	3	4	5	____
Ability of medical staff to coordinate resident care with outside health care providers (VA Hospitals, County Hospitals)	1	2	3	4	5	____
Overall medical care received by residents	1	2	3	4	5	____

Do you recall any experiences that either you or your family member had in the area of medical care that were extremely negative or positive?

B. INDIRECT CARE

	Poor				Excellent	Don't Know
Food						
Quality	1	2	3	4	5	____
Quantity	1	2	3	4	5	____
Variety	1	2	3	4	5	____
Transportation Provided for Residents						
Ambulatory Residents	1	2	3	4	5	____
Nonambulatory Residents	1	2	3	4	5	____
Maintenance of Buildings/Grounds	1	2	3	4	5	____
Housekeeping						
Cleanliness of resident rooms	1	2	3	4	5	____
Cleanliness of common areas	1	2	3	4	5	____

Do you recall any experiences that either you or your family member had in the area of indirect care that were extremely positive or negative?

C. RECREATIONAL ACTIVITIES/SOCIAL PROGRAMS

	Poor				Excellent	Don't Know
Counseling Services						
Spiritual	1	2	3	4	5	____
Chemical Dependency	1	2	3	4	5	____
Other _____	1	2	3	4	5	____
Recreational Activities						
Quality	1	2	3	4	5	____
Quantity	1	2	3	4	5	____
Participation of Residents	1	2	3	4	5	____
Rehabilitative Programs						
Quality	1	2	3	4	5	____
Quantity	1	2	3	4	5	____
Participation of Residents	1	2	3	4	5	____

Do you recall any experiences that either you or your family member had in the area of recreational activities/social programs that were extremely positive or negative?

D. RESIDENT RIGHTS

	Strongly Disagree				Strongly Agree	Don't Know
Whenever possible, the staff respects a resident's right to privacy	1	2	3	4	5	____
Whenever possible, the staff treats residents with respect and dignity	1	2	3	4	5	____
The personal articles of residents are free from theft	1	2	3	4	5	____
Residents are free from physical harm by staff or other residents	1	2	3	4	5	____
Staff and management listen to resident/family concerns and respond in a positive fashion without retaliation	1	2	3	4	5	____

Do you recall any experiences that either you or your family member had in the area of resident rights that were extremely positive or negative?

DO YOU HAVE ANY ADDITIONAL CONCERNS (strengths, weaknesses, changes you would make, etc.) REGARDING THE MINNESOTA VETERANS HOMES THAT YOU WOULD LIKE TO COMMENT ON?

Appendix D

MANAGEMENT ANALYSIS DIVISION
SURVEY FOR VOLUNTEERS OF THE
MN VETERANS HOME - MINNEAPOLIS

Survey mailed to random sample (25) of Mpls MVH volunteers
1 survey returned as undeliverable
Response rate = 63% (15 out of 24 surveys returned)
Results are in bold print/parentheses

1. Are you a member of a veterans service organization?
(14) Yes (1) No

2. When did you start volunteering at the home?
(Range = 1962 to 1987)
(Average number of years spent volunteering = 9.6)

3. Why did you start volunteering at the home?

(3) I was personally recruited by the home's Volunteer Services Coordinator

(1) My service organization was contacted by the home's Volunteer Services Coordinator

(6) My service organization volunteered its services on its own initiative

(4) I volunteered my services to the home on my own initiative

(1) Other **(explanation would identify volunteer)** _____

4. How many hours per year do you spend on volunteer activities for the home?
(Range = 54 to 1200 hours per year
Average number of hours cannot be computed with data supplied
Most common response was 100 hours per year)

5. As a volunteer, I:

(7) donate personal funds/supplies to the home
(10) help to raise funds/supplies for the home
(11) visit the home's residents on a 1-to-1 basis
(12) take part in group activities for the home's residents (bingo, etc.)
(5) work at the home
(0) other _____

6. How often do you interact with the home's staff? (other than the Volunteer Services Coordinator)

(0) never
(7) occasionally
(8) on a fairly regular basis

	Poor				Excellent	Don't Know
7. How would you rate the staff's attitude towards and willingness to cooperate with volunteers?	(1) 1	(0) 2	(1) 3	(3) 4	(9) 5	(1) ____
8. How would you rate the Volunteer Services Program at the home with respect to:						
Recruitment of volunteers	(2) 1	(0) 2	(0) 3	(5) 4	(7) 5	(1) ____
Placement of volunteers according to the needs and interests of volunteers	(0) 1	(1) 2	(1) 3	(2) 4	(9) 5	(2) ____
Communicating the needs of the home and coordinating the activities of the volunteers to meet those needs	(1) 1	(0) 2	(1) 3	(5) 4	(6) 5	(2) ____
Providing a means for staff and volunteers to communicate and coordinate their activities	(0) 1	(0) 2	(4) 3	(2) 4	(6) 5	(3) ____
Providing recognition for volunteers	(1) 1	(0) 2	(2) 3	(3) 4	(9) 5	(0) ____

9. What changes would you make with respect to the home's Volunteer Services Program? How might volunteers be further involved in the operation of the home?

<u>Recruitment</u>

***allow volunteer coordinator to actively recruit volunteers without the interference of politics**

***return MVH to DVA and let veterans in the state know they are needed as volunteers**

***vast pool of potential volunteers in vets organizations. Volunteer coordinator should attend vets organization conventions in order to recruit volunteers**

(cont'd)

Providing a means for staff and volunteers to communicate and coordinate their activies.

*long-time volunteers not receptive to new volunteers and don't include them in some activities

Communicating the needs of the home and coordinating the activities of the volunteers to meet those needs.

*volunteers could make beds and feed residents in the morning. Residents like socializing during meals and are often too weak to feed themselves

*use volunteers to keep information desk (bldg 17) open from 9:00 a.m. to 9:00 p.m. on weekends to provide a more friendly and secure atmosphere for residents

*more volunteers are needed on a 1-to-1 basis

*little effort made to pair volunteer up with residents and get constructive program going. Volunteer left to "flounder" while someone is trying to decide what volunteer can do.

*encourage supervisors to properly utilize volunteer skills to enhance the programs as well as the daily lives of residents

Recognition

*send a thank you letter to volunteers who bring in clothing and supplies, as was done in the past. "Have heard volunteers say they'd rather give to Hastings MVH because they receive a thank you."

*"I have been treated with great appreciation while I'm there"

*"volunteers are all doing their very best.....if it wasn't for volunteers, some of our facilities would be in sad shape"

*volunteer coordinator should attend vets organization conventions to thank volunteers

Appendix E

MANAGEMENT ANALYSIS DIVISION
SURVEY FOR VETERANS ORGANIZATIONS
MINNESOTA VETERANS HOMES

Mailed to 17 vets groups. 7 surveys returned (41%). Results are shown in bold print/parentheses.

1. Please rate the quality of the Minnesota Veterans Homes' operations over the last year on a scale of 1 to 5 in each of the following areas: (# of responses shown)

   A. Quality of Nursing/Medical Care

Mpls Home		Hastings Home	
(0)	1 Poor	(0)	1 Poor
(0)	2	(0)	2
(4)	3	(0)	3
(2)	4	(4)	4
(1)	5 Excellent	(1)	5 Excellent
(0)	Don't know	(2)	Don't know

   B. MN Veterans Homes' Coordination with other Health Care Providers (Veterans Administration Medical Centers, Hennepin and Dakota Counties)

Mpls Home		Hastings Home	
(0)	1 Poor	(0)	1 Poor
(0)	2	(0)	2
(0)	3	(0)	3
(3)	4	(2)	4
(3)	5 Excellent	(2)	5 Excellent
(1)	Don't know	(3)	Don't know

   C. Quality of Indirect Care (Food Services, Laundry, (Housekeeping, Security, Transportation)

Mpls Home		Hastings Home	
(0)	1 Poor	(0)	1 Poor
(0)	2	(0)	2
(3)	3	(3)	3
(3)	4	(1)	4
(1)	5 Excellent	(2)	5 Excellent
(0)	Don't know	(1)	Don't know

   D. Quality of Physical Surroundings (Buildings, Grounds, Equipment)

Mpls Home		Hastings Home	
(0)	1 Poor	(0)	1 Poor
(0)	2	(0)	2
(3)	3	(2)	3
(3)	4	(2)	4
(1)	5 Excellent	(2)	5 Excellent
(0)	Don't know	(1)	Don't know

E. Quality of Recreational Programs/Activities

Mpls Home		Hastings Home	
(0) 1	Poor	(0) 1	Poor
(1) 2		(0) 2	
(1) 3		(1) 3	
(4) 4		(4) 4	
(1) 5	Excellent	(1) 5	Excellent
(0)	Don't know	(1)	Don't know

F. Quality of Social Services, Spiritual Counseling, Chemical Dependency Counseling

Mpls Home		Hastings Home	
(0) 1	Poor	(0) 1	Poor
(1) 2		(0) 2	
(2) 3		(0) 3	
(2) 4		(3) 4	
(2) 5	Excellent	(3) 5	Excellent
(0)	Don't know	(1)	Don't know

G. Quality of Volunteer Programs

Mpls Home		Hastings Home	
(0) 1	Poor	(0) 1	Poor
(0) 2		(0) 2	
(1) 3		(0) 3	
(0) 4		(0) 4	
(6) 5	Excellent	(6) 5	Excellent
(0)	Don't know	(1)	Don't know

H. Relationship with Community/Veterans Organizations

Mpls Home		Hastings Home	
(0) 1	Poor	(0) 1	Poor
(0) 2		(0) 2	
(0) 3		(0) 3	
(2) 4		(0) 4	
(5) 5	Excellent	(6) 5	Excellent
(0)	Don't know	(1)	Don't know

I. Caring Attitude of Staff

Mpls Home		Hastings Home	
(0) 1	Poor	(0) 1	Poor
(0) 2		(0) 2	
(0) 3		(0) 3	
(5) 4		(2) 4	
(2) 5	Excellent	(3) 5	Excellent
(0)	Don't know	(2)	Don't know

J. Overall Quality of Care

Mpls Home Nursing	Mpls Home Domiciliary	Hastings Home Domiciliary
(0) 1 Poor	(0) 1 Poor	(0) 1 Poor
(0) 2	(0) 2	(0) 2
(1) 3	(1) 3	(0) 3
(3) 4	(4) 4	(3) 4
(3) 5 Excellent	(2) 5 Excellent	(2) 5 Excellent
(0) 6 Don't know	(0) 6 Don't know	(2) 6 Don't know

2. Please determine which of the items A through J are the most critical to the future success and effectiveness of the Minnesota Veterans Homes. Please list your top 3 critical priorities in order of their importance to you.

First Priority **Quality of Nursing/Medical Care-(5)**

Second Priority **Quality of Indirect Care-(4)**

Third Priority **Caring Attitude of Staff-(3)**

3. If you feel there are other areas/issues that are critical to the future success and effectiveness of the MN Veterans Homes that are not listed under Section 1, please list these areas in order of their importance to you

1st Priority **return to DVA, adequate staff & funding, strong administrator, coordination with outside health care providers**

2nd Priority **well-defined administrator, social services**

3rd Priority **clinical pharmacist in residence**

4. During our interviews with employees of the MN Veterans Homes and other relevant parties, a variety of suggestions and issues arose with respect to the operations and mission of the MN Veterans Homes. They are presented here as a series of hypothetical choices in order to assess the level of importance you assign to some of these issues. Please choose only 1 of the options presented in each category.

A. Given the choice, the MN Veterans Homes should:
- (0) implement a strict, uniform admissions policy based on objective criteria with little or no room for exceptions to be made
- (6) implement a more informal admissions policy which can be tailored to individual circumstances and allow for exceptions
- (1) no response

B. Given the choice, the MN Veterans Homes should:

(6) increase rates to increase the types and levels of services offered
(0) attempt to keep rates and services at current levels
(1) **no response**

C. Given the choice, the MN Veterans Homes should:

(5) implement a structured and monitored domiciliary system with emphasis on rehabilitative programs
(0) implement an unstructured and unmonitored domiciliary system with emphasis on board and care
(2) **no response**

D. Given the choice, the MN Veterans Homes should:

(4) establish admissions priorities according to non-service related factors such as age, income, type and level of care needed
(1) establish admissions priorities according to service related factors such as length of service, period of service (WWI, WWII, etc), POW status
(2) **no response**

E. Given the choice, the MN Veterans Homes should:

(0) place more importance on admitting spouses and parents of war-time veterans than on admitting peace-time veterans
(4) place more importance on admitting peace-time veterans than spouses and parents of war-time veterans
(3) **no response**

5. Please rank the areas within each grouping on a scale from highest priority (1) to lowest priority (4) according to how critical they are to the mission of the MN Veterans Homes. **(Average rank shown.)**

Group A

(2.2) domiciliary care for low-income veterans
(1.2) nursing care for low-income veterans
(3.5) domiciliary care for middle-to high-income veterans
(3.3) nursing care for middle-to high-income veterans

Group B

(1.3)providing heavy skilled nursing care
(2.2)providing light to intermediate skilled nursing care
(3.7)providing heavy skilled psychiatric or psychological care
(3.0)providing light to intermediate skilled psychiatric or psychological care

Group C

(1.5)serving war-time veterans whose disabilities are service related

(2.3)serving war-time veterans whose disabilities are NOT service related

(2.8)serving peace-time veterans whose disabilities are service related

(3.5)serving peace-time veterans whose disabilities are NOT service related

6. Have you ever visited the MN Veterans Homes?
Yes(7)No(0)
If yes:
month/year of last visit 1987-(6), 1986-(1)
frequency of visits per year (5.6 average)

7. Have you ever been a resident of the MN Veterans Homes?
Yes(0) No(7)
If yes, dates of last stay _____

8. Would you recommend the MN Veterans Homes to eligible family members or friends who were in need of residential or nursing care?

Nursing Care-Mpls Yes(6) No(1)
Domiciliary Care-Mpls Yes(5) No(2)
Domiciliary Care-Hastings Yes(4) No(2) don't know (1)

9. If, in the future, you are in need of residential or nursing care, would you choose the MN Veterans Homes?

Nursing Care-Mpls Yes(5) No(1) don't know (1)
Domiciliary Care-Mpls Yes(5) No(1) don't know (1)
Domiciliary Care-Hastings Yes(4) No(1) don't know (2)

When we receive your survey, this sheet will be separated from your survey and used for statistical purposes only. Those participating in this survey will NOT be identified individually.

Name: _____

Veterans Group(s)
You Belong To: VFW (4), DAV (3), PVA (2), Am Leg (3)
Am Vets (1), V of WWI (1), CSO (1)

Age: (average age = 53)

Period(s) of Service:

(1) WWI (1) WWII (2) Korean (2) Vietnam

(2) Peace-Time (1) Other (Auxiliary member)

RETURN SURVEY TO:

VIRGINIA DODDS
DEPT OF ADMINISTRATION
MANAGEMENT ANALYSIS DIVISION
203 ADMINISTRATION BUILDING
50 SHERBURNE AVENUE
ST. PAUL, MN 55155

Appendix F

CORRECTION ORDERS ISSUED TO OTHER MINNESOTA FACILITIES BY THE MINNESOTA DEPARTMENT OF HEALTH

Introduction

Given the large number of correction orders issued to the Minnesota Veterans Home in Minneapolis, during recent years, the Management Analysis study team conducted research at the Minnesota Department of Health to determine the number of correction orders issued to similar facilities in the state, for purposes of comparison.

Methodology

Samples. There are 446 facilities in the state licensed by the Health Department to provide nursing care and 63 dual-licensed facilities (nursing care and boarding care). Sample facilities were selected from each group based upon their similarity to the Minnesota Veterans Home in Minneapolis, as determined by their licensed bed capacity and/or case-mix index.

Nursing care facilities. Most licensed nursing care facilities in the state provide a higher level of care than does the Minnesota Veterans Home in Minneapolis (i.e., have a higher case-mix index). Therefore, selection of this sample was based upon the size of the facility, as determined by its licensed bed capacity. All facilities with 250 or more licensed beds were studied. The sample ranged from 256 to 559 licensed beds. The Minnesota Veterans Home is licensed to provide nursing care for 346 beds.

Dual-licensed facilities. Most dual licensed facilities in the state are much smaller than the Minnesota Veterans Home in Minneapolis. Selection of this sample was based primarily on case-mix index, with size being the secondary factor. Case-mix indices ranged from 1.56 to 2.25. The Minnesota Veterans Home has a case-mix index of 1.63.

Correction orders. The number of Health Department correction orders for each selected facility is based upon the three most recent Health Department annual and/or biennial state licensing surveys on file. Correction orders issued as a result of follow-up inspections or complaints received by the Office of Health Facilities Complaints were not included, nor were correction orders issued as a result of surveys done for the sole purpose of federal certification.

Qualifiers/variables. Not all state surveys were conducted within the same time frame. The following chart shows the variables which determined time frame for inspections:

1987 Data Available?	Inspection Schedule	Years Inspections Took Place
Yes	Annual	1987, 1986, 1985
No	Annual	1986, 1985, 1984
Yes	Biennial	1987, 1985, 1983
No	Biennial	1986, 1984, 1982 or 1985, 1983, 1981

Inspections, then, could have taken place anytime from 1981 through 1987. This has two implications:

According to the Health Department, survey methodology changed in July 1986 to a more thorough method which may have resulted in more correction orders being issued to all facilities after that time. Two of the Minnesota Veterans Home inspections took place after that time, whereas not all of the other facilities studied had two or even one state licensing inspection conducted after July 1986. If all inspections conducted prior to July 1986 are discounted, the average number of correction orders per inspection for large nursing homes was 11, with a range from 6 to 16. For dual-licensed facilities the average was 12.7, with a range from 3 to 24. The corresponding average for the Minnesota Veterans Home was 27.

During the mid-1980's, the system for writing up correction orders changed. Under the previous system, one correction order may have referenced more than one statute or regulation citation and may have pertained to more than one deficiency. Under the new system, each correction order has only one citation and pertains to only one deficiency. This means that more correction orders would be issued under the new system. This variable was controlled by showing both the number of correction orders and the number of citations in cases where a correction order may have referenced multiple citations.

Explanation/Analysis of Tables

Table A shows correction order data for all nursing homes in the state with 250 or more licensed beds. Data shows that the Minnesota Veterans Home in Minneapolis was issued 68 correction orders (3 correction orders applicable to only boarding care facilities were not included) during its three most recent annual surveys, while the corresponding average for all other large nursing homes was 26.9, with a range from 12 to 47. The fines for noncompliance with correction orders are based on the seriousness of the violation as defined by Health Department regulations. The correction orders for each facility were weighted according to the fines that would be assessed for noncompliance. In other words, 10 $50 violations (e.g.,employee not wearing name tag) would equal 1 $500 violation (e.g.,certain types of medication errors). The fines established by Minnesota Rules 4655.0000 fall into these categories: $50, $100, $150, $200, $250, $300, $350 and $500. The figures in Table A show that, when correction orders are weighted according to fines, the Minnesota Veterans Home's potential for fines is substantially larger than that of similar facilities.

TABLE A

COMPARISON OF MINNESOTA VETERANS HOME CORRECTION ORDERS
with those issued to all
STATE LICENSED NURSING HOMES
with 250+ Licensed Bed Capacity

Facility	Licensed SNF Bed Capacity	#MDH Correction Orders Issued Last 3 MDH Annual Surveys	Average # of MDH Correction Orders Per Survey	Potential for Fines for Correction Issued During Last 3 MDH Surveys*
MVH	346	68**	22.7	$16,300
Public				
Ah-Gwah-Ching	343	19	6.3	$4,150
Oak Terrace	350	43	14.3	$10,350
Private				
Facility A	559	27	9.0	$6,450
Facility B	300	25 (16)***	8.3 (5.3)	$6,650
Facility C	262	12	4.0	$3,100
Facility D	302	47 (37)	15.7 (12.3)	$12,200
Facility E	256	15	5.0	$3,950
Facility F	292	36	12.0	$10,050
Facility G	490	22	7.3	$5,350
Facility H	368	28	9.3	$7,200
Facility I	310	22 (16)	7.3 (5.3)	$4,450
Average****		26.9 (24.6)	9.0 (8.2)	$6,718

* Based on current day fine schedule. Number represents potential for fines, not actual fines assessed by the Health Department.

** Does not include correction orders applicable only to boarding care facilities.

*** Currently, Health Department orders reference only one regulation/statute citation per order. In past years, correction orders may have referenced multiple citations. Number in parenthesis represents actual (MDH) number of correction orders. Preceding number represents number of regulation/statute citations.

**** Does not include correction orders issued to the Minnesota Veterans Home.

Table B shows correction order data for a sample of 10 dual-licensed (nursing care and boarding care) facilities. Data shows that the Minnesota Veterans Home in Minneapolis was issued 71 correction orders during its three most recent annual surveys, while the corresponding average for the other facilities was 20.7, with a range of 13 to 31. Again, the data also shows that the Minnesota Veterans Home's potential for fines is substantially larger than that of similar facilities.

TABLE B

COMPARISON OF MINNESOTA VETERANS HOME CORRECTION ORDERS
with those issued to sample of
STATE DUAL-LICENSED FACILITIES

Facility	Case Mix Index*	Licensed Nursing Beds	Licensed BC Beds	MDH# Correction Orders Issued During Last 3 MDH Annual Surveys	Average # Correction Orders Per Survey	Potential for Fines for Correction Orders Issued Dur- Last 3 MDH Surveys**
MVH	1.63	346	194	71	23.7	$17,050
Private						
Facility A	1.97	149	58	13 (12)***	4.3 (4.0)	$2,900
Facility B	2.01	290	92	21 (17)	7.0 (5.7)	$5,300
Facility C	1.87	115	63	16 (14)	5.3 (4.7)	$3,350
Facility D	1.56	157	249	22 (19)	7.3 (6.3)	$4,700
Facility E	1.78	63	122	24 (21)	8.0 (7.0)	$6,350
Facility F	1.84	109	54	15	5.0	$4,050
Facility G	2.09	155	60	14 (11)	4.7 (3.7)	$3,550
Facility H	2.25	252	50	25 (19)	8.3 (6.3)	$5,200
Facility I	2.09	140	37	26 (25)	8.7 (8.3)	$6,250
Facility J	2.15	233	26	31 (29)	10.3 (9.7)	$8,600
Average****				20.7 (18.2)	6.9 (6.1)	$5,025

* Per assessments conducted during 1986 or 1987.

** Based on current day fine schedule. Number represents potential for fines, not actual fines assessed by the Health Department.

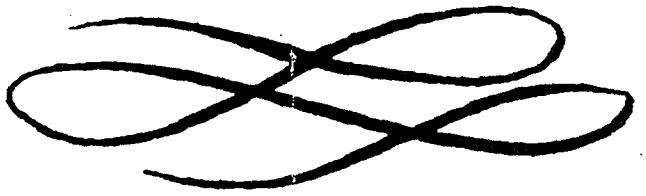
*** Currently, Health Department orders reference only one regulation/statute citation per order. In past years, correction orders may have referenced multiple citations. Number in parenthesis represents actual (MDH) number of correction orders. Preceding number represents number of regulation/statute citations.

**** -Does not include correction orders issued to the Minnesota Veterans Home.

MISSION STATEMENT
of the
MINNESOTA VETERANS HOMES

It is the mission as well as the inherent responsibility of the Minnesota Veterans Homes to assure a "maximum quality of life" for eligible veterans and their spouses residing in the state of Minnesota.

The care provided will ensure that each resident has a structured environment and an individualized program within which he/she can function or be assisted to function at their highest level of physical, social, and mental abilities: solicit participation from each resident in structuring his/her care: and encourage the independence of each resident. Such care will be rendered in a professional and considerate manner providing for the comfort and recognizing the human dignity of each individual.



Appendix H

TABLE 1

MINNESOTA VETERANS HOMES
RESIDENT POPULATION
BY AGE AND FACILITY,1980 and 1988

Age	Minneapolis Nursing Care		Minneapolis Domiciliary		Hastings Domiciliary		TOTAL	
	1980	1/15/88	1980	1/15/88	1980	9/30/87	1980	Current
Under 21	0	0	0	0	0	0	0	0
21 - 44	1	4	31	35	6	35	38	74
45 - 64	7	54	170	63	83	87	260	204
65 - 74	22	101	80	29	28	36	130	166
75 - 84	28	76	45	13	12	11	85	100
85 +	32	80	21	6	4	4	57	90
N/A *					2		2	0
TOTAL	90	315	347	146	135	173	572	634

* N/A means either non-applicable or not available.

SOURCE: MVH Data 1/15/88, HVH Report to DOH 9/30/87, and 1980 MAD Study.

TABLE 2

MINNESOTA VETERANS HOMES
COUNTY OF ADMISSION, 1980 and 1987

	Mpls 1987	%	Hastings 1987	%	CURRENT TOTAL	%	1980 TOTAL	%
Metro Area	342	72.2%	67	40.1%	409	63.8%	328	57.3%
Outstate	120	25.3%	55	32.9%	175	27.3%	225	39.3%
Other *	12	2.5%	45	26.9%	57	8.9%	19	3.3%
TOTAL	474	100%	167	100%	641	100%	572	100%

* Other includes admissions from other states or unknown

SOURCE: DHS Presentation to the Blue Ribbon Commission 10/26/87 and 1980 MAD Study.

TABLE 3

MINNESOTA VETERANS HOMES
PERIOD OF MILITARY SERVICE
BY FACILITY, 1980 and CURRENT

Period	Mpls 1/15/88	%	Hastings 10/26/87	%	Current Total	%	1980 Total	%
World War I	60	13.0%	1	0.6%	61	9.7%	98	17.1%
World War II	292	63.3%	76	45.5%	368	58.6%	373	65.2%
Korea	32	6.9%	39	23.4%	71	11.3%	49	8.6%
Vietnam	39	8.5%	31	18.6%	70	11.1%	17	3.0%
Peace-time	19	4.1%	20	12.0%	39	6.2%	18	3.1%
Non-Veteran	13	2.8%	0	0.0%	13	2.1%	17	3.0%
Unknown	6	1.3%	0	0.0%	6	1.0%	0	0.0%
TOTAL	461	100%	167	100%	628	100%	572	100%

SOURCES: MVH Data 1/15/88, DHS Presentation to the Blue Ribbon Commission 10/26/87, and 1980 MAD Study

TABLE 4

MINNESOTA VETERANS HOMES
SEX OF RESIDENT
BY FACILITY, 1980 and CURRENT

Sex	Mpls Current	%	Hastings Current	%	Current Total	%	1980 Total	%
Female	30	6.3%	0	0.0%	30	4.7%	21	3.7%
Male	444	93.7%	167	100.0%	611	95.3%	551	96.3%
TOTAL	474	100%	167	100%	641	100%	572	100%

SOURCE: DHS Presentation to the Blue Ribbon Commission 10/26/87 and 1980 MAD Study

TABLE 5

MINNESOTA VETERANS HOMES
LENGTH OF STAY FOR CURRENT RESIDENTS
BY FACILITY *

FACILITY	NUMBER OF RESIDENTS	AVERAGE LENGTH OF STAY	MAXIMUM LENGTH OF STAY	MINIMUM LENGTH OF STAY
Minneapolis (nursing care)	315	5.2 Yrs	45.0 Yrs	1 Month
Minneapolis (domiciliary)	159	6.3 Yrs	28.4 Yrs	3 Months
Hastings (domiciliary)	167	3.1 Yrs	9.4 Yrs	3 Months
TOTAL	641	4.9 Yrs	45.0 Yrs	1 Month

* Length of stay is calculated from residents' last admission.

SOURCE: DHS Data 12/87

TABLE 6

MINNEAPOLIS VETERANS HOMES
RESIDENTS'LENGTH OF STAY
AS OF 1/15/88

Years	Nursing Care	%	Domiciliary	%	Total	%
Less than 1	25	7.9%	19	13.0%	44	9.5%
1	61	19.4%	20	13.7%	81	17.6%
2	41	13.0%	11	7.5%	52	11.3%
3	61	19.4%	4	2.7%	65	14.1%
4	24	7.6%	22	15.1%	46	10.0%
5	35	11.1%	17	11.6%	52	11.3%
6	3	1.0%	5	3.4%	8	1.7%
7	3	1.0%	4	2.7%	7	1.5%
8	8	2.5%	9	6.2%	17	3.7%
9	13	4.1%	9	6.2%	22	4.8%
10 - 14	20	6.3%	14	9.6%	34	7.4%
15 - 19	8	2.5%	8	5.5%	16	3.5%
20 - 29	12	3.8%	4	2.7%	16	3.5%
More than 30	1	0.3%	0	0.0%	1	0.2%
TOTAL	315	100%	146	100%	461	100%

SOURCE: MVH Data 1/15/88

TABLE 7

MINNESOTA VETERANS HOMES
AGE OF RESIDENTS BY FACILITY
AS OF 10/26/87

Age	MPLS Nursing Care	%	MPLS Domiciliary	%	Hastings Domiciliary	%	TOTAL	%
20 - 29	0	0.0%	4	2.5%	4	2.4%	8	1.2%
30 - 39	0	0.0%	20	12.6%	15	9.0%	35	5.5%
40 - 49	3	1.0%	21	13.2%	21	12.6%	45	7.0%
50 - 59	15	4.8%	26	16.4%	43	25.7%	84	13.1%
60 - 69	112	35.6%	38	23.9%	64	38.3%	214	33.4%
70 - 79	86	27.3%	26	16.4%	15	9.0%	127	19.8%
80 - 89	47	14.9%	17	10.7%	5	3.0%	69	10.8%
90 +	52	16.5%	7	4.4%	0	0.0%	59	9.2%
TOTAL	315	100%	159	100%	167	100%	641	100%

SOURCE: DHS Presentation to the Blue Ribbon Commission 10/26/87