Overview
The Department of Veterans Affairs (VA) Northern Indiana Health Care System (VANIHCS) consists of two campuses in Marion, Indiana and Ft. Wayne, Indiana. Both the Ft. Wayne and Marion campuses provide primary, specialty, urgent care and mental health care. Additionally, the Marion campus provides chronic and acute psychiatric care and long-term care while the Ft. Wayne campus provides inpatient medical and surgical care, and an intensive care unit.

Budget
The facility’s overall budget for FY 2011 was $231 million and in FY 2012 the budget was increased to $255 million. VANIHCS budget will allow both campuses to maintain 2011 levels of services, open enrollment and staffing levels. In FY 2011, $19 million of the budget was authorized for fee/contract care and in FY 2012, the fee basis expenditures increased to $31 million. In 2011, there were 2,729 authorized fee basis appointments which increased to 4,107 in 2012.

Closure of Inpatient Services
On October 11, 2012, the Ft. Wayne campus placed a pause on ICU and Telemetry admissions. In addition, on October 22nd, the decision was made to pause all in-patient admissions. The way that veterans from the local community became aware of the pause of inpatient services was through a local media article in the newspaper. Many veterans became concerned due to the lack of transparency and information regarding the “pause” of services and thought that the hospital was closing permanently.

In a press release reported through a local paper, the VANIHCs stated “VANIHCs has temporarily paused inpatient operations on the Intensive Care Unit and Acute Medical Unit, at the Fort Wayne campus to afford us the opportunity to review our processes, provide training to our staff, and ensure our continued ability to maintain the most flexible systems and highest standard of care for our veterans.” There was not an official VA letter sent to veterans enrolled at the Ft. Wayne campus explaining whether VA Central Office, Veteran Integrated Service Network (VISN) or facility leadership made the decision for closure, the particular reasons for the closure and/or steps to resumption of services.

The VANIHCs leadership assessed the pause and implications on Friday, October 12, 2012, in an effort to provide congressional staff not only the information regarding the pause but the rationale as well. The Public Affairs Officer (PAO) prepared a media release on Monday October 15, 2012, for review and approval through OPIA/VISN. While awaiting approval, the PAO personally contacted congressional staff on October 15, 2012, to inform them of the pause and the rationale. On October 17, 2012, the PAO sent the approved statement to the congressional staff and CVSO’s. On October 22, 2012, the PAO sent the approved media statement to the media.
Veterans from the local community and state levels asked The American Legion’s System Worth Saving Task Force to conduct an official site visit to assess the reasons for the closure and ensure that the hospital would resume these necessary services.

**Town Hall Meeting**
On December 5, 2012, VA&R Chairman Ralph Bozella and Jacob Gadd, Deputy Director for Healthcare conducted a town hall meeting at American Legion Post 330 in New Haven, IN. The purpose of the town hall meeting was to understand the reasons for the pause of services and impact this has caused for veterans in the local area. Approximately 55 veterans enrolled at Ft. Wayne facility attended the town hall meeting along with The American Legion Department of Indiana Commander, Richard A. Jewell and The American Legion Department of Indiana Service Officer John Hickey, Mayor of New Haven Terry McDonald, local media and representatives from the Ft. Wayne hospital.

Several concerns were identified, which included: no clear understanding of the reasons for the pause or steps necessary for resuming services; fear of the hospital losing specialty care services and full closure since the facility was slated to be shut down through the Capital Asset for Realignment for Enhanced Services several years ago; patients that had emergencies would not have known that surgery and other acute services were closed and difficulty with traveling to other facilities such as Marion or Indianapolis for services, which has increased since the closure.

**Site Visit Overview**
On December 6-7, the System Worth Saving Task Force conducted a site visit of the Ft. Wayne campus. The American Legion Department of Indiana Commander Richard A. Jewell and The American Legion Department of Indiana Service Officer John Hickey also attended the site visit. During the two-day visit, the task force met with executive leadership, inpatient care/staff education and training officer, quality manager, patient safety manager, risk manager, utilization management, systems redesign, human resources, women veterans’ program manager and the facility patient advocate.

There were several systemic reasons why inpatient services in acute care and the intensive care unit were “paused” but two specific events during the same evening served as a catalyst in triggering the closure. Two patients that were admitted to the acute care unit for heart-related conditions protocols were not followed correctly, which could have caused significant harm to these patients. One patient had an elevated troponin level that was transferred from another facility and the physician did not order the necessary labs for the patient that evening. The second patient had an irregular heart beat and was prematurely discharged from the hospital only to be admitted back to the facility’s ICU two hours later.

According to the majority of staff interviewed, the systemic issues the hospital faced were with staffing and the poor relationships leading to conflict between doctors, nurses and mid-level leadership at the facility. There was a “culture of fear” as some employees of the facility stated and information did not flow from the top down or from the bottom up. Frontline employees did not feel their voices “were being heard” or there were no mechanisms to provide feedback or sharing of concerns.
A couple of concerned staff members notified supervisors of these patient safety missteps the next day as well as shared the other concerns with the systemic staffing problems. Coincidentally the Veteran Integrated Service Network (VISN) was conducting a quality review during this time and was informed of these concerns. The VISN and facility leadership decided at that time to “pause” inpatient services to prevent any future patient safety issues until the facility had instituted improvements in the hiring of staff, training and processes, developed stronger feedback and communication mechanisms and to ensure veterans received timely and quality care.

**Staffing**

There have been three different VANIHCS directors in the last 18 months. On Monday, December 3, 2012, Denise Deitzen was appointed as the permanent director of VANIHCS. Ft. Wayne has immediate staffing vacancies for a board certified Cardiologist, Pulmonologist and Emergency Room Director/Physician and a Chief of Mental Health. A recruiter from the VISN is assisting the facility in the hiring of these priority-fill positions. The facility has a total of 136 full time employee equivalents (FTEE) registered nurses and 22 FTEE Licensed Practical Nurses (LPNs) at the Fort Wayne Campus. There has been a turnover of 11 nursing staff in 2012 (2 transferred to another VAMC, 1 removal, 2 resignation, 6 voluntary retirement) as well as a turnover of 3 LPNs (2 voluntary retirements and 1 disability retirement).

Ms. Deitzen served formerly as the director of the Saginaw, Michigan VA Medical Center since 2004. During interview with Ms. Deitzen, she informed our task force that she applied for this position and that VANIHCS was where she wanted to be. Every staff member interviewed expressed their enthusiasm, respect and full support for Ms. Deitzen and hoped that she would stay as director to provide some stability during these challenging circumstances.

**Phases to Reopening Services**

After Ft. Wayne’s pause of inpatient services, The VA Office of the Medical Inspector (OMI) that reports to Dr. Robert Petzel, Under Secretary for Health at VA Central Office conducted a quality review site visit. The VISN and facility worked collaboratively to implement a Rapid Process Improvement Workgroup (RPIW) to assess how the facility could improve quality of care processes, conflict resolution, staffing concerns and training/education/competencies. The RPIW was the first time that frontline staff were engaged and empowered to make improvements with the facility processes. Ft. Wayne also conducted a System Level Improvement/Root Cause Analysis (RCA) as well as conducted internal and external peer reviews of staff relating to these events.

The facility has a four-step process to resumption of services, which includes ensuring training and staff competencies with the following areas in stages: 1) chemotherapy; 2) 4 East (acute care), 3) cardiac telemetry and 4) reopening of ICU. On December 3, the VANIHCS held a closed-door briefing with Congressional offices and county veteran service officers. This meeting was not open to Veteran Service Organizations or to the media. That same day, the facilities completed the first stage of their resumption of services and re-opened chemotherapeutic infusion procedures. It was estimated by the facility that resumption of full services will not be until March or April of 2013.
In the meeting with Ms. Deitzen, she stated that the National Center for Organizational Development will be conducting training with the staff. Ms. Deitzen also is conducting a transition briefing/orientation with supervisors and frontline employees, as well as instituting a “10 Minutes with the Director” program where staff can meet with the director to discuss any issues or concerns.

**The American Legion’s System Worth Saving Site Visit Recommendations**

**Improve External Communication**

**It is recommended:**
- VANIHCS send a letter to all enrollees in their healthcare system explaining the reason for the “pause” of inpatient services and steps/phases for resumption of these services.
- VANIHCS send a letter to Veteran Service Organizations explaining the reasons for the “pause” and steps/phases for resumption of these services so VA’s message can be properly communicated to the local area veterans.
- VANIHCS create a hotline for questions regarding the “pause” of inpatient services for veterans with questions or concerns.
- The Medical Center director conduct a town hall meeting with veterans in the local area to introduce herself and explaining the reason for the pause and steps/phases for reopening of these services.
- VANIHCS leadership conduct routine TV/media interviews explaining the progress of resumption of services.
- VANIHCS institute and facilitate quarterly congressional/veteran service organization meetings to provide updates and sharing of mutual issues and concerns.

**Improve Internal Communication and Address Facility Staffing Concerns**

**It is recommended:**
- VANIHCS institute a supervisor training for mid-level staff as there were many challenges between frontline employees and leadership and information not flowing from the top/down and bottom/up.
- VANIHCS carry out their plan to conduct the National Center for Organizational Development, Transition Briefing/Orientation, “10 Minutes with the Director” as well as consider adding employee surveys, focus groups, culture training and team building.
- VANIHCS continue to use Rapid Process Improvement Workgroups to empower frontline employees and nurses to more effectively work with doctors to ensure the quality and safety for veterans.
Staffing

- There is an immediate need to hire/fill of the following positions (Cardiologist, Pulmonologist, ED Director/Physician, Chief of Mental Health) – continue to work with VISN recruiter and/or have VA Central Office and other private agencies expedite the hiring of these positions.

Final Summary

While the “pause” of inpatient services was a proactive measure to ensure the quality and safety of medical care to veterans, Ft. Wayne and other facilities must strive to identify issues and concerns, and follow procedures and hire the right staff to prevent future pauses or interruptions of needed medical services to our nation’s veterans. VA Central Office, VISN and the VA Medical Center must ensure that communication with Congressional offices, Veteran Service Organizations and especially veterans enrolled at the facility is conducted in a timely and transparent manner. The System Worth Saving Task Force has planned to conduct a follow up visit to Ft. Wayne in six months to see what corrective actions and improvements have been made.