Office of the Auditor General
Performance Audit Report

Kalamazoo Psychiatric Hospital
Michigan Department of Health and Human Services

July 2020

State of Michigan Auditor General
Doug A. Ringler, CPA, CIA

391-0220-19

The auditor general shall conduct post audits of financial transactions and accounts of the state and of all branches, departments, offices, boards, commissions, agencies, authorities and institutions of the state established by this constitution or by law, and performance post audits thereof.

The auditor general may make investigations pertinent to the conduct of audits.

Article IV, Section 53 of the Michigan Constitution

OAG
Office of the Auditor General

Report Summary

Performance Audit

Kalamazoo Psychiatric Hospital (KPH)

Michigan Department of Health and Human Services (MDHHS)

Report Number:
391-0220-19

Released:
July 2020

KPH is an inpatient psychiatric hospital that provides treatment for adults with mental illness. KPH's mission is to provide the highest quality behavioral health services, in a safe and supportive environment, that maximize opportunities for individual recovery, growth, and successful community reintegration. Patients include those who are not guilty by reason of insanity, incompetent to stand trial, and other court ordered. As of July 31, 2019, KPH had 146 patients.

Audit Objective	Conclusion
Objective #1: To assess the sufficiency of KPH's provision of patient care services.	Sufficient, with exceptions

Findings Related to This Audit Objective	Material Condition	Reportable Condition	Agency Preliminary Response
KPH did not complete 42.5% and 57.5% of physical and psychiatric admissions assessments, respectively, within the 24-hour requirement, ranging from 1 to 167 days late (Finding #1).	X		Agrees
KPH did not remove the accused employees from having patient contact during 3 (15.8%) investigations of abuse or neglect allegations. Also, KPH responded to 17 Office of Recipient Rights (ORR) investigation findings from 1 to 180 days late (Finding #2).	X		Agrees
KPH had not reviewed user access roles for the 531 active Avatar users and, therefore, could not ensure that user role privileges were consistent with the user's position, duties, and job responsibilities to help prevent unauthorized access, use, disclosure, modification, or destruction of confidential data (Finding #3).		X	Agrees

Audit Objective	Conclusion
Objective #2: To assess the effectiveness of KPH's efforts to provide for the safety and security of its patients, staff, and visitors.	Moderately effective

Findings Related to This Audit Objective	Material Condition	Reportable Condition	Agency Preliminary Response
For the 40 incident reports that we reviewed, 67.5% were not properly documented by the end of the shift and 27.5% did not have documentation of required notifications to patient guardians, ORR, MDHHS's Adult Protective Services, the Michigan Department of State Police, and Kalamazoo Public Safety (Finding #4).	X		Agrees
Regarding key security, 25 (62.5%) employees possessed 115 unassigned keys on their KPH key rings and 10 (25.0%) employees were missing 29 assigned keys (Finding #5).		X	Agrees
For the 7 sentinel events (unexpected deaths or serious injuries) from August 1, 2017 through July 31, 2019, KPH convened its Morbidity and Mortality Review Committee for the 2 patient deaths 2 to 3 days late, notified the Joint Commission of 5 sentinel events 2 to 21 days late, and did not document its notification to MDHHS of 4 sentinel events (Finding #6).		X	Agrees

Audit Objective	Conclusion
Objective #3: To assess the effectiveness of KPH's controls over pharmaceuticals.	Effective

Findings Related to This Audit Objective	Material Condition	Reportable Condition	Agency Preliminary Response
None reported.	Not applicable.		

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July 28, 2020

Mr. Robert Gordon, Director
Michigan Department of Health and Human Services
South Grand Building
Lansing, Michigan

Dear Mr. Gordon:

This is our performance audit report on the Kalamazoo Psychiatric Hospital, Michigan Department of Health and Human Services.

We organize our findings and observations by audit objective. Your agency provided preliminary responses to the recommendations at the end of our fieldwork. The *Michigan Compiled Laws* and administrative procedures require an audited agency to develop a plan to comply with the recommendations and to submit it to the State Budget Office upon completion of an audit. Within 30 days of receipt, the Office of Internal Audit Services, State Budget Office, is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

We appreciate the courtesy and cooperation extended to us during this audit.

Sincerely,

Doug Ringler

Doug Ringler
Auditor General

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TABLE OF CONTENTS

KALAMAZOO PSYCHIATRIC HOSPITAL

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AUDIT OBJECTIVES, CONCLUSIONS, FINDINGS, AND OBSERVATIONS

PATIENT CARE SERVICES

BACKGROUND

Kalamazoo Psychiatric Hospital (KPH) is an inpatient psychiatric hospital that provides treatment for adults with mental illness. Each patient admitted to KPH is assigned to a treatment team composed of professional staff appropriate to the patient's individual needs, including a psychiatrist and a registered nurse. KPH completes activity therapy, nutrition, social work, psychological, psychiatric, physical (medical), and nursing assessments to determine the patient's needs and to develop an individual plan of service* (IPOS). The IPOS documents the patient's problem areas, goals, and strategies to be employed, such as medication, activity programs, and therapy groups. From August 1, 2017 through July 31, 2019, KPH both admitted and discharged 251 patients.

To serve and manage patients, KPH developed standards for minimum direct care nursing staffing levels by unit and shift. KPH indicated that typical minimum staffing is 2 certified staff (registered nurses or licensed practical nurses) and 5 resident care aides (RCAs) per residential unit, per shift (with the exception of the midnight shift), plus an additional RCA for each patient who requires one-on-one supervision.

AUDIT OBJECTIVE

To assess the sufficiency of KPH's provision of patient care services.

CONCLUSION

Sufficient, with exceptions.

FACTORS IMPACTING CONCLUSION

- The 12 KPH employees that we reviewed were properly licensed.
- The 40 KPH employees that we reviewed completed 99% of their required training.
- KPH adequately met its planned staffing levels for the 10-day period reviewed.
- KPH substantially complied with IPOS procedures for the 40 patient files that we reviewed.
- KPH complied with discharge procedures for the 40 patient files that we reviewed.
- Material conditions* related to improving its controls over admissions activities and its processes regarding allegations of abuse or neglect (Findings #1 and #2).
- Reportable condition* related to improving its controls over Avatar user roles (Finding #3).

** See glossary at end of report for definition.*

FINDING #1

Improved controls over admissions procedures needed.

KPH needs to improve its controls over its admissions activities to ensure that patients are assessed in a timely manner and that patient photographs are available for identification purposes.

The *Michigan Compiled Laws (MCL)* and KPH's operating policies outline the criteria and procedures that staff must adhere to when admitting a patient.

Our review of patient files for 40 patients admitted from August 1, 2017 through July 31, 2019 noted that KPH did not:

Admissions assessments not completed in a timely manner.

a. Complete admissions assessments in a timely manner, as depicted below. *MCL* Sections 330.1710 and 330.1430 and KPH's admissions procedure require assessments within 24 hours of admission.

Admissions Assessment	Not Completed Within 24 Hours	Not Completed Within 48 Hours	Range of Additional Time to Complete After 24 Hours
Physical	17 (42.5%)	4 (10.0%)	1 to 167 days
Psychiatric	23 (57.5%)	6 (15.0%)	1 to 7 days
Nursing	4 (10.0%)	3 (7.5%)	1 to 79 days

b. Complete 4 (10.0%) of the psychological assessments within 3 days of admission in accordance with Michigan Department of Health and Human Services' (MDHHS's) Comprehensive Examinations policy for facilities/hospitals, APF 183, ranging from 1 to 4 days late.

c. Upload photographs in Avatar for 7 (30.4%) of the 23 patients for whom KPH had consent to take their picture. KPH policy 02-05-002 requires patient's photographs to be placed with the patient's medical records upon admission when written consent is given.

KPH indicated that it interpreted the *MCL* Sections to require the assessments to be drafted within 24 hours and finalized within 48 hours. KPH also indicated that patients (or guardians) may consent to be photographed and later be uncooperative.

We consider this finding to be a material condition because of the significance of the exception rate of untimely physical and psychiatric assessments, the additional time it took to complete the assessments, and the potential negative impact on patient treatments.

RECOMMENDATION

We recommend that KPH improve its controls to ensure timely completion of admissions activities.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

KPH agrees with the finding and is in the process of implementing or has implemented the following:

- *KPH performs audits of all admission assessments on a monthly basis to ensure assessments are completed in a timely manner, any deviations identified are followed up on. KPH's goal for completion rate is 90% or above and is a key performance indicator reported to leadership monthly. Medical (physical) assessments completion rates have increased to 87% and nursing evaluation completion rates have increased to 92% completion since January 2019. The psychiatric evaluation timeline has changed to ensure compliance with the* MCL*.*

- *A guardian may sign a consent for a photograph, but at the time of the attempt to photograph the patient may be uncooperative. KPH will develop a process to follow up on any initial refusals to ensure failed attempts are documented in the record and the Standard Operating Procedure (SOP) will be reviewed for any necessary modifications. KPH conducted a review of patients for which a consent has been received and will develop a process where the KPH Health Information Management Department will coordinate with the Social Work Department to follow up with patients after an initial refusal to be photographed for a second attempt.*

FINDING #2

KPH, in conjunction with the Office of Recipient Rights (ORR), needs to improve its processes regarding abuse and neglect allegations to ensure the safety and rights of patients.

Processes regarding abuse and neglect allegations need improvement.

KPH policy 03-01-006 requires that accused employees be removed from patient contact at the time of the abuse or neglect allegation. Also, *MCL* Section 330.1782 requires KPH to submit a corrective action plan to ORR within 10 business days of KPH receiving a copy of the ORR investigative report.

Our review of 30 of the 70 complaints substantiated by ORR from August 1, 2017 through July 31, 2019 noted:

15.8% of employees accused of abuse or neglect continued to have patient contact.

a. For 3 (15.8%) of the 19 complaints that involved allegations of abuse or neglect, KPH did not remove the accused employees from having patient contact during the investigations. KPH indicated that a miscommunication with ORR caused 2 of the exceptions, including 1 for which ORR could not provide documentation supporting that it had notified KPH of the neglect investigation. For the third exception, KPH did not suspend the contracted psychiatrist because of a shortage of psychiatrists at the time.

56.7% of responses to ORR investigations were late.

b. For 17 (56.7%) complaints, KPH did not respond to ORR investigation findings in a timely manner, ranging from 1 to 180 days late and averaging 32 days late. KPH stated that it did not have a control to ensure compliance with the 10-day requirement.

We consider this finding to be a material condition because of the potential negative impact on the safety and rights of patients by allowing employees accused of abuse or neglect to continue their contact with patients during investigations. Also, the significance of the exception rate and duration of untimely corrective action plan submissions by KPH impacted our conclusion.

RECOMMENDATION

We recommend that KPH, in conjunction with ORR, improve its processes to respond to abuse and neglect allegations.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

KPH and ORR agree with the finding. KPH will work with the ORR director to improve communication between ORR staff and KPH to ensure timely responses to allegations of abuse and neglect in compliance with the Michigan Mental Health Code and KPH SOP. In addition, KPH staff will develop a tracking mechanism to ensure timely response on ORR investigations.

FINDING #3

Access controls over patient data need improvement.

KPH needs to improve its controls over Avatar user roles to help prevent and detect inappropriate access and protect confidential information from unauthorized access, use, disclosure, modification, or destruction.

State of Michigan Technical Standard 1340.00.020.01 requires agencies to establish a process to control and document the assignment of access rights based on current job responsibilities and the principle of least privilege* and to monitor privileged users' activity. Also, the Federal Information System Controls Audit Manual* (FISCAM) indicates that access to sensitive or privileged accounts should be restricted to individuals having a legitimate need for business purposes.

Avatar, KPH's electronic health record system, contains information such as patient assessments, treatment plans, progress notes, and medications. Avatar had 531 active users as of July 31, 2019. Each active user could be assigned one or more of 58 user roles with read-only or edit capabilities and access to up to 836 informational screens, forms, and reports.

Our review of access controls* over Avatar noted that, as of July 31, 2019, KPH had not periodically reviewed user access roles and, therefore, could not ensure that user access role privileges were consistent with the user's position, duties, and job responsibilities.

RECOMMENDATION

We recommend that KPH improve its controls over Avatar user roles.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

KPH agrees with the finding.

KPH will develop a methodology to periodically review user access roles to ensure that role privileges are consistent with each user's current job responsibilities.

** See glossary at end of report for definition.*

SAFETY AND SECURITY OF PATIENTS, STAFF, AND VISITORS

BACKGROUND

To help provide a safe and secure environment, KPH:

- Completes criminal history background checks before hiring employees.
- Maintains a preventative maintenance schedule for routine maintenance and tracks maintenance work order requests.
- Completes quarterly fire drills and annual tornado drills.
- Monitors facility access.
- Restricts access to areas deemed appropriate.
- Utilizes surveillance cameras in common areas.
- Provides training to staff on intervention with disruptive patients, fire safety, first aid, workplace safety, and hazardous materials.

AUDIT OBJECTIVE

To assess the effectiveness* of KPH's efforts to provide for the safety and security of its patients, staff, and visitors.

CONCLUSION

Moderately effective.

FACTORS IMPACTING CONCLUSION

- KPH conducted background checks for the 10 employees that we reviewed.
- None of the KPH staff, employed as of May 4, 2019, had a criminal history that would prevent them from being employed at KPH.
- KPH completed the work in a timely manner for 95% of the work order requests that we reviewed.
- Material condition related to the need to improve its completion of incident reports (Finding #4).
- Reportable conditions related to the need to improve controls over its keys and its processes to report and follow up on sentinel events (Findings #5 and #6).

** See glossary at end of report for definition.*

FINDING #4

KPH needs to improve the completion of its incident reports to ensure that the information is as accurate and detailed as possible to help safeguard patient rights and well-being.

Completion of patient incident reports needs improvement.

Incident reports are required to be completed for unusual incidents. An unusual incident is defined by KPH SOP 03-01-001 as an occurrence involving a patient that results in a disruption of, or has an adverse effect upon, the normal routine of treatment or care of a patient, management of the living unit, or administration of KPH. Examples of unusual incidents include assaults on or by a patient, the restraint or seclusion of a patient, medication errors, and suspected criminal offenses involving a patient.

We reviewed 40 of the 4,376 incident reports recorded from August 1, 2017 through July 31, 2019 and noted the following:

67.5% of the incident reports reviewed did not include timely witness statements.

a. For 27 (67.5%) reports, all staff who witnessed the incidents did not document their information by the end of the shift, ranging from 6 hours to 34.5 days after the end of the shift. KPH SOP 03-01-001 requires each witness to document the incident by the end of the shift.

b. For 7 (58.3%) of the 12 reports relating to incidents that occurred on or after March 6, 2019, KPH did not create the report within one hour, ranging from 18 minutes to 11.5 hours after the required deadline. According to the policy in effect as of March 6, 2019, these incident reports were required to be started within the first hour of the observance or notification of an incident.

c. For 14 (35.0%) reports, KPH did not write a patient progress note detailing the incident. KPH SOP 03-01-001 requires KPH to document incidents in the patient's progress notes by the end of the shift.

27.5% of required notifications were not documented for the incident reports reviewed.

d. For 11 (27.5%) reports, KPH did not document required notifications to parties including patient guardians, ORR, MDHHS's Adult Protective Services, the Michigan Department of State Police, and Kalamazoo Public Safety, as appropriate. KPH SOP 03-01-001 requires that, when informed of an incident, KPH contacts the required parties.

e. For 2 (5.0%) reports, KPH did not document patient injury assessments. KPH SOP 03-01-001 requires KPH to immediately assess patients for injuries when an incident occurs.

KPH did not have controls to ensure that staff completed patient incident reports, notifications, and assessments as required.

We consider this finding to be a material condition because of the significance of the exception rates of untimely reports and undocumented progress notes, the lack of notifications to third parties, and the potential negative impact on the patient's rights and well-being.

RECOMMENDATION

We recommend that KPH design and implement controls to ensure that incident reporting is completed as required.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

KPH agrees with the finding.

KPH will review internal processes and SOPs pertaining to incident reporting and make sure there are controls in place to ensure timely completion. In addition, KPH will review its processes to ensure they align with other State psychiatric hospitals. KPH implemented a new tracking system during October 2019 to review all incident reports and report to administration, on a daily basis, any required reports that have not been completed by staff in the previous 24 hours.

KPH is also reviewing the applicable SOPs to determine the feasibility for nursing staff to initiate the incident report and required witness staff to complete their statements in the current timeframes. Differences in scheduling between nurses (working 12-hour shifts) and RCAs (working 8-hour shifts) may lead to situations where it becomes impossible for the RCA to complete the documentation on their current shift.

FINDING #5

Controls over keys need improvement.

KPH needs to improve controls over its keys. An up-to-date inventory of all keys should be maintained to ensure that access is limited to authorized personnel to enhance the safety of patients and staff and the security of their belongings.

KPH's key assignment and control procedure, SOP 05-02-007, indicates that it shall maintain a database of all hospital keys issued to control access to all areas within the facility.

KPH maintained a Microsoft Access database in which it tracked certain keys assigned to employees (4,863 keys as of July 31, 2019) and maintained a hard-copy index card to track the 8 medication room key sets (key rings) and their respective keys. However, KPH did not track medication room key sets or keys in its Access database or properly update the hard-copy index card; did not track unit specific key assignments, such as patient locker keys, at all; and did not solder key rings issued to its employees. Our detailed review of KPH's controls over its keys noted that for 40 employees, 2 patient units, and 2 medication rooms:

a. 25 (62.5%) employees had a total of 115 keys on their KPH key rings that were not assigned to them according to the database, including keys for office, classroom, and cabinet access.

b. 10 (25.0%) employees did not have a total of 29 keys that were assigned to them, including keys for office, classroom, and cabinet access.

c. None of the 108 keys physically located in the 2 patient units were listed in the database or otherwise tracked, including keys to unit cabinets and patient lockers.

d. 5 (45.5%) of the 11 keys on the 2 medication room key sets were not listed on the hard-copy index card.

e. 2 (25.0%) of the 8 medication room keys listed on the hard-copy index card were not on either of the respective medication room key sets.

KPH indicated that these deficiencies were because of a lack of communication, poor tracking and disposal controls, and staff keeping personal keys on the KPH key rings. Also, although KPH views it as unnecessary, we believe that soldering the key rings would help alleviate the issues of additional and missing keys identified in parts a. and b. of this finding.

RECOMMENDATION

We recommend that KPH improve controls over its keys.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

KPH agrees with the finding. During the audit period, KPH transitioned to a new tracking system for keys. The new tracking system eliminates the hard-copy card catalog and requires quick response code scanning. KPH continues to believe that soldering key rings would create an undue burden on KPH's locksmith, unnecessary additional costs, and will provide no added value when discrepancies in a staff person's key inventory would be identified and addressed during their respective inventory audit.

AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE*

KPH asserts that discrepancies in an employee's key inventory would be identified and addressed during the respective inventory audits. However, we contend that soldering key rings would help prevent the discrepancies identified in parts a. and b. of this finding by physically preventing keys from being inappropriately added to or removed from the assigned key rings. Therefore, the finding stands as written.

** See glossary at end of report for definition.*

FINDING #6

Sentinel event review processes need improvement.

KPH needs to improve its processes to report and follow up on sentinel events. Timely reporting, investigating, and corrective action may help protect patients by mitigating future occurrences.

A sentinel event is an unexpected occurrence involving a patient death or serious physical or psychological injury or the risk thereof. KPH policy 03-01-002 and Joint Commission* requirements include:

- The KPH Morbidity and Mortality Review Committee must meet within three working days of a patient's death for a preliminary review of the possible sentinel event.
- KPH must notify MDHHS central office within three working days of the determination that an incident is a sentinel event.
- KPH must notify the Joint Commission within five working days of the determination that an incident is a sentinel event.

Our review of the 7 sentinel events that occurred from August 1, 2017 through July 31, 2019 noted:

a. For the 2 sentinel events that involved a patient's death, KPH did not convene its Morbidity and Mortality Review Committee within 3 working days. KPH convened the meetings 5 and 6 days after the sentinel event.

b. For 5 (71.4%) sentinel events, KPH did not notify the Joint Commission in a timely manner, ranging from 2 to 21 days late and averaging 11 days late.

c. For 4 (57.1%) sentinel events, KPH did not have documentation that it notified MDHHS. KPH informed us that it notified MDHHS of sentinel events by phone and did not have documentation to substantiate the notifications.

KPH informed us that it did not have the necessary processes in place to maintain sentinel event documentation and meet timeliness requirements.

RECOMMENDATION

We recommend that KPH improve its reporting and follow-up of its sentinel events.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

KPH agrees with the finding. KPH will improve the process for documenting the notification of sentinel events to MDHHS management; document the determination that an incident was

** See glossary at end of report for definition.*

sentinel; and ensure complete documentation of compliance with corrective action plans. Additionally, the Morbidity and Mortality Review Committee will formally meet within the timeframe stipulated by the SOP.

PHARMACEUTICAL CONTROLS

BACKGROUND

To accommodate patients' medication needs, KPH operates an on-site pharmacy that orders, receives, and stocks hundreds of prescription and over-the-counter medications, including controlled* and noncontrolled* substance medications. Pharmaceuticals are generally purchased through contracted wholesalers. The pharmacy dispenses all medications prescribed for KPH patients.

For fiscal year 2018, KPH purchased medications totaling $1.64 million, consisting of $1.59 million and $50,000 in noncontrolled and controlled substance medications, respectively.

Pharmacy, medical, and nursing staff utilize Avatar to order, dispense, and administer medications. The pharmacist reviews all prescriptions for appropriateness and consults with medical staff as necessary. After medications have been dispensed by the pharmacy, nursing staff administer the medications to patients with active prescriptions.

In addition to ordering and dispensing medications, the pharmacy:

- Completes a weekly inventory of controlled substance medications maintained in the pharmacy.
- Completes a monthly inventory of noncontrolled substance medications maintained in the pharmacy.
- Completes a monthly maintenance inspection of medication rooms.
- Maintains emergency boxes* for emergency medication dispensing purposes.

AUDIT OBJECTIVE

To assess the effectiveness of KPH's controls over pharmaceuticals.

CONCLUSION

Effective.

FACTORS IMPACTING CONCLUSION

- KPH conducted an inventory of the controlled substance medications maintained in the 8 patient units at each shift change for the 10 days that we reviewed.
- KPH properly verified the contents of, locked, and labeled the 3 emergency boxes that we reviewed.

** See glossary at end of report for definition.*

- KPH implemented an electronic perpetual inventory process during June 2019. Our physical count of 35 noncontrolled substance medications substantially agreed with the inventory count in the electronic database.

- The 40 medication invoices that we reviewed were properly approved, indicating that the medication purchased was received in compliance with KPH procedure.

- KPH's inventory controls over the 2 medication carts that we reviewed were effective.

- KPH completed 97% of monthly maintenance inspections of medication rooms that we reviewed.

- KPH completed inventories of noncontrolled substance medications for the sections of its pharmacy that we reviewed.

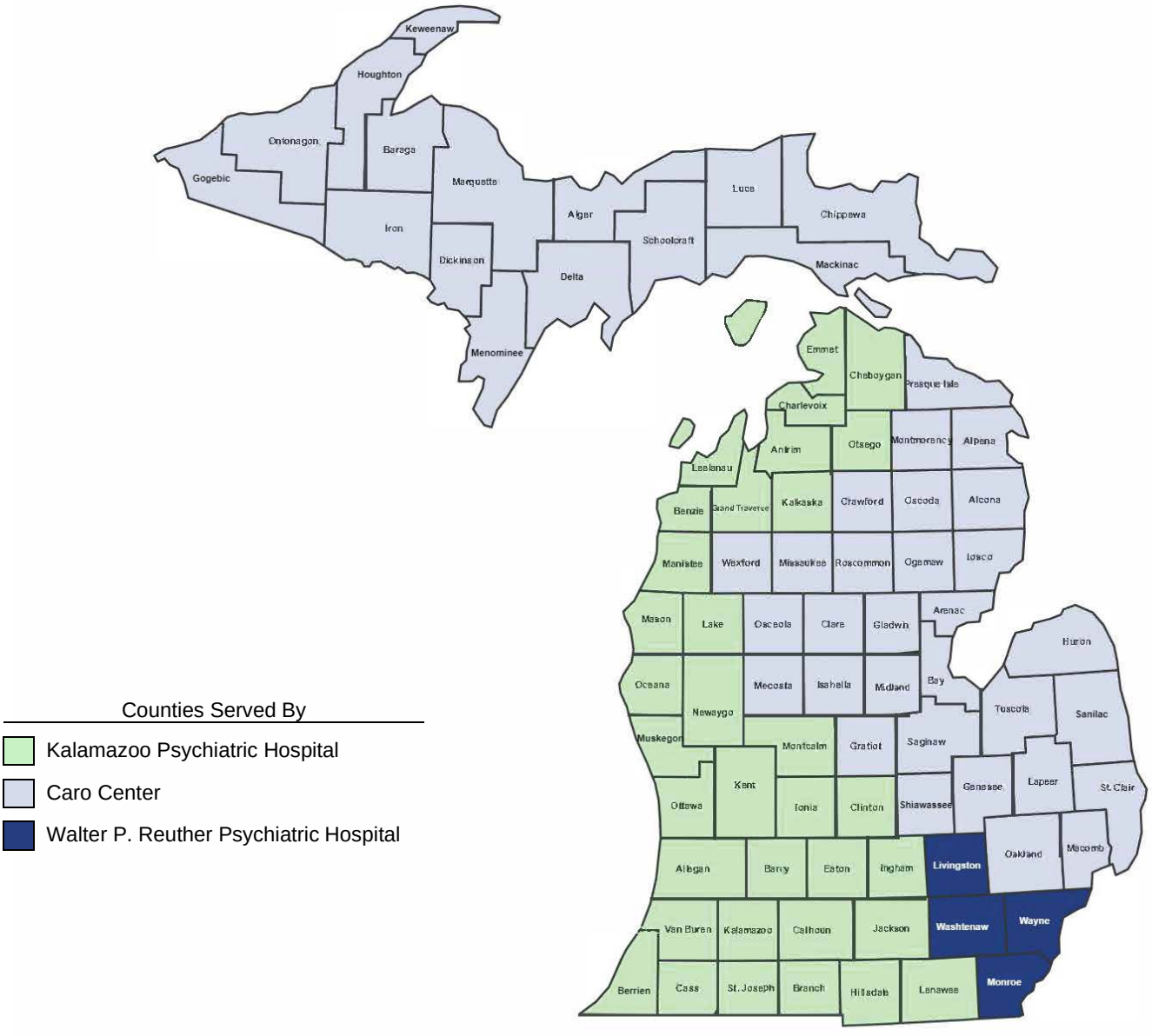
- KPH completed inventories of controlled substance medications maintained within its pharmacy for the weeks that we reviewed.

SUPPLEMENTAL INFORMATION

UNAUDITED
Exhibit #1

KALAMAZOO PSYCHIATRIC HOSPITAL
Michigan Department of Health and Human Services

Service Area Map
As of July 31, 2019

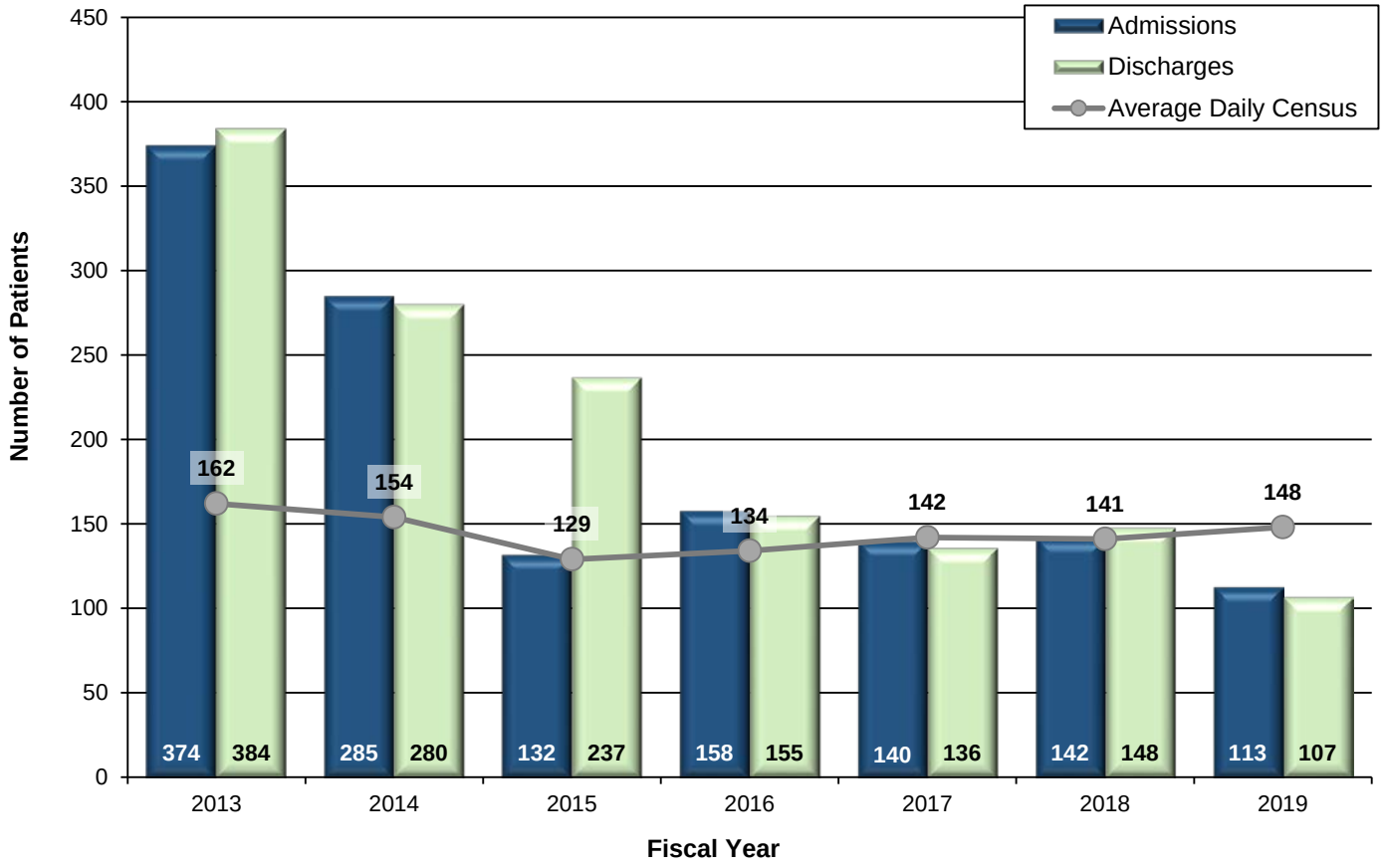


Note: MDHHS also operates the Hawthorn Center in Wayne County for children and adolescents and the Center for Forensic Psychiatry in Washtenaw County which serve all 83 Michigan counties.

Source: The OAG prepared this exhibit from a map provided by MDHHS.

KALAMAZOO PSYCHIATRIC HOSPITAL
Michigan Department of Health and Human Services

Patient Admissions, Discharges, and Average Daily Census Data
Fiscal Years 2013 Through 2019



Note: As of September 30, 2019, KPH had a capacity of 183 patients.

Source: The OAG prepared this exhibit based on data provided by KPH.

KALAMAZOO PSYCHIATRIC HOSPITAL
Michigan Department of Health and Human Services

Expenditures and Average Cost Per Patient
Fiscal Years 2016 Through 2019

	Fiscal Year				
	2016	2017	2018	2019	Four-Year Average
Personnel costs	$ 53,603,369	$ 54,995,597	$ 55,931,629	$ 55,891,439	$ 55,105,508
Medications and medical supplies costs	2,063,467	1,939,224	1,684,980	1,714,387	1,850,514
Materials, supplies, and equipment costs	2,906,261	3,876,561	2,852,003	3,790,494	3,356,330
Food service costs	357,172	379,467	486,548	522,970	436,539
Fuel and utilities costs	425,680	526,879	401,011	381,326	433,724
Travel and other costs	60,778	64,732	109,577	74,047	77,283
Total expenditures	$ 59,416,727	$ 61,782,459	$ 61,465,748	$ 62,374,662	$ 61,259,899
Average number of patients	134	142	141	148	141
Average cost per patient	$ 443,408	$ 435,088	$ 435,927	$ 421,450	$ 434,467

Source: The OAG prepared this exhibit from KPH's Budgetary Control Report Summary.

AGENCY DESCRIPTION

KPH is located in Kalamazoo, Michigan, and is 1 of 5 psychiatric hospitals operated under the jurisdiction of MDHHS. KPH's mission* is to provide the highest quality behavioral health services, in a safe and supportive environment, that maximize opportunities for individual recovery, growth, and successful community reintegration. KPH is accredited by the Joint Commission and is certified as a provider of inpatient psychiatric hospital services by the Centers for Medicare and Medicaid Services.

KPH primarily services the 34 counties in the western half of the Lower Peninsula (see Exhibit #1), and its average daily census for fiscal year 2019 was 148 patients (see Exhibit #2). As of July 31, 2019, KPH had 486 employees, including 271 direct care nursing staff*; 146 patients (25 not guilty by reason of insanity, 16 incompetent to stand trial, and 105 other court ordered); and a capacity of 183 patients. For fiscal year 2019, KPH had operating expenditures of $62.4 million, 89.6% of which were personnel costs (see Exhibit #3).

** See glossary at end of report for definition.*

AUDIT SCOPE, METHODOLOGY, AND OTHER INFORMATION

AUDIT SCOPE

To examine records related to selected operational activities at KPH. We conducted this performance audit* in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Within the scope of the audit, we reviewed various compliance activities related to a patient's admission to KPH, services and care provided while a resident at KPH, and discharge activities. Because we do not possess expertise in the medical or psychiatric fields, we did not review or conclude on the appropriateness of the professional medical and psychiatric opinions related to a patient's condition, the reasonableness of the medications prescribed, the recommended treatment plan, or the length of stay.

PERIOD

Our audit procedures, which included a preliminary survey, audit fieldwork, report preparation, analysis of agency responses, and quality assurance, generally covered August 1, 2017 through July 31, 2019.

METHODOLOGY

We conducted a preliminary survey to gain an understanding of KPH's operations and internal control* to formulate a basis for establishing our audit objectives, scope, and methodology. During our preliminary survey, we:

- Reviewed applicable federal regulations, *MCL*, KPH policies and procedures, and Joint Commission Accreditation Surveys applicable to KPH's operations related to incident reporting, safety and security, unauthorized patient leave of absences, key control, hiring practices, criminal background checks, pharmaceuticals, preventative maintenance, licensing, and training.
- Toured the hospital and interviewed KPH staff regarding the operations and processes.
- Reviewed documentation of fire and tornado drills.
- Examined patient files related to unauthorized leave of absences.
- Conducted limited procedures related to patient admissions, discharges, and medication administration;

** See glossary at end of report for definition.*

employee licenses, training, and criminal history background checks; pharmaceutical inventory; key controls; vehicle and other preventative maintenance; and work orders.

- Analyzed KPH's expenditures from August 1, 2017 through July 31, 2019 and procurement card expenditures from October 1, 2016 through July 10, 2019.

- Reviewed KPH's controls over handling cash and patient funds.

OBJECTIVE #1

To assess the sufficiency of KPH's provision of patient care services.

To accomplish this objective, we:

- Reviewed licenses for 12 of the 119 KPH active employees required to be licensed as of July 31, 2019.

- Reviewed training records for 40 of the 327 direct care workers* employed as of July 31, 2019.

- Compared KPH staffing logs of planned staffing with the Data Collection and Distribution System (DCDS) data from June 20, 2019 through June 29, 2019 to determine whether planned staffing levels were met. We judgmentally selected the dates based on the availability of supporting documentation. Therefore, we could not project our results into the entire population.

- Reviewed the files for 40 of the 395 patients that resided at KPH at any time from August 1, 2017 through July 31, 2019 to determine whether KPH had complied with required IPOS procedures.

- Reviewed discharge records for 40 of the 251 patients discharged from August 1, 2017 through July 31, 2019 for compliance with discharge procedures.

- Reviewed admission records for 40 of the 251 patients admitted from August 1, 2017 through July 31, 2019 for compliance with admission procedures.

- Reviewed the employment status of all 531 users with access to Avatar to determine whether they were active State employees or contractors.

- Inquired about Avatar access privileges to determine whether they were reasonable.

** See glossary at end of report for definition.*

- Reviewed 30 of the 70 complaints made to ORR that were substantiated from August 1, 2017 through July 31, 2019 to determine whether KPH responded to the results of the investigations in a timely manner, completed remediation efforts, and placed staff on administrative leave, as appropriate.

Unless otherwise noted, our samples were randomly selected to eliminate bias and enable us to project our testing results to the respective populations.

OBJECTIVE #2

To assess the effectiveness of KPH's efforts to provide for the safety and security of its patients, staff, and visitors.

To accomplish this objective, we:

- Conducted criminal history background checks of all 454 KPH staff employed as of May 4, 2019 and reviewed personnel files for 10 of the staff to determine whether KPH completed background checks.

- Reviewed 40 of 6,468 work order requests, including 9 required preventative maintenance activities, open at any time from August 1, 2017 through July 31, 2019 to determine whether the maintenance was performed and completed in a timely manner. The population included work orders for work related to safety, patients, the public, and staff that KPH prioritized as higher importance as well as preventative maintenance activities.

- Reviewed 40 of the 593 key rings identified in KPH's key inventory database as assigned to employees to determine whether the keys on the key rings matched the keys listed in the database.

- Reviewed the keys in 2 of the 8 patient units to determine whether assignments of the unit keys were being tracked.

- Compared the key rings for 2 of the 8 medication rooms with the keys listed on the hard-copy index card to determine whether the keys were properly inventoried.

- Reviewed 40 of the 4,376 reports related to incidents that occurred from August 1, 2017 through July 31, 2019 to ensure that KPH timely and properly documented and investigated the incidents.

- Reviewed the 7 sentinel events that occurred from August 1, 2017 through July 31, 2019 to determine whether KPH timely and properly responded to them.

Our samples were randomly selected to eliminate bias and enable us to project the results to the respective populations.

OBJECTIVE #3

To assess the effectiveness of KPH's controls over pharmaceuticals.

To accomplish this objective, we:

- Reviewed controlled substance medication count sheets for 10 days from August 1, 2017 through July 31, 2019 to determine whether nurses verified the inventory at each shift change.
- Reviewed 3 of the 12 emergency boxes to confirm that the contents were verified, and that the boxes were locked and labeled by a pharmacist.
- Counted 35 of 897 noncontrolled substance medications in the pharmacy on August 26, 2019 and compared our count with that of the database.
- Reviewed 40 of 2,253 invoices for medications purchased from August 1, 2017 through July 31, 2019 to ensure that they were properly approved, they were signed off when the items were received, and the purchase order printout agreed with the corresponding invoice.
- Reviewed the 194 medications prescribed to 30 of 144 patients at KPH as of July 31, 2019 to verify the accuracy of the inventory in the medication carts.
- Reviewed inspection reports for 5 months from August 2017 through July 2019 to determine whether the inspections were completed for the medication carts, medication rooms, pharmacy, and night drug cabinet*.
- Reviewed 2 of 24 monthly medication room maintenance inspection reports to determine whether the inspections were completed.
- Reviewed KPH's completion of inventory for 3 of the 8 pharmacy sections for June and July 2019 (when KPH began conducting a complete pharmacy inventory).

Our samples were randomly selected to eliminate bias and enable us to project our testing results to the respective populations.

CONCLUSIONS

We base our conclusions on our audit efforts and any resulting material conditions or reportable conditions.

When selecting activities or programs for audit, we direct our efforts based on risk and opportunities to improve State government operations. Consequently, we prepare our performance audit reports on an exception basis.

** See glossary at end of report for definition.*

AGENCY RESPONSES

Our audit report contains 6 findings and 6 corresponding recommendations. MDHHS's preliminary response indicates that KPH agrees with all of the recommendations.

The agency preliminary response that follows each recommendation in our report was taken from the agency's written comments and oral discussion at the end of our fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and the State of Michigan Financial Management Guide (Part VII, Chapter 4, Section 100) require an audited agency to develop a plan to comply with the recommendations and to submit it to the State Budget Office upon completion of an audit. Within 30 days of receipt, the Office of Internal Audit Services, State Budget Office, is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

PRIOR AUDIT FOLLOW-UP

Following is the status of the reported findings from our August 2011 performance audit of the Kalamazoo Psychiatric Hospital, Bureau of Hospitals, Centers, and Forensic Mental Health Services, Department of Community Health (391-0220-10):

Prior Audit Finding Number	Topic Area	Current Status	Current Finding Number
1	Monitoring of Patient Services	Rewritten*	1, 2, 4, and 6
2	Monitoring and Reporting of Patient Elopements	Complied	Not applicable
3	Verification of Patient Identification	Rewritten	1
4	Employee Training Practices	Complied	Not applicable
5	Inventory Controls Over Non-Controlled Substance Medications	Complied	Not applicable
6	Process to Report, Investigate, and Respond to Complaints	Rewritten	2

SUPPLEMENTAL INFORMATION

Our audit report includes supplemental information presented as Exhibits #1 through #3. Our audit was not directed toward expressing a conclusion on this information.

** See glossary at end of report for definition.*

GLOSSARY OF ABBREVIATIONS AND TERMS

access controls	Controls that protect data from unauthorized modification, loss, or disclosure by restricting access and detecting inappropriate access attempts.
auditor's comments to agency preliminary response	Comments that the OAG includes in an audit report to comply with *Government Auditing Standards*. Auditors are required to evaluate the validity of the audited entity's response when it is inconsistent or in conflict with the findings, conclusions, or recommendations. If the auditors disagree with the response, they should explain in the report their reasons for disagreement.
controlled substance medication	A drug or other substance, or immediate precursor, included in Schedule I, II, III, IV, or V of the federal Controlled Substance Act (Title 21, section 801, et seq., of the *United States Code*), which controls the manufacture, distribution, and dispensing of controlled substances.
direct care nursing staff	Registered nurses, licensed practical nurses, and resident care aides.
direct care workers	Positions that bear the responsibility of immediate patient supervision and education such as activity therapy; dietary services; medical services (including clinic, occupational therapy, and physical therapy); and nursing.
effectiveness	Success in achieving mission and goals.
emergency boxes	A medication box maintained in patient residential units containing anaphylaxis, blood sugar, and other essential emergency medications to treat patients in an emergency situation.
Federal Information System Controls Audit Manual (FISCAM)	A methodology published by the U.S. Government Accountability Office (GAO) for performing information system control audits of federal and other governmental entities in accordance with *Government Auditing Standards*.
individual plan of service (IPOS)	The fundamental document in the patient's record, developed in partnership with the individual using a person-centered planning process that establishes meaningful goals and measurable objectives. The plan must identify services, supports, and treatment as desired or required by the patient.
internal control	The plan, policies, methods, and procedures adopted by management to meet its mission, goals, and objectives. Internal

	control includes the processes for planning, organizing, directing, and controlling program operations. It also includes the systems for measuring, reporting, and monitoring program performance. Internal control serves as a defense in safeguarding assets and in preventing and detecting errors; fraud; violations of laws, regulations, and provisions of contracts and grant agreements; or abuse.
Joint Commission	An independent, not-for-profit organization that accredits and certifies more than 21,000 health care organizations and programs in the United States. Joint Commission accreditation and certification are recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.
KPH	Kalamazoo Psychiatric Hospital.
material condition	A matter that, in the auditor's judgment, is more severe than a reportable condition and could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the judgment of an interested person concerning the effectiveness and efficiency of the program. Our assessment of materiality is in relation to the respective audit objective.
MCL	*Michigan Compiled Laws.*
MDHHS	Michigan Department of Health and Human Services.
mission	The main purpose of a program or an entity or the reason that the program or the entity was established.
night drug cabinet	A locked cabinet maintained for after-hours use when the KPH pharmacy is closed. The cabinet contains medication prepared and pre-packaged to provide the minimum number of doses necessary to safely maintain the patient's medication regimen.
noncontrolled substance medication	A drug or other substance, or immediate precursor, that is not included in Schedule I, II, III, IV, or V of the federal Controlled Substance Act (Title 21, section 801, et seq., of the *United States Code*), which controls the manufacture, distribution, and dispensing of controlled substances.
ORR	Office of Recipient Rights.

performance audit	An audit that provides findings or conclusions based on an evaluation of sufficient, appropriate evidence against criteria. Performance audits provide objective analysis to assist management and those charged with governance and oversight in using the information to improve program performance and operations, reduce costs, facilitate decision-making by parties with responsibility to oversee or initiate corrective action, and contribute to public accountability.
principle of least privilege	The practice of limiting access to the minimal level that will allow normal functioning. Applied to employees, the principle of least privilege translates to giving people the lowest level of user access rights that they can have and still do their jobs. The principle is also applied to things other than people, including programs and processes.
RCA	resident care aide.
reportable condition	A matter that, in the auditor's judgment, is less severe than a material condition and falls within any of the following categories: an opportunity for improvement within the context of the audit objectives; a deficiency in internal control that is significant within the context of the audit objectives; all instances of fraud; illegal acts unless they are inconsequential within the context of the audit objectives; significant violations of provisions of contracts or grant agreements; and significant abuse that has occurred or is likely to have occurred.
rewritten	The recurrence of similar conditions reported in a prior audit in combination with current conditions that warrant the prior audit recommendation to be revised for the circumstances.
SOP	Standard Operating Procedure.

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