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Report to the Congress; by Elmer B. Staats, Comptroller General.

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St. Elizabeths Hospital is operated by the Department of Health, Education, and Welfare (HEW), but efforts have been made to transfer its administration to the District of Columbia Its accreditation was taken away in 1975 and, currently, it is the subject of a lawsuit to provide alternative facilities for patients who do not need the level of care provided at the hospital. Mental health services in the District are also provided by three mental health centers operated by the District's Mental Health Administration and by several private facilities. Findings/Conclusions: There has been a lack of effective joint planning, coordination, and agreement on how best to provide mental health services to District residents which has resulted in overlaps and gaps in services. Inadequacies in services result from failure of the District to provide adequate resources, reorganizations, and program cutbacks. Improvements at St. Elizabeths are needed in central admissions, treatment programs, outplacement services, work schedules, medical records management, industrial and recreational therapies, and medical and surgical services. A higher than necessary level of care was being provided at some facilities for many patients who could have been cared for in nursing or foster care homes if adequate facilities were available. The National Institute of Mental Health planned to request $75 to $100 million to regain accreditation for the hospital and to provide better housing for patients. Planned programs exceeded what was needed to regain accreditation, and plans have been subsequently revised. St. Elizabeths did not have an effective system for information gathering, planning, evaluating, budgeting, staffing, and training because of inadequate implementation of a decentralized management system and inefficient use of committees for making management decisions. Recommendations: The Mayor of the District should: direct the community mental health centers to evaluate patients'

needs and establish programs based on needs, direct the Emergency Mental Health Services and Combined Adult Inpatient Services units to establish follow up procedures for discharged patients, and provide resources to the community mental health centers' partial hospitalization programs. The Secretary of HEW should require the superintendent of St. Elizabeths to: provide guidelines for staff use, make appropriate staffing changes, organize and monitor patient treatment plans, plan and evaluate outpatient programs, simplify the medical records system, develop admission criteria, perform cost-benefit analyses of services, establish criteria for identifying patients ready for outplacement, and work with the District to resolve outplacement problems. The Secretary should also require actions to improve the management system and administrative services at St. Elizabeths. (HTW)

7826

BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

St. Elizabeths Hospital And District Of Columbia Are Improving Their Mental Health Services

Mental health delivery services in the District of Columbia are divided among St. Elizabeths Hospital, the District Mental Health Administration, and private organizations--each providing services almost completely independent of each other. The following deficiencies were found in the District and St. Elizabeths:

- Many patients were being cared for in units that provide a higher than necessary level of care.
- St. Elizabeths needed to reevaluate construction and renovation plans.
- St. Elizabeths needed to improve its management system and administrative services.

HEW and the District have tried extensively to correct these problems.

HRD-78-31
SEPTEMBER 27, 1978

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-133099

To the President of the Senate and the
Speaker of the House of Representatives

This report discusses the problems in providing mental health services at St. Elizabeths Hospital and in the District of Columbia and recent efforts to improve these services.

Our review was made because of (1) the Federal Government's efforts during the last several years to transfer responsibility for St. Elizabeths Hospital to the District of Columbia, (2) the hospital's loss of accreditation, (3) the preliminary ruling of the U.S. District Court which required the placement of patients in the least restrictive alternative facility necessary for their care and treatment, and (4) plans to renovate and construct new facilities at the hospital.

We made our review pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

Copies of this report are being sent to the Director of the Office of Management and Budget; the Secretary of Health, Education, and Welfare; and the Mayor of the District of Columbia.

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

ST. ELIZABETHS HOSPITAL AND DISTRICT OF COLUMBIA ARE IMPROVING THEIR MENTAL HEALTH SERVICES

D I G E S T

St. Elizabeths Hospital has been a subject of controversy for several years. It is operated by the Department of Health, Education, and Welfare, but repeated efforts have been made to transfer its administration to the District. Its accreditation was taken away in 1975 and, currently, it is the subject of a lawsuit to provide alternative facilities for patients who do not need the level of care provided at the hospital. As of May 1, 1978, the hospital provided services to 2,022 inpatients and 3,388 outpatients, and had a staff of about 4,300.

FRAGMENTATION OF THE MENTAL HEALTH DELIVERY SYSTEM

In addition to St. Elizabeths, mental health services are provided in the District primarily by three mental health centers operated by the District's Mental Health Administration and by several private facilities. Each of these facilities operates almost completely independently of each other. There has been a lack of effective joint planning, coordination, and agreement on how to best provide mental health services to District residents. As a result, there are overlaps and gaps in services, in obtaining foster care, and in making nursing home placements. Furthermore, residents do not have equal access to all services. One main reason for these problems is that the District has not provided adequate resources to meet all the requirements of a community-based mental health system. St. Elizabeths has contributed to this situation by supplementing many community services that should be provided by the community. (See ch. 2.)

SERVICES PROVIDED BY THE DISTRICT

Reorganization and program cutbacks have reduced many services. Some patients were not receiving the full-range of services as originally intended and the women's alcohol detoxification unit was understaffed. In addition, partial hospitalization services were generally inadequate in the District because sufficient funds and staff were not available at the District's community mental health centers. (See ch. 3.)

SERVICES PROVIDED BY ST. ELIZABETHS HOSPITAL

GAO found that St. Elizabeths could provide patients with more appropriate, efficient, and effective care if improvements were made in

--central admissions;

--treatment programs;

--outplacement services;

--work schedules;

--medical records management;

--industrial and recreational therapies; and

--medical and surgical services.

For example (1) some patients did not meet the admissions criteria, (2) many patients returned to inpatient status because outpatient services were inadequate, and (3) there was a questionable need for the extensive medical and surgical branch maintained at St. Elizabeths Hospital.

The hospital employs five full-time surgeons, four of whom averaged only one operation every 4 workdays during the first 6 months of fiscal year 1977. The chief surgeon performed no surgeries. (See ch. 4.)

INAPPROPRIATE LEVEL OF CARE

St. Elizabeths, the area D community mental health center, and the District's Mental Health Administration's centralized inpatient units were providing a higher than necessary level of care to many of their patients, a great number of whom could have been cared for in nursing homes and foster care homes. However, adequate facilities of these types were not available in the community.

GAO also found that one of the two wards comprising the Combined Adult Inpatient Services unit which serves the three District-operated community mental health centers was filled with geriatric patients who should have been in nursing homes. (See ch. 5.)

ST. ELIZABETHS CONSTRUCTION AND RENOVATION PLANS

At the time the GAO review was being made, the National Institute of Mental Health planned to request $75 to $100 million to regain accreditation for the hospital and to provide better housing for patients. The planned facility construction and renovation program exceeded what was needed to regain accreditation, the planned size of the new facility was based on inaccurate and incomplete data for determining needs, and the construction program was not based on a determination of the hospital's role in providing mental health delivery services in the District and the number of beds and types of facilities needed to meet that role.

These plans have subsequently been revised to include the reconstruction of existing patient care buildings and no engagement in construction of new patient care buildings. The estimated cost for this reconstruction is $55,300,000.

ST. ELIZABETHS MANAGEMENT SYSTEM AND ADMINISTRATIVE SERVICES

St. Elizabeths did not have an effective system for information gathering, planning, evaluating, budgeting, staffing, and training because of an inadequate implementation of a decentralized management system and inefficient use of committees for making management decisions. In 1971 the hospital decentralized the management system to 10 divisions. The intent was to give division directors control over their resources; however, few division staff members were trained to assume these responsibilities. In addition, the superintendent's office has not always provided sufficient guidance and monitoring of division activities.

The Division of Administration's staff had not performed many of their functions as efficiently or effectively as possible. GAO found problems in the areas of procurement, property control, control of patient funds, patient clothing and laundry systems, management of patient burials, maintenance of facilities, and employee housing. Some problems were created or heightened by insufficient communication with the clinical divisions.

This report contains several recommendations to the Secretary of HEW and the Mayor of the District of Columbia to improve the delivery of mental health services. (See pp. 19, 34, 44, and 74.)

HEW and the District generally agreed with the recommendations and pointed out actions that they either had taken or were taking. The District said that (1) a psychiatrist has been assigned to administer the clinical program for Combined Inpatient Services where he is assessing and coordinating the full-range of clinical services and (2) a needs assessment of patients has been completed and plans for effecting necessary community placements and for improving all facets of services will be carried out. Included will be a mechanism to tighten linkages between the emergency mental health services and

the community mental health centers. The system will have a case management capability to assure continuity of services. The District also advised GAO that there has recently been a bridging of communication gaps which previously existed between HEW and the District.

HEW has developed a St. Elizabeths Initiative as part of the department's major initiative tracking system. A project manager has been appointed in the Office of the Assistant Secretary for Health to direct the activities of the initiative. In addition HEW has created four joint task forces with the District to establish goals and objectives, analyze problems, and formulate problem-solving approaches for implementation. One of these task forces will determine the appropriate St. Elizabeths size and role. Another is developing a comprehensive and unified mental health delivery system plan that integrates and/or merges the institutional and community based services.

HEW has taken or is taking corrective action on many of the service delivery, administrative, and management problems identified in the report and has awarded two contracts which will address other identified problems.

Tear Sheet

Contents

ABBREVIATIONS

CMHC	community mental health center
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
HOPE	helping older people effectively program
JCAH	Joint Commission on Accreditation of Hospitals
NIMH	National Institute of Mental Health

CHAPTER 1

INTRODUCTION

The residents of the District of Columbia are provided mental health services by a delivery system that consists primarily of St. Elizabeths Hospital, one community mental health center operated by the hospital, three District-operated community mental health centers (CMHCs), and several private hospitals that provide psychiatric care.

St. Elizabeths Hospital was established in 1855 as a public health psychiatric facility to provide the most humane care and enlightened curative treatment of the mentally ill of the Army, the Navy, and the District of Columbia. Since then the hospital has provided psychiatric care and treatment to other categories of Federal beneficiaries. Over the years, the hospital has been located organizationally within the Department of the Interior, the Federal Security Agency, and, since 1953, the Department of Health, Education, and Welfare (HEW). In 1967 it was transferred from HEW's Office of the Secretary to HEW's National Institute of Mental Health (NIMH).

As of May 1, 1978, St. Elizabeths had 2,022 inpatients and 3,388 outpatients. About 86 percent of the inpatients are residents of the District. Other patients are mainly from the Virgin Islands, former servicemen, and other non-District residents. The hospital has a staff of about 4,300 and operated with a budget of about $88 million in fiscal year 1977, which included the cost of operating a community mental health center.

During the first half of fiscal year 1977, the hospital's inpatient and outpatient costs per day were reported as $95.71 and $21.32, respectively. For fiscal year 1976 the District reimbursed the hospital $25.18 per day for inpatient care for District residents, and the hospital estimates the same reimbursement rate for fiscal year 1977. Reimbursements are not made for outpatient services. The District's reimbursement to the hospital is specified in the District's annual appropriations bill and is limited to the fiscal year 1970 reimbursement of about $24 million. Annual reimbursements have amounted to about $21 million in recent years. Besides the District's reimbursement, the hospital estimates that it will receive Medicare reimbursements of about $300,000 annually for fiscal years 1977 and 1978. The District does not provide Medicaid benefits to the hospital.

The hospital complex consists of more than 100 buildings on 336 acres in southeast Washington. It is organized into 13 divisions. There are special units for patients involved in criminal proceedings, deaf patients, children, adolescents, alcoholics, drug abusers, and the elderly. The hospital's management system has largely been decentralized which gives the division directors much operational authority. Some functions, such as personnel and budget in the Division of Administration and quality assurance in the Office of the Superintendent, are centralized.

Since the mid-1960s the hospital and its role as part of the integrated mental health delivery system for the residents of the District have generated much discussion. In 1964 the Secretary of HEW established a special advisory group to make recommendations concerning the institution. This group recommended that St. Elizabeths serve as a national model of transition from an old-style mental hospital to a smaller, community-based facility. Accordingly the hospital was transferred from the Office of the Secretary to NIMH in 1967, with the intent to develop and implement a demonstration conversion model in preparation for a probable transfer to the District.

The hospital has been "about to be transferred" ever since. HEW officials have noted that the hospital has been placed in an untenable holding pattern awaiting the outcome of proposed legislation and decisions regarding its future. A state of administrative suspension has prevailed for years and culminated in 1975 when the hospital's accreditation was withdrawn by the Joint Commission on Accreditation of Hospitals (JCAH) for numerous deficiencies in (1) patient treatment and support services, (2) patient safety, (3) staffing, and (4) environment. In addition the hospital had an acting superintendent from July 1975 to October 1977.

The District has four community mental health centers, including the center operated by St. Elizabeths. Each center serves a designated geographic area of the city--catchment areas A, B, C, and D. The centers in areas A, B, and C are funded primarily by the District and are administered by the District's Department of Human Resources.

The budgets for the three centers amount to about $7 million and are included in the budget for the Bureau of Mental Health Services in the Mental Health Administration, which, in fiscal year 1977, amounted to $31,140,600. Of this amount $21,523,500 was for reimbursement to St. Elizabeths and about $3 million was for other Bureau costs.

The area D community mental health center was established in 1969 by St. Elizabeths Hospital and differs from the other centers in several ways. The District exercises no control over this center. The center's director reports to the hospital superintendent and all funding for operations, construction, and renovation comes from St. Elizabeths' appropriations. No satellite operations can be established in the catchment area because HEW officials have interpreted the authorizing legislation as prohibiting the expenditure of funds outside the hospital grounds. As with other publicly operated centers, the citizens' board acts in an advisory, rather than controlling, capacity.

The hospital's reported costs for area D for fiscal year 1976 were $3.8 million for direct costs and an additional $3.2 million for the center's share of allocated hospital costs.

MENTAL HEALTH SERVICES FOR THE DISTRICT PROVIDED BY ST. ELIZABETHS

St. Elizabeths admits emergency patients through its central admissions service. Many of the patients entering St. Elizabeths are not referred through the community mental health centers. Three of the inpatient divisions with a capacity of about 1,100 beds are designated to provide acute and long-term treatment for mentally ill patients and substance abusers for catchment areas A, B, and C. Each of the three divisions also provides occupational therapy, a day care program, and outpatient aftercare which is primarily physical treatment and medication, and supervises patients in foster homes. Overall, St. Elizabeths supervises about 200 foster homes. Centralized services to the divisions include recreational and industrial therapy, pastoral counseling, and psychodrama.

The hospital also operates an acute and long-term inpatient treatment program for children and adolescents under 18 years of age from the three catchment areas, residential programs for substance abusers, a program for the deaf, and a forensic program for criminal offenders with psychiatric disorders. The medical and surgical unit at the hospital provides services to inpatients and outpatients at St. Elizabeths.

Area D community mental health services

The area D community mental health center provides a comprehensive range of services for about 170,000 residents south of the Anacostia River. Area D cannot do any billing

for services. The hospital's basic authorizing legislation (24 U.S.C. 161 et seq.) predated reimbursement and, thus, is completely silent on the issue of reimbursement for outpatient care. HEW legal staff question whether the hospital has authority to bill or authority to deal with the private sector.

The catchment area is divided into four subareas and each is served by organizationally distinct general clinical branches of the area D CMHC. Each branch consists of an inpatient service and an outpatient clinic. The total inpatient capacity for acute and chronic patients is about 80. The average number of outpatients being served by the four outpatient teams at any given time is approximately 1,300 to 1,500. Generally none of the inpatients from the catchment area are in the other hospital divisions. The day treatment program is centralized, and consultation and education services are decentralized to the general units but centrally coordinated. Area D also has three specialized programs: a comprehensive services program for seriously disturbed children and youth 3 to 16 years of age, an alcoholism rehabilitation program, and a drug abuse program.

On October 2, 1977, there were 1,508 outpatients on the rolls. Information is not available on the number of outpatients who are former inpatients on convalescent leave or who never needed hospitalization. Area D has a staff of about 250; we estimate that 15 to 20 percent of staff members work either solely or primarily with outpatients.

THE DISTRICT'S COMMUNITY MENTAL HEALTH SERVICES

The Department of Human Resources has been designated as the authority responsible for the District's mental health services which are administered by the Department's Mental Health Administration.

The District's mental health services consist mainly of three community mental health centers A, B, and C, an adult inpatient unit known as Combined Adult Inpatient Services, and an emergency and intake unit known as the Emergency Mental Health Services. The emergency and inpatient units provide centralized services to the three centers. The Mental Health Administration also includes the Bureau of Forest Haven (a residential care facility for the developmentally disabled), the Bureau of Alcohol Treatment and Prevention, Interstate Compact Division, Forensic Psychiatry, and a division which offers mental health services to residents of the District's

two long-term care facilities under the Community Health and Hospitals Administration, that is, D.C. Village and Glen Dale Hospital.

The three community mental health centers reported that they had about 5,500 outpatients, as of December 1976. Each of the centers has a day care treatment program, various youth services programs, and limited consultation and education services which are primarily directed toward the school system.

PRIVATE SECTOR'S MENTAL HEALTH SERVICES

There are many facilities and psychiatrists in the private sector who provide mental health services for patients with private sources of payment or third-party insurance coverage. The private sector includes seven general hospitals that, as of December 1976, were collectively identified as having a capacity of 227 psychiatric beds. An additional 205 beds were in the Psychiatric Institute which brings the total acute psychiatric inpatient capacity, available through the private sector, to 432 beds. These hospitals also provide emergency services, limited day treatment for their own patients, and some outpatient services. Outpatients (1) obtain treatment from private psychiatrists, (2) are referred to low cost clinics in the District, or (3) are referred to community mental health centers.

In addition to the above, Children's Hospital initiated a small inpatient unit for children in July 1977. Other services available to children include two long-term residences, several private outpatient clinics, and private practitioners who work with children.

PURPOSE AND SCOPE OF REVIEW

We made this review because of (1) the Federal Government's efforts during the last several years to transfer responsibility for the hospital to the District, (2) the hospital's loss of accreditation resulting from its failure to meet the JCAH standards, (3) the preliminary ruling of the U.S. District Court for the District of Columbia in the Dixon versus Weinberger (now Dixon v. Califano) case (civil action no. 74-285) which required the placement of patients in the least restrictive alternative facility necessary for their treatment or care, and (4) NIMH officials' plans to spend about $75 to $100 million to renovate and construct new facilities at the hospital.

Our objectives were to determine whether NIMH and the hospital were adequately interacting with the District to provide appropriate mental health care to District residents; whether the hospital was being managed efficiently; whether the hospital's actions to regain accreditation were adequate; and whether the construction and renovation planned for the hospital is appropriate.

Our work was done principally at St. Elizabeths Hospital and the District's three community mental health centers. We reviewed pertinent records, regulations, instructions, memorandums, reports and plans; and interviewed or contacted personnel at various levels of authority and responsibility at NIMH; hospital divisions that include Administration, Clinical Support Programs, Medical-Surgical Programs, Nichols/Haydon, O'Malley, Richardson, and area D; the District's Department of Human Resources, and areas A, B, and C community mental health centers; and private organizations, such as hospitals, nursing homes, and a halfway house.

We reviewed the (1) JCAH and Medicare survey reports on the hospital, (2) relevant legislation regarding hospital appropriations and types of ownership, (3) HEW's master plan for developing hospital facilities, and (4) Dixon versus Weinberger preliminary ruling by the U.S. District Court for the District of Columbia on less restrictive facilities for patients. We also traced the status of 1,284 patients 1 year after the ruling.

On March 28, 1977, we testified before the House Committee on District of Columbia, Subcommittee on Fiscal and Government Affairs, on H.R. 3335, a bill to create a Government corporation to operate St. Elizabeths.

We did our fieldwork at the agencies from October 1976 to May 1977.

CHAPTER 2

FRAGMENTATION OF THE DISTRICT'S MENTAL HEALTH SERVICES DELIVERY SYSTEM

The District has a fragmented and uncoordinated mental health care delivery system. St. Elizabeths Hospital, the District's Mental Health Administration, and the private sector operate almost completely separate of each other. There is a lack of effective joint planning, coordination, and agreement on how to best provide mental health services to District residents. As a result there are overlaps and gaps in services, in obtaining foster care, and in making nursing home placements. Furthermore, residents do not have equal access to all services. Deficiencies in the delivery of services are discussed in chapters 3 and 4, and the inappropriate level of care for some patients is discussed in chapter 5.

One of the primary factors contributing to the lack of a comprehensive, integrated system appears to be the lack of adequate resources provided by the District to meet all the requirements of a community-based mental health system. St. Elizabeths contributes to this situation by supplementing many community services that should be provided by the community. 1/

LACK OF EFFECTIVE JOINT PLANNING AND COORDINATION

Planning and coordination among the various groups which have responsibilities for providing mental health services in the District of Columbia has been minimal in some cases and nonproductive in others. Even when there has been joint planning, there have been difficulties in implementing the plans. HEW officials advised us that considerable time and effort had been made by hospital, NIMH, and District officials in identifying problems that hinder full cooperation and coordination for developing a coordinated mental health plan. They added that while efforts have been maximal, results have been minimal. One of the primary reasons for the problems with joint planning and coordination has been the atmosphere of hostility which has previously existed between HEW and District officials.

1/This statement is not meant to fault the hospital for providing the services but to explain one of the reasons why the District has not provided the services.

St. Elizabeths long-range plans have been developed with no input from District officials, and the District's State mental health plans have been prepared without coordination with St. Elizabeths. The private hospitals in the District that provide psychiatric services had no input to either plan.

Attempts to coordinate activities between St. Elizabeths and the community mental health centers have had little success. In 1967 the hospital admitted patients to its clinical divisions based on their residence or residential status at the time of admission. Catchment areas for the divisions corresponded to the geographical boundaries previously defined by the Department of Human Resources for the centers. According to District and hospital officials, the hospital clinical divisions and their corresponding centers had varying degrees of cooperation and communication concerning patient care and other common areas of concern.

In the spring of 1976, agreements were signed between the hospital divisions and the centers. Roles were established for each center and hospital clinical division in the delivery of mental health services.

--Area A center and O'Malley Division developed general procedures outlining areas of understanding and joint efforts to be pursued.

--Area B center and the Nichols/Haydon Division outlined a system of joint committees for the purpose of joint planning for the delivery of services and being responsive to special needs of the community, for opening lines of communication, and for improving evaluations and program development.

--Area C center, along with the Richardson and O'Malley Divisions, outlined general areas of agreement on the types of services and coordination that could take place. In addition, the establishment of six joint committees was outlined.

Few provisions included in the affiliation agreements approved by the centers' directors and the hospital division directors have been implemented because, according to HEW, they were never approved by the Administrator of the District's Mental Health Administration. The agreements are currently being reviewed and updated. The District advised us that the hospital and the centers now have standing joint committees which meet periodically to address mutual concerns and to make

adjustments to informally agreed upon procedures, as indicated. Such an arrangement seems to allow for more flexibility and to enhance what is a growing sense of mutual trust and respect between the hospital and the District.

In response to the Dixon versus Weinberger preliminary ruling, the hospital and the District's Department of Human Resources signed an agreement outlining formal procedures, including dispositional conferences, for transferring, from the hospital, the responsibility for the care of patients who will be relying upon the Department of Human Resources for support. Yet, more than 1 year later, dispositional conferences had reviewed only five patients through this formalized procedure. Confusion between the District and the hospital regarding the intent of the conferences resulted in a stalemate that lasted for several months. The hospital's acting superintendent noted that the hospital stopped pressing the District to hold additional conferences, but various hospital divisional people had maintained contact with center personnel at the operational level.

Also, in response to the Dixon versus Weinberger case, the National Institute of Mental Health and the Department of Human Resources submitted a proposed plan to the court for transferring, from St. Elizabeths, those patients who did not need that level of care. The District later submitted a supplemental plan without, according to an NIMH official, the knowledge of or input from NIMH or St. Elizabeths officials.

There also has been little coordination and/or lack of continuity of care between the community mental health centers and the general hospitals in the District. Staff of several general hospitals informed us that they had little communication with the community mental health centers. Area A community mental health center and one general hospital did report giving preference to each other's patients and the use of area A's day treatment program by the hospital.

The construction plan for St. Elizabeths appears to have been developed by NIMH without adequate discussion with and input from Mental Health Administration and other District officials as to the District's needs or St. Elizabeths' role in providing mental health services in the District. NIMH planned to construct a 460-bed psychiatric facility; the administrator of the Mental Health Administration thought that these were to be nursing home beds.

In April 1977 St. Elizabeths developed a 5-year plan for youth services which was based on the number of mentally

ill children, as estimated by the District's Mental Health Association. The plan was developed by an in-hospital committee and was not coordinated with the District or the private sector.

OVERLAPS AND GAPS IN MENTAL HEALTH SERVICES

Because of the uncoordinated delivery system, there are gaps and overlaps in many of the mental health services available to District residents. Overlaps include emergency services, outpatient and aftercare services, day care programs, foster home placements, and vocational rehabilitation programs. Gaps in services include children services and consultation and education services.

At St. Elizabeths, 24-hour service is available to emergency patients through its central admissions service. About 300 patients, including emergency cases, are admitted each month. The District's Emergency Mental Health Service provides 24-hour centralized mental health intake and emergency treatment for areas A, B, and C. Although the program was set up as a centralized service for areas A, B, and C, the program chief informed us that preliminary evaluations are done for area D clients who come to the unit. The unit sees about 600 to 700 patients a month.

Despite the fact that the District operates its own emergency services, some of the emergency services and admissions at St. Elizabeths are for residents of areas A, B, or C who have not first visited or been referred through the community mental health centers in those areas. Emergency psychiatric services are also available at several private hospitals. However, we were told by several general hospital officers that, generally, patients who could not pay are sent to the Emergency Mental Health Services unit and, if beds are not available, they are sent to St. Elizabeths. These arrangements are very confusing to patients, relatives, police, and other service providers seeking to obtain emergency services because of the uncertainty of where the patients should go.

St. Elizabeths, through its clinical divisions and area D CMHC, provides outpatient psychiatric, medical and surgical, and rehabilitation services. The hospital has over 3,000 outpatients on its rolls at any given time. The District reports about 5,500 outpatients in areas A, B, and C. This figure may be overstated since the reporting system used does not identify how long it has been since the patient's last visit. The general hospitals also provide some outpatient services.

Although the Congress has specified particularly that aftercare should be provided in the community (Public Law 94-63), St. Elizabeths continues to provide most aftercare for its patients; the care provided is primarily medication and general medical care. Some patients go to CMHCs or obtain private services. Aftercare at St. Elizabeths is not very accessible to many patients living in the north and west portions of the city who may have to spend up to 4 hours in traveling back and forth. It would be easier for these patients to go to their area community mental health centers.

Three St. Elizabeths hospital divisions and the area D community mental health center provide to their outpatients day care services such as psychiatric treatment, job-skill maintenance, retraining, and recreational and cultural activities. These programs served an estimated 266 patients in fiscal year 1977. The community mental health centers in areas A, B, and C also have day care programs. According to staff members, area A's enrollment is 30, area B's is 42, and area C's is 75 patients. Some general hospitals provide limited day treatment to their own patients.

There appears to be little joint planning between St. Elizabeths and CMHC day-treatment programs. Furthermore, there appears to be no joint planning between CMHCs and the general hospitals except for area A and one general hospital.

Although the District and St. Elizabeths share available foster homes, St. Elizabeths has access to most of the beds. Private hospitals believe that this arrangement has the effect of excluding most patients referred by the private hospitals (see p. 43). Also, as discussed in chapter 4, both the District's vocational rehabilitation program and St. Elizabeths industrial therapy program draw from the same base of participants.

Gaps exist in both the type of service available and the area of availability. For example, the area D center provides comprehensive consultation and education services to residents of that catchment area. Residents of the other three catchment areas receive limited or reduced service.

Although mental health services are available to children, the amount of services available is insufficient to meet the needs of the children in the District. A District of Columbia Mental Health Association study estimated that there may be some 43,000 children and youths in the District who are seriously or less seriously disturbed, and only about 4 percent were being reached by the community mental health centers.

TOO MUCH EMPHASIS ON INPATIENT CARE

The fragmentation of the mental health delivery system in the District is compounded by the emphasis placed on caring for inpatients at St. Elizabeths. While national emphasis is on caring for the mentally ill in the community, most of the resources in the District are provided to St. Elizabeths. Fund and staff allocations between the District and St. Elizabeths contribute to the duplication of and gaps in services.

Although the three community mental health centers in the District are responsible for providing the full range of community mental health services to the 589,000 residents of areas A, B, and C, the Bureau of Mental Health Services 1/ budget, including the emergency and intake unit and the three centers, was about $7 million for fiscal year 1977. In contrast area D, which serves as a catchment area containing 170,000 residents, had expenditures of about $7 million for fiscal year 1976. Fiscal year 1977 budget information for area D CMHC was unavailable. It should be noted, however, that the $7 million budget for area D includes the cost of providing inpatient services to an estimated 180 patients. Budgets for the three community mental health centers have declined from fiscal year 1973 to fiscal year 1977, as shown below.

--Area A's fiscal year 1977 budget was $1.5 million including $230,000 in Federal grant money and an additional $56,000 in Medicaid receipts. In fiscal year 1973 the budget was $2 million.

--Area B's fiscal year 1977 budget was $2.6 million; in 1973 it was $3.3 million.

--Area C's budgets in the same years were $2.5 million and $3.5 million, respectively.

According to a District official, Federal grants to the District have decreased over the years, but the District has not picked up the difference. This has resulted in program cutbacks in recent years. In contrast St. Elizabeths budget has been increasing over the years. It is our belief that

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1/The Bureau is one of the operating units within the Mental Health Administration.

St. Elizabeths' readiness to provide many services that should be provided by the community mental health centers could have lessened the incentive for the District to provide all community services.

The same trend can be seen regarding the number of staff. In fiscal year 1977, the staff working in the three areas was as follows:

--Area A--58 full-time equivalent positions.

--Area B--118 full-time equivalent positions.

--Area C--165 authorized positions. However, only 128 were filled, 18 of which were assigned to the Combined Adult Inpatient Services unit. In addition the Emergency Mental Health Services unit has 20 staff positions to provide intake and emergency care.

In contrast the hospital had about 4,300 staff, which includes about 250 full-time equivalent staff for area D. While staff at the hospital and area D have increased over the years, staff in the three District-operated community mental health centers has decreased by about 36 percent since 1973. It should be noted that differences in the number of staff assigned to these three centers and area D may be explained mostly by the fact that area D provides extensive inpatient services while the other three centers' inpatient services are minimal.

CONCLUSIONS

St. Elizabeths, the District, and the general hospitals need to coordinate their services and develop an integrated community mental health care delivery system. Gaps and overlaps need to be corrected in the delivery of many services and programs such as emergency services, outpatient and aftercare services, day care programs, and consultation and education services.

The District should fund the community mental health centers so that adequate services will be provided.

In a draft of this report submitted to HEW and the District for comment, we included a proposed recommendation that the Congress require the organizations involved in the delivery of mental health care in the District to develop

a coordinated plan for the provision of mental health services in the District. We proposed that the plan designate responsibilities of the various organizations involved in delivering services and providing funds.

HEW subsequently advised us that the Secretary has established, as one of his health initiatives, the revitalization of St. Elizabeths and has committed the full support of his office to the initiative.

The purpose of this initiative is to regain accreditation; improve the quality of patient care, treatment programs, and management and administration of the hospital; and integrate the hospital into a revitalized, comprehensive, unified mental health delivery system to be administered by the District.

The strategy for the initiative includes (1) regaining accreditation, (2) developing improved patient care and treatment programs to upgrade the quality of services, (3) improving the management and supervision of the hospital under permanent leadership, (4) assisting in the development of a plan to provide for long-term care needs of discharged patients, (5) determining the appropriate size and role of the hospital within a comprehensive system, (6) effectively maximizing Federal resources to be made available to the District, and (7) negotiating the transfer of the hospital to the District Government.

The St. Elizabeths Hospital Initiative Officer, the District Government, and St. Elizabeths have established four joint task forces to establish goals and objectives, analyze problems, and formulate problem-solving approaches for implementation, as follows:

--The "Patient Evaluation-Quality Assurance Program" task force is responsible for conducting a patient evaluation survey of all St. Elizabeths' inpatients who have been at the hospital 90 days or more to assess needs to fulfill the court order of outplacing patients requiring care in the least restrictive setting.

--The "Outplacement Facilities-Community Support Systems" task force is responsible for surveying and preparing an inventory of outplacement facilities and for surveying community support services available to discharged patients to recommend an approach that will lead to the development of a community support system.

--The "Determination of Appropriate Saint Elizabeths Hospital Size and Role" task force is developing a picture of the inpatient psychiatric and forensic bed needs in terms of patients to be served.

--The "Policy Formulation and Decision-Making" task force is developing a comprehensive and unified mental health delivery system plan that integrates and/or merges the institutional and community-based subsystems which are currently the responsibility of separate jurisdictions--the District of Columbia and the Federal Government.

District officials commented that there has recently been a bridging of communication gaps which previously existed and that earnest collaboration now seems a reality. Given this, they questioned the need for the proposed recommendation.

Because these task forces are addressing the problems discussed in this chapter and because of the apparent improved communications between HEW and the District officials, we believe that the objectives to which our recommendations would have been addressed will, if completed as planned, fulfill the objective of our proposed recommendation. We, therefore, are making no recommendations at this time.

CHAPTER 3

MORE IMPROVEMENTS NEEDED IN THE DISTRICT'S MENTAL HEALTH SERVICES

Community mental health center staffs report that reorganizations and program cutbacks have reduced many services. Some patients are not receiving the full range of services as originally intended, and the women's alcohol detoxification unit is understaffed. In addition partial hospitalization services are generally inadequate because of insufficient funds and staffing at the three centers.

PROBLEMS WITH CENTRALIZED EMERGENCY AND INPATIENT FACILITIES

In an effort to reduce CMHC operating costs, the Mental Health Administration and the Department of Human Resources centralized adult inpatient and emergency services for centers A, B, and C. Initially, the reorganization required that the centralized units be administered by the three center directors, but this arrangement did not work. Therefore, the emergency and adult inpatient units were established as units separate from the three centers. The establishment of the combined adult inpatient unit resulted in an overall loss of bed space.

The chiefs of the Emergency Mental Health Services and the Combined Adult Inpatient Services units are not accountable to the centers. Their responsibilities cease once patients are discharged and records are forwarded to the applicable center. These units have made no evaluation to determine whether referrals were appropriate or whether individuals kept appointments. According to HEW region III personnel, the combined unit concept should have been eliminated because many sectors were dissatisfied with the functioning of these units.

Staff at the inpatient wards told us that patients in the geriatric unit receive limited treatment. Few therapeutic programs are available. The lack of staff is a major problem and inpatient wards make extensive use of overtime.

The youth inpatient unit, according to the staff, has never functioned as designed. Youth needing mental health treatment are not adequately accommodated because beds are filled primarily with court referrals and referrals from the District's Social Rehabilitation Administration awaiting placement in appropriate treatment facilities which the District officials state they do not have.

The women's alcohol detoxification unit was reviewed by area C staff in 1976. A report recommended more staff, additional treatment, and different approaches for patients having multiple admissions to the unit. According to staff, however, no special programs have been implemented.

PARTIAL HOSPITALIZATION PROGRAM INADEQUATE

According to community mental health center staff, partial hospitalization programs are not providing sufficient services to satisfy needs. Primary reasons are that space allocated for these programs is inadequate, programs lack necessary supplies, and programs in all three centers need additional staffing with specialized skills.

Partial hospitalization in the District community mental health centers consists of day treatment programs for patients who are well enough to live in the community but who need a daily supervised program before resuming usual activities. Day treatment programs are supposed to be a major alternative to inpatient hospitalization for people in an acute emotional crisis.

Area A staff noted that because the District is not providing advancement opportunities for staff, the program had difficulty keeping qualified personnel. Also, the program lacked resources to encourage patients in specific development of skills and hobbies and needed an occupational therapist or a recreational specialist.

Staffing for all centers' programs was generally comparable in terms of number of staff hours per week. Area A provided more professional staff hours while areas B and C had high ratios of paraprofessionals. Two centers noted weaknesses in their programs concerning the provision of meals to patients and lack of supplies to support the programs, while staff from the third center emphasized the need for furniture and fixtures to improve the environment.

None of the centers' programs had information regarding the effectiveness of partial hospitalization programs in preventing patients from returning to the hospital as inpatients.

REDUCTIONS IN STAFFING AND FUNDING LEVELS AFFECT COMMUNITY PROGRAMS

Decreased funding and staffing at the three centers has hindered development of a comprehensive community-based program.

All three of the community mental health centers have had reductions in funding. According to District officials, as Federal grant money decreased over the years, the District government did not provide adequate resources to offset the loss of the expiring grants. Consequently, the three centers have had program cutbacks in recent years.

All three centers were being funded primarily by District appropriations and Medicaid billings. Only area A had NIMH staffing grants. Area B reported two grants awarded from other agencies. None of the centers billed patients or insurance companies.

Program officials said that insufficient staff had severely affected programs and was a major concern. One instance cited was the area A day care therapeutic program which was moving more towards a custodial program. Two years ago the day care program had a staff of 24; the current level is 8. The area B alcoholism program staff was reported to have decreased from 32 to 12 in the last few years. The emergency and inpatient units were reported to be understaffed, resulting in very little therapeutic treatment.

District officials advised us that the reason why centers could not maintain qualified staff was that positions were frozen as staff left. They advised, however, that this is no longer the case.

Little money was included in the centers' budgets for staff training. Areas A, B, and C reported fiscal year 1977 training budgets as $0, $500, and $500, respectively. According to one center coordinator, even if money were available, current staff shortages, especially in the inpatients' programs, would make it almost impossible for staff to attend training sessions during work hours. Training was being provided to all four centers, including area D under an NIMH grant. According to the grant recipients, the training program was going quite well but there was some difficulty in developing longer term training. District officials advised us that in addition, the Department of Human Resources has a Personnel and Training Division which administers training activities for the entire Department. The division provides a broad range of direct training for staff at all levels and provides for training through universities and other training sources outside of the Department where appropriate and feasible. We did not determine the extent that center staff were able to take advantage of these training opportunities.

CONCLUSIONS

The District's Mental Health Administration is aware of the shortages in funds and staff that are contributing to the centers' problems. Additional funds will help, but improvements are needed in how services are provided. Procedures need to be established to determine the appropriateness of referrals from the Emergency Mental Health Services and Combined Adult Inpatient Services units, and therapeutic programs need to be established for geriatric patients in the adult inpatient ward. The programs for youth inpatients and female alcoholic inpatients in area C and the partial hospitalization services in all three areas need to be examined to determine how available resources can be efficiently and effectively used.

RECOMMENDATIONS TO THE MAYOR OF THE DISTRICT OF COLUMBIA

We recommend that the Mayor of the District of Columbia:

--Direct the community mental health centers to evaluate the needs of the patients in the adult, youth, and female alcoholic inpatient wards in area C, and establish programs for their treatment and care based on those needs.

--Direct the Emergency Mental Health Services and Combined Adult Inpatient Services units to establish followup procedures for discharged patients.

--Provide resources to the community mental health centers' partial hospitalization programs to the extent available and needed.

AGENCY COMMENTS

The District advised us that the recommendations:

"* * * relate to part of an ongoing process within the Administration which seeks to achieve individualized evaluation and treatment services for each patient who enters the system. Indeed the recommendations are seen as products of our staff philosophy and input to the auditing staff. Every effort is being exhausted to provide needed services within the limited financial resources available. A psychiatrist has recently been assigned to administer the clinical program for Combined Inpatient Services where he is assessing

and coordinating the full range of clinical services including the night panel, follow-up planning, etc. A needs assessment of patients on Combined Inpatient Services has been completed and implementation of plans for effecting necessary community placement, and for improving all facets of services is forthcoming.

"Included in the Mental Health Administration's plan for development of a Community Support System is a mechanism to tighten linkages between the Emergency Mental Health Services and the Community Mental Health Centers. The system will have a case management capability which assures continuity of services."

CHAPTER 4

IMPROVEMENTS BEING MADE IN THE DELIVERY OF MENTAL HEALTH SERVICES AT ST. ELIZABETHS

At the time of our review we found that St. Elizabeths could provide patients with more appropriate, efficient, and effective care if improvements were made in

--central admissions,

--treatment programs,

--outplacement services,

--work schedules,

--medical records management,

--industrial and recreational therapies, and

--medical and surgical services.

In commenting on a draft of this report (see app. I), HEW advised us of several actions they had taken or were taking to improve the delivery of mental health services at St. Elizabeths, which, if properly implemented, should resolve the problems identified in this chapter.

SOME PATIENT ADMISSIONS INAPPROPRIATE

In 1976 and 1977, the hospital reviewed patient admissions and found indications that some patients were admitted who did not meet the admissions criteria. One reason for this appears to be that guidelines for implementing the criteria need to be clarified.

The Central Admissions Service evaluates and admits patients to the clinical divisions and area D 24 hours a day, 7 days a week. Patients are accepted both on an emergency and arranged basis. Admissions criteria specifically provide for admitting only those voluntary patients substantially in need of hospitalization and emergency patients who have symptoms of a mental illness and who may injure themselves or others. Instructions state that persons needing only medical or social treatment, or geriatric patients not in need of mental health services should not be admitted. However, no

guidelines have been developed for staff use in evaluating potential admissions to prevent inappropriate admissions to the extent possible.

Admitting psychiatrists have few alternatives to admitting persons who may not need 24-hour psychiatric treatment. Staff advised us that individuals who do not need inpatient psychiatric care are sometimes admitted to keep them off the street. Social workers in Central Admission Services work from 8:30 a.m. to 8:30 p.m., Monday through Friday. Analyses of admission records showed that a smaller percentage of voluntary patients are admitted when social workers are on duty than when such workers are not on duty.

MORE INNOVATIVE APPROACHES NEEDED IN PATIENT TREATMENT

Patient treatment plans are generally developed individually. Some patients have failed to respond satisfactorily to the usual approaches to psychiatric treatment. In January 1977, the acting superintendent of the hospital instructed division directors to allow staffs to develop more innovative approaches. Some special group activity programs have already been initiated, apparently successfully, at the hospital. However, the hospital does not have a management system which can identify successful treatment approaches which can be replicated in other divisions.

Most units have acute, chronic, geriatric, and potential community-reentry patients; therefore, staff must provide treatment to meet many different patient needs. One way staff have tried to meet the various needs is by establishing milieu therapy or therapeutic community programs. This therapy is based on the premise that staff-to-patient and patient-to-patient interactions are meaningful aspects of patient treatment. Staff and patients are supposed to participate in the unit's decisionmaking.

We were told and observed that the only special ingredient of a milieu therapy unit is the community meeting in which patients and staff meet to discuss ward issues, problems, or patient privileges. Most of the time patients watch television, play pool, or just sit unless their treatment plans require occasional therapy.

Although a hospital instruction and American Psychiatric Association standards indicate activity programs should be provided for each patient, patients participated in few programs. A hospital evaluation official said that, generally,

the only ward-wide activities are those held when patients live together, such as the community meetings. We examined the activities for 23 randomly selected inpatients and found that:

--Only six had most of their days occupied with school, day-treatment, jobs, or a community program.

--Nine participated in therapy programs or ward groups for 1 to 5 hours each week in addition to general ward activities.

--Two (one a mute, brain-deteriorated patient and another, a patient with a hearing problem) did nothing.

--Six participated only in general ward activities, such as card games, television, and community meetings.

The amount of activities for many of these patients appears to have been minimal. Some clinical managers said patients' days should not be regimented and some patients do not want to participate in activities.

Our review showed that some patient treatment plans did not indicate that patient problems were being treated. For example, although all but 1 of 53 inpatient records examined had treatment plans, 11 did not appear to be fully meeting the needs of the patients. Generally hospital staff had identified patients' problems, but there was not always an indication that staff were working with the patients to alleviate the problems. HEW subsequently advised us that on September 30, 1977, a contract was signed with the National Association of State Mental Health Program Directors to evaluate the patient treatment and care program at the hospital and to assist in upgrading all facets of the patient care and treatment program to meet JCAH and Medicare standards.

Programs designed to assist more than one patient at a time do not exist in many units of the hospital. Instead, most staffs develop and implement treatment plans on an individual basis rather than aggregating the separate plans into a unit program. Those programs which staffs develop for groups of patients are rarely evaluated. Therefore, there is little chance that successful programs will be replicated elsewhere in the hospital.

Programs designed to meet group needs are successful in several units of the hospital. These include Richardson division's HOPE (helping older people effectively) program, O'Malley division's Oasis Partial Hospitalization program, and Nichols/Haydon division's behavior modification program.

The HOPE program's goal is to provide care for geriatric patients and prepare them for return to the community. In 40 months program staff were able to place 98 patients in nursing homes.

Some activities geared to the older patients' needs include

--training table in the dining room to teach table manners;

--weekly occupational therapy;

--weekly recreational therapy;

--bowel and bladder training for incontinent patients; and

--numerous groups run by the nursing assistants, including arts and crafts, sewing, bedmaking, hymn singing, and weekly singing group.

Patients have also formed group activities of their own.

The HOPE staff said that the program was good and provided much job satisfaction. This enthusiasm and direction toward a common goal seems to have allowed them to cater more directly to the patients' needs. For example, the program's physician found that the amount of medication patients take could be reduced and this is one reason why patients are more active.

The staff work with patients' families and follow the progress of patients after placing them in community nursing homes. Staff believe that the main reason nursing homes accept their patients is that they know HOPE program staff will provide necessary support.

The Oasis Partial Hospitalization Program is designed to prepare patients (students) for reentry to the community and help prevent their return to inpatient status. Program staff work with students to help them develop a more positive self-image and improve those skills necessary for everyday living.

Families are involved as cotherapists and program staff work with community agencies to secure delivery of aftercare services. Staff and patients were very enthusiastic about the program. We were told that no patient discharged after completing this program has ever returned to the hospital. Forty-three patients had been in the program through January 1977.

Nichols/Haydon's behavior modification program uses tokens as remuneration and behavior modification techniques to supplement the unit's therapeutic community program. Staff follow patients' progress in the program and are developing criteria for determining which patients benefit from this therapy. In addition, staff are trained in behavior modification techniques.

OUTPATIENT SERVICES INADEQUATE-- MANY RETURN TO INPATIENT STATUS

Many patients return to inpatient status because of inadequate planning 1/ before patients are placed in the community. Furthermore, it appears that there is a need for more staff to work with outpatients and a system to evaluate outpatient programs and patient responses to them. If outpatient services were improved, the number of returnees could be reduced.

In fiscal year 1976, excluding area D, 1,364 of 2,652 inpatients (51 percent) admitted to St. Elizabeths were readmissions. Sixty-four percent of the readmitted patients had been discharged for less than 1 year. The number of readmissions does not include patients on convalescent leave who have returned to the hospital.

As shown in the following table, many patients placed on convalescent leave (on indefinite leave from inpatient status but traveling to the hospital for outpatient treatment) return to inpatient status.

1/This is not to imply that inadequate planning is the only cause for patient returns.

Return Rates for Convalescent Leave Patients

No. of patients	Oct.-Dec. 1975	Oct.-Dec. 1976	Jan.-Mar. 1976	Jan.-Mar. 1977
Placed on leave	530	674	645	711
Returned	383	458	442	435
Returned as a percentage of patients placed	72	68	69	61

Those patients returning from convalescent leave were not necessarily the same ones placed on such leave during that period. NIMH reports showed that from 1974 to 1975, about 70 percent of the patients placed by St. Elizabeths on long-term leave returned. The national average was about 62 percent.

The hospital's Office of Quality Assurance has started to analyze the reasons why so many patients return to the hospital from convalescent leave. In reviewing patient records, we noted some patients failed to take prescribed medications or had family, alcohol, or medical problems.

Although hospital instructions require that discharge planning begin immediately after admission, this is not always done. Sometimes arrangements were not made for known alcoholic patients to seek treatment in the community and known family problems were not always dealt with before release. For example, one elderly patient did not want to live with her daughter but was unable to care for herself. A personal care home was not available. The patient was released to the daughter, returned to inpatient status, and then was released to her daughter again. The record did not indicate any planning to help prevent future returns.

Although hospital officials often cite statistics showing that the hospital serves many outpatients, actual cost data indicates that only a small percentage of total salaries and benefits are attributable to outpatient services. Based on data for the first half of fiscal year 1977, outpatient costs were projected to be $5.6 million. Of this, $1.4 million was projected for salaries and benefits, and the remaining $4.2 million, to other direct and prorated costs for items such as housekeeping, electricity, and maintenance. The $1.4 million is less than 2 percent of the $88 million fiscal year 1977 hospital budget, of which $68 million was estimated to be for salaries and benefits. Therefore, it appears that few personnel are assigned to provide outpatient services.

Furthermore, the hospital does not have a system to identify: (1) the amount of time outpatients spend in hospital day care programs, (2) whether hospital outpatient programs correspond to District community mental health center programs, (3) whether outpatients from one division return to inpatient status at a higher rate than those from another division; (4) the number of times each patient returns after being discharged, or (5) the varying lengths of time patients stay in the community after being put on convalescent leave. Such data would be very helpful for developing an effective outpatient program. The hospital is currently studying a test group of patients to determine the length of time convalescent leave patients remain in the community.

STAFF SCHEDULING NEEDS IMPROVEMENT

Work schedules are frequently designed for staff convenience, rather than patient needs. In addition a hospital official said the 10 psychiatrists working part-time in the Central Admissions Service have sometimes refused to work their assigned hours, causing scheduling problems.

Most ward staff prefer weekends off. Most nonnursing clinical professionals work 8:30 a.m. to 5:00 p.m., Monday through Friday. Therefore, patients admitted on Friday afternoons or the weekends receive little treatment, except medication, until Monday morning.

Nursing staff, which also includes nursing assistants, provide care for three shifts, 7 days a week. However, fewer staff members work Friday to Monday than Tuesday to Thursday, as shown below.

Average No. of Nursing Staff Available for Each Ward to Provide Coverage by Day of Week and Shift

Shift	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
Day	4.2	3.8	5.0	5.7	4.2	4.2	2.6
Evening	2.8	2.0	4.0	4.0	4.0	2.0	2.7
Night	2.3	2.0	2.8	3.5	2.4	2.0	2.4

The hospital has been aware of an inadequacy in the scheduling of nursing staff and had compiled the above figures before we mentioned the issue.

Staff told us that nursing assistants provide most of the direct patient care, especially on evening and night shifts. They also used much of the hospital's $1,235,000 fiscal year 1977 overtime budget. The overtime budgets for nursing assistants were $650,000 in the Forensic division and about $281,000 in the other clinical divisions.

Because nursing assistants provide a large proportion of the care to patients, ward activities are generally disrupted when one is absent. When a nursing assistant takes unexpected leave, a supervisor must pull one from another ward and risk disrupting its activities or have another one work overtime. HEW advised us that the connotation that work schedules are frequently designed for staff convenience rather than patients' needs gives the impression that this is an arbitrary decision on the part of the hospital. It said that professional nurses, physicians, and nursing assistants are a very difficult group of personnel to recruit and, frequently, in order to employ large numbers in this category, work schedules and other items have to be modified for their convenience. To do otherwise would cause many staff vacancies, as other hospitals would accommodate their requirements.

At the time of our review, 10 psychiatrists were employed in the hospital's Central Admissions Service on a part-time basis because psychiatrists willing to work evenings, nights, and weekends on a full-time basis are difficult to recruit. Furthermore, some of them were regularly scheduled to work one weekend a month for 23 or 24 consecutive hours and have, at times, refused to work their tours of duty. This created scheduling problems for the hospital. The acting director, Division of Clinical Support Programs, has been working on this matter for more than 1 year and recently met with the employee relations staff in the personnel office to discuss abolishing certain positions and establishing others with different tours of duty.

MEDICAL RECORDS MANAGEMENT NEEDS TO BE IMPROVED

The organization of some medical records is confusing and staff cannot obtain medical records on a timely basis for readmitted patients. However, medical record documentation is better than several years ago, as evidenced by the 53 inpatient and 15 outpatient records we reviewed. The Joint Commission on Accreditation of Hospitals cited the deficiencies in the medical records as major when it withdrew the hospital's accreditation in 1975.

A hospital instruction specifies that information contained in the record should be in a certain order, but some records are not so arranged. Eighteen records lacked treatment plans, and 15 treatment summaries were not up-to-date. Two of 12 records for area D readmitted inpatients did not contain any record of outpatient treatment. Current patient information is in several sections of the medical record. Not only is this confusing but it makes it difficult to quickly assess the patient's condition.

In late May 1977, a subcommittee of the Medical Records Committee recommended consolidating some sections of the records and eliminating some forms.

Another problem is that staff cannot obtain medical records for readmitted patients until several days after readmission because clinical divisions lack appropriate procedures for obtaining records from the medical records branch. Although records for patients who were discharged more than 5 years ago are in a Federal records storage center in Maryland, more recent ones are in medical records storage at the hospital.

Staff contend that the delay in obtaining medical records means that patient care is initially hindered since staff begin treatment without access to prior treatment information.

INDUSTRIAL THERAPY PROGPAM SERVES FEW PATIENTS

The hospital's industrial therapy program, which is under the direction of the Division of Clinical Support Programs, does not provide services and benefits to many patients who need them.

The program can only serve a limited number of patients because the participants are not being encouraged to seek employment in the community and, therefore, are remaining in the program. In addition no mechanism has been developed to transfer patients to the District's vocational rehabilitation program.

The goal of industrial therapy, regarding rehabilitation, is to provide an opportunity for patients to learn, regain, or confirm a specific work skill which would help them become contributing members of the community. However, if there is little possibility of a patient leaving the hospital in the near future, the aim is to help the patient become a more responsible and productive hospital citizen. Program

officials noted that the program does not provide any formal skill development training although patients may learn some skills through on-the-job training provided by supervisors. There is no program to place successful workers in community jobs.

According to hospital staff, patients are allowed to participate in the industrial therapy program as long as they want and since their earnings have been relatively high (especially considering the fact that inpatients do not contribute to the cost of their care), they lack incentive to seek work in the community. For example, some patients have earned more than the amount established as the 1977 national poverty level for individuals ($2,970). As of May 1977 more than half the patients in the program worked 20 hours or more a week, and of these, 88 patients earned over $3,000; one outpatient earned about $7,600.

The industrial therapy program has no effective way to transfer patients to the District's vocational rehabilitation program which provides community employment to rehabilitated patients. This is significant since more than half the patients in industrial therapy are outpatients and already living in the community. Approximately 327 patients now participate in industrial therapy--147 inpatients and 180 outpatients. In addition about 76 percent of the inpatients and 80 percent of the outpatients have been in the program more than 1 year.

The cost of the program increased from $80,000 in fiscal year 1975 to a budgeted $930,000 for fiscal year 1977 because of increased patient participation in the program and increases in the salary schedules against which the wages are determined. Patients are paid a percentage of general schedule or wage board salaries based on their productivity levels.

Patients are referred to the industrial therapy program by the clinical divisions. Industrial therapy referrals are interviewed and assessed by therapists for suitability in the programs. Most referrals had been accepted, we were told, because there are many jobs in the program that patients can perform. About 60 to 70 patient referrals were being made each month by the divisions. However, about September 1976, very few new patients were accepted because the amount of funds available would provide wages for only the number currently in the program. A current list of patients awaiting entry into the program is not maintained since many patients' conditions change and patients may not be eligible when they reach the top of the waiting list.

The Division of Clinical Support Programs has never established criteria for admitting patients to the program, nor can the director of his division make policy decisions about program operations, only recommendations. All decisions about program procedures must be approved by the clinical division directors.

In May 1977 the division directors established a quota system for allocating positions in the program. Divisions will base participation on either the patient population as of April 28, 1977, or a dollar amount per pay period.

The District's vocational rehabilitation program at St. Elizabeths serves both hospital patients and Southeast Washington residents. The program provides evaluation, testing, counseling, physical restoration, job placement and followup, and a transitional workshop which teaches employment skills while patients perform simple tasks for nominal wages. The transitional workshop served 210 St. Elizabeths patients in fiscal year 1972 and served 149 patients in fiscal year 1976.

A technical assistance consultant reported that the low level of referrals to the vocational rehabilitation program stems primarily from the higher wages paid to industrial therapy patient-workers. The consultant further reported that the decreasing number of rehabilitated patients (14 in fiscal year 1974) is a result of the increasing number of difficult and older patients entering the program. The patients with the most rehabilitation potential enter the industrial therapy program.

RECREATION THERAPY ACTIVITIES AVAILABLE TO FEW PATIENTS

The availability of recreational therapy to patients was improved in fiscal year 1976 when the recreational therapy staff was increased from 21 to 36. We believe, however, on the basis of our review of recreational therapy provided to patients in four divisions and discussions with recreational therapy staffs assigned to those divisions and the Division of Clinical Support Programs, that many more patients could be benefiting from recreation therapy. Several factors preclude this, including lack of supplies and a designated budget, and inability of patients to attend activities off their wards.

Staff told us that because the program has no designated supply budget, they do not know what is available to spend or what supply requisitions will be approved. As a result, staff

are unable to properly plan recreational activities. Prior to being placed in the Division of Clinical Support Programs in 1975, recreation therapy was under the direct supervision of the hospital's assistant superintendent and had a budget. The staff believed that they provided better services to the patients.

Recreation therapy staff assigned to the clinical divisions said that they received few supplies from their own division. The recreational therapy staff in all four divisions with whom we discussed this matter said that they had received no supplies from the Division of Clinical Support for over 1 year. They had to obtain most supplies from the clinical divisions to which they were assigned, even though supplies were supposed to come from the Division of Clinical Support Programs. A recent Medicare survey report cited the shortage of recreation therapy supplies.

Often patients are denied opportunities to attend activities off their wards because nursing staff cannot escort them. Other times, transportation to activities off hospital grounds is unavailable. One recreation therapy staff member said that complimentary tickets are often available for patients to attend community theatres and other special events, but the hospital did not provide the necessary transportation.

The recreation therapy section and the hospital motor pool arrange bus schedules for recreation activities; however, if other hospital buses break down or if a driver is needed elsewhere, the recreation therapy bus or driver is sometimes reassigned. The division director has discussed this with the motor pool to try to prevent this in the future.

QUESTIONABLE NEED FOR EXTENSIVE MEDICAL AND SURGICAL SERVICES AT THE HOSPITAL

There is a questionable need for the extensive medical and surgical services provided at St. Elizabeths because many services, particularly those involving rehabilitative care, could be adequately and less expensively provided by other facilities. Also, the number of surgeries performed does not seem to warrant a staff of five full-time surgeons.

The Medicine and Surgery Branch of the Division of Medical and Surgical Support Programs provides services to inpatients and outpatients from all of the hospital's divisions. The

division had a fiscal year 1977 personnel ceiling of 466 positions; of these, about 362 positions are in its Medicine and Surgery Branch. The branch operates a 266-bed hospital in two buildings, one with 117 beds for general medical patients, and the other with 149 beds for rehabilitation patients. The branch provides complete diagnostic and therapeutic services. As of March 29, 1977, there were 202 inpatients being treated by the branch.

The fisal year 1977 budget for the branch was about $7 million. Second quarter costs were about $326 per day for general medical patients and about $62 per day for patients in rehabilitation medicine. The branch director said that many of the inpatients then in rehabilitation medicine could be served in skilled nursing homes. Such facilities would cost a minimum of $30 to $34 per patient day.

In April 1977 only 24 of the 115 patients in rehabilitation medicine were receiving psychiatric treatment; 79 patients were 60 years of age and older; 20 patients had been in the unit for at least 5 years, 52 for 1 to 4 years and 42 for less than 1 year. About 23 patients were administrative admissions, that is, sent to rehabilitation medicine from other divisions when old buildings were closed. Recently the branch attempted to return these patients but the divisions said that there was no room to accommodate them.

The branch employs five full-time surgeons; four averaged only one operation every 5 work days during the first 6 months of fiscal year 1977. The chief surgeon performed no surgeries. The 144 surgeries performed cost an average of $716 in surgeon salaries per procedure. Consultants for specialized cases performed 45 surgeries during this period which averaged only about $75 each. Surgeries include such procedures as cataract extractions, breast biopsies, and hernia repair.

St. Elizabeths does use community hospitals to provide some specialized medical services. Between July 1976 and January 1977, 14 patients received treatment costing $120,909 in community hospitals. St. Elizabeths paid $59,946. The other $60,963 was paid for by patients' insurance.

Whether St. Elizabeths should be providing medical and surgical services or should be contracting for them with other hospitals has been a concern since 1975. In May 1977 the National Institute of Mental Health directed a task force of Public Health Service officials to evaluate the advisability of contracting for medical, surgical, and rehabilitation services. The task force report issued in June 1977 was a

compilation of past and projected census data and some theoretical analyses of projected future costs. A cost benefit analysis was not made nor did the task force consider the cost of correcting fire safety deficiencies (see p. 47) or the availability of services in community hospitals. The study developed a method for the hospital to use for comparing costs of hospital services to costs for contracting out services. The report said that in some areas more questions were raised than answered and that certain areas were of such importance that a subsequent examination should be made.

CONCLUSIONS

Most inpatients and outpatients at St. Elizabeths seem to be receiving sufficient care; however, there is a need for more innovative approaches to individual patient treatment plans and a need to reduce the number of patient readmissions. Several group treatment programs have been successful and could be good examples for other divisions to follow.

Innovative approaches accompanied by (1) more specific admissions guidelines, (2) better planning before discharging patients, (3) evaluation of outpatient programs, (4) staff scheduling to meet patients' needs, (5) better management of medical records, and (6) better management of its recreation and industrial therapy programs should insure that patients needing only social services are not admitted and that patients receive care in an effective, efficient, and timely manner.

Whether the hospital should continue to provide all the medical and surgical services now being provided is a question that needs answering. Contracting out some services may be more cost effective. Further analysis of this matter is needed.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that the Secretary of HEW require that the superintendent of St. Elizabeths Hospital take the following actions:

(1) Provide more specific guidelines for staff use in applying admissions criteria.

(2) Replace the part-time psychiatrists that are not cooperating in hours of duty.

(3) Group, where appropriate, patients needing similar treatment and organizing group programs to meet assessed patient needs similar to the "helping older people effectively" and Oasis programs.

(4) Monitor treatment plan development and implementation.

(5) Require proper outplacement planning so that patients know where to obtain necessary social and medical services in the community.

(6) Increase evaluation of outpatient programs, particularly as they pertain to reasons why patients return to inpatient status.

(7) Provide more nursing staff services on evenings and weekends, and evaluate the need for and use of overtime.

(8) Implement a simplified medical records system and establish a procedure to give staff immediate access to readmitted patients' records.

(9) Develop criteria for admission and continuing participation in the industrial therapy program and require that industrial therapy and vocational rehabilitation staffs better coordinate their efforts.

(10) Provide recreation therapy staff with a budget, necessary supplies, and adequate transportation for patients.

(11) Perform a cost-benefit analysis of the services provided by the Medicine and Surgery Branch, including surgeries and services for long-term patients, and determine if it would be more cost effective to contract out at least some of the services provided by the branch.

AGENCY COMMENTS AND ACTIONS TAKEN

HEW advised us that it had guidelines for staff use in applying admissions criteria and would enforce them more rigidly. If more enforcement of these guidelines results in more appropriate admissions, it will have met the intent of our recommendation. HEW agreed to perform a cost-benefit analysis of the services provided by the Medicine and Surgery Branch. HEW advised us that the St. Elizabeths Initiative Office is coordinating a feasibility study to determine the cost effectiveness of contracting for a variety of medical and surgical services now being provided by the Medicine and Surgery Branch. The study includes the determination of interest on the part of local health care providers interested in contracting with the hospital.

The department partly agreed with our recommendation relating to the industrial therapy and vocational rehabilitation programs. It advised us that criteria will be developed for assignment and retention of patients in the industrial therapy program. HEW did not believe that strict time limits for participation in the program were appropriate.

Our concern was that the program is not able to serve all the patients who could benefit from it and there is a lack of incentive for those in the program to leave. The intent of our recommendation was that there should be criteria for determining whether a patient should remain in the program. The criteria would not be based on a strict time limit but would consider individual progress. We believe that this portion of the recommendation is still appropriate but have revised the language of the recommendation to clarify the intent.

HEW advised us with respect to our other recommendations that contracts were awarded in September 1977 to (1) conduct a review of direct patient care and treatment programs and (2) develop a work force management program, management criteria, goals and objectives, and more adequate information reporting systems. Since these contracts deal substantially with issues addressed in the recommendations, the Department will defer comment until the completion and review of the contract studies' findings and recommendations. Both studies are scheduled for completion by September 1978.

CHAPTER 5

INAPPROPRIATE LEVEL OF CARE PROVIDED MANY PATIENTS

Many of the patients at St. Elizabeths, the area D Community Mental Health Center, and the District's Mental Health Administration centralized inpatient units at area C are being cared for in units that provide a level of care higher than is needed. Many patients could be cared for in nursing homes and foster care homes. However, adequate facilities of this type are not available in the community. The amount of savings that would be possible if such alternate facilities were available would depend on several factors, including whether staffing could be reduced, the amount of reduction in overhead costs, and whether complete buildings could be closed.

ST. ELIZABETHS EFFORTS TO DEINSTITUTIONALIZE PATIENTS

Despite the ruling in the Dixon versus Weinberger case that patients be placed in the least restrictive setting consistent with their needs, many patients remain in St. Elizabeths Hospital even though they are capable of living in other types of lesser care facilities. The primary reason for this is that adequate facilities are not available in the community.

The release of patients from psychiatric hospitals and their returns to the community has been a national goal since 1963. Deinstitutionalization, as this process is commonly referred to, is an approach to improve the care and treatment of the mentally ill. It involves stimulation and support of various community services as alternatives to institutional care. These services are supposed to enable mentally ill persons to remain in or return to the community and be as independent or self-supporting as possible.

Deinstitutionalization became a major issue for St. Elizabeths in 1974 when a lawsuit was filed in U.S. District Court (Dixon v. Weinberger). The suit charged that the hospital had patients no longer needing inpatient psychiatric treatment. In January 1976 the hospital's staff identified 1,284 of 2,689 patients (or 48 percent of the total resident population) as being candidates for placement in alternate facilities, such as nursing and foster homes, and

halfway houses. One year later, 846 (66 percent) of the 1,284 patients were still in the hospital; 223 (17 percent) were reported living in the community but were still on the hospital's rolls as convalescent leave patients; 115 (9 percent) had been discharged; 84 (7 percent) had died, and 15 were on unauthorized leave.

Of the 846 patients still in the hospital, 740 1/ were identified as being appropriate for nursing home care, foster home care, or halfway houses. As shown in the following table, if these persons were transferred from St. Elizabeths to these types of facilities, it would cost $7.8 million to provide care to these patients. The per diem rate at St. Elizabeths was $74.66 in fiscal year 1976. Therefore, on that basis, the cost of caring for the patients was $19.9 million for the year. The hospital's accounting system does not provide information on the cost of providing care to the various categories of patients; therefore, we could not determine the exact cost of caring for the 740 patients. Hospital officials expressed the opinion, although they had no data to support it, that the cost of the patients who should be released is considerably less than the average for all patients.

Estimated Annual Cost to Provide Care to Patients Who Could Benefit From Other Levels of Care

Type of facility	No. of patients	Cost per patient month	Cost per year	Total cost per year
Nursing home:	565			
Skilled and intermediate care		a/$1,050	$7,119,000	
Psychiatric treatment		b/19	128,820	$7,247,820
Foster care:	157			
Foster care payment		200	376,800	
Psychiatric treatment		b/43	81,012	457,812
Halfway house:	18			
Halfway house payment		480	103,680	
Psychiatric treatment	-	b/43	9,288	112,968
Total	740			$7,818,600

a/Monthly rates are computed using a daily rate of $35 multiplied by 30 days.

b/Psychiatric treatment is estimated to be one visit per month per patient.

1/The remaining 106 patients were identified as requiring other types of institutional care, being able to return to their families, or live independently.

The Acting Superintendent advised us that while $74.66 was the average cost to maintain an individual in the hospital in fiscal year 1976, many patients identified for outplacement were in wards where the costs of operation were less than other portions of the hospital. Consequently, it was his opinion that the $74.66 did not represent a true cost to keep these patients at St. Elizabeths.

We recognize that the cost to maintain an individual in St. Elizabeths varies, depending on the level of care provided. However, since the hospital's accounting system has not been developed to the point where it can accurately identify costs of the various types of care provided, we believe that use of the average cost per patient provides a reasonable estimate of the costs involved.

NO CENTRALIZED SYSTEM TO IDENTIFY PATIENTS WHO COULD BE OUTPLACED

At the time of our review, the hospital did not know the total number of hospital inpatients needing a different level of care. At least one division has developed this type of information but, generally, only individual unit staffs within divisions know which patients could be outplaced. The hospital plans to implement a system which could be used to evaluate a patient's potential for an alternate living arrangement, but presently, this is not part of the hospital's information system.

Each clinical division outplaces its own patients. Most efforts in this regard are fragmented. One division has centralized all outplacement efforts. Another division has centralized intermediate care placements. The remaining divisions rely on their ward-based social workers to outplace patients in nonfoster care facilities. They usually cultivate their own contacts with outplacement facilities with guidance from the chief social workers in each division.

The Acting Director of the Nichols/Haydon Division informed us that the recently centralized approach for all outplacement efforts was working well. According to division staff, the outplacement unit has succeeded in removing more eligible patients from the hospital within the last 3 months than the previous 8-month decentralized approach.

Requiring inpatient staff to assume responsibility for outplacing patients appears to be one reason why patients sometimes have a long wait for outplacement. Our review of 53 randomly selected inpatient records showed that 19 of

the patients were waiting for outplacement. We were able to determine that one patient had been waiting since 1973, four since 1974, two since 1975, three since 197[illegible], and one since March 1977. Some delays were caused by lack of available facilities in the community, but records also show that staff had not been consistently trying to place the patients.

FEW CRITERIA FOR USE IN IDENTIFYING PATIENTS WHO COULD BE OUTPLACED

There are not enough criteria or guidelines to either help staff identify patients needing alternate levels of care or to guide staff in bringing patients to their optimum functioning levels so that they can be outplaced. For example, although hospital instructions establish broad criteria to determine patients who could be placed in foster care facilities, there are no similar criteria for those who could be placed in nursing homes. The hospital is considering adopting an assessment procedure which should serve to more consistently identify the patients' functioning level and need for care and treatment.

OTHER PROBLEMS IN OUTPLACING PATIENTS

Outplacement efforts are sometimes complicated by a reluctance on the part of some patients to leave the hospital and by difficulties encountered in obtaining public assistance for indigent patients. Many patients have been in the hospital for years and, therefore, may be unaccustomed to community living. Despite this, there are no hospital-wide guidelines or programs designed to orient patients to community living.

Patients have encountered numerous problems in obtaining Supplemental Security Income payments. For example, the Social Security Administration, which administers the program, may take several months to process an application. In the meantime, patients ready for outplacement must remain hospitalized or the outplacement facility manager must agree to temporarily bear the cost of patient care until the patient begins receiving his check. Hospital records showed that [illegible] processes its part of the application promptly. Delays appear to be outside of the hospital's jurisdiction.

In area D about one-half of the 80 to 100 patients in the four general units were identified by hospital staff as being inappropriate for inpatient psychiatric care. Most of these were geriatric patients and needed nursing home or custodial care but could not be outplaced because of lack of facilities or objections by the patients or patients' families to outplacement.

Only one of the four units caring for these inpatients had a staff member who specialized in working with geriatric patients. However, this staff member's duties were limited to the one unit. One individual said that in spite of two attempts to upgrade care for geriatric patients, little has been accomplished. One staff member advised us that units do not want to develop aggressive programs to treat geriatric patients for fear that all geriatric patients would be directed to them.

In January 1976, St. Elizabeths and the District's Department of Human Resources signed an agreement outlining formal procedures for transferring from St. Elizabeths those patients who will be relying on the Department of Human Resources for financial or health services. Disputes between the two agencies over the intent of the agreement had stalemated the process for months. As of May 1977 only 5 patients had been transferred pursuant to this agreement.

DISTRICT'S EFFORTS IN DEALING WITH DEINSTITUTIONALIZATION PROBLEMS

District officials have long been concerned with the problem of moving patients from St. Elizabeths Hospital. Some District and St. Elizabeths officials believe, however, that hospital patients are better off remaining in the hospital rather than occupying the limited bed space in community facilities.

The deinstitutionalization of mentally ill patients is also a significant problem in the District. Many patients are being housed for long periods in facilities that do not provide the type of care needed.

A recent study by the District of Columbia Municipal Research Bureau, Inc., of long-term care patients in District facilities noted that in 1975, 357 patients were being improperly placed at District of Columbia General Hospital, Glen Dale, and District of Columbia Village. This was due to the declining number of long-term beds in the District. Eighty percent of the 357 patients were identified as needing skilled or intermediate nursing care. The study also noted that a 1973 HEW survey showed that there were only 35.2 long-term care beds (skilled, intermediate, and residential care) per 100 aged residents. The national average was 51.9 beds per 100 aged residents. One District employee estimated that at any one time, at least 500 applications for skilled and intermediate beds covered by Medicaid were in various stages of processing. This does not include St. Elizabeths patients.

Adult and youth inpatients

There are not enough acute psychiatric beds available in the community, and those beds in the adult and youth inpatient units are often filled by persons who do not need that level of care. Because there are not enough psychiatric beds in the community and the District's inpatient units are often filled, persons are being unnecessarily referred to St. Elizabeths Hospital.

The Combined Adult Inpatient Services unit was established at area C in 1974 as the short-term acute inpatient program for residents of catchment areas A, B, and C. However, one of the two wards is used for geriatric patients who, we were told, should be in nursing homes.

For the first quarter of fiscal year 1977, about 347, or 44 percent, of all 793 patients identified by the Emergency Mental Health Services unit as requiring psychiatric inpatient treatment were referred to St. Elizabeths. If detoxification admissions and referrals are excluded from admissions attributed to the District, then 77 percent, or 347 of the 450 patients requiring psychiatric inpatient treatment were referred to St. Elizabeths. Practically all of these patients would have been referred to acute inpatient facilities in the community if such facilities were available.

The youth inpatient program does not function as a short-term acute residential program primarily because the program lacks control over its admissions. Children sent to the program by the courts and the District's Social Rehabilitation Administration have to be accepted.

Children requiring social rehabilitation are often the hardest to outplace. One has been at the center for 3 years waiting for a therapeutic foster home. Usually, 75 percent of the youth inpatients are of this type rather than youths with acute mental illnesses. The results of mixing these types of youths are that neither group receives adequate treatment.

District reimbursment rates for community facilities

Although St. Elizabeths is a Federal institution, it has to function within an environment which is often significantly affected by District policies and procedures. In the past the District's low reimbursement rates to facilities have had an adverse effect on the supply of available beds, especially intermediate care beds.

Many patients who should be in skilled or intermediate facilities have to rely on Medicaid funds to pay the monthly bills for these facilities. Prior to February 1977, monthly District Medicaid reimbursements were limited to $600 for skilled care and $450 for intermediate care. Non-Medicaid patients at two nursing homes we visited are charged $1,020 and $900 per month for skilled nursing care and $900 and $870, respectively, per month for intermediate care.

At the same time surrounding jurisdictions were paying market rates. Maryland's monthly maximum Medicaid payment was $750 while Virginia paid $950. Since most of St. Elizabeths patients cannot afford to pay the private rates, skilled and intermediate care beds provided through the private sector are usually not available for them.

As of February 1977 the District began reimbursing skilled and intermediate care facilities on a cost basis. Since then, according to one District official, 75 additional private beds became available to Medicaid recipients.

Prior to December 1, 1976, the District reimbursed proprietors of approved residential care facilities up to $150 a month for patients receiving Supplemental Security Income payments. The monthly payment was increased in December 1976 to $180 a month to residential care facility proprietors, with the increase being retroactive to January 1, 1975. A St. Elizabeths official told us that prior to December 1976, the District payment to foster care sponsors made it difficult to bring new homes into the hospital's program. The hospital has about 200 homes in its foster care program. Although the rates have been raised, hospital and District officials believe that the $180 is still not enough to obtain the number of homes needed.

GENERAL HOSPITALS ALSO HAVE PROBLEMS OUTPLACING MENTAL PATIENTS

The majority of the general hospitals we surveyed noted that lack of outplacement facilities presented a major problem. Despite the fact that St. Elizabeths has a viable foster care program which we believe could be used as a source for placing such patients outside of the hospital system, the staffs of two hospitals were especially concerned about the difficulty of finding foster care homes for their patients needing outplacement.

These general hospitals accept patients whose treatment is paid for by Medicaid. However, when a patient needs a lesser

level of care, such as a nursing home, the hospitals find it difficult to place the patient because a sufficient number of nursing home beds are not available.

In commenting on a draft of this report, District officials advised us that private hospitals, clinics, or individual physicians may make referrals for foster home placement through the community mental health center after care units serving their respective catchment areas. Based on these comments we contacted the hospitals and CMHCs again and found that, while the services are available, there were very few referrals from the private hospitals and there was much confusion among the hospitals about the availability of the services and who could be served.

CONCLUSIONS

St. Elizabeths should improve management of its outplacement program, even though all community facilities that are needed are not available. The fragmented outplacement procedures should be incorporated into a single procedure for all the clinical divisions. These procedures should be integrated into patient treatment programs and activities to assure outplacement when patients are ready and facilities available. Standard reporting formats should be designed so that activities can be monitored centrally.

The hospital also needs to coordinate closely with the District to identify and place patients in proper community facilities.

The District will also not solve its outplacement problems until there are sufficient facilities available. Therefore, the problem for both agencies will not be fully solved until there is an integrated St. Elizabeths and District community mental health delivery system. Areas of responsibility need to be established for each agency with sources of funding adequate to provide sufficient reimbursement rates to encourage private investment.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that the Secretary of HEW require the Superintendent of St. Elizabeths to:

--Establish criteria and guidelines for identifying patients ready for outplacement.

--Integrate the outplacement activities of all divisions into one program.

--Work with the Social Security Administration to improve the timeliness of Supplemental Security Income payments.

--Work with the District to resolve problems between the District and the hospital regarding outplacement of patients.

AGENCY COMMENTS

HEW agreed with our recommendation that the Secretary require the Superintendent to work with the Social Security Administration to improve the timeliness of Supplemental Security Income payments. The Department advised us that discussions have been initiated with the Social Security Administration on this and related problems. At present, a case worker is sent to the hospital weekly to take Supplemental Security Income applications for inpatients, and the District's Department of Human Resources has a special mail-in unit where the hospital case worker assists the patient in completing the application form which is submitted by mail. HEW advised us that most eligibility determinations are presently completed within 40 days. HEW believes that the increased attention being given to this problem will improve the timeliness of Supplemental Security Income payments.

HEW agreed with the intent of our recommendation to resolve problems between the District and the hospital regarding the outplacement of patients. HEW advised us that the recommendation, as it was worded in a draft of this report, assumes that the problem is within HEW's full authority to resolve, which it is not. We have reworded the recommendation to remove that connotation. HEW advised us that the Department and District officials are collaborating to resolve this and other problems. Its efforts include meeting the responsibilities affirmed in the Dixon v. Califano class action suit and developing short- and long-term approaches for continuing outplacement of patients.

HEW advised us with respect to our other recommendations that contracts were awarded in September 1977 to (1) conduct a review of direct patient care and treatment programs and (2) develop a work force management program, management criteria, goals and objectives, and more adequate information

reporting systems. Since these contracts deal substantially with issues addressed in the recommendations, the Department will defer comment until the contract studies' findings and recommendations are completed and reviewed. Both studies are scheduled for completion by September 1978.

CHAPTER 6

ST. ELIZABETHS CONSTRUCTION AND RENOVATION PLANS HAVE BEEN REEVALUATED

National Institute of Mental Health officials were of the opinion that $75 to $100 million was required to regain and retain accreditation for the hospital and to provide better housing for patients. The hospital's construction plans included the following problems:

--The planned facility construction and renovation program exceeded what was needed to regain accreditation.

--The planned size of the new facility was based on inaccurate and incomplete data for determining needs.

--The construction program was not based on a determination of the hospital's role in providing mental health delivery services in the District and the number of beds and types of facilities needed to meet that role.

One reason for this was that NIMH determined the size and type of the facility which it felt was needed without adequately coordinating with the District. Implementation of the NIMH plans would have, in our opinion, perpetuated the unbalanced and uncoordinated mental health delivery system described in chapter 2.

EFFORTS TO REGAIN ACCREDITATION

The Congress has provided $11.86 million to correct patient safety, overcrowding, and patient services deficiencies identified by the Joint Commission on Accreditation of Hospitals. Hospital officials estimate that an additional $5.5 million is needed to complete the correction of patient safety deficiencies.

In December 1975 JCAH withdrew the hospital's accreditation. Before withdrawing accreditation, JCAH had awarded accreditations which were regarded as probationary and conditional in 1973 and 1974. Accreditation is both an assessment of the quality of mental health services provided by the hospital and an evaluation of the facilities in which the services are provided. One main reason for facility deficiencies was the hospital's failure to meet the National Fire Protection Association's Life Safety Code Standards which establishes certain requirements for fire protection

and prevention to guard against loss of life and property. Overcrowding was also cited as a facility deficiency.

During fiscal years 1975 and 1976 the Congress provided $11.86 million to correct deficiencies in the hospital's physical plant; the status of these funds, as of March 1977, is as follows.

Deficiency	Amount provided	Status	
		Obligated	Unobligated
Patient safety:	$ 7,440,000		
Emergency lighting, sprinkler systems, and fire detection and alarm systems		$2,343,000	
Earmarked for remaining life safety deficiencies			$2,950,000
Awaiting completion of design contracts			2,147,000
Overcrowding:	3,025,000		
Master facilities plan		125,000	
Facilities design			2,900,000
Patient privacy items:	250,000	250,000	
Other patient services:	1,145,000	977,000	168,000
	$11,860,000	$3,695,000	$8,165,000

Following a June 1977 review of contracts awarded to develop architectural and engineering plans to identify patient safety problems, the hospital estimated that the cost of making life safety improvements would be about $7.5 million. Ironically, the correction of patient safety problems will either create new environmental problems or make existing ones worse. For example, to provide firesafe doors, the existing ventilating system in one building will be closed off and cause the rooms

to become unbearably hot in the summer unless an alternate ventilation system is constructed.

Although the number of inpatients will continue to fluctuate and overcrowding may continue to exist in some units of the hospital, overcrowding hospital-wide is no longer a significant problem. The hospital's acceptable bed capacity (meeting minimum standards developed by the hospital) was 1,953 in August 1977. As of August 1, 1977, the inpatient status 1/ was 1,953. Although this number of inpatients was the same as the acceptable level, it was still more than the 1,758 inpatient level the hospital considers desirable.

Other environmental deficiencies were not primarily structural and can be corrected without any major alteration to the existing buildings. Following are several examples of environmental deficiencies noted by JCAH and corrective actions that have been taken by the hospital:

--Sleeping facilities shall provide appropriate privacy and every resident should have ample closet and drawer space. The hospital is installing "living walls" around bed areas which supply patients with a sense of being in an individual or small bedroom area. These walls also include space for closets and drawers.

--The quality of the environment should be improved by the addition of drapes, pictures, plants, and other items, and by painting some areas. The hospital has made considerable improvements in this area.

--All areas should be free of undesirable odors. Approximately $50,000 was spent for deodorizing units.

PLANS FOR A MODEL PSYCHIATRIC FACILITY

In 1976 the Congress required HEW to develop a master plan for the hospital. The plan is now complete and provides the framework for the future physical plant development of the hospital.

1/ Inpatient is a subset of total resident patients. Resident patients include inpatients as well as individuals on temporary leave and unauthorized leave. These other categories have remained at a relatively constant level for the last few years.

As described by NIMH, the plan contains an analysis of the current conditions and use potential of all existing facilities at the hospital. It provides for the development of the hospital over the next 20 years with the projected hospital size assumed to be between 1,500 and 2,700 patients. The development scheme is designed in such a way that the facilities complex can be expanded from the 1,500 patient facility to any number up to 2,700.

The plan sets forth three levels of renovation--minimum, moderate, and complete. Minimum renovation would be restricted to accomplishment of essential life safety improvements. Moderate renovation would provide for continued building use for up to 20 years, including the installation of air conditioning, improving basic patient comfort, and upgrading lighting and heating. Complete renovation would include improvements which are required to extend the buildings' physical usefulness beyond 20 years.

The master plan reviews existing buildings and places them in one of the three renovation categories--minimum, moderate, complete--depending on which level of renovation would be most cost effective. Based on space standards and cost analysis, the beds available in existing buildings and their renovation status are listed below.

Complete--more than 20 years	687
Moderate--up to 20 years	856
Minimum	515
Total	2,058

At the time of our review, NIMH was making plans to implement the proposals of this master plan. An NIMH analysis of bed requirements showed that 1,800 beds would be needed at St. Elizabeths. The cost to construct and renovate facilities for the 1,800 beds was estimated to be about $75 million.

The number of beds was computed by NIMH as shown below.

Patient category	Basis	Beds necessary
District residents	D.C. population of 721,000 multiplied by 1.75 beds required per 1,000 population	1,262
Nonresidents	Average number of nonresidents and Federal beneficiaries at St. Elizabeths	324
Allowance	10 percent of beds necessary for District residents and nonresidents	a/175
Special programs	Arbitrary amount for alcohol, drug abuse, and adolescent and children programs	40
Total (rounded)		1,800

a/This figure was provided by NIMH and does not necessarily equal 10 percent.

The estimate of 1,262 beds for District residents was developed using a factor of 1.75 beds per 1,000 population. This was based on analysis and comparison of two studies. The first was an NIMH compilation of 1974 statistics on existing nationwide psychiatric inpatient beds per 1,000 population. The second study dealt with existing psychiatric beds in low-income metropolitan areas in 1974. The number of inpatient beds per 1,000 population, as reflected by each study, was 1.587 and 1.727, respectively. Based on these studies and their knowledge of the District, NIMH decided to use a factor of 1.75 beds per 1,000 population.

The factors of 1.587 and 1.727 represent total beds available and include nonresident, allowance, and special program beds. In addition the factors include both private and Veterans Administration beds that would have to be subtracted to arrive at actual public bed needs.

If the above computations had used the actual inpatient bed figures in the two studies (1.587 and 1.727) and eliminated Veterans Administration and private beds (.263 per 1,000), one could conclude that between 1.324 and

1.464 beds per 1,000 population were needed in the District. This translates to a requirement of 955 to 1,056 1/ public psychiatric inpatient beds for the hospital instead of 1,800.

NIMH determined that 1,340 beds should be provided through the renovation of existing buildings and 460 beds, through the construction of a new facility. This decision was based on the desire to have a model psychiatric facility. According to the master facilities plan, many beds which would be replaced by the new facility could be renovated at a much lower cost ($17,600 v. $82,900 per inpatient bed) and still meet and maintain full accreditation for 20 or more years. If this were done and the proposed new facility were not built, NIMH could save about $37.9 million.

Implementation of the master facilities plan at the hospital assumes that hundreds of inpatients will be removed to alternative facilities in the community as directed by court action in Dixon versus Weinberger. Recognizing the critical shortage of outplacement facilities in the District, NIMH is considering a request for authority to provide the District with $500,000 to develop a study of outplacement facility needs. A followup action being considered would be to make up to $25 million available to the District to develop essential outplacement facilities in the community.

Participation by District officials in determining construction needs appears to have been minimal. We were told by District officials that they were not aware of the current construction plans at St. Elizabeths. District mental health officials also indicated to us that

--prior to the commencement of any building program at the hospital, there is an urgent need for studying the overall mental health needs of the District and developing an integrated mental health care delivery system to avoid spending $75 million on something "irrelevant" and

--the $25 million tentatively proposed for necessary outpatient facilities was not enough.

1/These figures include an allowance for nonresidents and special programs comparable to those used by NIMH.

RECENT AGENCY ACTIONS

In submitting a draft of this report to HEW and the District for comment, we concluded that before funds were requested to build new facilities at the hospital, St. Elizabeths needed to define its role in providing mental health services in the District. We proposed, therefore, that the Congress not authorize or appropriate funds for construction of new facilities at St. Elizabeths until a coordinated plan had been developed. We also proposed that the Congress require that any funding requests for new construction clearly demonstrate that the construction is needed and that it is more cost advantageous than renovation of existing facilities.

We have subsequently been informed that present plans for regaining JCAH accreditation for the hospital include the reconstruction of existing patient care buildings and no engagement in new construction of patient care buildings. The estimated cost for reconstruction is $55,300,000. The Department has requested these additional funds in a supplement to the 1978 appropriation. HEW advised us that upon completion of the planned reconstruction, the hospital is expected to be in compliance with both the JCAH and Medicare standards.

CONCLUSIONS

Because HEW and the District are currently involved in developing a comprehensive mental health plan for the District (see p. 14) and because NIMH no longer plans to build new facilities at the hospital, we believe that a recommendation to the Congress is no longer needed and that actions being taken by NIMH and the District should result in a more coordinated and cost effective mental health system.

CHAPTER 7

IMPROVEMENTS BEING MADE IN MANAGEMENT SYSTEM AND ADMINISTRATIVE SERVICES AT ST. ELIZABETHS

At the time of our review, St. Elizabeths did not have an effective system for information gathering, planning, evaluating, budgeting, staffing, and training. The principal reasons for this were the inadequate implementation of a decentralized management system and the inefficient use of committees for making management decisions. In 1971 the hospital decentralized the management system to 10 divisions. The intent was to give division directors control over their resources; however, few division staff were trained to assume these responsibilities. In addition the superintendent's office has not always provided sufficient guidance in monitoring division activities.

Division of Administration staff have not performed many of their functions as efficiently or effectively as possible. We found problems in the areas of

--procurement,

--property control,

--control of patient funds,

--patient clothing and laundry systems,

--management of patient burials,

--maintenance of facilities, and

--employee housing.

Some problems were created or heightened by insufficient communication with the clinical divisions. Although Division of Administration functions rarely provide direct patient services, all activities support clinical staff who provide these services, and their inefficient performance can affect patients.

INSUFFICIENT AND INADEQUATELY UTILIZED INFORMATION IMPEDES DECISIONMAKING

Sufficient information is not compiled for use in making management decisions. However, a contract has been awarded

to assist the hospital in determining its needs. Much information is available but is not collected in a manner that can be used to make management decisions. The allocations of costs are based on old data and made to inappropriate categories.

Lack of patient-related information means that the staffs of the Office of the Superintendent and clinical divisions cannot determine what treatments are most effective. For example, the Biometrics Branch in the Division of Clinical Support Programs collects aggregate patient information on how many patients are admitted, discharged, or die. The Branch cannot provide information on patient illnesses other than the initial diagnoses, treatment provided, or number of times specific patients return to the hospital. Such information could be very useful in assessing the effectiveness of hospital treatment. The Branch is currently working with the Office of Quality Assurance to computerize admission and treatment data.

The Biometrics Branch is also working to implement a packaged computer system developed by a New York psychiatric hospital for use in psychiatric hospitals. However, the acting superintendent recently noted that the hospital was well into the second year awaiting Biometrics' development of the information system, and Biometrics and the Medical Records Committee should not prolong implementation. The Director, Division of Clinical Support Programs, said that there have been coordination problems with the system supplier.

In an effort to provide administrative and clinical managers with the information necessary to establish goals and evaluate programs, the hospital awarded a 1-year management review contract estimated to cost $400,000. Work was started on September 6, 1977, to:

--Analyze work done by all hospital units and establish a workload reporting system.

--Develop goals, objectives, and staff allocations for all hospital programs.

--Provide an analysis of the information needed to support an evaluation process and develop ways to satisfy unmet data needs.

--Analyze data presently available at the hospital and determine how to obtain unavailable data.

The allocation factors used to distribute costs had not, as of May 1977, been updated since July 1973, and the accuracy of the allocating percentages is not known by the cost accounting personnel. In addition reported patient per diem costs are inaccurate because the cost of long-lived assets are not included.

Cost categories are not properly or clearly defined, causing the allocation of costs to inappropriate categories. For example the Medicine and Surgery Branch is including, as outpatient costs, visits to its clinics by patients who are treated on an outpatient basis by the Medicine and Surgery Branch but are inpatients in other divisions of the hospital. As a result, outpatient costs are inflated and inpatient costs understated.

HOSPITAL PLANNING PROCESS NOT ADEQUATE

The hospital's internal planning process does not comply with the guidelines established by the HEW operational planning system which is the Department's approach to management by objectives. The system is based on four principles: (1) defining clearly what one wants to accomplish, (2) establishing objectives, (3) measuring progress periodically against the objectives, and (4) analyzing accomplishments in relation to the objectives. The system translates forward planning goals of 2 to 6 years into specific measurable objectives by laying out the short-term steps which should lead to the long-range goals.

The hospital began a formal planning process in 1976. The process consists of the divisions preparing planning statements and providing them to the Program Planning and Analysis Branch for incorporation into a hospital-wide plan. However, plans produced are primarily compilations of background information and broad goals, and contain little specific information on implementation. They are written as if the hospital was the sole provider of mental health services in the District of Columbia instead of one of the providers.

Clinical division plans are not based on programs in place or needed to meet assessed patient needs. Instead, they are merely presentations of patient projection figures and broad goals, such as outplacing more patients or assuring more patient privacy. One division director said that program planning is futile because the number of patients could increase quickly, thus negating the plan.

Division of Administration planning is equally broad and is hindered by lack of coordination within the division. Numerous administrative deficiencies could be related directly to inadequate planning before implementation.

Planning officials said that, with two exceptions, divisions did not even draft their own plans but merely supplied statistical and goal information to the Program Planning and Analysis Branch that wrote the plans.

A hospital official told us that their plans are based on providing comprehensive mental health services because of the belief that the District will not expand mental health services in the next 5 years. Also, in the past, discussion of transferring the hospital to the District has hindered planning. National Institute of Mental Health officials also pointed out the difficulties of long-range planning during this period. The acting superintendent thus decided that since decisions about the size of the hospital as it relates to the District are political ones, the hospital will be concerned only with internal planning.

The importance of jointly planning and providing services to District residents was emphasized in a 1969 decentralized planning document. It stated that inpatient beds and special programs should be reduced to provide an incentive for the District to develop community resources. Instead, partly due to the lack of coordination, the hospital has increased outpatient services and developed more special treatment programs. HEW officials pointed out that a major factor that has led the hospital to continue or in some instances increase both its inpatient and outpatient services has been the lack of funds and resources to enable the District to carry on essential services to District residents requiring psychiatric care and treatment.

LACK OF EFFECTIVE EVALUATION PROCESS

Clinical and management activities have not been effectively monitored and evaluated by the hospital, NIMH, or the HEW Audit Agency. There is no effective process for determining whether programs and activities accomplished their goals and objectives or operated efficiently. The need for an effective evaluation process is exemplified in the numerous clinical and administrative deficiencies discussed in this report.

The Office of Quality Assurance is responsible for evaluating clinical activities. However, the office is hindered in performing these evaluations by only being able to request, and not require, the necessary information. Present Office of Quality Assurance activities include coordination of the peer review, 1/ evaluation of long-term and readmitted patients, and comparison of several similar alcohol, youth, and geriatric programs.

The Management Analysis Section of the Program Planning and Analysis Branch performs management surveys, but the number has been limited because of other responsibilities including managing forms and maintaining the policy and procedures manual. Prior to 1976 this section did not have authority to initiate management surveys.

An HEW Audit Agency official said that his "best recollection" was that they have never made a comprehensive review of hospital activities but did review some procurement procedures and practices in 1969.

Several clinical divisions have established program analyst positions for internal analyses. However, two of these analysts were not performing program analysis full-time--one functioned as a special assistant to the division director and the other performed no program analysis because of other duties.

BUDGET CONTROL INADEQUATE

Lack of adequate control over the budget almost led to financial crises at the ends of fiscal years 1975 and 1976. Divisions were told that they could not spend budgeted funds for travel, training, or supplies, and we were told that in fiscal year 1975 there was a question as to whether employees could be paid. A primary reason for this is that the budget office does not certify the availability of funds before personnel actions (paperwork authorizing the hiring, firing, or promoting of employees) are finalized.

1/The peer or concurrent review is being made in conjunction with the Congress mandate that the medical profession establish Professional Standards Review Organizations to evaluate care delivered to beneficiaries of Medicare, Medicaid, and Maternal and Child Health programs. An independent organization, the National Capital Medical Foundation is conducting the review which consists of examining appropriateness of admissions and treatment.

Since personnel costs comprise 85 percent of the budget, this lack of personnel fund certification means that a significant portion of the budget is not adequately controlled.

In 1976 NIMH analysts made several recommendations designed to improve the financial management process. Fund certification prior to final approval of personnel actions was one recommendation. The hospital's budget officer has also made this proposal. Although an instruction was issued in May 1977, as of August 1978 it had not been implemented because the planned information system had not been completed.

The funding problem continued in fiscal year 1976 and the transition quarter because the hospital was required by NIMH to attempt to reach its full employment ceiling at the end of these two periods. Because of its lack of control of personnel costs, the hospital was curtailing other expenditures and ended fiscal year 1976 with almost $230,000 in unobligated funds and the transition quarter with almost $253,000 in unobligated funds.

At June 30, 1976, the hospital had 4,094 employees on the rolls which was 38 below the employment ceiling of 4,132 and 86 above the funded level of 4,008. During the transitional quarter 175 additional positions were approved that increased the ceiling to 4,307. At September 30, 1976, there were 4,154 employees on the hospital rolls which was 24 below the budgeted ceiling of 4,178.

A hospital budget official believes that the financial crisis resulted from a combination of factors: the hospital's lack of adequate budget control, insufficient funding, and the requirement to try and hire to the employment ceiling.

LACK OF EFFECTIVE POSITION MANAGEMENT

The hospital has no effective method for managing staff growth and the manner in which staff are distributed. Hospital staffing studies made by division staff have not been based on any work measurement studies or evaluated by a central office. The large percentage of staff working on nonpatient care duties at the hospital may be the result of inadequate monitoring of staff growth and distribution.

Nearly as many staff are in administrative and maintenance positions as are in patient care positions, as shown on the following page.

Type of staff	Percentage of hospital employees in category as of December 1976
Direct patient care	a/50.8
Patient-related staff support	3.9
Administrative management	13.3
Service support/maintenance	32.0

a/Because we could draw data from only position titles and classification series, these figures include all doctors, nurses, psychologists, and others with patient-oriented tasks. Many of these staff perform administrative duties full-time. They include the Superintendent, division directors, and chief nurses or psychologists.

We compared the hospital's staff distribution with public, private, and Veterans Administration psychiatric hospitals, using data prepared in 1974 by NIMH. St. Elizabeths had 9.8 to 13.6 percent more staff in administrative and maintenance positions than other psychiatric hospitals, as shown below.

Type of hospital	Administration and maintenance	Professional patient care	Nonprofessional patient care
	(percent of staff)		
St. Elizabeths Hospital	48.9	21.1	30.0
Public psychiatric	35.3	20.5	44.2
Veterans Administration psychiatric	37.6	31.2	31.2
Private psychiatric	39.1	32.3	28.6

HEW officials disagreed with our analysis and pointed out that St. Elizabeths has a different mission, operates under circumstances unique from the other hospitals, and the other hospitals have support systems that are not included in their personnel figures, such as, road maintenance and fire protection services. We recognize that the staffing needs of hospitals vary with the services they are required to provide. However, these figures can be used as indicators in determining whether more analysis is warranted.

Although inpatients decreased from 5,603 to 2,253 from fiscal years 1966 to 1976, 730 additional staff were hired. The hospital sees more outpatients than it did in 1966, but few staff members work with outpatients. Between 1966 and 1976, 730 positions were added of which 39.7 percent were for direct and related patient care and 60.3 percent for administrative and maintenance staff, as shown below.

Distribution of 730 Positions Established Between October 1966 and December 1976

Staff function	No. of positions 10/66	No. of positions 12/76	Increase
Direct patient care staff	1,973	2,196	223
Patient-related staff support	102	169	67
Administrative management	322	576	254
Service support/maintenance	1,196	1,382	186
	3,593	4,323	730

Since work measurement or position management evaluations have not been done, there appears to be no precise reasons for staff growth and distribution. From available information and discussions with hospital staff, there are several explanations for the manner in which staff has increased:

--Budget requests noted the need for additional staff because of decentralization.

--St. Elizabeths and nationwide mental institutions now provide more treatment for patients than they did in 1966.

--JCAH criticisms about shortages of nurses, social workers, psychologists, mental health workers, and housekeepers have led to new hires.

Although Civil Service Commission regulations specify that personnel offices should play an active role in position management and control the Division of Administration's Personnel Branch does not do so. Rather, hospital official said that broad powers are delegated to the divisions, including control over staff positions.

Although the hospital's basic tool for position management is the table of organization (the updated listing

of all positions and their Civil Service pay rates), a personnel official said that it is not serving the intended purpose and is not maintained by the Personnel Branch. Because the table is not totally based on the budget, divisions make numerous changes throughout the year, sometimes substituting a high-graded position for a low-graded one.

ADDITIONAL PERSONNEL MANAGEMENT IMPROVEMENTS NEEDED

The Acting Superintendent suggested that the Personnel Branch's classification section limit its role in position management after the Branch had recommended position management changes for the area D Community Mental Health Center. This review was made in conjunction with the HEW-required review of hospital positions.

A Personnel Branch official said that overhiring elsewhere in the Division of Administration, for example, food service workers, caused the Personnel Branch to not be allowed to fill several of its vacancies in February 1977. Work backlogs were created particularly in the classification section. The personnel officer suggested that if the work force had to be brought to the ceiling levels, the only way it could be accomplished immediately was by a reduction in force in the Division of Administration to bring the number of Division employees down to the authorized level. The acting superintendent suggested that the reduction could begin in the Personnel Branch, despite the vacancies there.

Furthermore, a Personnel Branch official said that the Branch has often not been consulted during recruiting campaigns. Many professional employees were recruited and promised positions by clinical staff while attending professional meetings without prior approval from the Personnel Branch. The Personnel Officer told us that clinical staff have been advised they cannot make offers to candidates.

After critical reports by NIMH and the Public Health Service on the Personnel Branch in 1974 and 1975, several Branch officials were replaced and many deficiencies were corrected. However, Branch officials told us that many staff in the division need additional training to familiarize themselves with Civil Service regulations and proper procedures.

NO ASSURANCE THAT FRAGMENTED TRAINING PROGRAMS MEET HOSPITAL NEEDS

Many offices and organizations have training responsibilities which are not well coordinated. Therefore, management has no assurance that the training provided meets hospital needs. In addition, we were told that the overall cost of training programs is not known.

The clinical divisions have the primary responsibility for their employees' development and, in addition, have training budgets and staff. The hospital is proposing training courses for instructors to gain and build on fundamental skills.

In addition, numerous groups, offices, and individuals also have training responsibilities, such as the Staff Development Council, the Continuing Medical and Nursing Education Committees, the Overholser Division of Training, the Employee Development and Upward Mobility sections in the Division of Administration, and the associate directors of the various professional disciplines.

The three organizations with hospital-wide functional training responsibilities--Overholser Division, Employee Development, and Upward Mobility--have limited policy roles. The Employee Development and Upward Mobility's main functions are to assure that other training complies with Federal regulations. The Overholser Division offers clinical courses to the staff.

The Staff Development Council advises the superintendent on hospital-wide policies and priorities, and disburses training funds. The Council was instructed to advise the Employee Development Section on the section's activities.

An indication that training should be monitored hospital-wide is that a larger percentage of employees in upper general schedule (GS) and wage board positions received training than employees in lower positions. In fiscal year [illegible] inservice, Upward Mobility, non-Government, and Government training of 8 hours or more was distributed as follows.

Positions	No. of employees	Percentage of employees attending training
GS-4 and below	375	63
GS-5 to 8	1,836	32
GS-9 to 12	588	a/148
GS-13 to 15	268	84
GS-16 to 18	16	a/160
Wage Board supervisory	211	47
Wage Board nonsupervisory	892	29

a/Percentages above 100 percent indicate that some employees received training more than once.

This arrangement for staff training and development has been criticized by hospital employees, and some have suggested ways for improvement, including (1) having the acting superintendent provide more leadership and (2) giving the Staff Development Council authority to relate training to hospital needs, establish policies and procedures, and monitor staff development functions. At the time of our review, these suggestions had not been acted upon.

COMMITTEE SYSTEM INEFFICIENT AND INEFFECTIVE

St. Elizabeths committee system does not provide for adequately coordinating activities to avoid duplication of efforts and seems to dilute managers' authority in the functional areas.

There are 40 hospital-wide standing committees and many subcommittees and ad hoc committees. Divisions also have similar committees. Staff advised us that they spend much time preparing for and attending committee meetings.

Committees cover many different functional areas, some of which are closely related, yet the committees generally do not coordinate their efforts. For example one hospital staff member found 11 ad hoc and standing committees examining the problem of "assaultive" patients. None were aware of the others' activities.

Some committees are not responsible to the management office having primary authority in the functional area. Also the Chief of the Office of Quality Assurance has

no control over the numerous committees, such as the Accreditation Committee, the Medical Records Committee, the Patient Care Audit Committee, and the Nursing Audit Committee that deal with quality assurance.

In May 1977 the hospital began an effort to better define the role of committees.

INADEQUATE PROCUREMENT PROCEDURES

The hospital does not have adequate procedures to assure that supplies, equipment, and services that are purchased are (1) needed in the quantities or for the purposes stated by the requisitioners, (2) ordered in sufficient time to obtain adequate competition, (3) made at the least administrative cost and in accordance with regulations, and (4) obtained in a timely manner so that they can be effectively utilized. Following are examples of deficiencies noted.

--In fiscal year 1976 the hospital owned over 100 small Cushman vehicles, which averaged 11 to 446 miles of usage per month. Sixteen of these vehicles averaged 50 miles or less a month. The hospital, nevertheless, bought 17 additional Cushmans. Each unneeded vehicle represents an unnecessary expenditure of about $3,100.

--In August 1976 the hospital asked NIMH to submit a supplemental building and facilities appropriation, which included a request for an automatic pumping station. Information was not provided to NIMH to demonstrate the amount of possible savings. The request was denied. We computed possible savings of about $92,500 per year after the first year.

--After a homicide at the hospital, a security guard company was hired for 90 days using sole-source procurement procedures. The contract was extended for 60 additional days rather than be advertised because the clinical division involved did not notify the procurement section in time to solicit bids. When the contract was later advertised for 1 year's services, the sole-source firm bid $48,180. The firm selected bid $39,420.

--The procurement section did not monitor blanket purchase arrangements to assure that all purchases were properly made. Blanket purchase arrangements are used to authorize purchases of material from commercial vendors when the material is not available from Federal

sources. The procedure reduces the procurement section's workload because individual purchase orders do not have to be processed. Each purchase arrangement with a vendor establishes an annual maximum amount of purchases. The total amount of such arrangements for fiscal year 1977 was about $552,000. In addition the personnel using these purchase arrangements were not trained in the proper procedures and, in many cases, the necessary documents were not forwarded to the finance section for payment. Appropriate data was not entered on the documents. Therefore, this section had to locate the obligating documents and spend unnecessary time recording required data, such as names and vendor control numbers, on these documents. In May 1977 instructions were drafted on the proper use of blanket purchase arrangements, and a staff meeting was held to explain the procedures.

The functions of finance, property control, and procurement are being integrated into an automated material requisition system. Full operations were expected in October 1977 but no one within the Division of Administration has planned to insure that operating procedures are written, appropriate personnel are trained, or staff are realined as necessary.

Clinical divisions have not had input to the system's development despite HEW instructions which state that the prime objective of a cost system is to furnish maximum useful information commensurate with established needs and facilitate supervision, evaluation, formulation, and implementation of management policies and decisions.

In November 1976 the office of the associate superintendent for administration asked the section chiefs of procurement, property, and finance to determine changes in responsibilities, workloads, and staff necessary to make the transition to the automated requisition system. As of May 1977 section chiefs had not responded.

HOSPITAL PROPERTY NOT ADEQUATELY CONTROLLED

Hospital equipment and supplies are not adequately controlled. No one has required that inventories be taken and reconciled; therefore, there is no assurance that the hospital's inventories of nonexpendable and expendable items are accurate. In addition the hospital's key control procedures are not adequately monitored.

An April 1977 inventory of nonexpendable personal property (items costing more than $200) listed 20,544 items valued at $11,092,590. However, the property section chief said that there was no way of knowing whether the inventory included all items which should have been included.

Our review of inventory reconciliations done by one clinical division showed that 15 percent of the division's nonexpendable property was missing, and 13 percent was not in its proper location. We do not know whether this same situation exists in other divisions but if it does exemplify the situation throughout the rest of the hospital, there may be a great deal of property missing.

HEW instructions require an annual inventory and referral of a list of shortages to a board of survey to determine responsibility for and disposition of loss. This has not been done.

Hospital instructions also require that all items be assigned to specific property custodians; an inventory be taken on change of custodian; and a master list be maintained, noting location and serial numbers of property. The property section was unable to provide us with a current list of property custodians, and there was no evidence that physical inventories were taken when custodians changed.

Some property serial numbers may have been improperly recorded. For example Michigan police traced a stolen radio they recovered to the hospital through the manufacturer's serial number. The hospital had no record of receiving the radio. A May 1977 property check indicated many items had not been tagged with appropriate identification.

For expendable personal property (that charged as an expense when received or issued), we were unable to determine if the required 1976 inventory was taken. In addition there was no evidence that the 1975 inventory was taken in conformance with HEW requirements that specify that non-warehouse personnel should supervise the inventories.

Some divisions did not compare expendable items received with a monthly report of items issued to those divisions by the property section. Other divisions did not reconcile their differences between receipts and issues with the property section. As a result, divisions do not know if they were overcharged or undercharged for items. When one division compared drugs received with the property section's monthly

report of drugs delivered, they found that the unexplained differences averaged $305 per month for a 7-month period.

Although an instruction establishes procedures for controlling hospital keys, the individual with these responsibilities had not performed the required control functions. Supervisory personnel in clinical divisions controlled keys with various methods, resulting in strong control in the Forensic Division, to limited control in other divisions.

The chiefs of security and engineering, the head locksmith, and clinical division staff said that many thefts were apparently made using hospital keys, as there was no indication of forced entry.

Although security reports indicated that thefts were occurring because black plastic bags were used to remove hospital property as if it were trash, a recommendation to use clear plastic rather than black trash bags took 3 years to implement. The delay was attributed to the General Services Administration not having clear bags in stock. Since out-of-stock items can be purchased commercially, there should not have been a delay.

PATIENT CARE SUPPORT SERVICES NOT ADEQUATELY MANAGED

Inadequate management and control of patient funds, patient clothing, and laundry services has increased possible misuse, loss, and inefficient use of patient and hospital resources.

In 1977 the hospital deposited in the U.S. Treasury over $2 million belonging to about 2,500 patients. These accounts are very active since withdrawals and deposits from such sources as social security and retirement plans amount to about $131,000 a month. At the time of our review, the patients did not earn interest on these funds. Failure to pay interest was brought to the hospital's attention in September 1975 during an onsite review of representative payees by the Social Security Admininistration. From that date until June 1977, patients could have earned about $200,000 if interest had been authorized.

On December 19, 1977, Public Law 95-215 was signed which, among other things, authorizes the disbursing agent with the approval of the Secretary of the Treasury to invest funds on

behalf of St. Elizabeths patients who receive social security disability benefits. Interest on such investments would be credited to the patients' accounts.

We also found that controls were inadequate to assure that patient funds are not misused. The hospital mailroom sent directly to the cashier only that mail which could be identified as patient funds without being opened. The same individual, the cashier, who opens the mail also records receipt of funds and makes deposits. Other mail which may contain patient funds could be sent to the patient or elsewhere. For this type of mail, control over funds is lessened and patients' accounts are not immediately credited. 1/ No one regularly monitors anticipated payments to patients, such as social security, to insure their receipt.

Although the hospital conducts quarterly cash verifications, no internal audit has been conducted. This failure precluded the hospital from insuring that all funds are accounted for, amounts held are not in excess of cash requirements, and there is adequate protection of funds.

In addition cash, rather than U.S. Treasury checks, was given to patients for large withdrawals because the required 7-workday advance notice for patients to withdraw funds was not being enforced. Therefore, patients are given large sums of cash without having an adequate place for safeguarding it.

The failure to coordinate within the Division of Administration and communicate with the clinical divisions has prevented some patients from receiving proper and needed clothing. The property section chief obtains patient clothing from General Services Administration-approved contractors with little advice from the procurement section even though he has little knowledge of what is available.

Clinical division staff said that they had been unable to obtain clothing suitable for the needs of incontinent patients, patients who rip their clothing, or bedridden patients. They believed it was nearly impossible to get action from the Division of Administration on this issue.

1/We do not mean to imply by this that the hospital should open patients' mail. There is no requirement that patients deposit their funds. It would be inappropriate and a violation of patients' rights to open mail because of speculation that it might contain money.

In addition the laundry system does not deter loss or improper use of patient clothing and hospital linens, and poor communication between the administration and clinical divisions has prevented patients from using a patient laundry program. The lack of control over laundry has led to an inability to account for large usage of linens and patient clothing. For example, during fiscal years 1975 and 1976, the hospital issued the following quantities of new patient clothing and linen items.

Item	Issued in FY 1975	Issued in FY 1976
Dresses	9,200	15,344
Trousers	4,265	5,796
Shirts	3,744	7,162
Sheets	18,432	22,697
Towels (bath)	60,676	25,072
Washcloths	40,100	50,400

The existing system does not provide controls over the receipt and issue of items from the laundry. Only two divisions count dirty items before sending them to the laundry; however, this practice is not a control because the laundry issues clean items to the divisions based on the needs of each ward and not on dirty items received. The amount of clean laundry returned to the divisions should nearly equal the dirty laundry received.

Clinical divisions were ordered on June 17, 1976, and again on May 9, 1977, to implement laundry counting procedures so that they would know how many items are sent to the laundry. The laundry would return only this number, making it responsible only for washing the clothing and linens supplied; the clinical divisions would then have responsibility for assuring that patients have adequate clothing and linens. Despite these orders, laundry counting has been implemented in only two divisions. The second deadline has since been rescinded and, instead, a complete study is being done.

Most patients wear the clean clothing sent to the divisions by the laundry; however, the clothing sent by the patients is not the same clothing received. A program was started in July 1976 allowing patients to deliver and pick up their own clothing at the hospital laundry. However, only one patient had used the service and most clinical division staff said that they were unaware of the program.

HOSPITAL INCURRING UNNECESSARY BURIAL COSTS

Deceased indigent patients who were residents of the District of Columbia are being buried by the hospital, although this is the responsibility of the District. The District, by law, is responsible for burying indigent residents; however, it has refused to bury St. Elizabeths patients even after being reminded by the hospital in 1975.

When patients die without sufficient funds for private funerals, they are buried in a cemetery on hospital grounds at a cost of about $275. In fiscal year 1976 the hospital buried 28 such indigent patients, 24 of whom were District residents.

The District could contract with a mortician to bury patients for less than hospital burial costs. For calendar year 1977 the District procurement schedule for funeral services showed that cemetery services for adults, including the burial plot, could be obtained for $175.

HEW officials, when reviewing a draft of this report, stated that the hospital has made repeated efforts to secure the compliance of the appropriate District agencies for the burial of indigent District residents. In the absence of any such action by the District, the hospital has dealt with the immediate situation of burials in the most humane manner by providing available labor and material within the hospital. They added that the hospital's response to these situations, which are emergent in nature, can only be classified as ad hoc and not as a recognized statutory hospital function.

The hospital does not contract out burial functions because the Public Health Service Act (42 U.S.C. 248e) precludes expending appropriated funds for burial without permission of the Secretary of HEW. The hospital, however, believes expending available labor and material is within the law, but contracting this service to a funeral home violates the act. Hospital officials have discussed obtaining permission for contracting out burial services with HEW's General Counsel.

FACILITIES MAINTENANCE INEFFICIENT

The hospital does not know if all facilities are being maintained adequately and efficiently since (1) work measurement standards are not used, (2) costs are not adequately accumulated for specific work, and (3) the preventive maintenance program is not adequate.

The clinical and administrative divisions have no orderly procedure for initiating maintenance work, nor does the Engineering Branch make routine facilities' inspections to identify and consolidate needed work. Instead, hospital staff submit numerous written or verbal work requests. Some divisions do not monitor work requests to insure that work is completed.

JCAH cited the lack of a preventive maintenance system in the patient safety section of its 1975 survey report. The hospital believed that personnel were not qualified to establish a system and requested funds to hire a private consultant in 1976. NIMH denied the request and another request has not been resubmitted.

Each of the three sections in the Engineering Branch is autonomous. Three different systems are used for accounting for labor, controlling materials, and reporting the work accomplished. The Branch has no control system to insure that work requests are not lost or to notify divisions when work was completed or delayed.

Although all sections accounted for total labor used, only one section distributed labor to individual jobs. It would be impractical, therefore, to evaluate time necessary to complete jobs.

No section used a central locator system or attempted to order supplies in the most economic quantities possible. One did not report all supplies used. One supply issuing system was an honor system or "get what you need." The Engineering Branch Chief accounted for the divergences in procedures by saying "he inherited them that way." The hospital recently drafted an instruction which would institute a common cost reporting system for engineering work.

There is no work measurement system to determine if property maintenance is being done efficiently. One official said that maintenance employees required excessive time to complete some tasks, and in some instances, work had to be redone.

Office of Management and Budget Circular A-44 outlines a management program to improve productivity through the use of industrial engineering techniques. Another Circular, A-11, states that work measurement, unit cost, and productivity indices should be used to support budget justifications for staffing requirements. The hospital has made no efforts to comply with the circulars.

There have been no studies to determine if any Engineering Branch work could be performed less expensively by the private sector. Office of Management and Budget Circular A-76, issued March 1966 and updated October 1976, stated that the Federal Government's general policy is to rely on the private enterprise system to supply needed products and services, in preference to having the Federal Government engage in commercial or industrial activity.

HEW officials commented that while no formal studies have been made, judgments have been made for at least 15 years concerning the comparative merits of work done by hospital employees versus outside contracts, and decisions have been made accordingly. They added that in fiscal year 1977, $3.5 million in work was done by outside contract and the hospital is studying additional areas where contracting out could occur in a cost-effective manner.

EMPLOYEES UNDERCHARGED FOR RENTAL OF GOVERNMENT-OWNED HOUSING

Seven houses and 66 apartments are available on the hospital grounds for rent by hospital employees. Rents are based on various appraised factors. At the time of our review the hospital had not developed a justification for employees to be housed on the grounds, and employees who were living in the seven houses were undercharged $13,607 per year for rent and utilities.

HEW regulations require that housing be provided only when positively demonstrated as being necessary to maintain the continuity and efficiency of service or to protect property which cannot otherwise be protected. Hospital officials responded to our review and developed justifications which were forwarded to NIMH officials who convened a task force to judge their validity.

Hospital officials also responded to our observation on understated rents by contracting with a private appraiser to determine the proper charges for the seven houses and 66 apartments.

Contrary to hospital regulations, some work performed by Government employees for the tenants was for their benefit. Also more was spent for maintenance of the houses than rents collected from them. From July 1974 to September 1976, the hospital collected $40,030 in rents and spent $53,173 for repairs.

CONCLUSIONS

The hospital needs to improve its management system to meet current and future needs. For clinical division activities, a system is needed to determine (1) the needs of the patients--outpatients and inpatients, (2) what treatment programs or plans are effective or ineffective, (3) what information is needed and available to monitor and evaluate programs and plans, (4) the staffing needs necessary for these programs and plans, (5) the manner in which staff is being used, and (6) the training needed to assure that staff will provide proper treatment. This information could be used to establish an integrated management system to provide the Superintendent and his staff sufficient data on the best methods to manage resources and provide patient care.

The Administration Division provides services, supplies, and equipment to other hospital divisions and is an integral part of the management system. However, there are subsystems and management controls that need to be developed separately to correct the many deficiencies noted. The division needs to provide more timely, adequate, and efficient support to other divisions.

The problem of not being able to pay interest on patient funds held in the U.S. Treasury was resolved by the passage of Public Law 95-215 which authorizes interest to be paid on these funds.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that the Secretary of HEW require that the following actions be taken to improve the management system and administrative services at St. Elizabeths.

(1) Develop a more effective and integrated management system which allows optimum utilization of resources to meet clinical needs.

(2) Reassess division functions and reassign those which could be better performed centrally, require more central monitoring of division administrative and clinical activities to determine which activities are effective and should be considered for use by other divisions, and those which are ineffective and should be discontinued.

(3) Place the planning functions of the Program Planning and Analysis Branch in the Office of

the Superintendent and require the Branch to develop and provide the divisions with planning criteria and instructions.

(4) Place the management evaluation function in the Superintendent's office.

(5) Assure that the quality assurance staff has appropriate authority to carry out its evaluation responsibilities.

(6) Make one office responsible for establishing and implementing training policies and procedures.

(7) Require that committees be used only for advisory purposes and that staff with functional responsibilities be the decisionmakers.

(8) Appoint staff with functional responsibilities to head committees which relate to their responsibilities and establish a mechanism for coordinating the work of various committees so that numerous groups are not pursuing the same tasks.

(9) Give the Personnel Branch the necessary authority to perform all the appropriate functions necessary for position management, require the Division of Administration not to overhire in some branches at the expense of others, and require that Branch employees receive necessary training.

(10) Authorize the Personnel Officer to establish a recruiting program in the Personnel Branch and require close coordination with clinical division staff to assure that staff recruited meet division needs.

(11) Require that personnel actions be sent through the budget office for certification of funds before they are finalized.

(12) Require the Financial Management Branch Chief to insure that cost bases and definitions are accurate and that all hospital divisions use the same cost definitions.

(13) Develop procedures to assure that only required items are purchased, including purchases under blanket purchase arrangements.

(14) Increase efforts to insure that all HEW regulations and hospital instructions dealing with property control are complied with.

(15) Develop and implement adequate controls over patient funds.

(16) Establish a system for accumulating maintenance cost and performance information and transforming the data into a work measurement and evaluation system, develop a facilities preventive maintenance system, and determine which functions could be performed less expensively if contracted to the private sector.

(17) Insure that rents for employee housing are accurately computed and that maintenance employees perform only required maintenance work.

(18) Improve controls over receipt and issuance of laundry.

(19) Request the HEW General Counsel to coordinate with the hospital legal office and resolve the issue regarding the responsibilities of the hospital and the District for burying deceased indigent patients who were District residents.

AGENCY COMMENTS AND ACTIONS BEING TAKEN

HEW agreed with many of the recommendations in this chapter and advised us that regarding the others, it will defer specific comments until the completion of contracts awarded to study direct patient care and treatment programs and to develop a work-force management program, management criteria, goals and objectives, and more adequate information reporting systems. HEW pointed out several actions it was taking to improve the management system and administrative services at St. Elizabeths. These actions include:

--Development of a St. Elizabeths Hospital initiative as part of HEW's major initiative tracking system. The purpose of this initiative is to regain accreditation, improve the quality of patient care and treatment programs, improve the management and administration of the hospital and to integrate the hospital into a revitalized comprehensive unified mental health delivery system to be administered by the District Government. A project manager has been appointed to direct activities of the initiative in the Office of the Assistant Secretary for Health.

--Selection of an associate superintendent for administration to fill this previously approved but unfilled position.

--Awarding of a contract to the National Association of State Mental Health Program Directors to conduct a total review of direct patient care and treatment programs.

--Awarding of a contract to MEDICUS to develop a workforce management program, including workload review, management evaluation criteria, goals and objectives, and review the adequacy of information reporting systems. HEW anticipates that a comprehensive management information system will develop from this effort.

--The hospital superintendent is reviewing all hospital committees to streamline committee functions, eliminate duplications and overlaps, and insure that chairpersons and members have related functional responsibilities.

--Methods and techniques are under examination to improve recruitment of staff.

--A comprehensive study was completed of hospital procurement operations. Some needed improvements were identified and corrective action is being taken.

--An intensive effort is in progress to improve property control in all areas of the hospital.

--Issuing new instructions to provide better control and safeguards throughout the process of receiving, maintaining, and disbursing of patient funds.

--New rent schedules are now in effect for employee housing and new instructions have been issued to insure that all applicable regulations are adhered to.

--A review of the linen and laundry distribution and collection system has been completed and resulted in the development of revised procedures which define responsibility and accountability within the clinical divisions. Central linen rooms are now in use in most divisions, providing improved control over receipt and issuance of laundry.

--The HEW General Counsel has been asked to review the matter of patient burials.

We believe that these actions are resulting in substantially improved administration of the hospital and are responsive to our recommendations.

APPENDIX I

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

JUL 3 1978

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Problems in the Delivery of Mental Health Services at St. Elizabeths Hospital and in the District of Columbia." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Thomas D. Morris
Inspector General

Enclosure

APPENDIX I

COMMENTS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON THE COMPTROLLER GENERAL'S DRAFT REPORT ENTITLED "PROBLEMS IN THE DELIVERY OF MENTAL HEALTH SERVICES AT ST. ELIZABETHS HOSPITAL AND IN THE DISTRICT OF COLUMBIA"

General Comments

The Department is in substantial agreement with the basic conclusion of this draft report, based on the General Accounting Office (GAO) review completed in May 1977, that serious problems existed within the District of Columbia (D.C.) mental health system, in general, and with Saint Elizabeths Hospital (SEH), in particular. However, we consider it unfortunate that the report does not specifically recognize the significant corrective actions in progress and the Department's development of the SEH Initiative. We hope the final report will note the remedial actions that were in progress or taken since completion of the field work, that bear on program and management matters.

At the present time, the mission, management, and general operations of SEH are going through what is probably the most comprehensive set of changes in a century. Many of the problems addressed by the GAO review either no longer exist or are in the process of being corrected or eliminated. This is due primarily to the early attention the Department, in conjunction with members of the President's staff, Congress, and officials of other interested bodies, devoted to the analysis of problems at SEH and the development of coherent strategy and plan for improvement.

There is full accord that the SEH should be an integral part of the D.C. mental health delivery system, but concern exists over the best method to be followed in achieving a unified, integrated system. The impetus of the SEH Initiative should substantially and significantly improve the delivery of mental health services in D.C.

A project manager has been appointed to direct activities of the SEH Initiative in the Office of the Assistant Secretary for Health. The project manager's function is to coordinate the efforts of the Department and to serve in a liaison capacity between the Department, the D.C. Government, and other Federal agencies.

The SEH Initiative Office has been instrumental in creating four joint task forces with the D.C. Government and the SEH to establish goals and objectives, analyze problems, and formulate problem solving approaches for implementation.

Responsibilities of the SEH Initiative Office include: regaining accreditation of the SEH, developing improved patient care and treatment programs, improving management and supervision, assisting in the development of a plan to provide for the long-term needs of discharged patients, determining the appropriate size and role of SEH within a comprehensive system, maximizing Federal capacity for assistance to the D.C., and negotiating the transfer of the SEH to the D.C.

Other noteworthy activities directed toward improving the quality of care at the SEH include the following:

a. The identification of the revitalization and accreditation of SEH as a major priority to be undertaken by the Department.

b. The appointment of a permanent Superintendent of the SEH who is a board-certified psychiatrist and nationally recognized mental health administrator.

c. The selection of an Associate Superintendent for Administration to fill the key management position at SEH.

d. The certification by the Bureau of Health Insurance for continued Medicare payments.

e. The accreditation of the Area D Community Mental Health Center for one year.

f. The award of contracts in September 1977 to (1) conduct a review of direct patient care and treatment programs; and (2) develop a manpower management program, management criteria, goals and objectives, and more adequate information reporting systems.

g. The request for a 1978 supplemental budget appropriation of $55.3 million for renovation.

Since the contract studies referenced above deal substantially with issues addressed by GAO in several recommendations of this report, specific Department comments are deferred until the completion and review of the contract studies' findings and recommendations. Both studies are scheduled for completion by September 1978. The recommendations on which comments are being deferred are: page 49, (2); page 49-50, (3); page 50, (4) (5) (6) (7) (8); page 51, (10); page 64, first and second sections; page 106, (1) (2) (3) (4) (5); page 107, (6) (9); and page 108, (16).