

DOCUMENT RESUME

00524 - [A1051800]

[Review of St. Elizabeth's Hospital]. March 28, 1977. 21 pp.

Testimony before the House Committee on District of Columbia:
Fiscal and Government Affairs Subcommittee; by Gregory J. Ahart,
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Issue Area: Health Programs: Health Facilities (1203).

Contact: Human Resources Div.

Budget Function: Health (550).

Organization Concerned: Alcohol, Drug Abuse, and Mental Health
Administration: National Inst. of Mental Health; Department
of Health, Education, and Welfare; Saint Elizabeth's
Hospital, Washington, DC.

Congressional Relevance: House Committee on District of
Columbia: Fiscal and Government Affairs Subcommittee.

Authority: Dixon v. Weinberger (1975).

Current levels of planning, coordination and interaction among the National Institute of Mental Health (NIMH), St. Elizabeth's Hospital, and the District of Columbia Government have failed to produce an integrated mental health care system for the District. Too many patients who could have been treated at an alternate facility are being treated at St. Elizabeth's. As long as patients remain on the rolls of St. Elizabeth's, the District community mental health centers do not take an active roll in providing treatment. St. Elizabeth's has informally served as the "catch all" institution for the District when alternate facilities are not available, and many patients' mental status would likely improve if they were placed in an alternate facility or deteriorate if they were not placed. Of 1,284 patients identified as not needing the level of care provided at the hospital, 848 were still in St. Elizabeth's as of January 31, 1977. Its accreditation was removed in 1975. The hospital is currently planning construction improvements, but there has been minimal participation by District officials in determining construction needs. There is a lack of communication across clinical division lines, discharge planning seems weak, and patient followup work is lacking. The hospital does not have a management system that adequately integrates the complex management areas of budget, planning, evaluation and personnel. The organizations involved in mental health care delivery in the District should jointly develop a coordinated plan for the provision of mental health services. (QM)

00524

United States General Accounting Office
Washington, D.C. 20548

FOR RELEASE ON DELIVERY
Expected at 10 a.m., EST
Monday, March 28, 1977

Statement of
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Human Resources Division
before the
Subcommittee on Fiscal and Government Affairs
Committee on the District of Columbia
United States House of Representatives
on
Saint Elizabeths Hospital

Mr. Chairman and Members of the Subcommittee:

We are pleased to appear here today to discuss our ongoing review of St. Elizabeths Hospital. We started this review because of (1) the efforts by the Federal Government during the last several years to transfer responsibility for the Hospital to the District of Columbia, (2) the Hospital's loss of accreditation resulting from its failure to meet the standards of the Joint Commission on Accreditation of Hospitals (JCAH), (3) the ruling of the U.S. District Court in the Dixon v. Weinberger case which required the placement of patients in the least restrictive setting necessary for their treatment or care, and (4) the plans by National Institute of Mental Health (NIMH) officials to renovate and construct new facilities at the hospital.

The objectives of our review are to determine whether the hospital is being managed efficiently; whether NIMH and the

hospital are adequately interacting with the District of Columbia Government to provide mental health care to the residents of the District of Columbia; and whether the actions being taken by the hospital to regain accreditation are adequate.

Because our review is not yet complete the observations we are presenting must be considered as tentative. We have not fully developed the causes of the deficiencies noted nor have we developed recommendations for correcting them.

DELIVERY OF MENTAL HEALTH CARE
IN THE DISTRICT OF COLUMBIA

Results of our work to date indicate that current levels of planning, coordination and interaction among NIMH, St. Elizabeths Hospital and the District Government have failed to produce an integrated mental health care system for the District. The following factors appear to have contributed to this situation.

1. While national emphasis is on caring for for the mentally ill in the community, the majority of resources available for mental health services in the District are provided to St. Elizabeths Hospital.
2. Lines of communication within and between NIMH and the District of Columbia are cumbersome and adversely affect the decisionmaking process.

3. St. Elizabeths Hospital and the District Government have not jointly developed well defined goals for the delivery of mental health care in the District or a plan of action to attain these goals, and
4. The District Government has not adequately developed the support services necessary for a community based treatment program.

For mental health care service delivery, the District of Columbia is divided into four catchment areas--Areas A, B, C, and D. Areas A, B, and C are served by community mental health centers funded primarily by NIMH and the District Government. These three centers are administered by the District's Department of Human Resources. St. Elizabeths Hospital operates a community mental health center in Area D.

The Area D community mental health center was established in 1969, and differs from the other centers in several ways. The District Government exercises no control over this center. The director reports to the hospital superintendent and all funding for operations, construction and renovation comes from St. Elizabeths appropriations. This arrangement permits close collaboration on all services in Area D. No satellite operations can be established

in the catchment area because funds cannot be expended outside the hospital grounds.

St. Elizabeths provides the majority of inpatient services in the District. It also provides outpatient services for residents of all parts of the District. As of December 31, 1976, St. Elizabeths reported a population of 2,200 inpatients. In addition, it had 2,911 outpatients including 1,345 from the Area D community mental health center. The District Government reimburses the Hospital for part of the cost of the care for 1,905 of the 2,200 inpatients. Outpatients are served without charge to the District Government or the patient.

Current approaches to the treatment of the mentally disabled emphasize alternatives to institutionalized care in order for individuals to remain in or return to their communities and to be as independent and self-supporting as possible.

The Hospital acknowledges that comprehensive psychiatric treatment requires more than inpatient residential treatment. Many psychiatric treatment services, such as outpatient and short-term inpatient acute care, have previously been identified as the responsibility of community mental health centers. However, the community mental health centers in the

District have to a great extent relied on the Hospital to provide these services. To illustrate,

--During a previous review we asked the Hospital's Central Admission Service to determine how many persons admitted during a 1-month period could have been treated at a community mental health center or somewhere other than at St. Elizabeths. They determined that 90 of the 100 persons admitted as inpatients to the hospital from Areas A, B and C during the period February 14, 1975, to March 15, 1975, could have been treated just as well in an alternate facility. Fifty-one of the 90 persons admitted unnecessarily were referred by the community mental health centers in areas A, B and C. According to the Central Admission Service, the 90 persons were not treated in a community mental health center primarily because beds were not available or the centers could not handle the additional workload.

--As long as patients remain on the rolls of St. Elizabeths as either inpatients or outpatients, the District community mental health centers do not take an active role in providing treatment.

--St. Elizabeths, in addition to serving as a mental hospital, has informally served as the "catch all" institution for the District when alternate facilities are not available. In a survey taken in January 1976, hospital staff identified 451 inpatients as being custodial candidates who could live in an alternative facility without any attention from a mental health professional. An additional 611 were identified as patients who could live in an alternative facility in the community providing they continued to receive some attention from mental health professionals. The survey also identified 222 more patients whose

mental status would likely improve if they were placed in an alternate facility or deteriorate if they were not placed.

Efforts to Comply With
Dixon vs. Weinberger

The U.S. District Court for the District of Columbia ruled in 1975 in the Dixon vs. Weinberger case that civilly confined patients at St. Elizabeths Hospital have a right to placement in the least restrictive setting necessary for their treatment or care. The court ruled that the Federal Government and the District of Columbia Government must provide alternative facilities for those civilly confined patients not needing hospitalization.

In response to this ruling, St. Elizabeths identified 1,284 patients as of January 7, 1976, who did not need the level of care provided at the Hospital.

Plans for compliance with the court order were submitted to the courts by Federal defendants and the District of Columbia. Although general alternative actions were identified in plans submitted to the courts, we have been unable to determine specific actions taken by the District and HEW except that (1) the District Government raised the

monthly reimbursement rate for foster care and domiciliaries and changed the reimbursement method for skilled and intermediate care beds to encourage the facilities to accept these hard to place individuals and (2) an agreement was signed over a year ago between the Hospital and the District to jointly plan the release of patients from the hospital. In addition, St. Elizabeths has continued to identify patients who could benefit by being transferred to alternate facilities. This effort is more of a divisional or ward policy rather than a Hospital-wide effort.

Of the 1,284 patients who were identified as not needing the level of care provided at the Hospital, we found that as of January 31, 1977:

- 848 were still in the hospital,
- 114 had been discharged,
- 84 had died,
- 15 were on unauthorized leave, and
- 222 were on convalescent leave.

We were unable to account for one individual. Those on convalescent leave include 117 living independently or with their family, 80 in foster care homes, and 19 in skilled and intermediate care facilities. Of the 1,284 patients, 713 were originally identified as needing skilled or intermediate care. Seventy-nine percent were of these were still in the Hospital.

EFFORTS TO IMPROVE PHYSICAL
FACILITIES AT SAINT ELIZABETHS

The JCAH withdrew St. Elizabeths' accreditation in December 1975. One of the primary reasons was the Hospital's failure to meet the National Fire Protection Association's (NFPA) Life Safety Code Standards. These standards provide minimum requirements for fire prevention such as fire doors, fire alarms and sprinkler systems.

In response to this problem, the Congress has appropriated \$11.9 million which is being used as follows:

- \$341,000 for the development of architectural and engineering plans to correct patient safety problems,
- \$6,992,000 to correct patient safety problems,
- \$2,900,000 for facilities design,
- \$1,452,000 to correct other deficiencies noted by JCAH, and
- \$175,000 to develop a master plan for the Hospital.

The Hospital is currently in the process of correcting some of the deficiencies noted by JCAH. Architectural and engineering contracts have been awarded to develop a comprehensive list of construction projects needed to bring the Hospital into compliance with life safety code requirements. The Hospital expects construction work to commence in September 1977 and be completed approximately 1 year later.

Hospital officials have indicated that the \$7.3 million allocated to correct patient safety problems may not be sufficient, but until the design contracts are completed in July 1977 no better assessment of additional costs can be made.

Another deficiency cited by JCAH was overcrowding. The accreditation review was conducted in September 1975 when the inpatient population was 2,571. Since then, overcrowding has apparently been alleviated. The Hospital has identified acceptable bed capacity for 2,211 patients. As of December 31, 1976, there were 2,200 inpatients at the Hospital.

There is much uncertainty relative to the number of beds needed at the Hospital. In 1976 Congress required HEW to develop a master plan for the Hospital. The plan which is now complete, provides the framework for the future development of the Hospital based on an estimated inpatient population between 1,500 and 2,700.

An official at NIMH stated that NIMH, St. Elizabeths, and D.C. officials had determined that 2,000 inpatient beds were required to meet the mental health needs of the District of Columbia. To meet this need 1,543 existing beds would be renovated and 457 new inpatient psychiatric beds would be constructed. The head of the District's mental health program stated that he knew very little of NIMH's plan but believed the new facility would be a nursing home.

Subsequent to our initial investigations we were informed that the required 2,000 bed requirement had been reduced to 1,800.

Information which we have analyzed to date and interviews with officials at the Hospital, NIMH and the District of Columbia indicate that the planned construction and renovation at St. Elizabeths is not based on a determination of what the Hospital's future role should be in a comprehensive mental health service system in the District. Likewise, the number of beds, other facilities, and programs needed to fulfill that role has not been determined. There appears to have been minimal participation by District officials in determining construction needs.

SERVICES PROVIDED BY THE HOSPITALS CLINICAL DIVISIONS

We surveyed the four clinical divisions which provide services to Areas A, B, C, and D. Although the clinical divisions function independently of one another, they provide many similar services and have many similar problems. There was considerable inconsistency in the type and amount of service provided for similar patients in different units and divisions. Some units were testing special treatment methods but without evaluation or communication with units using different methods. Communication across divisions appears to be lacking.

Our review of 53 records indicated that treatment planning and recordkeeping varied among and within divisions, but was generally adequate. A recent Medicare survey team has come to the same conclusion.

Discharge planning seemed weak. Some patients who had waited for 2 or 3 years for discharge had become disillusioned and had begun to deteriorate in their behavior. When initial attempts to place a patient failed, new attempts would not be made for months. Richardson Division's Help Older People Effectively program is the only one we identified which aggressively attempts to place nursing home candidates.

Relatively few staff are assigned to the large number of outpatients and little community follow-up is undertaken. Fifty percent of the patients placed on convalescent leave are readmitted to the Hospital as inpatients. Frequent reasons for return are: failure to take medication, problems with families, and alcoholism. Arrangements were rarely made with community agencies to provide psychological support, psychotherapy, rehabilitation or alcoholism treatment.

In response to JCAH criticisms, St. Elizabeths has increased personnel in nursing, social work, psychology, and therapy. Psychological services, however, are still not provided in some wards on a regular basis.

Division personnel have numerous administrative and management responsibilities yet few staff are trained to perform these duties. Little has been done to relate

patient needs to staff requirements. Some staff advised us that management is reactive and crisis oriented. All clinical staff spend much time attending meetings and thus away from patients. Some meetings are patient related but many others are general staff or committee meetings.

Because many patients require general nursing care, much time is devoted to medical, rather than psychiatric care. Also, nursing assistants are sometimes pulled from their regular wards to cover "short-staffed" units. This disrupts the normal ward activities, as staff are not then available to work with patient groups or escort patients to clinics and special programs.

ADMINISTRATIVE AND MANAGEMENT PROBLEMS

St. Elizabeths Hospital does not have a management system that adequately integrates the complex management areas of budget, planning, evaluation and personnel. Decisionmaking, at all levels, is hampered by the lack of adequate planning and information gathering and reporting systems, and by the extensive use of committees which often impedes decisionmaking by bypassing staff with functional responsibilities.

The management philosophy at the Hospital is one of decentralization. The intent is to give division directors control over their resources (staff, supplies, training budget). In actuality it has given the divisions added administrative responsibilities, but little control over major resources

such as staff ceilings, promotions, and funds received for supplies or training. The Hospital's administrative staff has increased 79 percent in the last 10 years from 322 to 576. At the same time, the number of inpatients has decreased several thousand. Direct patient care staff rose 11.3 percent from 1,973 to 2,196.

The budget and personnel processes do not appear to be well coordinated. As a result, control over personnel costs, which comprise about 85 percent of the Hospital's budget, appears to be lacking.

The Hospital does little in the way of internal evaluation, and HEW has not conducted any comprehensive reviews. Several divisions now have a program analyst position. However, staff assigned to these positions perform analysis functions only part-time or not at all.

Deficiencies were found in virtually every facet of Hospital administration activities reviewed. Following is a description of some of the more significant deficiencies noted.

Financial and Budget

--There is no uniform system for capturing costs.

The cost accounting bases that are utilized do not appear to be accurate nor are they the ones commonly accepted by the American Hospital Association.

- There are three systems for recording the cost of maintenance, labor and materials. None of these systems allows a complete collection of the costs of performing a particular job or work order.
- Fixed assets are not being properly capitalized.
- In September 1975 the Social Security Administration recommended that patient funds deposited with the superintendent receive interest. As of the time of our review this had not been done and we estimate that patients lost more than \$200,000 in interest on their funds from September 1975 to date.

Engineering

- There are three different material requisition systems in the Engineering Department. One is the "honor system" which allows an employee to remove items from stock without recording them.
- There is no adequate priority system for accomplishing Hospital maintenance. The priority is left to the craft foreman.

--The design, review and control of work contracted to private industry is monitored by the head of each section. This has resulted in poor coordination and increased costs on large jobs run by HEW and the General Services Administration.

--There is no adequate preventive maintenance system. The Hospital requested that a consultant develop a system but NIMH denied the request.

Property Control

--HEW regulations require an annual inventory of all items over \$200 or easily pilferable. Since 1974 only one section's inventory had been reconciled with Hospital records.

No records exist for periods prior to 1974.

--The property section has no central stock locator system. Reliance is placed on the memory of the floor supervisor.

Procurement

--There are no written instructions on the procedures or controls required for blanket purchase agreements. This has resulted in the ordering of material from private sources when it was available from the General Services Administration.

--No adequate control exists to prevent unauthorized purchases when ordering under a Blanket Purchase Agreement.

--The Hospital does not ensure that only needed materials are purchased. There are 13 unused color TVs which have been in storage since 1973. The Hospital also purchased 138 small Cushmen trucks for approximately \$3,100 each. The number of miles that each vehicle was driven yearly ranged from 132 to 5,352 and averaged 1,300.

Administrative Services

--There is a key control procedure at the Hospital. However, the person in charge of monitoring compliance does not do so. A review of the divisions showed that keys were loosely controlled. Several divisional employees stated that some thefts were accomplished with Hospital keys since there was no sign of forced entry. This impression was confirmed by the Hospital's chief engineer and the locksmith.

Employee Housing

--We estimate that the current rents charged for 7 cottages on the Hospital grounds are \$13,600 per per year too low. Rental collections during the

last 27 months for all cottages rented totaled \$40,851.

Expenditures for repairs totaled at least \$53,173.

GAO COMMENTS ON THE ESTABLISHMENT
OF A GOVERNMENT CORPORATION TO
OPERATE SAINT ELIZABETHS

The Subcommittee is presently considering H. R. 3335 which would create a Government corporation to operate St. Elizabeths Hospital.

The General Accounting Office has consistently taken the position that the public interest is best served when Federal programs are operated by Government agencies rather than corporations. We believe that departures from this standard should be permitted only when an activity cannot be successfully operated in the public interest within that framework. Despite the deficiencies noted above, we are not convinced that successful operation of the hospital requires establishing a corporation.

If this bill were to be enacted

--Responsibility for providing comprehensive mental health services in the District of Columbia including the operation of the community mental health centers would still be split and therefore the development of an integrated mental health care system would not necessarily be achieved.

- Accountability to the Executive Branch and to the Congress would decrease.
- The corporation could not require the District of Columbia or NIMH to take action it considered necessary.
- Goals developed by the Corporation Board of Directors could possibly conflict with the goals of NIMH or the District.
- The Board would be given no authority to use appropriated funds other than for the operation of the Hospital. Funds would continue to be concentrated at St. Elizabeths Hospital.

We believe that as an alternative to H. R. 3335, the Subcommittee should consider requiring the organizations involved in the delivery of mental health care in the District of Columbia to jointly develop a coordinated plan for the provision of mental health services in the District. Organizations which should be involved are the District Government; the community mental health centers; private organizations such as the District of Columbia Mental Health Association; St. Elizabeths Hospital; NIMH; the cognizant HEW Regional Office; and HEW Headquarters. The Congress could require a report on the plan by a specified date. The Office of Management and Budget might be an appropriate agency to oversee such an effort.

We believe establishing a Board to operate St. Elizabeths for an interim period will only add an extra, perhaps confusing step to the process of establishing a coordinated District of Columbia mental health system.

If, however, the Subcommittee wishes to give favorable consideration to H. R. 3335, we believe that thought should be given to clarifying or revising the following provisions:

1. Section 2(b)1 which provides for the appointment of Board members does not contain any provision which would allow appointing officials to remove, for cause, any of the Board members. We believe such a provision should be added.

2. Section 2(d) would limit Board members to receive compensation for no more than 18 days a year. This may not be sufficient to carry out the Board's responsibilities, especially if it is to develop a comprehensive mental health plan as would be required by H.R. 3335.

3. Section 5(5) provides for the placement of patients in foster homes and other rehabilitation facilities. This should be clarified to define the District of Columbia Government's role.

4. Section 5(6) would provide for establishing an organizational entity separate from St. Elizabeths Hospital to be the governing body of the Area D Community Mental Health Center. Since the Federal Government, through appropriations to St. Elizabeths, now funds the cost of this center, a provision needs to be included for funding the new organization.

5. There is no provision in the bill for authorizing funds for the administrative support and other expenses of the Board. If the authorization for St. Elizabeths Hospital is intended to include salaries of the Board members, support staff, and other expenses of the Board, this should be specified.

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Mr. Chairman, this concludes my statement. We shall be happy to answer any questions that you or other members of the Subcommittee might have.