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BY THE COMPTROLLER GENERAL

Report To The Chairman Committee On District Of Columbia House Of Representatives

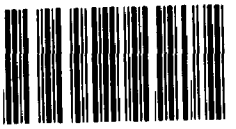
OF THE UNITED STATES

A Proposal For Transferring St. Elizabeths Hospital To The District Of Columbia

In response to the Chairman's request, GAO developed a plan for transferring St. Elizabeths to the District and integrating the hospital into a restructured mental health care system for District residents. The plan would shift the primary place of care from St. Elizabeths to community-based programs.

Under GAO's proposed system, three mental health service districts within the District's Mental Health Services Administration would provide community-based services and oversee needed inpatient care. General hospitals, rather than St. Elizabeths, would be used to provide acute (short-term) psychiatric inpatient care. St. Elizabeths would continue to provide long-term psychiatric care, as well as psychiatric care for patients referred by courts.

The proposed system would cost about $22 million less than St. Elizabeths and District-operated programs cost in fiscal year 1983. Because fewer patients would be treated at St. Elizabeths, it would need fewer staff and resources for mental health care programs.



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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D C. 20548

B-213732

The Honorable Ronald V. Dellums
Chairman, Committee on District
of Columbia
House of Representatives

Dear Mr. Chairman:

This report discusses our proposal for transferring St. Elizabeths Hospital to the District of Columbia. As you requested, the report characterizes the type of mental health services needed by District residents and proposes a system to meet those needs. This report also discusses the size of various system components, the staff required, land and buildings needed, and operating cost estimates.

Comments from the Department of Health and Human Services, the Mayor, and other interested parties are included as appendixes.

We are enclosing additional copies of the report for other members of the Committee. Unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,

Charles A. Bowsher

Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT
TO THE CHAIRMAN OF THE COMMITTEE
ON DISTRICT OF COLUMBIA
HOUSE OF REPRESENTATIVES

A PROPOSAL FOR TRANSFERRING ST. ELIZABETHS HOSPITAL TO THE DISTRICT OF COLUMBIA

D I G E S T

The future of St. Elizabeths Hospital has been debated for years. The Department of Health and Human Services (HHS), which pays most of the hospital's costs, wants to discontinue operating a mental health care facility that almost exclusively serves District of Columbia residents. HHS' fiscal year 1983 and 1984 budget proposals have provided for a phaseout of federal financial support for St. Elizabeths. The District, on the other hand, is reluctant to assume management and financial responsibility for St. Elizabeths without a comprehensive plan that addresses the hospital's patient population, operating costs, and physical plant.

The Chairman, House Committee on District of Columbia, requested GAO to determine how St. Elizabeths could be transferred to the District and integrated into its mental health care system. GAO was not asked to evaluate whether the current system needed change or whether transfer was the most appropriate solution to the cost and governance questions. Rather, GAO was requested to propose a method for transferring St. Elizabeths to the District whereby the District would assume both operating and financial responsibility for the hospital.

District residents currently can receive mental health services either from inpatient and outpatient programs operated by St. Elizabeths or from outpatient programs at District-operated community mental health centers. As of September 1982, about 1,700 inpatients and 2,300 outpatients were receiving treatment at St. Elizabeths. District-operated programs serve about 1,900 outpatients. These patient populations were about the same at the end of fiscal year 1983.

A PROPOSED MENTAL HEALTH SYSTEM FOR THE DISTRICT OF COLUMBIA

GAO is proposing a comprehensive mental health system for the District that would shift the primary place of care from St. Elizabeths to community-based programs and facilities as the clinically preferred treatment setting. The District's Mental Health Services Administration would have overall responsibility for administering the system. (See pp. 4 and 5.)

Under that Administration, three mental health districts, corresponding to the current mental health service areas, would have both budgetary and clinical responsibility for all care provided to patients living in their service areas. Each district would operate (1) a community mental health center to provide outpatient, day treatment, and case management services; (2) a crisis resolution unit specially trained to evaluate and treat patients experiencing a psychiatric crisis and to authorize hospitalization; and (3) mobile treatment teams to serve difficult-to-treat patients and attempt to keep them stabilized and functioning in the community. (See pp. 5 and 6.)

St. Elizabeths' role in the new system would be limited to providing long-term inpatient care: intensive and rehabilitative psychiatric care, intensive and rehabilitative psychiatric nursing care, and forensic[1] psychiatric care. (See pp. 6 and 8.) This would be achieved by:

--Outplacing about 300 St. Elizabeths inpatients to community treatment settings more appropriate to their needs.

--Transferring about 100 inpatients from hospital alcohol and drug abuse programs to community or institutional programs administered by the District's Alcohol and Drug Abuse Services Administration.

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[1]Individuals sent to St. Elizabeths by the court system for psychiatric evaluation and/or treatment.

--Shifting acute (short-term) psychiatric care (about 200 to 250 patients) to one or more general hospitals because federal regulations limit Medicaid reimbursements to patients under 22 and over 64 when care is provided by institutions for mental disease like St. Elizabeths. District general hospitals do not currently have enough excess capacity on psychiatric wards to accommodate these patients, so conversion of beds to psychiatric use would be required.

When these steps are completed, St. Elizabeths' inpatient population would be reduced from 1,700 to about 1,000.

COMPARISON OF CURRENT SYSTEM WITH PROPOSED SYSTEM

The chart on the following page compares the fiscal year 1983 system for providing mental health services--including programs and services offered, patients served, costs, and direct patient care staffing--with GAO's proposed system. The fiscal year 1984 mental health system could be different because of budget cutbacks at St. Elizabeths and planned reductions in patients, staff, and costs. Because most of these changes have not been implemented, GAO's proposal uses fiscal year 1983 information as the current baseline.

COST OF PROPOSED SYSTEM

The proposed system would cost about $22 million less annually than the fiscal year 1983 system cost of about $144 million. The District would pay almost double its current payment of about $37 million, while the federal government's contribution (through Medicare and Medicaid payments and payments for care provided to federal beneficiaries) would be about 38 percent of its 1983 expenditure of about $105 million. These cost savings are based on the assumption that D.C. General Hospital would provide all acute psychiatric care. Costs of about $7.4 million would be incurred as a result of outplacing patients to community facilities and transferring substance abuse patients to District-operated programs. (See pp. 15 and 16.)

Comparison of the Current District Mental Health System With GAO's Proposed System

	Current	Proposed
I. Programs/services:	Responsibility/location	Responsibility/location
Hospital inpatient:		
Acute psychiatric	Federal/St. Elizabeths	District/General hospital(s)
Long-term	Federal/St. Elizabeths	District/St. Elizabeths
Forensic	Federal/St. Elizabeths District/D.C. General	District/St. Elizabeths
Mental Health Program for the Deaf	Federal/St. Elizabeths	District[a]/St. Elizabeths
Outpatient	District/North Center South Center Federal/St. Elizabeths: Area D Center Other clinics	District/ Mental Health District #I[b] Mental Health District #II[b] Mental Health District #III[b]
Crisis intervention	District/centralized crisis resolution unit	District/crisis resolution units in each mental health district
Research	Federal/St. Elizabeths	Federal/St. Elizabeths
Training	Federal/St. Elizabeths	District[a]/St. Elizabeths
II. Patients:	Provider/number	Provider/number
Inpatient	St. Elizabeths/ 1,700	St. Elizabeths/ 1,000 General Hospitals/ 200
Outpatient	St. Elizabeths/ 2,300 District centers/1,900	District centers/4,600
Total	5,900	5,800[c]
III. Costs (fiscal year 1983):	(in millions)	(in millions)
District of Columbia	$ 37.0	$ 76.8
Federal	104.6	40.2[d]
Other payors	2.6	4.9
Total	$144.2	$121.9[e]
IV. Direct patient care staffing:	(No. of full-time equivalent employees)	
Inpatient	2,006	1,088
Outpatient	286[f]	315
Total	2,292	1,403

[a]District would operate if federal funds were provided.

[b]See page 7 for map of Mental Health Districts.

[c]Does not include about 100 substance abuse patients who would be treated in other District programs.

[d]Includes costs of federal beneficiaries, Medicare costs, and the federal share of Medicaid.

[e]Includes costs of $7.4 million ($5.4 District, $1.8 federal, and $0.2 other) incurred as a result of patient outplacement to community facilities and transfer of patients to other District programs.

[f]Includes both District and St. Elizabeths outpatient staff.

At least 1,400 of the 2,300 current patient care staff would continue under the proposed mental health system. An additional 330 patient care positions would be retained if a District-run facility such as D.C. General were used for acute psychiatric care. (See p. 12.) Another 250 research and training positions would be contingent on continued federal funding.

About 80 percent of the cost reduction relates to the outplacement of current St. Elizabeths inpatients to community facilities and the transfer of substance abuse inpatients to less costly District-operated programs. The remaining savings result from the reduced staff needed to operate the proposed system. Moving acute care to general hospitals would not result in any total cost savings but could reduce costs to the District by enabling more Medicaid reimbursements. (See p. 30.) GAO's cost estimates do not consider other economic impacts of the transfer, such as unemployment costs.

IMPLEMENTATION

GAO proposes that the new system be implemented over a 2-year period beginning on October 1, 1985, during which the District would outplace or transfer St. Elizabeths' inpatients who could appropriately be treated elsewhere and begin providing acute mental health care in one or more general hospitals. (See p. 17.)

How to select those employees to operate the reduced programs at St. Elizabeths is a difficult issue. Factors needing to be considered include employee rights and the need to staff the system with the best qualified employees available. GAO believes that the Congress is the appropriate body to balance the various interests of the groups involved. (See pp. 18 and 19.)

GAO also proposes that the federal government provide the District funding subsidies during the 2-year period to cover the increased costs that the District would incur in operating the system. GAO estimates that the subsidy would be about $40 million a year. Federal subsidies beyond the 2-year period, if any, would be determined annually when the District's federal appropriation is considered. (See p. 19.)

Finally, GAO proposes that a commission be established to monitor the transfer and report implementation progress and problems to the Congress and the District.

In developing its proposal, GAO was careful to consider the accreditation of St. Elizabeths and the objectives of the Dixon Consent Decree. The Decree, which resulted from a 1975 court order, provided for St. Elizabeths, HHS, and the District to transfer outpatients to the District's community mental health centers and to outplace St. Elizabeths patients who could be treated in community facilities.

COMMENTS OF HHS, THE DISTRICT, AND OTHER GROUPS

Ten local and national organizations in addition to HHS and the District commented on GAO's draft report. (These comments are discussed in detail in ch. 4; copies of the comments are contained in apps. VI through XVII.) The comments deal with virtually every aspect of the proposal and represent a variety of views and perspectives that will no doubt be brought to bear as the future of St. Elizabeths is debated and resolved. However, none of the arguments advanced persuaded GAO to significantly alter its proposal.

All commentors expressed the desire to have a mental health care system in the District capable of providing quality mental health services, although there was a wide divergence of opinion as to whether that was best achieved by maintaining the status quo, transferring the hospital to the District, or putting the hospital under the control of a nonprofit corporation.

HHS endorses the transfer of St. Elizabeths to local control but believes a private nonprofit corporation should be established to administer the system. The District wants to develop its own mental health services rather than accept a system designed by the federal government.

Some commentors said GAO's study was too narrowly focused and should have considered whether St. Elizabeths should be transferred, not just how. Two said that other governance options should have been studied. GAO studied how to transfer the hospital at the direction of the Committee. Although other governance structures were not considered, GAO's work was broad enough to consider the merits of various service delivery and financing mechanisms. (See pp. 38 and 39.)

Several commentors endorsed GAO's proposed service delivery system, but psychiatric groups expressed concerns about the shift to community-based services. In this regard, GAO was guided to a great extent by the Dixon Consent Decree, which requires mental health services to be provided in the community to the extent possible. (See pp. 39 to 41.)

Two commentors said that GAO's proposal did not adequately address patient needs. Yet the methods GAO used for determining patient needs were endorsed by the parties to the Decree. (See pp. 41 and 42.)

One commentor said GAO should have based its inpatient program staffing estimates on programs currently operating at St. Elizabeths. Initially GAO attempted to use St. Elizabeths programs but found them not useful for estimating needed staffing levels because they varied among hospital divisions and among wards within divisions. (See pp. 42 and 43.)

Both HHS and the District said, and GAO agrees, that further study is needed of possible uses of St. Elizabeths resources.

Professional organizations said GAO overemphasized cost and failed to adequately consider quality of patient care. GAO's staffing estimates were based on the levels needed for accreditation. This, of course, does not guarantee quality services, but it does imply that quality services are achievable. The District questioned several of GAO's cost estimates and said GAO's savings estimates were overstated. GAO, however, continues to believe that its cost estimates are realistic and accurate because the estimates are based on patient needs and the staff necessary to accommodate those needs. (See pp. 44 to 46.)

Several commentors expressed concerns about GAO's proposed process for implementing the new system. The District was particularly concerned about the level and extent of federal funding, the 2-year transition period, and the October 1, 1985, date proposed for the District to assume system responsibility. The District proposes a 6-year transition period providing incremental assumption of system responsibility and continuance of federal funding support at the current level.

GAO continues to believe that the suggested time frames are reasonable and would allow for effective system implementation in a timely manner and that the level of federal support should be determined during consideration of the District's appropriation. GAO also believes that the exact length of the transition period as well as the date on which the District should assume responsibility are matters that should be the subject of discussion and negotiation, leading ultimately to a congressional judgment. In GAO's opinion, the process and time frames it suggests could provide a useful basis for discussion during the ensuing congressional deliberations. (See pp. 46 to 48.)

Contents

ABBREVIATIONS

AFSCME	American Federation of State, County, and Municipal Employees
CMHC	community mental health center
CRF	community residential facility
GAO	General Accounting Office
HHS	Department of Health and Human Services
WPS	Washington Psychiatric Society

CHAPTER 1

INTRODUCTION

District of Columbia residents needing public mental health services can receive assistance from two sources--federally supported St. Elizabeths Hospital or the District-operated mental health care system. This two-provider system creates duplication of some services; is more costly per capita than any state's mental health care system, according to National Institute of Mental Health data; and places the federal government in the unique role of both funding and operating a psychiatric facility primarily for District residents.

BACKGROUND

St. Elizabeths was established in 1855 as a federal institution for mental illness serving District residents and members of the Army and Navy. Almost 130 years later, the hospital continues to be the main provider of mental health services in the District, offering both inpatient and outpatient services and running national research and training programs, at a cost of about $132 million in fiscal year 1983. As of September 30, 1983, St. Elizabeths was providing care to about 1,700 inpatients and 2,300 outpatients.

The District, by comparison, runs a relatively small mental health program--its $12 million fiscal year 1983 budget supported the activities of (1) two community mental health centers (CMHCs) offering outpatient and day treatment services, (2) a crisis resolution unit offering 24-hour telephone and consultative services for the mentally ill who are in crisis, (3) programs for certain forensic[1] patients, and (4) programs providing resocialization and other patient support services operated by community-based contractors. About 1,900 outpatients were actively receiving treatment through the District-operated programs in fiscal year 1983. Patients needing hospitalization are referred to St. Elizabeths.

The District's payment for St. Elizabeths' services has traditionally been capped in the federal appropriation to the District. In fiscal year 1983, the District paid to St. Elizabeths $24.7 million, or about 20 percent of the hospital's costs to care for District residents.

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[1]Individuals sent to St. Elizabeths by the court system for psychiatric evaluation and/or treatment.

Over the last 20 years several attempts have been made to deal with the future of St. Elizabeths, particularly the questions of who should run the hospital and who should pay for its operation. The most recent such attempt is the U.S. Department of Health and Human Services' (HHS') proposal to establish either a public or private corporation to oversee St. Elizabeths and the District's mental health and substance abuse programs. HHS has developed a 10-year plan to gradually reduce federal funding of St. Elizabeths. HHS' rationale for change is that St. Elizabeths is the only federal psychiatric hospital for the general public and that providing direct mental health services is an inappropriate federal role.

The District, however, has been reluctant to assume responsibility for the hospital. The Mayor has taken the position that the hospital's appropriate size and function should be considered before its governing structure is changed.

In addition to the political and financial pressures to change the configuration of District mental health services, there has also been a legal issue. In 1975, the U.S. district court ordered (Civil Action 74-285) the federal government and the District to develop a comprehensive system to treat mentally ill patients in the least restrictive setting. Through the resulting Dixon Consent Decree, HHS and the District agreed to the transfer of many St. Elizabeths outpatients to District-run programs and to place St. Elizabeths inpatients in nursing homes or boarding homes (called community residential facilities--CRFs) when appropriate.

As a result of a budget cut for fiscal year 1984, St. Elizabeths reduced its staff by about 400 positions in December 1983. The District and St. Elizabeths also agreed to reduce the inpatient population by about 300 as a result of the budget shortfall, but this action was not to be completed until April 1, 1984.

OBJECTIVES, SCOPE, AND METHODOLOGY

In June 1982, the Chairman of the House Committee on District of Columbia requested us to (1) determine how St. Elizabeths could be transferred to the District and (2) develop a plan to integrate the hospital into the District's mental health system.

Our charge from the Committee had some specific parameters. We were asked not to evaluate whether the current system needed change or whether transfer was the most appropriate solution to the cost and governance questions. Rather, we were to assume that the District would have both operational and financial

jurisdiction over St. Elizabeths. We sought to develop a system that would (1) include incentives to provide necessary mental health services in the least restrictive setting, (2) be organized in a manner to minimize the total cost of its operation and the cost to the District consistent with quality care, and (3) use the existing physical plant and staff as much as possible.

The Chairman specifically asked us to determine

--the number of patients needing services,

--the number of staff needed to operate the facilities,

--the land and buildings needed and other uses for unneeded facilities,

--the need for community services, and

--the ways of handling national research and training programs now ongoing at St. Elizabeths.

As a result, our study considered changes that, for either patient treatment or cost reasons, would improve the system. During our study, we met with many individuals, organizations, and agencies to obtain expert reactions to our proposal.

Although our proposal assumes the direct transfer of St. Elizabeths to the District, we believe that it is applicable to any governing structure since it establishes a framework for providing mental health services efficiently and effectively.

The methodology used in determining the number of St. Elizabeths' patients outplaceable to community facilities as well as the number who could be served in acute, specialty, and long-term psychiatric treatment settings can be found in appendix I. Methodologies for estimating (a) the staff needed for programs to continue at St. Elizabeths, (b) the staff needed for community-based programs, and (c) costs and cost sharing are provided in appendixes II, III, and IV, respectively. Appendix V lists the groups and individuals briefed on our proposal during the study. Appendixes VI through XVII contain the formal comments on our proposal from HHS, the District, and other interested organizations. Because most of the actions planned as a result of St. Elizabeths' fiscal year 1984 budget reduction had not been taken, we used fiscal year 1983 data as the current baseline.

CHAPTER 2

A PROPOSAL FOR A NEW MENTAL HEALTH CARE SYSTEM FOR THE DISTRICT OF COLUMBIA

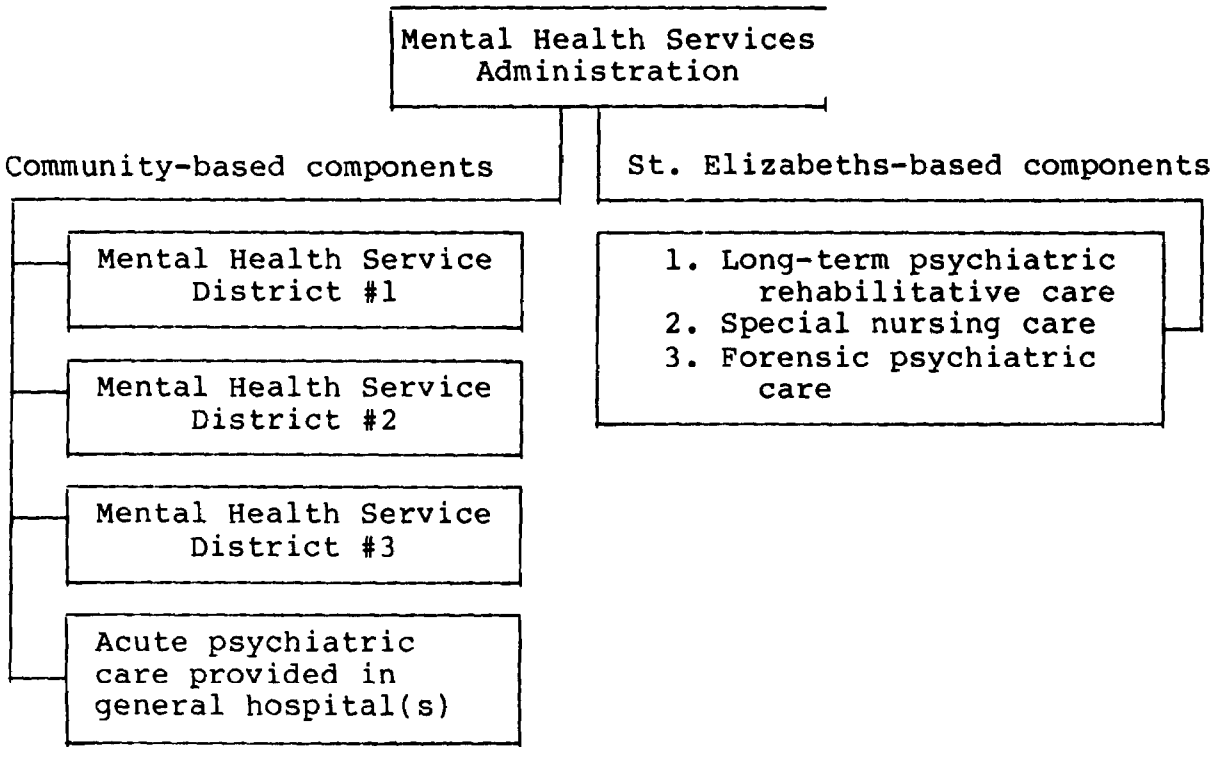
We are proposing a comprehensive mental health care system for the District of Columbia that would shift the primary place of care from St. Elizabeths to community-based programs and facilities. St. Elizabeths' role in the proposed system would be limited to providing long-term intensive and rehabilitative psychiatric care, intensive and rehabilitative psychiatric nursing care, and forensic psychiatric care. Fewer staff and facilities would be needed to operate the proposed system, and it would cost about $22 million less than the $144 million spent to operate St. Elizabeths and the District's system in fiscal year 1983.

PROPOSED MENTAL HEALTH SYSTEM FOR THE DISTRICT OF COLUMBIA

The proposed mental health system for the District would provide quality community-based services to meet the needs of District residents. The District's Mental Health Services Administration would have overall responsibility for administering the system. The system's major components would be

- --three mental health districts offering community-based services, outreach services, and crisis resolution services;
- --psychiatric wards of general hospitals for treatment of acute psychiatric patients; and
- --St. Elizabeths Hospital for longer term inpatient care.

The following diagram shows the organization of our proposed system.



Community-based programs

The mental health districts would have responsibility for patient treatment and financing. They would provide some services directly and contract for others, as is the practice now, while generally overseeing the patient's care. Each district would be allocated a budget to provide care for patients within its geographic boundaries, including inpatient services delivered to its patients by either general hospitals or St. Elizabeths.

Generally every patient in the system would be on the rolls of one of the three mental health districts. If a patient is referred for inpatient care, the referring district would be responsible for monitoring and budgeting for that care. The district would also be responsible for planning patients' return to the community.

The difficult-to-treat patients would be the responsibility of special mobile community treatment teams attached to each mental health district--three-person teams offering services

7 days a week, 2 shifts a day, for about 125 patients. Through outreach services the teams would attempt to keep patients stabilized and functioning in the community.

The mental health districts would also offer crisis resolution services. We propose that each district have a team specially trained to evaluate and treat patients experiencing a psychiatric crisis. Hospitalization would be a last resort, used only after the crisis unit is unable to stabilize a patient and only with the unit's authorization. One district would offer these services (including telephone counseling) 24 hours a day, 7 days a week; the other two districts would operate two shifts a day, 7 days a week, turning over their caseloads to the citywide district during the night shift.

Under our proposal, patients who require acute psychiatric hospitalization would be treated in general hospitals rather than at St. Elizabeths. Although general hospitals' psychiatric wards currently have insufficient capacity to accommodate 200 adult and 30 children acute psychiatric patients, sufficient capacity could be provided by (1) renovating space for psychiatric use at D.C. General Hospital or (2) converting medical, surgical beds in other general hospitals to psychiatric use.

The map on the following page shows the geographic split of the District of Columbia into the three current districts and their respective outpatient populations. The current CMHCs are marked, as are general hospitals.

St. Elizabeths-based programs

At St. Elizabeths, four general adult inpatient psychiatric programs[1] would be available--rehabilitative psychiatric care, rehabilitative nursing care, intensive psychiatric care, and intensive psychiatric nursing care. In addition, special programs would be offered for forensic patients and deaf patients.

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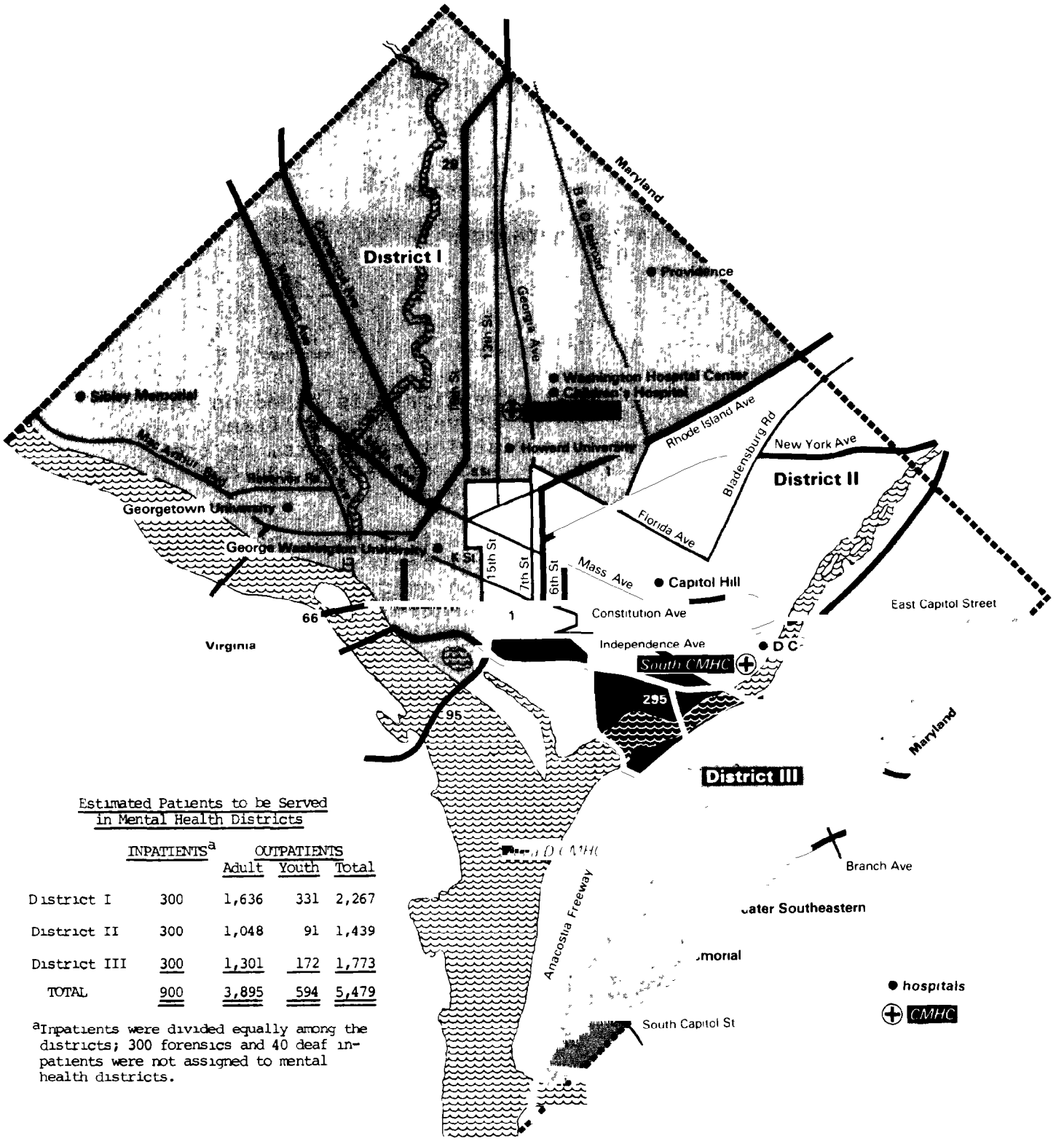
[1]For a description of the functioning characteristics of patients in these various programs, see appendix I.

DISTRICT HOSPITALS AND COMMUNITY MENTAL HEALTH CENTERS



Estimated Patients to be Served in Mental Health Districts

	INPATIENTS[a]	OUTPATIENTS		
		Adult	Youth	Total
District I	300	1,636	331	2,267
District II	300	1,048	91	1,439
District III	300	1,301	172	1,773
TOTAL	900	3,895	594	5,479

[a]Inpatients were divided equally among the districts; 300 forensics and 40 deaf inpatients were not assigned to mental health districts.

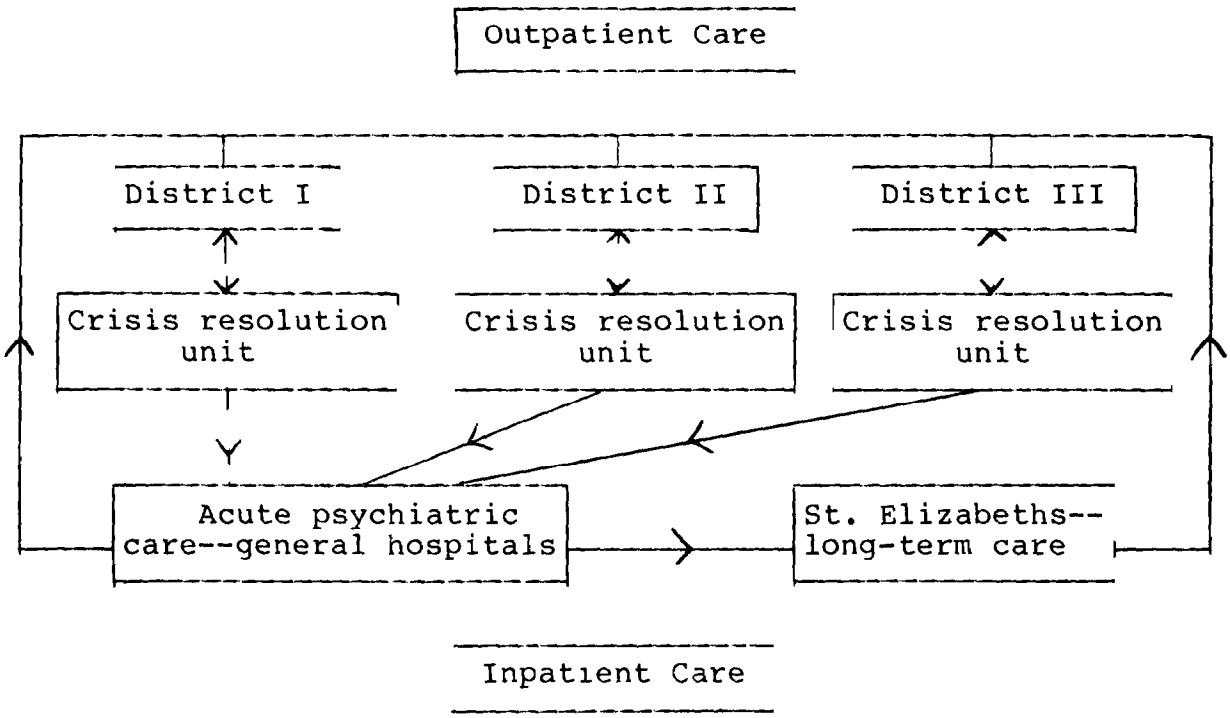
We estimate that the inpatient population would average about 1,010 patients, as shown below.

	Number of patients
Programs:	
Rehabilitative psychiatric	160
Rehabilitative psychiatric nursing	230
Intensive psychiatric	140
Intensive psychiatric nursing	140
Deaf[a]	40
Forensic	300
Total	1,010

[a]The deaf program patient population estimate is based on the continuance of this program, which serves patients from throughout the nation as well as District residents, by the federal government. A smaller patient population would be treated under a District-supported program.

Except for forensic and deaf patients, all of these patients would also be on the rolls of the mental health districts. Because the courts maintain jurisdiction over patient treatment of forensic cases, the clinical and financing responsibility could be maintained by the forensic psychiatry program. The deaf program would maintain its own patient rolls.

The following chart shows anticipated patient flow in the proposed system.



Comparison of proposal with current system

The system differs from the current one in two significant respects. First, St. Elizabeths' programs would be greatly reduced by

--transferring all outpatients to District-operated programs and 300 inpatients to nursing homes or CRFs,

--transferring 100 substance abuse inpatients to programs operated by the District's Alcohol and Drug Abuse Services Administration, and

--eliminating acute psychiatric care programs at St. Elizabeths and establishing them at general hospitals.

As a result, St. Elizabeths' inpatient census would be reduced from about 1,700 to about 1,000. Programs to remain at St. Elizabeths would be aimed at patients who have not responded to acute hospitalization. Specialty programs for forensic patients would continue at St. Elizabeths. The continuation of current research and training programs and a special program for deaf

patients would depend on the availability of federal funding. The District could assume operation of training programs and the deaf program if federal funds were continued, but research programs would continue to be federally operated with support services provided by the District.

Second, the community-based components would be significantly expanded by

--increasing the number of patients treated by the CMHCs,

--consolidating the financial responsibility for patient care under the three mental health districts, and

--decentralizing the crisis resolution units to give each mental health district the capability to screen its patients before hospitalization.

Unlike the current CMHCs, the mental health districts would become the system's focal point for treatment and payment. They would have more staff and greater authority under our proposal.

Our proposal focuses treatment in the community rather than at St. Elizabeths because this is the clinically preferred treatment option accepted by parties to the Dixon Consent Decree and mental health professionals generally.

Further, we propose integrating the clinical and financial responsibility for patients in the mental health districts to establish a system that promotes the appropriate treatment of patients in a cost-conscious manner. If the mental health districts authorize all patient care and pay for that care from their budgets, they are better able to shift patients away from hospital settings by providing quality community-based services. Giving the mental health districts clinical and financial control over patient decisions should provide incentives to deliver high quality community-based services and limit the use of more costly hospitalization.

We are proposing changes to reduce costs--either total system costs or costs to the District. Because the District could collect Medicaid reimbursements for patients who are over 21 or under 65 years of age, we propose that acute psychiatric care be moved to general hospitals. Federal regulations prohibit payment for these patients when they are treated in an institution for mental disease, such as St. Elizabeths. To consolidate other programs we are proposing that

--substance abuse patients be transferred to the District's Alcohol and Drug Abuse Services Administration and

--District forensic programs be moved to St. Elizabeths.

Finally, to prevent unnecessary disruption to patients, many parts of the system were not altered. We propose that the mental health districts correspond to the current health service areas. Also community organizations would still be relied on to provide supplementary patient resocialization and other support services through contracts with the Mental Health Services Administration.

STAFF NEEDED TO OPERATE THE PROPOSED SYSTEM

Outplacing 300 patients to community facilities, transferring substance abuse patients to District-operated programs, and moving acute care to general hospitals would result in a decrease of 918 ward-based staff at St. Elizabeths and an increase of 29 staff over the number presently providing outpatient services at District centers and St. Elizabeths for community programs. About another 250 employees would lose their research and training positions if federal funding is discontinued.

There are no nationally agreed-upon staffing standards for inpatient or outpatient mental health programs. Our inpatient program staffing estimates were derived from a simulation developed by the Ohio Department of Mental Health which indicates staffing levels needed to obtain accreditation from the Joint Commission on Accreditation of Hospitals. Our methodology for developing the inpatient staffing estimates can be found in appendix II. Staffing estimates for community-based programs were developed from the Outpatient Needs Assessment Survey and service standards agreed to by the parties to the Dixon Consent Decree. This methodology is described in appendix III.

We did not estimate how many administrative and support staff were needed for either inpatient or community-based programs because acceptable staffing standards for these activities are not available. Also, St. Elizabeths was reviewing several support functions pursuant to Office of Management and Budget Circular A-76 to determine if services could be obtained at a lower cost through contracts.

The following table summarizes the patient care staff we estimate would be needed for the proposed District mental health care system.

Estimated Patient Care Staff Needed to Operate Inpatient and Community-Based Programs

Program	Location	Medical officers	Psychologists	Social workers	Nursing staff	Therapists	Ward administrative staff	Total staff
Long-term psychiatric and special nursing programs	St. Elizabeths	15.5	11.9	29.0	591.9	52.1	22	722.4
Specialty programs:	St. Elizabeths							
Forensic		7.1	8.5	10.3	263.5	23.4	12	324.8
Deaf		1.0	1.0	2.2	31.8	2.1	2	40.1
Acute program: Children & adults	D.C. General[a]	37.1	12.8	27.1	220.8	14.1	18	330.0
Community-based programs	District I	20.4	11.9	24.8	51.3	20.6	-	129.0
	District II	8.9	2.0	11.4	38.7	10.8	-	71.8
	District III	12.3	4.7	14.3	34.2	5.9	-	71.4
	Crisis resolution units	2.0	11.9	11.9	17.0	-	-	42.8
Total		103.4	64.7	131.1	1,242.2	129.0	54	1,732.3

[a]Acute staffing estimates assume that all care will be centralized in one location, such as D.C. General Hospital.

In fiscal year 1983, St. Elizabeths employed about 2,450 patient care staff--2,000 for inpatient care, 250 in research and training, 140 in outpatient activities, and 60 in medical support functions. Under our proposal, about half of these employees would continue at St. Elizabeths. The following table summarizes fiscal year 1983 St. Elizabeths inpatient staff and projected staff needed if the inpatient population is reduced to about 1,000.

	St. Elizabeths fiscal year 1983	Projected need	Difference
Medical officers	119	24	(95)
Psychologists	47	21	(26)
Social workers	91	42	(49)
Nurses	1,470	887	(583)
Therapists	188	78	(110)
Administrative and clerical	91	36	(55)
Total	2,006	1,088	(918)

Some of the 918 staff who will not be needed at St. Elizabeths may be employed in other components of the mental health system. About 330 staff would be needed to operate acute psychiatric care programs if they are centralized in D.C. General Hospital. However, these programs may not be under the direct operation of the District government if hospitals other than D.C. General are used to meet the acute psychiatric care demand. In addition to the District and St. Elizabeths outpatient staff employed in fiscal year 1983, another 29 staff would be needed to provide outpatient services. The following table shows the fiscal year 1983 outpatient staff (including St. Elizabeths components) and the projected need.

Discipline	St. Elizabeths and District total	Projected need	Difference
Medical officers	46	44	(2)
Psychologists	19	31	12
Social workers	59	62	3
Nurses	131	141	10
Therapists	31	37	6
Total	286	315	29

FACILITIES NEEDED FOR THE PROPOSED SYSTEM

Only a portion of St. Elizabeths' extensive land and buildings resources would be needed to accommodate the reduced inpatient population projected at the hospital. Outpatient services could be provided at the three current CMHC locations.

St. Elizabeths Hospital is situated on a 336-acre campus with about 100 buildings. All but a few buildings are used for inpatient and outpatient care as well as administrative and support services. With the inpatient population being reduced to about 1,000 patients and outpatients being transferred to the District CMHCs, all patient care functions could be accommodated in 11 buildings on the east side of the campus, as shown by the following schedule.

Service	Estimated number of patients	Buildings	Bed capacity	
Forensic psychiatry	285[a]	John Howard Pavilion	240	
		C.T.[b] #4	56	296
Rehabilitative psychiatric	455[c]	Dix Pavilion	60	
		C.T. #1,2	118	
Intensive psychiatric		C.T. #3,6,7,8	225	
Intensive psychiatric nursing		Eldridge	100	503
Rehabilitative psychiatric nursing	228	Dix Pavilion		240
Mental Health Program for the Deaf[d]	38	C.T. #5		45
W.A. White research[d]	30	C.T. #5,6		30
Total	1,036			1,114

[a]Includes 20 District forensic patients who would be treated at St. Elizabeths.

[b]C.T. refers to a complex of eight inpatient care buildings called the Continuous Treatment Complex.

[c]About 45 forensic psychiatry patients, including 15 juveniles, are being treated in nonforensic environments, and 9 nonforensic patients are treated in forensic programs.

[d]If the federal government continues this program.

Each of the above buildings has been or is being renovated to correct fire and life safety code deficiencies. These renovations are scheduled to be completed in 1986.

All administrative and support services could also be accommodated on the east side of the campus except for the power plant, laundry, and warehouse, which are located on the west side.

Forensic psychiatry services are now provided by both St. Elizabeths and the District; however, St. Elizabeths provides most such services. Although the District provides psychiatric evaluations for federal and District court cases as well as psychiatric services for D.C. Jail inmates, staff providing these services could be located at St. Elizabeths and provide services elsewhere when needed.

Each of the three CMHCs could continue to provide outpatient services at its present location and become the headquarters for its area's mental health district. The North Community Mental Health Center (District I) would continue operations at Spring Road, NW., with its satellite site at P Street, NW. The Area D Community Mental Health Center (District III), located on the west side of St. Elizabeths, could continue operation there serving the District's southeast quadrant. The South Community Mental Health Center (District II) is on the grounds of D.C. General Hospital. However, the building now housing the center is also the best candidate for an acute psychiatric facility if acute care is placed at D.C. General rather than having patients dispersed among other community hospitals. According to D.C. General officials, another building on its grounds could accommodate a CHMC activity.

COST OF THE PROPOSED SYSTEM

Comparing all estimated costs associated with the proposed system with the $144 million budgeted in fiscal year 1983 by the District and federal governments for public mental health services in the District, we estimate that the proposed system will cost about $22 million less annually. Estimated costs associated with operating the proposed system and other costs are shown in the table on the following page.

	Cost			
	District	Federal[a]	Other[b]	Total
	(millions)			
Mental Health System				
Administration	$ 1.00	$ -	$ -	$ 1.00
St. Elizabeths Hospital	43.80	14.02	2.94	60.75[c]
Acute psychiatric care:				
Adults[d]	9.64	7.94	.93	18.50[c]
Children & adolescents[e]	1.44	.76	.12	2.32
Community-based care	15.52	3.54	.72	19.78
Total	71.40	26.25[c]	4.71	102.35
Specialty Programs				
Mental health program for the deaf	-	2.33	-	2.33
Research	-	3.81	-	3.81
Training	-	6.02	-	6.02
Total	-	12.16	-	12.16
Other Program Costs[f]				
Income Maintenance & Long-Term Care Administration[g]	2.04	1.82	.15	4.01
Alcohol and Drug Abuse Services Administration[h]	3.40	-	-	3.40
Total	5.44	1.82	.15	7.41
Grand total	$76.84	$40.23	$4.86	$121.92[c]

[a]Includes federal share of Medicaid, Medicare, and cost of treating federal beneficiaries.

[b]Private insurers and private pay.

[c]Does not add due to rounding.

[d]Assumes that adult acute psychiatric care will be provided at D.C. General Hospital.

[e]Assumes that child and adolescent acute care will be provided at D.C. General Hospital or St. Elizabeths.

[f]Non-mental health system recurring costs that would be incurred as a result of implementation of the proposed system.

[g]Includes outplacement of 300 patients--200 to community residential facilities and 100 to nursing homes.

[h]Includes 100 patients transferred to District substance abuse programs.

Note: Cost sharing between the federal and District governments and other payors is based on the estimated number of patients who are eligible for Medicare and Medicaid, the number of current federal beneficiaries, and the estimated number of patients who have insurance or the ability to self-pay.

The District's contribution to the system would be double the amount paid in fiscal year 1983. The amount spent by the federal government would be about 38 percent of its fiscal year 1983 expenditure if the mental health program for the deaf and the research and training programs are continued. These costs do not include costs of employee separation, unemployment costs, or other economic effects associated with implementing the proposal.

The methodology used to estimate costs and cost sharing is explained in appendix IV.

HOW THE PROPOSED SYSTEM CAN BE IMPLEMENTED

For the proposed system to provide necessary mental health services cost effectively, the transition from the current system must be orderly and systematic. Four major implementation issues need to be resolved before the transfer:

--When should the District assume responsibility for operating the system?

--How would the transfer of staff from federal to District jurisdiction take place?

--How would the system be financed during the transition period?

--Would the entire St. Elizabeths' tract be transferred to the District or just those resources needed for mental health programs?

We attempted to obtain comments from officials of the District and federal governments and the American Federation of State, County, and Municipal Employees (AFSCME) on how the new system could be implemented, but District and union officials preferred to await our draft report before commenting. (See p. 46.) HHS personnel officials were generally receptive to our implementation plan, which is described below.

We propose that the District assume administrative responsibility for the system and its implementation at the beginning of a 2-year phase-in period. This would give the District maximum flexibility to manage the transition, be directly involved in system reorganization and consolidation, and evaluate and select the staff needed to operate the system.

Early in the 2-year period, the District would need to determine which community hospitals would provide acute psychiatric care so that these services can be terminated at St. Elizabeths. It would also need to outplace patients who could be cared for in community facilities and transfer all outpatients to CMHCs.

How to select and transfer employees from the federally run St. Elizabeths to a reduced District program is a difficult issue to resolve. Federal "transfer of function" regulations specify that when such a transfer contemplates a reduction-in-force, all employees would be transferred to the District before a reduction-in-force procedure. This process could, however, be altered by the transfer legislation.

A number of factors would need to be balanced in deciding whether to apply the current regulations or to specify special provisions. First is the issue of employee rights. The District and federal governments recognize virtually identical employment priorities for job retention during a reduction-in-force. However, the District requires its employees to be residents. About half of the St. Elizabeths staff do not meet the residency requirement, thereby complicating the employment priority question. Second, employment priority characteristics generally favor retention of the more senior, higher salaried employees. This may entail shifting administrative staff to patient care positions and could result in increased cost to the District because of regulations concerning severance pay and retention of pay for 2 years. These factors could increase the costs to the District above our projected levels and could reduce the system's overall quality during a critical period.

During meetings with many individuals and groups, we discussed a possible process for selecting the employees to staff the programs to continue at St. Elizabeths as a means of eliciting comments and suggestions in this important area. The District could be required to staff St. Elizabeths from the current pool of employees but not be restricted to which employees it could select by employee priority characteristics or residency. This would be a legislative decision that could allow the District some flexibility in determining which persons would become its employees and better enable St. Elizabeths to operate with qualified staff. On the other hand, this process would likely result in some employees not being retained who would be retained if reduction-in-force procedures were used. Reconciling these various interests is one of the most sensitive issues affecting the success of the transfer. We believe the Congress is the appropriate body to balance these considerations as part of the transfer legislation.

The salaries and benefits of employees selected by the District should change little. District employees participate in federal retirement, health insurance, and life insurance programs. Salaries, sick and annual leave accrual rates, and other employee benefits are virtually identical.

To implement this system effectively, we believe the District should assume operation of St. Elizabeths in a financially certain environment. As a result, we propose that the District not incur any additional financial burden for operating the system during the 2-year transition period. The funding needed would continue to be provided by the federal government. We estimate that the amount of the additional federal subsidy would be almost $40 million a year based on fiscal year 1983 costs. Because the proposed system is estimated to cost less, the federal government would still be paying about $24 million less than it paid in fiscal year 1983. After the 2-year transition period, the amount of the federal subsidy for St. Elizabeths, if any, would be determined annually by the Congress when the District's federal appropriation is considered.

Which buildings and grounds are transferred to the District would depend largely on the District's ability to identify effective uses of the resources not needed for mental health programs. Transferring the entire tract would shift to the District the expense of buildings and grounds maintenance, which it may be reluctant to assume. The District may choose to take only those resources needed to operate the mental health programs. In this case the federal government would continue responsibility for maintenance until other federal uses could be identified or the property is sold. Any sale would be governed by the restrictions of the historic designation of the St. Elizabeths tract (see p. 29).

Another compromise would be for the federal government to continue maintaining the entire tract and bill the District for services rendered relating to facilities it uses. A feature of this option is that the existing St. Elizabeths maintenance staff could continue as federal employees and the District would not need to assimilate these employees.

During the transition, the Congress and the public will want to know the status of the District's progress in assuming responsibility for providing public mental health services to its residents. We believe that a commission or panel should be established to regularly report to the Congress and the Mayor on the system implementation progress. While this group should not be directly involved in system implementation activities, it should remain close to the process to report progress and problems in the transition. It should also give the Congress an evaluation of the need for federal funding subsidies beyond the transition period.

CHAPTER 3

QUESTIONS AND ANSWERS

To aid the Chairman and other Members of Congress in considering our proposal, we are presenting the following questions, most of which were asked by persons we briefed on the proposal. The questions and our responses, organized by the major sections of chapter 2, provide more detailed information about various aspects of the proposal.

PROPOSED MENTAL HEALTH CARE SYSTEM

Q. Has this kind of system been tried elsewhere? Has it been successful?

A. Many aspects of the system are being used in other parts of the country. For example, Wisconsin's Dane County mental health program, considered by authorities to be a model program, uses many components that are proposed for the District's mental health care system. These include using community hospitals to provide acute psychiatric care, a mobile treatment team to work with the most difficult chronically mentally ill patients, and crisis intervention services to immediately assist persons in crisis and to provide hospital admission screening services to preclude inappropriate hospitalizations. Dane County also uses a budget system similar to the one proposed in which patient care costs are funded from the mental health budget regardless of where the care is provided. The medical director of the Dane County Mental Health Center believes that its budget system is crucial to establish incentives for treating patients in the community as much as possible and to operate an effective community-based treatment program.

Dane County's program, which serves a population of about 300,000, has been effective. According to information published by the program, over the last 5 years its crisis intervention program has averted about 75 percent of the potential hospital admissions. As a result, only 17 percent of the amount spent on public mental health services goes for inpatient care, and the remainder supports community-based services. The program's effectiveness is also demonstrated by its 25-percent hospital readmission rate, which is less than half the national average.

Q. How was the number of patients outplaceable to community facilities determined?

A. These estimates were based on a level-of-care survey St. Elizabeths uses to measure individual patient psychiatric and

medical needs. By determining a patient's physical, psychiatric, behavioral, and social functioning, the survey places him or her into 1 of 10 groups of treatment settings. The survey assessment is completed for all patients residing continuously at St. Elizabeths for more than 90 days and every 6 months thereafter as long as the patient continues to reside there. The survey is built on the assumption that measures of a patient's physical and mental health functioning can be used to estimate the kind or level of care he or she requires. The measures used in the survey are sensitive to the traits, behavior, and symptoms that bear most heavily upon the decision of what kind of care to provide.

St. Elizabeths uses the level-of-care survey to provide (1) an overall picture of the physical and mental health of the hospital's patients by depicting the mix of patients and (2) the basis for assessing current program capabilities and for planning services to better meet the needs of the present hospital patient population. As part of the Dixon Consent Decree, St. Elizabeths also uses the survey to monitor the appropriateness of inpatients' continued hospitalization. While the survey's results are not definitive as they relate to an individual patient's readiness for outplacement, the survey appears to be the best method available for estimating the group of patients whose physical and psychiatric characteristics make them most appropriate for attempted outplacement. The level-of-care survey is described in detail in appendix I.

Q. Who was briefed on the proposal and what were their comments?

A. Besides the staff of congressional committees, we met with officials of HHS, the District, and St. Elizabeths Hospital as well as interested individuals and groups affiliated with mental health programs and organizations throughout the District. A list of these contacts is included in appendix V.

Overall, the reaction to the proposal was favorable. Moving acute psychiatric care to general hospitals was endorsed by officials at St. Elizabeths and the Joint Commission on Accreditation of Hospitals and generally by District officials as a constructive change. Others involved in mental health questioned the general hospitals' ability and willingness to treat indigent psychiatric patients. One St. Elizabeths official was concerned that the hospital's character would change significantly if only the more chronic psychiatric patients were treated there. Another private psychiatrist thought this change would be detrimental to St. Elizabeths' training program, which focuses on the short-term acute stage of illness. There were no specific objections to the concept of the mental health districts.

For a detailed analysis of formal comments to a draft of this report, see chapter 4.

Q. What changes were made to the proposal to respond to experts' comments?

A. The proposal has evolved in a number of ways as a result of discussions with interested parties. First, we had initially believed that D.C. General Hospital would be the preferred setting for acute psychiatric care. District budget and policy officials persuaded us that other general hospitals may be able to treat indigent psychiatric patients by converting excess bed capacity. We verified that sufficient excess capacity does exist (see p. 26). Medical/surgical beds, however, would need to be converted to psychiatric use to meet the current demand. Accordingly, we developed cost information using both D.C. General Hospital and other general hospitals for acute psychiatric care (see p. 71) but did not specify which the District should choose.

Our second change was to set up crisis resolution units in each of the three CMHCs rather than have one centralized unit. This arrangement was most strongly supported by the Dixon Implementation Monitoring Committee. One committee member pointed out that by centralizing a crisis facility, the payment responsibility remains with the districts even though they are not directly controlling hospital admission decisions. We reconfigured our proposal to include one 24-hour, 7-day-a-week, crisis facility offering outreach and telephone counseling and two 16-hour, 7-day-a-week, crisis units at the other mental health districts.

Q. How consistent is the proposal with the Dixon Consent Decree and Final Implementation Plan?

A. Generally, they are compatible. The Dixon Implementation Monitoring Committee believes that to achieve the mandate of shifting the primary place of care from a hospital-based system to a community-based system, St. Elizabeths' and the District's mental health services must come under the same administrative structure. While the Committee does not specify that transfer is the preferable option, the proposal does consolidate the system under one authority.

In terms of specific planning for the number of patients needing services, we used the tools identified or developed as part of the Dixon Final Implementation Plan. The level-of-care survey was used to identify the number of patients who could be outplaced. While the parties to the Dixon Consent Decree agreed that patients in levels 1 through 7 could be treated in the community, our estimates used levels 1 through 4. We took a more conservative viewpoint because

--based on the level-of-care analysis, more than two-thirds of the level 5 patients had not had a successful outplacement attempt in over 2 years;

--the Superintendent of St. Elizabeths identified level 5 patients as very difficult to place in the community and thought plans to do so might be unrealistic;

--the data analysis process of a patient's level of care was modified by New York State, the developer of the survey, in a way that made more seriously disabled patients appear eligible for outplacement;

--New York State does not consider patients in levels 5 and above to be treatable in the community; and

--the special placement nursing facilities needed to treat patients in levels 6 and 7 are not currently available in the District.

The outpatient needs assessment survey and standards for providing outpatient services were also developed by St. Elizabeths and the District's Mental Health Services Administration as part of the Dixon plan. The outpatient needs survey and standards formed the basis for our estimates of staff needed by the CMHCs. (See app. III.)

We met several times with members of the Dixon Implementation Monitoring Committee and staff, and they have expressed no major exceptions to the service delivery system we propose.

Q. How was the fiscal year 1984 budget shortfall at St. Elizabeths resolved and does this affect the proposal?

A. St. Elizabeths expected a fiscal year 1984 operating budget of $143.5 million but requested only $62.7 million in appropriations. St. Elizabeths assumed that the District would contribute $68.7 million, including $16 million in federal Medicaid payments, and Medicare and other reimbursements would yield another $12.1 million. However, in its federal budget proposal, the District requested only $29.4 million for St. Elizabeths, resulting in a $25 million budget shortfall.

This budget shortfall was resolved through actions by the Congress, the District, and St. Elizabeths. The Congress appropriated an additional $5.7 million to the District for St. Elizabeths. The District agreed to accept (1) 89 St. Elizabeths substance abuse patients and (2) 200 St. Elizabeths inpatients

who can be treated in nursing homes and CRFs. This action, combined with savings resulting from administrative actions taken by St. Elizabeths, including a staffing reduction of about 400 employees, will result in a $19 million reduction in fiscal year 1984 services at St. Elizabeths and a $3.4 million increase in fiscal year 1984 services offered by the District.

These changes are consistent with the proposal we presented to District and HHS officials and others to (1) transfer substance abuse patients to District-operated programs and (2) outplace patients who do not need to be treated at St. Elizabeths.

Q. Are sufficient resources available in the community to accommodate the 300 outplaceable St. Elizabeths patients?

A. As of August 4, 1983, 382 beds in CRFs in the District were vacant, more than enough to house the estimated 200 St. Elizabeths patients who could reside in these facilities. Despite a current shortage of nursing home beds, by the end of 1984, about 900 new beds will be available in the District. The 100 patients outplaceable to nursing homes should be able to be accommodated by this increased capacity.

Q. How would special classes of patients--such as federal beneficiaries, nonresidents, and patients with no fixed address--receive treatment since they would not be part of any mental health district?

A. Federal beneficiaries could continue to be treated under this system under a contractual arrangement between the District and the federal government. Because there will be adequate space at St. Elizabeths and because of the traditional eligibility of these patients for treatment at the hospital, we estimate that about 100 civilian and 50 forensic patients sent by federal agencies would continue to be treated there.

Should the federal government choose not to continue using St. Elizabeths for patients sent by the Army, Navy, State Department, U.S. Courts, etc., contractual arrangements with other providers may be needed.

Nonresidents would continue to be treated under this system because the District is a member of the Interstate Compact on Mental Health. The Compact is a reciprocal agreement among states to treat nonresidents and noncitizens needing mental health services. There are also provisions for transferring patients to other states when it is beneficial to the patient. Consequently, the mechanisms to assure treatment of nonresidents are already in place.

For patients with no fixed address, an administrative arrangement would need to be set up to assign these patients to the most appropriate mental health district. Similar administrative arrangements would be needed for patients who moved from one area of the city to another.

Q. Would research and training programs and other St. Elizabeths specialty programs be continued?

A. Under the proposal the District would not be responsible for continuing mental health research and training programs. These programs represented $3.8 million and $6.0 million, respectively, of St. Elizabeths' fiscal year 1983 budget. Transfer of St. Elizabeths should not directly affect the programs. The research program could continue much as it has in the past under a contractual agreement with the District to provide necessary support services. A similar agreement exists between St. Elizabeths and the National Institute of Mental Health. Training programs could be affected somewhat by our proposal because many of the residents/students work in acute psychiatric care programs that would no longer operate at St. Elizabeths. However, we believe agreements could be made between the federal government, the District, and the general hospital or hospitals that would provide acute psychiatric care to continue the training programs.

The critical factor as to whether research and training programs would continue after the hospital's transfer to the District is the federal government's willingness to fund them. We asked a National Institute of Mental Health official about this and were told that continuing the research and training activities had not yet been considered.

The Mental Health Program for the Deaf offers both inpatient and outpatient services to District residents as well as patients from other parts of the country. Because the program serves more than District residents, the District is unlikely to continue the program on its current scale. We are proposing that the National Institute of Mental Health fund this program as a demonstration project under the District's administration.

St. Elizabeths' Hispanic Program is a day program for Spanish-speaking inpatients and outpatients. It is organized under the Office of the Superintendent with about 50 patients and 10 staff. The program could be continued by hiring Spanish-speaking patient care staff to serve Hispanic patients. In the past the District has used a contractor to meet some of these patients' needs.

Q. Which general hospitals would provide acute psychiatric care? Do they have the capacity to assume this responsibility without major construction?

A. We have not specified which general hospitals might be used for acute psychiatric care because we believe District officials should have flexibility in this decision. Various options are available for acute care. As discussed later (see p. 33), the costs and number of Medicaid-eligible patients will likely influence those decisions.

D.C. General Hospital already serves indigents of the District, but does not offer a full-scale psychiatric program. One building on the grounds, now used as the south community mental health facility, had been used as an inpatient psychiatric facility. Its capacity is generally adequate for the District's acute psychiatric needs, and the patients treated there could qualify for Medicaid reimbursements. D.C. General estimated that about $5 million would be needed to renovate this building to meet life and fire safety codes.

Another option would be to convert beds at other general hospitals in the District to psychiatric use. This kind of conversion would probably require approval by District health planners before a certificate of need would be issued, but excess beds are available for conversion.

Seven general hospitals in the District offer inpatient psychiatric care for adults. Their psychiatric and medical/surgical bed capacities and occupancy rates in 1982 are shown in the tables on the following page. Except for Greater Southeastern Community Hospital in District III, all the hospitals are located in District I. (See map on p. 7.) Two other general hospitals--Capitol Hill and Hadley Memorial--not currently offering psychiatric services are in Districts II and III, respectively. Capitol Hill averaged 45 unoccupied beds and Hadley averaged 16 in 1982. Also, District general hospitals have about 100 beds that are licensed but not in operation. If beds can be converted from medical/surgical to psychiatric, there should be adequate space in existing facilities to accommodate patients needing acute psychiatric care.

Psychiatric Beds Available in General Hospitals

Hospital	Psychiatric beds	Percent occupancy	Average psychiatric beds unoccupied
Georgetown University Hospital	17	89	1
Greater Southeastern Community Hospital	20	82	3
George Washington University Hospital	34	79	7
Howard University Hospital	26	75	6
Providence Hospital	20	86	2
Sibley Memorial Hospital	26	90	2
Washington Hospital Center	42	76	10
Total	185	83	31

Medical/Surgical Beds Available in General Hospitals Offering Psychiatric Care

Hospital	Operating beds	Percent occupancy	Average beds unoccupied
Georgetown University Hospital	417	83	70
Greater Southeastern Community Hospital	368	87	47
George Washington University Hospital	431	89	47
Howard University Hospital	389	89	42
Providence Hospital	275	89	30
Sibley Memorial Hospital	312	88	37
Washington Hospital Center	724	81	137
Total	2,916		410

SOURCE: Report entitled "Hospital Utilization in the Metropolitan Washington Area: A Monthly Report (Summary January-December 1982)" published by the Health Information System of the Metropolitan Washington Council of Governments.

STAFF NEEDED TO OPERATE THE PROPOSED SYSTEM

Q. Is there flexibility in the numbers and types of patient care staff projected?

A. The numbers and types of inpatient staff included in our proposal are an indication of what would be needed to operate an accredited psychiatric program. Because there are no nationally agreed-upon staffing standards for inpatient psychiatric facilities, staffing practices vary. Currently, St. Elizabeths has varying numbers and types of staff handling similiar programs. We envision that this variety would continue and that program managers would have flexibility in substituting certain types of staff for others to achieve specific program goals.

Q. Would St. Elizabeths be able to maintain its accreditation?

A. We believe our projections for patient care staff needed at St. Elizabeths would be adequate to maintain accreditation. These estimates were provided to officials of the Joint Commission on Accreditation of Hospitals for comment. In an October 7, 1983, letter, the President of the Commission stated:

> "The staffing model you provided has been reviewed by staff who feel that--assuming a reasonable level of productivity and an average expectable level of patient acuity--the staffing levels should be adequate for compliance with our standards."

Q. Would the additional staff needed to provide community-based services require special training or retraining?

A. Both special training and retraining would be needed. Some of the special training is already taking place through an arrangement the District has developed with the Mental Health Center in Dane County, Wisconsin, to train individuals to be used to staff the District's mobile treatment units. Additional training would be needed in this area as well as in the crisis resolution activities. Staff shifting from St. Elizabeths to community-based programs would require retraining to reacclimate them to these treatment programs. We did not determine the costs of the needed training and retraining.

FACILITIES NEEDED FOR THE PROPOSED SYSTEM

Q. How were the facilities to be needed at St. Elizabeths determined?

A. Patient care buildings from among those scheduled to be renovated under St. Elizabeths' ongoing renovation program were matched with anticipated bed needs to develop a proposal for building use. Bed requirements were estimated allowing about 8 percent excess above the expected census.

St. Elizabeths undertook the renovation program because in 1975 the Joint Commission on Accreditation of Hospitals withdrew the hospital's accreditation citing deficiencies in its physical plant. Buildings did not comply with certain established requirements for fire protection and prevention to guard against loss of life and property. Overcrowding was also cited.

The renovation program's cost is currently estimated to be about $51.3 million. Twenty-nine buildings, most residential, are included in the program, which is organized into seven phases or contracts. As of October 1983, two of the seven contracts had been completed, three had been awarded with construction underway, one had been awarded with construction to begin in November 1983, and the final one had not been awarded. When completed in 1986, St. Elizabeths will have about 1,750 renovated beds on the hospital's east side.

Additionally, 440 beds were renovated for use while the construction program was underway. These interim use buildings meet life safety code requirements but lack correction of therapeutic environment deficiencies, such as patient privacy, cited by the Commission.

Q. What effect will St. Elizabeths' historical designation have on the hospital's future plans?

A. In 1979 St. Elizabeths was entered in the Interior Department's National Register of Historic Places. The entire campus was designated a national historic district; however, certain buildings were cited as having special significance. The historic designation requires the hospital owners to guard against altering the buildings' architectural significance and to prevent irreversible deterioration of the structures.

Once a property has been designated as historically significant, that designation is rarely lifted. Therefore, any future use of the St. Elizabeths complex will be restricted so that

historically significant buildings cannot be removed or their exterior appearance changed. The historic designation does not preclude new construction on the St. Elizabeths tract; however, the construction should be compatible to the surrounding historic property and comply with Interior Department guidelines.

COST OF THE
PROPOSED SYSTEM

Q. How are the net savings of $22 million realized?

A. The biggest savings result from placing patients in more appropriate, less costly treatment settings. By moving 300 patients to CRFs or nursing homes, savings of about $15 million annually can be realized. About $3 million would be saved as a result of the transfer of St. Elizabeths' substance abuse inpatients to District-operated programs.

Additional savings of about $6 million could result from changes in system staffing, but additional costs of about $2 million will be incurred by community programs.

Q. How do the proposed costs for St. Elizabeths compare with other state psychiatric hospitals?

A. Per diem costs at St. Elizabeths, even under our proposed model, would be higher than those of the other psychiatric hospitals we obtained cost data on. Using accreditation as one criterion and hospitals sized between 800 and 1,200 average census as the second, we contacted a number of states to obtain cost information on their hospitals. Compared to St. Elizabeths' $167 average per diem cost, the other hospitals' costs were significantly lower for general psychiatric care:

State/hospital	Per diem	Date of estimate
New York:		
Hudson River Psychiatric Center	$ 97	March 1983
Marcy Psychiatric Center	82	March 1983
Kingsboro Psychiatric Center	111	March 1983
New Jersey:		
Trenton Psychiatric Hospital	109	Fiscal year 1983
Marlboro Psychiatric Hospital	91	Fiscal year 1983
Greyston Park Psychiatric Hospital	96	Fiscal year 1983
Pennsylvania:		
Norristown State Hospital	106	June 1982
Maview State Hospital	115	Fiscal year 1983
North Carolina:		
Broughton Hospital	101-124	August 1983
Texas:		
Austin State Hospital	110	August 1983
Terrell State Hospital	100	August 1983
Rusk State Hospital	99	August 1983
San Antonio State Hospital	86	August 1983
Washington:		
Western State Hospital	101	Fiscal year 1982
California:		
Napa State Hospital	105-137	July 1983

The District of Columbia has had a very high expenditure for mental health. The District ranked first in the National Institute of Mental Health's survey of total mental health expenditures per capita ($201) in fiscal year 1979, followed by New York ($74) and Vermont ($65).

Q. What major factors could affect the estimated cost of the proposed system?

A number of factors could increase or decrease the mental health system's costs. First, our cost estimates are based on acute psychiatric care being placed in general hospitals. Placing acute psychiatric care at St. Elizabeths would cost the District about $5.3 million more than the D.C. General Hospital option, if about 70 percent of the patients are Medicaid eligible. As the average per diem costs for acute psychiatric care in community hospitals rise, the District's net savings diminish. As the following table shows, a $345 per diem rate negates the cost benefit to the District of using general hospitals to provide acute psychiatric care.

Location of acute care	Per diem	Costs Total	District[a]	Federal	Other
		(millions)			
St. Elizabeths	$213	$18.5	$14.9	$ 2.7	$ .9
D.C. General Hospital	213	18.5[b]	9.6	7.9	.9
Community general hospitals	250	21.7[b]	10.9	9.8	1.1
	300	26.1[b]	13.0	11.7	1.3
	345	30.0	15.0	13.5	1.5

[a]Assumes 70-percent Medicaid eligibility with 10 percent under 22 or over 64 years of age.

[b]Does not add due to rounding.

Second, if St. Elizabeths' indirect cost rate of $89 per patient day cannot be at least maintained, costs to the District would increase. Indications are, however, that the current rate is high. Preliminary results of recent efficiency reviews of three major support functions at St. Elizabeths--dietary, laundry, and housekeeping--indicate that costs could be reduced by about 40 percent. Also, comparing costs incurred by other large hospitals in several indirect cost categories with those incurred by St. Elizabeths indicates that St. Elizabeths' are higher. If St. Elizabeths' indirect cost rate can be reduced by $10, about $3.5 million could be saved.

Third, our distribution of costs assumes a fairly high degree of Medicaid eligibility based on the fact that few St. Elizabeths' patients have the resources or private insurance to pay for services. The Medicaid reimbursements for St. Elizabeths' programs may be overstated because we assumed that all patients with unknown eligibility who met the age criteria were eligible for Medicaid. Assuming that none of these were Medicaid eligible and all would be the District's responsibility, the District's costs would increase about $2.4 million for general and forensic patients, and federal payments would decrease by a similar amount. If only 30 percent rather than 70 percent of acute care patient days were covered by Medicaid, the District's contribution would increase by $3.5 million.

On the other hand, if collections from third parties could be increased to 10 percent of the total costs, the savings would amount to about $5 million. Because so little is known about the ability of patients or their families to pay for services and because a large percentage of individuals for whom there are no indications of assets also have no known Medicaid eligibility, it is difficult to estimate which of these assumptions is most reasonable.

Finally, implementing a community-based system may result in significantly different utilization of the system's inpatient psychiatric components. If the Dixon plan could be fully implemented and psychiatric hospitalization reduced by having 150 fewer long-term patients in adult rehabilitative psychiatric care and placing rehabilitative psychiatric nursing patients in special placement nursing homes, we estimated that the system's total costs would be decreased by about $9 million. Furthermore, if acute psychiatric care could be reduced 25 percent, $4.7 million in additional savings could be realized.

Q. If patient Medicaid eligibility were lower than the 70 percent projected, would the benefits of moving acute psychiatric care to general hospitals decrease?

A. Any percentage of Medicaid-eligible patients would make general hospitals a more attractive option than psychiatric hospitals as long as costs are comparable. When costs of acute psychiatric care programs in general hospitals are higher, the amount of Medicaid reimbursements becomes an important cost consideration. The following table shows the costs of acute psychiatric care considering various assumptions of patient Medicaid eligibility. The asterisk shows the best choice under that given set of assumptions. It is important to note that unless general hospital costs average below $350 per day, using St. Elizabeths for acute psychiatric care would be cheaper, even if Medicaid reimbursements are forfeited.

Comparison of Costs of Providing
Acute Psychiatric Care at Various Locations

Location of care	Costs				Assumptions	
	Total	District	Federal	Other	Per diem[a]	Percent Medicaid eligible[b]
	(millions)					
St. Elizabeths Hospital	$18.5	$14.8	$ 2.8	$0.9	$213	70[c]
* D.C. General Hospital	18.5	9.3	8.3	.9	213	70
General hospitals	30.4	15.2	13.7	1.5	350	70
St. Elizabeths Hospital	18.5	14.8	2.8	.9	213	50[c]
* D.C. General Hospital	18.5	11.1	6.5	.9	213	50
General hospitals	30.4	18.2	10.7	1.5	350	50
St. Elizabeths Hospital	18.5	14.8	2.8	.9	213	30[c]
* D.C. General Hospital	18.5	13.0	4.6	.9	213	30
General hospitals	34.7	24.3	8.7	1.7	400	30

[a]Per diem for St. Elizabeths and D.C. General based on staffing needed for 20-bed wards using $89 indirect cost rate. Per diem for general hospitals averages $322 per day room and board not including professional charges.

[b]Assumes 10 percent federal Medicare funding, 5 percent self-pay, Medicaid as indicated, and the remainder paid for by the District.

[c]Although this percentage is assumed to be Medicaid eligible, only 10 percent of the St. Elizabeths population meet Medicaid's age criteria for reimbursement (under 22 or over 64 years of age).

Benefits other than direct cost savings may also be involved. Joint Commission on Accreditation of Hospitals officials noted that if acute psychiatric inpatient care were provided at general hospitals, moving patients into long-term treatment at St. Elizabeths would be difficult.

Q. Why are costs reported by St. Elizabeths higher than those projected for the proposed system?

A. St. Elizabeths' average costs per patient day ($209 in fiscal year 1983) are simply the hospital's total inpatient costs divided by total patient days. Included in the costs are research and training activities, medical and surgical costs, as well as overhead for administration, security and safety, food service, laundry, etc.

If one compares the current costs (excluding training staff) at St. Elizabeths with our estimates, they are fairly similar, as shown below. An absolute comparison is difficult to make because St. Elizabeths is not organized by patient level of care and because staffing is based on different ward sizes.

Proposed program cost per day		St. Elizabeths' program average cost per day[a,b]	
Level of Care 5	$150	Long-term Rehabilitation	$159
Levels of Care 6&7	152	Geriatric	172
Level of Care 8	172	Intensive Treatment	175
Levels of Care 9&10	195	Medical/Surgical	239
Acute Care	213	Admissions Programs	240

[a]Assumes $89 per patient day indirect cost rate--fiscal year 1982 costs.

[b]St. Elizabeths' costs based on our analysis of program costs for fiscal year 1982, increased by 9 percent for inflation.

HOW THE PROPOSED SYSTEM CAN BE IMPLEMENTED

Q. When would St. Elizabeths be transferred to the District?

A. Before formal transition to the new system could begin, certain actions must be taken. Legislation to transfer the hospital would need to be enacted. The District would need to decide what St. Elizabeths land and buildings it wants. In addition, implementation would be expedited if the hospital's renovation program was at or near completion at the beginning of the transition period. Most buildings needed to accommodate patients will be completed by mid-1985. Though not critical to the hospital's transfer, the District should develop our proposed budget system, which is important to the new system's efficiency and effectiveness.

Considering these factors, an appropriate date for the beginning of the 2-year transition period for the District to assume responsibility for providing mental health services to all District residents could be October 1, 1985.

Q. What federal displacement programs would be available to St. Elizabeths employees?

A. Office of Personnel Management regulations require HHS to establish a program to help place employees not hired by the District. At a minimum, HHS must establish and maintain a reemployment priority list for the commuting area. Career employees can remain on the list for up to 2 years from the date of separation; career-conditional employees, for up to 1 year. HHS cannot fill a competitive position in the commuting area without first reviewing the reemployment priority list for qualified personnel. Office of Personnel Management regulations also require HHS to undertake reasonable efforts to help displaced employees find other employment. For example, HHS could conduct "job clubs," at which counseling and training in job search skills could be provided.

The Office of Personnel Management supplements the HHS programs through its Interagency Placement Assistance Program and Displaced Employees Program. The Interagency Placement Assistance Program works with employees before their displacement from federal service. An employee enrolled in this program can register for up to 10 occupations. Applications are provided to all federal, state, and local government agencies and private employers nationwide. The Office of Personnel Management requires federal agencies to review this program's registers before filling competitive positions with applicants from the general public. Since its inception in 1981, the program has placed over 3,000 persons.

The Displaced Employees Program is designed to help already displaced employees find employment. This program operates much like the Interagency Program but is more formally structured. Between April 1981 and March 1983 the Displaced Employees Program placed 1,713 persons in new jobs.

Q. Were potential uses identified for the land and buildings at St. Elizabeths that would not be needed for mental health programs?

A. We identified several potential uses for St. Elizabeths' resources that would not be needed for mental health programs. Because the west campus offers a college campus environment, we investigated the possibility of establishing a satellite campus of the University of the District of Columbia. Though many of

the buildings would need to be renovated for this use, we believed it would be supported by the community since it would make higher education opportunities readily available to the traditionally underserved Anacostia area. According to university officials, the university's expansion plans had already been made, and logistical problems would militate against establishing a campus at St. Elizabeths.

Another potential alternative use would be to establish a residential substance abuse program. Many of the west campus residential buildings are in excellent condition. Also, recently the District's Rehabilitation Center for Alcoholics in Northern Virginia was closed and patients were moved to facilities at D.C. General Hospital and to contractor-operated facilities. Space was not available for all patients. In addition, under our proposal the District's Alcohol and Drug Abuse Services Administration will assume responsibility for treating about 100 St. Elizabeths alcohol and drug abuse patients. All of the District's alcohol and drug abuse treatment programs could be consolidated in facilities on St. Elizabeths' west campus.

A third potential use of the west campus resources would be to establish a residential program to treat emotionally disturbed children. In fiscal year 1983, the District spent $4.5 million to care for 162 children receiving special services from 32 institutions in 11 states. Establishing a program for such children on the St. Elizabeths campus would enable the children to interact more often with their families. It would also save the District $42,000 in travel costs as well as other program costs. The District would incur only minor expenses in preparing west campus buildings for this purpose.

CHAPTER 4

ANALYSES OF COMMENTS ON OUR PROPOSED MENTAL HEALTH SYSTEM FOR THE DISTRICT OF COLUMBIA

We requested comments on a draft of this report from HHS, the District of Columbia Government, and several local and national organizations, including the American Psychological Association; the American Psychiatric Association; the Joint Commission on Accreditation of Hospitals; the Mental Health Association of the District of Columbia; the Washington Psychiatric Society (WPS), a District Branch of the American Psychiatric Association; the District of Columbia Chapter of WPS; the Dixon Implementation Monitoring Committee; AFSCME; the State Mental Health Advisory Council; and the Medical Society of the District of Columbia. Copies of these comments are included in appendixes VI through XVII. We solicited but did not receive comments from the National Association of State Mental Health Program Directors.

Several major issues were raised in the comments. Although they addressed virtually every aspect of our proposal, we were not persuaded, except to clarify the number of outpatient staff needed for the system, to make changes to our report. We have summarized the comments of the various groups and our responses to be generally consistent with the organization of the report.

STUDY TOO NARROWLY FOCUSED

A number of commentors disagreed with our study's focus--to determine how to transfer St. Elizabeths to the District of Columbia. Some said we should have focused on the issue of whether the hospital should be transferred. HHS endorses the transfer to local control but believes a private, nonprofit corporation to be the "best mechanism." HHS said that such a corporation would provide an objective and effective structure for dealing with the important and sensitive issues of personnel, facility use, and the development of strong and effective local mental health system management.

The District is opposed to taking over administrative and financial responsibility for St. Elizabeths and believes it should develop its own comprehensive mental health services, rather than accept a system designed by the federal government.

From the Dixon Implementation Monitoring Committee's perspective, there are two options for an integrated mental health system--management by the District or creation of a public

corporation. The Committee finds transfer to the District a logical choice given the District's continuing obligation under the Dixon Consent Decree.

AFSCME commented that our study should have included a determination of whether St. Elizabeths should be transferred to the District and concluded that a federal corporation is the best governance option.

GAO response

As noted in our report, the Chairman of the House Committee on District of Columbia directed us to study how, not whether, St. Elizabeths Hospital could be transferred to the District. As a result, other governance options were not evaluated. Nevertheless, our scope was broad enough to enable us to consider the advantages and disadvantages of various governance options. As a result, we did not feel compelled to consider only the existing service delivery system currently at St. Elizabeths.

Various corporation proposals have been discussed and proposed by the past two federal administrations. While initial proposals had the District's endorsement, recent HHS revisions to the private, nonprofit corporation proposal have caused the District to withdraw its support primarily because it would be required to provide most of the funding but, other than selecting most governing board members, have little control over the corporation's activities.

We have not attempted to evaluate the workability of corporation proposals because they do not include a comprehensive plan for providing mental health services. Given the dissension surrounding the current and past proposals, we believe a transfer option stands the best chance of satisfying the major concerns of the parties involved. First, the transfer option gives the District direct control--a situation both the District and HHS desire. Second, this option allows unification of the fragmented system. Finally, a transfer provides protection of many employee jobs under the District's civil service system, which is very similar to the federal personnel system.

REACTIONS TO THE SERVICE DELIVERY SYSTEM PROPOSED

HHS, the District, and the Dixon Implementation Monitoring Committee endorsed virtually every aspect of the service delivery system we propose. The District was silent on our proposal that system budgeting be centralized and controlled by the

CMHCs, but HHS and the Dixon Committee strongly endorsed the concept of the dollar following the patient. The Joint Commission on Accreditation of Hospitals said our proposal offers greater continuity of care and a more comprehensive mental health system for the District than is currently available through St. Elizabeths. Finally, the American Psychological Association and the State Mental Health Advisory Council also endorsed the community-based nature of the proposed system.

Opposing our proposal were the psychiatric groups, the Mental Health Association of the District, and AFSCME. WPS questioned the (1) community hospitals' ability to meet the acute care needs of patients now treated at St. Elizabeths, (2) workability of emergency outreach treatment teams, (3) quality of care delivered by District nursing homes, (4) capability of our proposed system to provide more continuity of care than St. Elizabeths services, and (5) desirability of changing programs for alcoholics and drug abusers. The District Chapter of WPS echoed some of these concerns, claiming that St. Elizabeths is a community-based hospital from the perspectives of both geography and treatment delivery, implying that the service delivery system needs no change.

The Mental Health Association of the District of Columbia also opposes the changes proposed because it envisions St. Elizabeths becoming a "warehouse" for the mentally ill and the District's already large homeless population increasing.

AFSCME also questioned the appropriateness of shifting acute care to community hospitals and the willingness of such hospitals to provide these services.

GAO response

Our proposed service delivery model uses the Dixon Consent Decree and Final Implementation Plan as its blueprint. Contrary to the District Chapter of WPS' assertion, St. Elizabeths does not constitute a community-based treatment setting under the Decree, which requires that outpatient care, nursing care, emergency treatment, and residential care be provided elsewhere. It appears that the psychiatric groups have not taken into account the Dixon mandates for mental health service delivery in the District.

Our reasons for consolidating the alcohol and drug abuse services are simple. We see no reason for the District to operate two distinct substance abuse programs--one at St. Elizabeths under the Mental Health Services Administration, the other under the Alcohol and Drug Abuse Services Administration. Deciding

which administration would serve which patients would become unnecessarily confusing and argues for consolidation. The District plans to assume responsibility for the St. Elizabeths alcohol and drug abuse patients this fiscal year.

We acknowledge in our report that community hospitals are not currently capable of accepting acute care patients from St. Elizabeths. However, we do not believe the current situation precludes the possibility of future arrangements. Shifting acute care to community hospitals is consistent with current mental health practice. In addition, the shift could provide a savings of $5.3 million to the District (see p. 31). Our report (see p. 24) acknowledges that adequate nursing home facilities are not now available but that the shortage should be eliminated by the end of 1984.

PATIENT NEEDS NOT ADEQUATELY ADDRESSED

WPS said we failed to study the needs of those already on the rolls of the District's Mental Health Services Administration; failed to say anything about the homeless population; and failed to consult patients, their families, or the St. Elizabeths staff on patient needs.

AFSCME noted that breakdowns in previous outplacement plans for St. Elizabeths patients increased the District's homeless population and that continued outplacement will exacerbate the problem. AFSCME also alleged that the quality of care in long-term community care facilities compares poorly with that provided at St. Elizabeths.

GAO response

Contrary to WPS' assertion, the outpatient needs assessment survey we used does estimate needs for District-served patients. The survey estimates a broad range of service needs (including the need for emergency shelters) for all outpatients--from either St. Elizabeths or the District. The homeless are not treated as a special class of patient. We did not specifically ask patients or their relatives to estimate their needs for community services. In our opinion, patients' interests should be well represented by the Dixon Implementation Monitoring Committee, which helped to develop the needs assessment survey, and by the clinicians who complete the needs survey for individual patients.

AFSCME's position of keeping outplaceable patients at St. Elizabeths is contrary to the Dixon Consent Decree and inconsistent with individual patient rights to be treated in the least restrictive environment. The community-based system we propose

provides incentives for services to be provided to persons needing them, including those in long-term community facilities, so as to avert unnecessary episodes of costly hospitalization.

We asked St. Elizabeths staff about patients' needs. Hospital staff worked with us to help estimate needs of both inpatients and outpatients. Likewise, our proposals dealing with staffing levels and building use were developed only after extensive consultation with the staff. Finally, we consulted with research and training staff on possible ways of integrating these functions into a District-run mental health system before developing our proposals.

DISAGREEMENTS OVER HOW WE ESTIMATED STAFFING NEEDS

WPS criticized our use of the Ohio staffing model and suggested that staffing should be based on the present staffing of good programs at St. Elizabeths. WPS suggests that we were incapable of evaluating St. Elizabeths programs and determining staffing needs. On the other hand, the American Psychological Association endorsed our use of the Ohio model and noted the importance of meeting accreditation standards. No commentor specifically questioned the overall staffing levels we proposed, although the American Psychological Association questioned the need for only 29 additional outpatient staff and provided staffing ratios for psychologists working in some inpatient settings.

GAO response

Initially, we attempted to estimate staffing needs based on current programs at St. Elizabeths. We found a wide diversity of staffing practices at the hospital among hospital divisions and on wards within divisions. For this reason we turned to more systematic staffing methodologies, such as the Ohio model, and conferred with the Joint Commission on Accreditation of Hospitals and others, including WPS, on our staffing proposal. We believe these organizations are well qualified to address staffing needs. WPS, despite its criticism of our methodology, did not point out any specific deficiencies in our proposed staffing levels or comment on the accreditation issue.

Apparently, the American Psychological Association did not realize that the 29 additional outpatient staff proposed were in addition to the current levels of both St. Elizabeths and District outpatient staffs. We have changed the report to clarify this point.

We attempted to analyze the ratio of psychologists needed in inpatient settings provided by the American Psychological Association. We generally agree with the ratios provided for forensic patients, but our staffing levels call for only one-third of the psychologists working in rehabilitative programs. Because of the question of substitutability of staff (for example, how often do social workers and psychologists offer equivalent patient treatment services) and because the American Psychological Association did not comment on our overall staffing level, we have not altered our staffing levels. Based on the staffing practices at St. Elizabeths and comments of the Joint Commission on Accreditation of Hospitals and other knowledgeable authorities, we believe that certain disciplines could be substituted for others in rehabilitative psychiatric programs without jeopardizing accreditation.

FURTHER STUDY PROPOSED FOR FACILITIES NEEDED TO OPERATE THE SYSTEM

The District said it wanted to study further the two options we proposed regarding its use of St. Elizabeths facilities--transfer of some facilities or lease of facilities by the District from the federal government. In either case, the District apparently does not want to assume responsibility for the entire St. Elizabeths tract.

HHS said that there is a need for further review and discussion on the issue of alternative uses for St. Elizabeths. HHS also said we were silent on its renovation activities at the hospital.

GAO response

In our opinion, further consideration of alternative uses for St. Elizabeths by both HHS and the District is appropriate. HHS is incorrect in its statement that we ignored its major renovation program at the hospital. In our report, we point out that the program, when completed in 1986, will have about 1,750 renovated beds available. Twice during our work, in July and October 1983, we advised HHS of our concerns about the program's scope. We proposed that the number of renovated beds be limited to 1,100 pending resolution of the transfer issue. HHS agreed and has delayed renovation plans for about 450 beds. We continue to believe that both the District and HHS should agree on future use of buildings before additional renovation funds are committed.

COST ESTIMATES OVEREMPHASIZED AND UNREALISTIC

Several professional associations commented that we focused primarily on costs, not quality patient care, in deciding how to effect the transfer. Most of the associations raised questions about the risk to patients who might be harmed by changes called for in the transfer. The District of Columbia Chapter of WPS expects such a transfer to result in more patients receiving less care because the current District system is "overburdened and underfinanced." The American Psychological Association, while not questioning the wisdom of the proposed changes, suggests that assurances about the success of outplacement are needed. It fears that patients will not receive needed care.

The District contends that our cost estimates are based on (1) unrealistic acute care costs, (2) omission of residential costs of hard-to-place patients, (3) definitions of questionable outpatient caseloads, (4) omission of capital costs, (5) overly optimistic Medicaid reimbursement expectations, and (6) understatement of administrative and management costs.

GAO response

Proposing adequate resources for the system is the best assurance we can offer that quality services could be made available. It was for this reason we made extensive efforts to estimate patient needs, to translate this into staffing considerations which would enable Joint Commission accreditation, and to develop detailed cost estimates. While we recognize that providing sufficient resources to achieve accreditation does not guarantee quality services, it does imply that quality services are achievable.

Because our cost estimates are based on patient needs and staff, we believe they are more realistic than comparative cost estimates developed from other hospitals or extrapolated from current services. To respond to the District's cost concerns, we note first that our estimates of acute psychiatric care costs are based on staffing levels needed for accreditation and St. Elizabeths' indirect cost rate. We continue to believe that these are accurate estimates of acute care costs if St. Elizabeths or D.C. General Hospital is the provider. Our report clearly states that acute care costs would likely be greater at other community hospitals. Our report also provides an analysis (see p. 32) which shows that, when acute care costs exceed $345 a day in community hospitals, the cost benefit of shifting acute care to general hospitals will no longer exist.

Second, costs to outplace difficult patients were not included in our estimates because we do not propose outplacing such patients. We propose outplacing patients in levels-of-care 1 through 4 (see p. 22) and assumed that these patients would require outpatient services. These patients are not normally considered to be placement problems. Our proposal provides for patients in levels-of-care 5 through 7, who are normally considered to be more difficult to place, to continue treatment at St. Elizabeths for reasons described in our report. The harder-to-place patients are included in our long-term rehabilitative care cost estimates.

Third, the outpatient needs assessment survey conducted by St. Elizabeths and the District and standards agreed to by the parties to the Dixon Consent Decree were used in determining outpatient staffing levels. The number of patients projected to be in need of outpatient services by the survey were applied to the standards to determine staffing levels needed to provide those services. Staffing levels were measured considering that staff will spend about 64 percent of its time providing services and the remainder on administrative duties, vacations, etc.

Fourth, besides the current costs to renovate the St. Elizabeths campus, the only capital costs that are associated with our proposed system are those to renovate space at D.C. General Hospital to accommodate acute psychiatric care should the District decide to place that care there. These one-time costs were identified in our report (see p. 26).

Fifth, our overall cost sharing estimates are based on optimistic Medicaid eligibility for acute care patients. However, we balance this with a detailed analysis of how the cost sharing would change if fewer patients were Medicaid eligible. The difficulty in making reasonable estimates of Medicaid-eligible patients is the inconsistency in the District's information on financial eligibility. Very few of the existing patients are considered capable of paying for services, and yet many of these do not have proven Medicaid eligibility. If, in fact, these patients are truly indigent, they probably should qualify for Medicaid. If they fail to qualify for Medicaid, some cost sharing by patients seems in order.

However, we recognize that under the current system, there is no incentive for the District to prove Medicaid eligibility because payments cannot be made for patients aged 22 to 64 treated at St. Elizabeths. Furthermore, patients are not denied treatment, so there is little incentive on the patients' part to

keep eligibility current. We believe implementing our proposal would create incentives for the District to maximize Medicaid reimbursements. For this reason, we project a high degree of Medicaid eligibility, rather than projecting a high degree of self-pay.

Finally, system administrative costs were estimated at $1 million, which represents an increase of $200,000 over administrative costs budgeted by the District in fiscal year 1983. Also, the indirect cost rate of $89 per patient day we used to compute costs for inpatient programs includes costs (about $23) related to general administration. In other words, the costs we have associated with inpatient programs include about $8.2 million for general administration, in addition to the $1 million estimate we made.

SYSTEM IMPLEMENTATION CONCERNS

Several commentors expressed concerns about the process we propose for implementing the new system. The District believes that the October 1, 1985, date for it to assume responsibility for the system and the 2-year period for restructuring the system are "highly unrealistic." Instead the District proposes a 6-year implementation period to design and implement a workable system. During this 6-year period the District would assume system responsibility incrementally and the federal government would maintain its present annual funding level of $67.8 million.

Several other District comments related to system funding--both during and after the implementation period. The District believes that it should not accept responsibility for St. Elizabeths inpatients until each District-administered alternative is prepared and that the federal government should retain responsibility for the lifetime care of over 400 patients who have been institutionalized at St. Elizabeths for many years, even decades. In addition, the District said we failed to consider the extraordinary volume of demand for services in the District, which is far beyond national norms. The District also said that the savings from the restructured system would not accrue in the first year, thus causing the District to provide additional resources.

HHS, commenting on our funding proposal, said that it provides for larger amounts of federal payments than HHS had planned during fiscal years 1984-86. AFSCME said that we did not consider the District's limited tax base and opportunities for increasing revenues. AFSCME said that federal funding of the system will be needed.

Both HHS and AFSCME said that federal employees at St. Elizabeths must be afforded appropriate protections. HHS added that transfer-of-function regulations, which would provide for the transfer of all hospital employees to the District, should be applied. The District, on the other hand, said it should assume responsibility for only those employees it needs and that the federal government should be responsible for the cost and the administrative task of planning for the others.

GAO response

While the process of transferring the hospital to the District should be a subject of discussion and negotiation, the District's 6-year transition plan, in our opinion, has serious drawbacks. Its most troubling aspect is that it continues the current two-provider system. The current system creates disincentives for providing mental health services efficiently and in the most appropriate treatment setting. Many of the Dixon Implementation Plan goals and timetables have not been met, in part because the responsibility for services is shared. Besides continuing a dual administration, it continues dual funding--an uncertain situation which this year resulted in a funding shortfall and layoffs. The District, we believe, should assume control of the entire system at one time and therefore the responsibility for timely outplacement and transfer of patients to more appropriate and less costly treatment settings.

At the same time, we believe that the District should not incur any additional costs during the 2-year implementation period to allow it maximum flexibility in putting the new system in place. Here again, the 2-year implementation period creates incentives for timely implementation of the system by the District.

We agree that the new system's financing beyond the implementation period is the most critical element affecting its ultimate success. The system needs to have a firm financial base. HHS recognizes that continued federal funding support will be needed. The amount of that support should, in our opinion, be determined when the Congress considers the District's annual federal appropriation. At this same time, the Congress can consider the extraordinary demand for mental health services in the District due to the federal presence in the same manner as extraordinary demands for many other services (police, fire, roads, etc.) are considered in determining the federal appropriation.

Regarding how the issue of St. Elizabeths employees should be resolved, we agree with the District and continue to believe that a special employee selection process such as the one we

describe (see p. 18) is needed so that programs to continue at St. Elizabeths are staffed with the best qualified staff at a reasonable cost rather than filling positions based exclusively on employee retention rights. The District, in our opinion, should have the opportunity to select employees but be restricted to the current pool of qualified employees at the hospital. The federal government, in any case, should be responsible for any costs, such as severance pay for displaced employees, associated with the transfer of the hospital.

OTHER CONCERNS

We received comments about the District's inability to administer its own mental health system, about our handling or failure to handle existing hospital research and training programs, and about moving acute care to enable Medicaid reimbursements.

Some commentors expressed concern about the District's ability to administer the system we propose. Two, the Mental Health Association of the District of Columbia and the Dixon Implementation Monitoring Committee, noted that the District will need strong leadership that has not existed in the past. AFSCME pointed out that the District's mental health services are in a shambles and giving it more responsibility would seriously damage patient treatment.

The psychiatric associations said we failed to recognize the importance of research and training programs.

The Mental Health Association suggested that exceptions to the Medicaid regulations be made to allow St. Elizabeths to collect Medicaid reimbursements for patients over 21 and under 65 needing acute psychiatric care. The Association said that moving dollars would be more appropriate than moving patients.

GAO response

Up to now the District has not accepted the total responsibility for providing mental health services to its residents and has relied on federally administered programs at St. Elizabeths to provide most services. Typically, mental health services are a local and state responsibility. The Mayor has stated that the District is willing to accept this responsibility and has already taken steps to do so. Recently a new administrator of the District's Mental Health Services Administration was named and a committee formed to assist the District in finalizing its plans for assuming responsibility for mental health services.

Research and training programs and their importance were not neglected in our study. Our report proposes continuing these efforts at federal expense because they represent federal interests and initiatives. We do not dispute the benefits of the research and training programs and suggest that arrangements could be made to continue them at St. Elizabeths or other settings if appropriate. We continue to believe that the District should not be to required to assume the costs of these national initiatives.

The Mental Health Association's suggestion regarding making acute care patients below age 65 eligible for Medicaid reimbursements was examined early in our work. We looked into the possibility of making St. Elizabeths administratively part of D.C. General Hospital and therefore eligible for Medicaid reimbursements for acute care for those between 21 and 65 years of age. We quickly concluded that the federal government would not permit such an arrangement since it would constitute a clear circumvention of the intent of Medicaid regulations. Also, allowing such a broad exception to the Medicaid regulations for the District and denying it to states raises equity questions. As a result, we adapted our proposal to make the District's relationship to federal assistance programs consistent with other states'.

HOW GAO ESTIMATED NUMBERS OF ST. ELIZABETHS PATIENTS NEEDING VARIOUS TREATMENT SETTINGS

Estimates of numbers of patients outplaceable to community facilities were determined through a survey of St. Elizabeths Hospital users to assess patients' psychiatric and medical needs. This level-of-care survey categorizes patients into 10 treatment settings by determining the patients' physical, psychiatric, behavioral, and social functioning characteristics. The survey assessment is completed for all patients residing continuously at St. Elizabeths for more than 90 days and every 6 months thereafter as long as the patient resides in the hospital.

St. Elizabeths adopted the level-of-care survey in September 1977 as the best known instrument for identifying aggregate patient needs. Designed in 1975 by the Bureau of Program Evaluation of New York State's Office of Mental Health, it is used by 14 states across the country.

St. Elizabeths uses the survey to provide (1) an overall picture of the physical and mental health of the hospital's patients by depicting the patient mix and (2) the basis for assessing current program capabilities and for planning services to better meet the needs of the hospital's patient population. As part of the Dixon Consent Decree, St. Elizabeths also uses the survey to monitor the appropriateness of inpatients' continued hospitalization. While the survey results are not definitive as they relate to the actual readiness of an individual patient for outplacement, the survey was the best method available for estimating the group of patients whose physical and psychiatric characteristics make them most appropriate for attempted outplacement.

The survey's product is an aggregate list of the number of patients in the survey population who fall into each of 10 defined "levels of care." These levels reflect an analysis of the combination of assessed variables and are related to specific types of placements for which the patient group can be considered eligible.

Determining these placements is based on the patient's psychiatric level of care in conjunction with his or her physical level of care, as shown in the following matrix.

APPENDIX I

Overall Level of Care

Psychiatric level of care	Physical level of care			
	Independent	Supervised	Intermediate nursing	Skilled nursing
Community	1	2	3	4
Rehabilitative	5		6	7
Intensive	8		9	10

The 10 levels of care are organized into three broader categories of placement--community residential settings (levels 1 through 4), rehabilitative psychiatric environment (levels 5 through 7), and intensive psychiatric treatment center (levels 8 through 10). These placement categories are described below, along with the specific type of placement appropriate for each level of care.

Community residential settings - Patients in this category do not require continuous psychiatric care. Included are patients who do not manifest a hazard to themselves or to others and whose mental condition does not seriously interfere with their functional capacity or social competence. Patients may or may not receive treatment as psychiatric outpatients within the community setting. Patients in this category are placed in levels of care 1 to 4 according to their functional needs.

Level 1 - Independent living - For patients who are able to meet their own personal needs independently without supervision and to manage their own affairs living alone, with family, or with others in congregate quarters.

Level 2 - Supervised care facility - For patients requiring limited assistance and supervision in personal care. Supervised living for such patients may be available in CRFs or other facilities in which supervision would be available, including the patient's home in cases where family members can provide needed supervision.

Level 3 - Health-related facility - For patients requiring intermittent nursing services of a supportive, restorative, and preventive nature that go beyond room and board but are less comprehensive than services provided in a skilled nursing facility.

Level 4 - Skilled nursing facility - For patients requiring 24-hour skilled nursing care and supervision because of chronic and/or acute physical illness and a need for skilled nursing services related to impaired self-care ability.

Rehabilitative psychiatric environment - Included are patients with mental illness who do not constitute a hazard to themselves or to others but whose mental illness seriously interferes with functional capacity and/or social competence or whose behavior is intolerable by prevailing community norms, thus requiring a structural residential setting staffed to provide necessary rehabilitative psychiatric care, supervision, and treatment intervention. Patients in this category are placed in levels of care 5, 6, or 7 according to their functional needs.

Level 5 - Rehabilitative psychiatric environment/supervised care unit - For patients requiring rehabilitative psychiatric care plus limited assistance and supervision in self-care activities. These patients, however, do not need nursing or medical attention for physical problems.

Level 6 - Rehabilitative psychiatric environment/intermediate care unit - For patients requiring rehabilitative psychiatric care plus intermittent nursing services of a supportive, restorative, and preventive nature that go beyond room and board but are less comprehensive than services received in a skilled nursing facility.

Level 7 - Rehabilitative psychiatric environment/skilled nursing unit - For patients requiring rehabilitative psychiatric care plus 24-hour skilled nursing care and supervision because of physical illness and a need for skilled nursing attention combined with major impairments in self-care abilities.

Intensive psychiatric treatment center - Patients in this group have mental illnesses necessitating intensive observation, supervision, and treatment indicated by the presence of conspicuous psychiatric symptoms or dangerousness to self, others, or property combined with impairment of functional capacity to fulfill appropriate social roles. Patients in this category are placed in levels 8, 9, or 10 according to their functional condition.

Level 8 - Intensive psychiatric treatment center/supervised care unit - For patients requiring intensive psychiatric care plus limited assistance and supervision in personal care.

Level 9 - Intensive psychiatric treatment center/intermediate care unit - For patients requiring intensive psychiatric care plus intermediate nursing services of a supportive, restorative, and preventive nature that go beyond room and board but are less comprehensive than services received in a skilled nursing facility.

Level 10 - Intensive psychiatric treatment center/skilled nursing unit - For patients requiring intensive psychiatric care plus 24-hour skilled nursing care and supervision because of physical debility due to chronic and/or acute physical illness.

The table below shows the number of general adult psychiatric patients at St. Elizabeths in the various levels of care as of September 30, 1982, and September 30, 1983.

Level of care	Number of patients 9/30/82	9/30/83
1	81	92
2	122	119
3	59	61
4	46	56
5	157	140
6	73	85
7	155	149
8	142	187
9	55	73
10	82	91
N*	245	193
	1,217	1,246

*Patients not having a level of care generally because they had not been inpatients for 90 continuous days.

According to the level-of-care survey, patients in levels 1 through 4 are outplaceable to nursing homes or CRFs. We used the level-of-care status of St. Elizabeths patients as of September 30, 1982, to estimate the number of patients who could be outplaced as well as the number to be served in acute psychiatric and long-term psychiatric treatment settings. From the above results, we estimated that the following numbers of patients could be treated by various components of the mental health system.

Location of care	Level of care	Estimated number 1982	1983
Community residential facilities	1 & 2	203	211
Nursing facility	3	59	61
Skilled nursing facility	4	46	56
St. Elizabeths:			
Rehabilitative psychiatric	5	157	140
Rehabilitative psychiatric nursing	6 & 7	228	234
Intensive psychiatric	8	142	187
Intensive psychiatric nursing	9 & 10	137	164
General hospitals	N	245	193

As the table shows, patient levels of care changed somewhat between 1982 and 1983. However, we did not update our staff, building use, or cost analysis because the change in patients did not warrant the additional time needed to redo these estimates. The end-of-year patient populations were virtually identical--1,707 to 1,708 total patients, respectively. The most significant change was a drop in acute patients--those at St. Elizabeths less than 90 days--and a corresponding increase of patients in levels 8, 9, and 10. According to the September 30, 1983, level-of-care survey, the general adult population in levels 5 through 10 increased by 61, but the acute patients (no level of care) decreased by 52 over the prior year's figures.

Specialty program patients were excluded from this analysis because their level of care may not be the best indicator of the most appropriate treatment setting. The numbers of patients by specialty program are listed below.

Program	Inpatients September 30, 1982	September 30, 1983
Forensic	297	274
Alcohol and drug	100	97
Deaf	38	29
Child and adolescent	26	37
Research	30	25

HOW GAO ESTIMATED STAFFING NEEDS FOR PROGRAMS TO CONTINUE AT ST. ELIZABETHS HOSPITAL

To determine a projected staffing level for our proposed model, we searched for but found no nationally recognized staffing standards for inpatient psychiatric facilities.

Because many mental health administrators told us that staffing is based primarily on experience, we first focused on understanding how St. Elizabeths Hospital currently staffs inpatient programs at the six adult general psychiatric divisions: Area D, Godding, Marr, Noyes, O'Malley, and Richardson. We concentrated on the staff types that were most easily compared among programs within these divisions. The disciplines we included were psychiatrists, medical doctors, psychologists, social workers, and nursing staff.

In our analysis of St. Elizabeths' current staffing practices, we found no consistent pattern in staffing for programs--either within or across divisions. Various factors appear to contribute to these staffing variations, such as the

--use of trainees from the St. Elizabeths training programs to supplement staff,

--different treatment philosophies of division and program directors,

--mixing of patients requiring various levels of care in one program, and

--different number of patients that could be accommodated on a ward.

Primarily as a result of these factors, we decided not to project inpatient staffing needs for our proposed system based on the hospital's existing staffing patterns.

Staffing data available at the National Institute of Mental Health also could not be used because they could not be broken down by inpatient and outpatient staff or by staffing patterns for specific programs.

Although generally accepted staffing models do not exist, we identified two staffing methodologies that address the numbers and types of staff needed for inpatient psychiatric facilities. One relates to a court case, Wyatt v. Stickney (344 F. Supp. 373 (1972)), in which a decision was rendered to deal with

an unacceptably low staffing level at an institution in Alabama. The other is a staffing simulation developed by the Ohio Department of Mental Health which projects staffing levels needed to attain accreditation from the Joint Commission on Accreditation of Hospitals.

The Wyatt v. Stickney standards establish minimally acceptable staffing levels for adult psychiatric patients in certain Alabama mental institutions. However, the standards were of limited usefulness to us because they do not consider (1) the different levels of patients' psychiatric and medical needs or (2) the specific needs of specialty groups, such as forensic, children, or deaf patients.

The standards developed by the Ohio Department of Mental Health project staffing needs in state mental health facilities. Current staffing levels (that is, for doctors, nurses, social workers, etc.) are compared with a projected staffing level that would allow the facility to attain or maintain accreditation.

The Ohio standards recognize that different treatment programs require different staffing patterns. For example, extended care units require different staffing levels than acute psychiatric units. For each program, such as acute psychiatric or geriatric, four variables are considered: (1) the average resident population, (2) the number of admissions, (3) the number of discharges, and (4) the number of wards to be operated.

Evidence indicated that these staffing estimates were useful in helping the Ohio institutions earn accreditation. By using this process, the Department of Mental Health was able to correct staffing deficiencies and obtain accreditation for 14 of 17 mental health hospitals. The other three did not receive accreditation because of life-safety requirements. Moreover, these hospitals received accreditation while being funded at only 80 percent of the Ohio model standards.

Because the Ohio staffing model considers the varying psychiatric and medical needs of the broad spectrum of patients in mental health hospitals and is based on staffing levels of hospitals receiving accreditation, we used it in developing staffing levels for programs to continue at St. Elizabeths.

We matched the levels of care of St. Elizabeths patients to Ohio State treatment programs using program descriptions, the functional ability of patients in various levels of care, and the patients' ages. Our plan for housing these patients used a variety of buildings with different ward capacities, based on the St. Elizabeths building program.

We discussed our staffing proposals with St. Elizabeths officials, representatives of mental health professional organizations, and representatives of other organizations involved in the District's mental health system. We also discussed the staffing estimates with officials of the Joint Commission on Accreditation of Hospitals. After we made minor modifications in the estimates to incorporate their comments, the Commission endorsed the estimates as adequate to meet its standards. The table on the following page summarizes the staffing projections for the inpatients to be treated in the proposed District mental health system.

Staffing Projection for Various Programs Under GAO Model

Type of program (level of care)	Number of patients	Est. # of wards	Medical officers	Psychologists	Social workers	Registered nurses	Licensed practical nurses	Direct care nursing staff	Recreational activity therapists	Admin. & mgmt.	Clerical	Total staff	Staff-to-patient ratio
Rehabilitative psychiatric (level 5)	154	11	3.5	3.0	8.8	20.0	36.0	44.5	13.3	2	2	133.1	.86:1
Rehabilitative psychiatric nursing (levels 6 & 7)	228	8	3.9	3.7	7.7	44.3	32.8	93.0	15.3[a]	4	3	207.7	.91:1
Intensive psychiatric (level 8)	140	7	2.5	2.5	6.2	25.2	33.6	89.6	10.8	3	3	176.4	1.3:1
Intensive psychiatric nursing (levels 9 & 10)	137	10	5.6	2.7	6.3	57.9	40.0	75.0	12.7[b]	3	2	205.2	1.5:1
Forensics	297	12	7.1	8.5	10.3	43.2	57.6	162.7	23.4	6	6	324.8	1.1:1
Deaf	39	2	1.0	1.0	2.2	11.2	9.6	11.0	2.1	1	1	40.1	1:1
Total	995	50	23.6	21.4	41.5	201.8	209.6	475.8	77.6	19	17	1,087.3	1.1:1

Staffing Projection for Acute Inpatient Unit

Type of program	Number of patients	Est. # of wards	Medical officers	Psychologists	Social workers	Registered nurses	Licensed practical nurses	Direct care nursing staff	Recreational activity therapists	Admin. & mgmt.	Clerical	Total staff	Staff-to-patient ratio
Acute	200	10	35.0	10.8	24.2	72.0	48.0	80.0	10.0	7	7	294.0	1.5:1
Children & adolescents	21	3	2.1	2.0	3.0	7.3	-	13.5	4.1[c]	2	2	36.0	1.7:1
Total	221	13	37.1	12.8	27.2	79.3	48.0	93.5	14.1	9	9	330.0	

[a]Includes 5.2 physical therapists.

[b]Includes 2.7 physical therapists.

[c]Includes 1 speech therapist and 1 special educator.

APPENDIX II

HOW GAO ESTIMATED STAFFING FOR COMMUNITY-BASED PROGRAMS

To deliver mental health services in the community to an increased outpatient population, staffing at the CMHCs would need to be increased. We estimate that the number of adult patients served at the CMHCs would increase from a current active population of 2,414 to 3,985. The increase would involve adult patients who could be transferred from St. Elizabeths outpatient clinics and outplaced from inpatient care. The District's children and youth outpatient population of 594 patients would not be increased as a result of outplacement and transfers. The number of staff providing outpatient services would change only slightly, from a current direct care staff of 286 to 315, as shown in the following table.

Staffing for Community-Based Services

	Number of full-time equivalent employees			
Discipline	District I	District II	District III	Total
Medical officers	20.9	9.9	12.8	43.6
Psychologists	15.3	7.1	8.1	30.5
Social workers	28.2	16.5	17.7	62.4
Psychiatric nurses	26.2	21.7	20.4	68.3
Mental health counselors	28.5	27.2	17.2	72.9
Therapists	20.6	10.8	5.9	37.3
	139.7	93.2	82.1	315.0

METHODOLOGY

To determine the number of staff needed to treat outpatients, we related the patient population and their needed services to the standard time and frequency of these services to arrive at the required staff. As a result of the Dixon Consent Decree, St. Elizabeths and the District's Mental Health Services Administration conducted an outpatient needs assessment survey to determine the characteristics and mental health and social service needs of inpatients and outpatients served by St. Elizabeths and the District. Questionnaires were completed on a sample of inpatients and outpatients by each patient's primary clinician. The survey included Dixon class patients, which excludes children and youths, forensic, deaf, and drug and alcohol abuse patients. Acute care patients were also included. Data

were aggregated to show demographic information as well as the number of patients needing psychiatric and social services.

The first survey was done in June 1980. Since then, two additional surveys have been performed. The latest data, collected in the fall of 1982, compiled information on 1,061 randomly selected patients from St. Elizabeths and the District's CMHCs. The following table shows universe and sample sizes and response rates for the latest survey.

Universe, Sample Sizes, and Response Rate
Outpatient Needs Assessment Survey

Patient type	Universe	Sample		Response	
		Number	Percent	Number	Percent
Outpatient:					
St. Elizabeths	1,279	200	15.6	190	95.0
District I	1,579	264	16.7	207	78.4
District II	1,226	202	16.5	148	73.3
District III	1,175	173	14.7	157	90.8
Inpatient	1,301	222	17.1	185	83.3
Total	6,560	1,061	16.2	887	83.6

We projected the services that the outpatient population will need using clinician recommendations. Services defined in the Dixon Implementation Plan are as follows:

--Evaluation/Assessment is the analysis of a patient's needs, strengths, and resources to determine the community residential, mental health, and support services he or she needs. It includes interviews with the patient and the family, psychological testing, and medical (including medication) assessment.

--Verbal therapy is the regular, supportive therapy/counseling, including alcohol and drug counseling as appropriate, on an outpatient basis, oriented to the patient's needs and goals.

--Drug therapy involves the psychiatrist or physician providing and monitoring the patient's medication.

--Day treatment is a structured, generally 5 days a week, daytime program, appropriate to the client's age and level of functioning. The program includes psychiatric

services, verbal therapy, milieu therapy, art and music therapy, psychodrama and other therapies, medical services, and education.

--Day activity, similar to day treatment, is a daily, generally 5 days a week, structured program appropriate to the patient's age and functioning. Activities include social, educational, recreational, and occupational rehabilitation and daily living training.

--Case management is accountable clinicians' efforts to link a patient with needed services. Its goal is to assure that the elements of treatment, residential, and supportive services needed for optimal community adjustment and continuity of care are provided.

NEEDED SERVICES AND STAFF REQUIRED

The following table shows how many patients in each district need various outpatient services and how we translated these needs into staff requirements.

Determination of Staff Needed for Outpatient Programs

Facility	Service[a]	Patients in need	x	Patient sessions per month	=	Number of sessions per month	x	Standard time per session	/ 1,733[b]	Direct service full-time equivalent employees
District #1 CMHC	Evaluation/ assessment	1,092		0.25		273		0.65		1.02
	Verbal therapy	1,313		3.3		4,332.9		0.83		20.75
	Drug therapy	1,283		1.0		1,283		0.36		2.67
	Day treatment (group of 30)	422		20.0		281.3		10.8		17.53
	Intensive case management	203		4.0		812		1.0		4.69
										46.66
District #2 CMHC	Evaluation/ assessment	745		0.25		186.25		0.65		.70
	Verbal therapy	802		3.3		2,646.6		0.83		12.68
	Drug therapy	780		1.0		780		0.36		1.62
	Day treatment (group of 30)	251		20.0		167.4		10.8		10.43
	Intensive case management	145		4.0		580		1.0		3.35
										28.78
District #3 CMHC	Evaluation/ assessment	902		0.25		225.5		0.65		.85
	Verbal therapy	1,063		3.3		3,507.9		0.83		16.80
	Drug therapy	837		1.0		837		0.36		1.74
	Day treatment (group of 30)	279		20.0		186		10.8		11.59
	Intensive case management	131		4.0		524		1.0		3.02
										34.00

[a]The District currently uses several contractors to provide day activity services, which we assume will continue to be provided on a contractual basis. As a result, no staff are projected for this service.

[b]Number of work hours in a month.

APPENDIX III

The number of patients in need is a direct result of the clinician's opinion obtained from the outpatient needs assessment survey. How often the patient would receive services and how much clinician time would be needed to deliver these services are from standards agreed upon by St. Elizabeths and the District's Mental Health Services Administration, as shown in the table.

Service Standards for Outpatient Services

Service	Number of monthly patient sessions	Standard staff time per session (in hours)
Evaluation/ assessment	0.25	0.65
Verbal therapy	3.30	0.83
Drug therapy	1.00	0.36
Day treatment (groups of 30 patients)	20.00	10.80
Intensive case management[a]	4.00	1.00

[a]Case management includes activities of an accountable individual aimed at linking needed services to a patient and coordinating various service components, in order to assure that the elements of treatment, residential, and supportive services needed for optimal community adjustment and continuity of care are provided. Intensive case management is provided to a select group of patients determined to need this service, such as those who experience frequent hospitalizations.

The number of patients projected to be in need was then applied to the staffing standards to determine the staffing level needed to provide the services. The above staffing levels were measured using direct service full-time equivalents (a direct service full-time equivalent equals a staff person working a 40-hour week and devoting all 40 hours to providing services directly to patients). Realistically, an employee cannot devote full time to direct patient care, since some time will be spent on administrative duties, vacation, etc. Recognizing this, the District's Mental Health Services Administration expects clinicians to devote 64 percent of their time to direct patient care.

Therefore, the staff had to be increased by 56.25 percent to allow for other than direct care time, giving the following full-time staff needed for these services:

Staff Needed to Provide Adult Outpatient Services

Facility	Number of full-time equivalent employees
District I	72.9
District II	45.0
District III	53.1
Total	171.0[a]

[a]At the 95-percent confidence level, full-time equivalent employee projections range from 157.2 to 184.8.

Because the staffing standards did not generally indicate which disciplines would provide services, we used the current complement of staff working in outpatient programs to determine the mix. The following table shows each discipline's representation as a percentage of the total direct care outpatient staff.

Staff by Discipline

Discipline	Percent of staff total
Medical officers	15.8
Psychologists	4.5
Social workers	23.2
Psychiatric nurses	22.1
Mental health counselors	26.0
Therapists	8.4
	100.0

CHILDREN AND YOUTH SERVICES SHOULD NOT INCREASE

The staff needs for children and youth programs would not change since this patient population will not increase as a result of transfer of St. Elizabeths outpatients or outplacement of St. Elizabeths inpatients. We assumed that the current staffing levels for youth programs at the CMHCs, shown in the following table, are sufficient to provide needed services.

Staff Used for Children and Youth Programs

Facility	Number of full-time equivalent employees
District I	50.3
District II	21.3
District III	12.8
Total	84.4

STAFFING THE CRISIS RESOLUTION AND MOBILE UNITS

Staffing levels for the crisis resolution and mobile units were provided by the Dixon Implementation Monitoring Committee. The suggested levels provide enough community support to significantly reduce hospital admissions. Three crisis resolution units, one for each CMHC, would operate in the new system. One unit would provide 24-hour, 7-day-a-week, telephone, walk-in, and outreach service, while the other two units would operate 16 hours for walk-in and outreach services. These units would require 42.8 full-time equivalent employees based on the following configuration.

Crisis Resolution Units

		Number of full-time equivalent employees
District II central facility service:		
24-hour telephone Crisis intervention	Mental health technicians	5.1
	Psychiatric nurses	5.1
	Psychologists	5.1
	Social workers	5.1
	Medical officer	1.0
		21.4
District I facility:		
Crisis intervention	Psychiatric nurses	3.4
	Psychologists	3.4
	Social workers	3.4
	Medical officer	0.5
		10.7
District III facility:		
Crisis intervention	Same as District I	10.7
Total staff		42.8

Mobile community treatment teams are expected to treat the most difficult chronically ill by going to the patient rather than requiring the patient to seek services at the CMHC. Mobile units operate 7 days a week for 16 hours a day. A mobile unit would be assigned to each CMHC, and each unit would require 10.7 full-time equivalent employees, consisting of 3.4 psychiatric nurses, 6.8 mental health technicians, and 0.5 medical officers, for a total of 32.1 full-time equivalent employees.

Half of the mobile units' nurses and mental health technicians, or 15.3 full-time equivalent employees, are considered as providing services during the CMHCs' normal hours of operation. Because this team is providing services measured in the outpatient needs survey, these 15.3 full-time equivalent employees were deducted from the CMHC adult programs (5.1 per district) to avoid overstaffing.

SUMMARY OF STAFF BY PROGRAM

The following schedule summarizes the patient care staff needed by various programs offering community-based services.

Staffing for Community-Based Services

Facility		Number of full-time equivalent employees
District I:		
Adult programs	67.8	
Children/youth programs	50.3	
Crisis resolution unit	10.7	
Mobile unit	10.7	139.5[a]
District II:		
Adult programs	39.9	
Children/youth programs	21.3	
Crisis resolution unit	21.4	
Mobile unit	10.7	93.3[a]
District III:		
Adult programs	48.0	
Children/youth programs	12.8	
Crisis resolution unit	10.7	
Mobile unit	10.7	82.2[a]
Total direct patient care staff		315.0

[a]Subtotals do not agree with those on page 59, due to rounding.

HOW GAO COMPUTED COSTS AND COST SHARING

The costs of operating the proposed mental health system, specialty program costs, costs that will be incurred by other programs, and how these costs will be shared are summarized in the following schedule.

Annual Costs of GAO Proposal

	Cost			
	Total	District	Federal[a]	Other[b]
	----------(millions)----------			
Mental health system costs:				
St. Elizabeths Hospital	$ 60.75[c]	$43.80	$14.00	$2.94
Acute care	20.82[c]	11.08	8.70	1.05
Community-based care	19.78	15.52	3.54	.72
Administration	1.00	1.00	-	-
Total	$102.35[c]	$71.40	$26.25[c]	$4.71
Specialty program costs:				
Mental Health for the Deaf	$ 2.33	-	$ 2.33	-
Research	3.81	-	3.81	-
Training	6.02	-	6.02	-
Total	$12.16	-	$12.16	-
Other program costs:				
Outplacement of 300 nursing/CRF patients	$4.01	$2.04	$1.82	$.15
Transfer of substance abuse programs	3.40	3.40	-	-
Total	$7.41	5.44	$1.82	$.15

[a]Includes Medicare, Medicaid, Supplemental Security Income payments for CRFs, and the costs of federal beneficiaries in the mental health system. Cost for research, training, and the deaf program at St. Elizabeths are also reported as federal costs.

[b]Includes estimated reimbursements from insurance and self-pay.

[c]Does not add due to rounding.

COSTS OF THE PROPOSED MENTAL HEALTH SYSTEM

The major cost components of the proposed mental health system for the District are (1) St. Elizabeths Hospital for long-term care, (2) acute care for adults and children, and (3) community-based care. The methodology for estimating these costs and the cost to administer the system are described in the following sections.

St. Elizabeths costs

As a long-term facility for psychiatric treatment, St. Elizabeths would cost the District about $60.75 million annually to operate (fiscal year 1983 dollars)--$39.60 million for general adult psychiatry programs and $21.15 million for the forensic psychiatry program. The following table shows the cost breakdown for the general adult programs at the hospital.

Estimated Costs of General Adult Programs at St. Elizabeths

St. Elizabeths component	Costs				
	Salaries[a]	Benefits	Other direct costs[b]	Indirect costs	Total
(Level of care)	(thousands)				
Rehabilitative psychiatric (level 5)	$ 2,909	$ 291	$ 224	$ 5,003	$ 8,427
Rehabilitative psychiatric nursing (levels 6 & 7)	4,441	444	342	7,407	12,634
Intensive psychiatric (level 8)	3,593	359	277	4,548	8,777
Intensive psychiatric nursing (levels 9 & 10)	4,512	451	347	4,450	9,760
Total	$15,455	$1,545	$1,190	$21,408	$39,598

[a]Includes direct patient care staff only.

[b]Includes costs, such as travel and supplies, associated with staff.

Salary costs were developed based on St. Elizabeths' average salary costs for each discipline and the number of staff needed for each program (see p. 58). We used St. Elizabeths' salaries because the District salaries are very similar to the federal schedule.

Employee benefit costs were estimated to be 10 percent of salary costs based on St. Elizabeths' current benefits, which average between 9 and 10 percent of salaries. Included in the benefits column are such items as the employer's contributions for life and health insurance and retirement. Although we used St. Elizabeths' experience, District benefits are virtually identical.

Other direct costs associated with patient care programs, such as travel and supplies, were assumed to be 7 percent of the salaries and benefits totals combined. This percentage is based on St. Elizabeths' experience.

Indirect costs were added at a rate of $89 a patient day--St. Elizabeths' rate for fiscal year 1982. This includes housekeeping, dietary, laundry, power plant, general administration, laboratory, and a variety of other medical and facility support costs.

Shown on the following page are the average salaries for various disciplines at St. Elizabeths and an example of how we calculated the salaries for the rehabilitative psychiatric program.

Calculation of Salaries for Adult Rehabilitation Program

Discipline	Average salary[a]	Positions	Salary costs
Doctors	$53,800	3.5	$ 188,300
Psychologists	36,600	3.0	109,800
Social workers	27,400	8.8	241,120
Supervisory nurses	34,600	8.8	304,480
Registered nurses	25,200	11.2	282,240
Licensed practical nurses	17,100	36.0	615,600
Direct care nursing	16,900	44.5	752,050
Recreational therapists	22,200[b]	13.3	295,260
Physical therapists	23,800	-	-
Speech therapists	33,600	-	-
Administration and management	46,800[c]	2.0	93,000
Clerical	13,500[d]	2.0	27,000
Total			$2,909,450

[a]Average computed using St. Elizabeths November 1982 salaries, adjusted to correct for the raise of the pay cap, which occurred in December 1982.

[b]Includes occupational therapists.

[c]Because the salary covered various St. Elizabeths positions, we targeted it at GS-14, step 5.

[d]Based on GS-4, step 5, salary--not an actual average.

Forensic program costs were estimated using the staffing reported on page 58 and the cost of current outpatient and District-operated programs. The 297 patients to be served at St. Elizabeths will cost $18,785,000 using average forensic salaries and staff levels needed for accreditation. Forensic salaries averaged slightly higher than the salaries for other programs. Forensic benefits were also assumed to cost 10 percent of salaries. Other direct costs were estimated at 7 percent of salaries and benefits, and indirect costs were assumed to be $89 a day. To this $18.8 million, we added the costs of District-operated forensic programs, budgeted at $1,943,000 in fiscal year 1983, which would be consolidated at St. Elizabeths. We also added $418,000 to cover the fiscal year 1983 costs for forensic outpatient programs expected to continue at St. Elizabeths. Total costs for forensic programs are estimated at $21,146,000.

Acute care costs

To treat patients in an acute stage of psychiatric illness, we estimate that the District's Mental Health Services Administration would need between $20.8 million and $39.6 million a year depending on where this care is provided. This estimate is based on 86,870 patient days of acute adult care services (238 average daily patient load) and about 10,000 days of child and adolescent services (27 average daily patient load).

Acute care for adults would range between $18.5 million and $34.7 million. Cost estimates for care at St. Elizabeths were $213 a day based on our staffing analysis, but up to $400 a day for room and board at general hospitals in the District for general adult psychiatric care. The following table shows various cost options for adults within this cost range.

Location of care	Per diem	Costs
St. Elizabeths Hospital	$213	$18.5
D.C. General Hospital	213	18.5
Community general hospitals	250	21.7
	300	26.1
	350	30.4
	400	34.7

Costs at St. Elizabeths are based on staffing for acute care operations approved by the Joint Commission on Accreditation of Hospitals. This $213 estimate is similar to the St. Elizabeths average cost of $220 per inpatient day to operate admissions programs in fiscal year 1982.

A variety of costs are shown for community hospitals because the rate would depend on where acute care treatment is delivered. If care is delivered at D.C. General Hospital, we estimate the costs would be similar to St. Elizabeths. Room and board charges on psychiatric wards in other general hospitals ranged between $245 and $400 a day in July 1983. The average charge among the general hospitals was $320 a day for room and board on psychiatric wards. Additional charges for professional services will increase these costs, but information was not available on routine charges for these services. District Medicaid reimbursements for professional services range from $11 to $45, depending on the type of service and the time involved. We were unable to determine the average number of services for inpatient stays.

An acute treatment program for children and adolescents would cost the District between $2.3 million and $4.8 million, again depending on where the program is located. Based on the salaries of the direct care staff needed for such a program, we estimate the costs for a children and adolescents program would be about $2.3 million at St. Elizabeths. If community hospitals are used, the costs would double to about $4.8 million. To estimate the cost of child and adolescent programs outside of St. Elizabeths, we used 10,000 patient total days of service (based on the fiscal year 1983 workload) and considered 4,200 would be children's services at a cost of $520 per day and 5,800 would be adolescent services at a cost of $450 per day. These rates are comprehensive and were provided by general hospitals that currently treat children and adolescents.

Cost of community-based programs

We estimate that it would cost about $19.8 million annually to provide services to outpatients at three CMHCs, including their crisis resolution and mobile units and contracts for psychosocial and other services.

As shown on page 59, about 315 full-time equivalent employees will be needed to provide direct care outpatient services at the three CMHCs.

The average fiscal year 1983 annual salary for District outpatient providers by discipline was:

Discipline	Average annual salary
Medical officer	$54,356
Psychologist	31,309
Social worker	27,436
Nurse	29,725
Mental health counselor	21,033
Therapist	21,651

Using the average annual salary, the current staff distribution, and the staffing needs projected by the outpatient needs assessment survey, we computed the salary and benefit costs for operating the adult outpatient programs at the three CMHCs to be $5.3 million, as shown on the following page.

APPENDIX IV

Staffing Needed and Direct Costs for Adult Outpatient Programs

Area	Discipline	Number of full-time equivalents	x	Average annual salary	=	Total salary cost for discipline	
District #1	Medical officer	11.52		$54,356		$ 626,181	
	Psychologist	3.21		31,309		100,502	
	Social worker	16.91		27,436		463,943	
	Psychiatric nurse	14.34		29,725		426,257	
	Mental health counselor	15.55		21,033		327,063	
	Therapist	6.13		21,651		132,721	
		67.66[a]				2,076,666	
		10-percent benefits				207,667	
							$2,284,333
District #2	Medical officer	7.10		$54,356		385,928	
	Psychologist	1.98		31,309		61,992	
	Social worker	10.30		27,436		286,157	
	Psychiatric nurse	8.19		29,725		243,448	
	Mental health counselor	8.27		21,033		173,943	
	Therapist	3.78		21,651		181,841	
		39.75[a]				1,233,309	
		10-percent benefits				123,331	
							1,356,640
District #3	Medical officer	8.39		$54,356		456,047	
	Psychologist	2.34		31,309		73,263	
	Social worker	12.32		27,436		338,012	
	Psychiatric nurse	9.99		29,725		296,953	
	Mental health counselor	10.41		21,033		218,954	
	Therapist	4.46		21,651		96,563	
		47.91[a]				1,479,792	
		10-percent benefits				147,979	
							1,627,771
							$5,268,744[b]

[a]Does not agree with page 66 due to rounding.

[b]The staffing costs for adult programs range from $4,811,256 to $5,727,314, at the 95-percent confidence level, using the staff range described on page 64.

Cost of staffing the crisis resolution and mobile units

Using the staffing estimates shown on page 65, we arrived at salary and benefit costs for the crisis resolution and mobile units to be $1.38 million and $.87 million, respectively.

Crisis Resolution Units

Discipline	Number of full-time equivalents	x	Average annual salary	Total cost for discipline
Medical officer	2.0		$54,356	$ 108,712
Psychologist	11.9		31,309	372,577
Psychiatric nurse	11.9		29,725	353,728
Social worker	11.9		27,436	326,488
Mental health technician	5.1		18,492	94,309
	42.8			$1,255,814
	10-percent benefits			125,581
				$1,381,395

Mobile Units

Discipline	Number of full-time equivalents	x	Average annual salary	Total cost for discipline
Medical officer	1.5		$54,356	$ 81,534
Supervisory psychiatric nurse	5.1		34,700	176,970
Psychiatric nurse	5.1		29,725	151,598
Mental health technician	20.4		18,492	377,237
	32.1			$ 787,339
	10-percent benefits			78,734
				$ 866,073

Children and youth program costs

Providing children and youth services will cost about $2.6 million in fiscal year 1983. As shown in appendix III, the children and youth patient population should not increase. Therefore, this cost should remain unchanged.

Contract costs

We estimate that contractual outpatient services will cost $5.3 million based on fiscal year 1982 costs and projected need. The outpatient needs assessment survey projected the number of patients needing various contractual services. For example, the survey projected that 1,151 patients need psychosocial day activities; additionally, a number of patients need homemaker, chore, and respite care services.

Contractor-provided psychosocial day activity programs cost $4,034 per patient year (fiscal year 1982). With 1,151 patients needing these services, the total cost of day activity is estimated at $4,643,134 annually ($4,034 x 1,151). The total cost for the other contract services is difficult to estimate since the volume of services needed is not based on standards as are other services, such as day activity. Fiscal year 1982 costs for the homemaker and respite care services were $101,269. Other contract services include emergency shelters and community education programs, which cost $549,431 in fiscal year 1982. Since these contracts were underutilized in fiscal year 1982, we considered that the costs of the needed services would not be greater than the fiscal year 1982 costs.

Indirect costs

Our estimates of indirect costs related to outpatient services include such items as administration, maintenance and repair, utilities, supplies and pharmaceuticals, housekeeping, laundry, and dietary costs. To estimate an indirect cost rate, we reviewed the indirect costs of three outpatient clinics affiliated with large accredited psychiatric hospitals in New York and the three CMHCs in the District. Indirect cost as a percentage of total costs ranged from 16.6 to 32.9 percent. Based on this range, we assumed indirect costs at 30 percent of total costs. The estimated direct and indirect costs for operating outpatient facilities are shown below.

Total Costs for Outpatient Facilities

Facility	Direct costs	Indirect costs	Total costs
District #1 CMHC	$ 3,838,111	$1,644,905	$ 5,483,016
District #2 CMHC	1,845,871	791,087	2,636,958
District #3 CMHC	2,141,839	917,931	3,059,770
Crisis resolution units	1,449,595	621,255	2,070,850
Mobile treatment units	866,073	371,174	1,237,247
Total	$10,141,489	$4,346,352	$14,487,841

Summary of community-based costs

The estimated $19.8 million for providing community-based services is made up of the following components:

Summary of Costs for Community-Based Services

Facility		Cost
District #1:		
Adult programs	$3,263,333	
Youth programs	2,219,683	$ 5,483,016
District #2:		
Adult programs	1,938,057	
Youth programs	698,901	2,636,958
District #3:		
Adult programs	2,325,387	
Youth programs	734,383	3,059,770
Crisis resolution units		2,070,850
Mobile treatment units		1,237,247
Contracted services		5,293,834
Total		$19,781,675

Administrative costs

We estimate that it would cost about $1 million to administer the proposed system. This estimate is based on the current administrative cost of $800,000 budgeted by the District in fiscal year 1983 and the need to increase administrative staff to oversee the system's operation. Additional administrative costs of about $8.2 million are included in the indirect cost rate ($89 per patient day) used to determine the cost of inpatient programs to continue at St. Elizabeths.

COST OF SPECIALTY PROGRAMS

Specialty programs for deaf patients and research and training programs are currently provided at St. Elizabeths but are not geared specifically to District patients.

Costs for the Mental Health Program for the Deaf totaled $2.6 million in fiscal year 1983. If the program is continued at St. Elizabeths at its current level, we estimate the annual costs would be $2.3 million using the direct care staffing described on page 58. This program receives referrals from throughout the country, and less than half of its patients are District residents. As a result, we propose that the program be continued as a demonstration program supported entirely by the federal government.

Two specialty research programs have been ongoing at St. Elizabeths--the William A. White Division, a clinically based program for about 25 inpatients, and the Hoffman Division, which conducts behavioral, nursing, social, and environmental research. These programs, as federal initiatives, could be continued at federal expense--about $3.8 million annually of St. Elizabeths' budget based on fiscal year 1983 costs.

One other specialty program, the Overholser Division of Training, sponsors clinical training for medical students, psychologists, social workers, as well as chaplains, therapists, and others serving the mental health population. About $6 million was spent in fiscal year 1983 to operate these training programs, and often trainees are used to supplement ward-based staff. We have included these training programs as federal costs if the federal government decides to continue them under its sponsorship.

COSTS TO OTHER PROGRAMS

Under our proposal, three categories of patients would be outplaced from St. Elizabeths--alcohol and drug abuse patients, nursing home patients, and patients who can be placed in CRFs. These patients add costs to other District-operated programs. Alcohol and drug abuse patients will be treated in programs operated by the District's Alcohol and Drug Abuse Services Administration. The current cost to treat these patients at St. Elizabeths is about $6.3 million. Programs run by the District have been less costly. The substance abuse workload handled by St. Elizabeths at the end of fiscal year 1983 was about 100 inpatients and 162 outpatients. The District recently estimated that it would cost about $3.4 million in fiscal year 1984 to provide services to these patients.

An estimated $4 million annually would be needed to provide nursing home care and CRFs for patients transferred to less restrictive settings. According to the level-of-care survey, about 200 St. Elizabeths patients are functionally similar to patients living in CRFs. Costs of CRF services are based on the reimbursement that licensed facilities receive. Small CRFs charge $376.50 a month, and large CRFs charge $486.50 because their licensing requires more program staff. Generally, this monthly fee is supplemented by a $35 personal allowance given by the District of Columbia to each resident. CRF payments usually consist of the resident's Supplementary Security Income payment (maximum of $284.30 a month), which is supplemented with funds from the District's Income Maintenance Administration, referred to as the D.C. Supplemental payment.

To determine the costs associated with the outplacement of these patients, we assumed that patients would be outplaced to small CRFs because this is consistent with the Dixon Implementation Plan. Overall, the costs of the CRF placements will be about $1 million.

About 100 St. Elizabeths patients can be treated in community nursing homes. To estimate the nursing care costs, we used information from the District's Long-Term Care Administration showing reimbursement rates for existing Medicaid nursing home beds. Intermediate care beds averaged $70 per day, and skilled nursing beds averaged $90 per day based on May 1982 information. Based on these rates and our level of care information, nursing care will cost about $3 million annually.

HOW THE COSTS WILL BE SHARED

Based on information on patient eligibility for Medicare, Medicaid, and other insurance, we estimate that the District will pay about 70 percent of total mental health costs and other sources will pay about 30 percent. The following table summarizes the assumptions used to determine who would pay the costs of various services.

Assumptions on Cost Sharing for GAO Proposal

	Percent eligible				
Mental health programs (level of care)	Medicaid	Medicare	D.C. Medical Charities	Other insurance self-pay	Federal beneficiaries
Acute care:					
Adults	70	10	15	5	-
Children	70	-	25	5	-
Intermediate nursing care (level 3)	80	-	15	5	-
Skilled nursing care (level 4)	80	-	15	5	-
Rehabilitative pysychiatric (level 5)	34	-	53	5	8
Rehabilitative pyschiatric nursing (levels 6 & 7)	62	-	25	5	8
Intensive psychiatric (level 8)	16	-	75	5	4
Intensive psychiatric nursing (levels 9 & 10)	44	-	41	5	10
Forensic	4	-	76	5	15
Outpatient services	52	-	43	5	-

Medicare

Medicare benefits can be expected to cover only a minor part of the total costs of care. While a number of St. Elizabeths inpatients are covered by Medicare, reimbursements for care are limited in a number of ways. First, Medicare imposes a special lifetime limit of 190 days of full hospitalization coverage for inpatient psychiatric care. In addition, hospitalization under Medicare can generally be covered for up to 90 days of treatment, at which point this "spell of illness" must be broken for 60 days before subsequent coverage is allowed. However, each patient has a 60-day lifetime reserve, so one spell of illness may be extended up to 150 days of coverage. Based on the level of care survey, virtually all of the patients to be treated at St. Elizabeths will have exceeded the 90-day spell of illness. As a result, our estimates assume the only Medicare coverage for St. Elizabeths patients will be for physician services. These services are now billed at $7.85 per day, and reimbursements should amount to about $500,000 annually.

We assumed that about 10 percent of acute inpatient costs would be covered by Medicare. This is based on our analysis of 166 acute care patients, of whom 13 percent had Medicare hospitalization benefits. We did not assume any Medicare benefits for nursing patients because coverage is limited to short-term care for patients who require daily delivery of skilled nursing or rehabilitative procedures. No Medicare reimbursements are expected for outpatient services because District CMHCs are not Medicare certified.

Medicaid

Medicaid reimbursements should cover about 40 percent of the costs of the system and will be shared by the District and the federal government. The District's Medicaid program covers persons needing subsidized medical assistance. Two categories of patients are automatically eligible for Medicaid--those eligible for Supplemental Security Income and those receiving Aid to Families with Dependent Children. The District's program also covers persons who meet certain income requirements to qualify as medically needy. Medically indigent persons between the ages of 21 and 65 who fail to meet any of the categories eligible for Medicaid may qualify for D.C. Medical Charities. The District will pay for the medical care of these individuals at District facilities or at contract hospitals at a rate of $76 per inpatient day and $12 per outpatient visit. The federal government does not share in the costs of care for D.C. Medical Charities.

Inpatient psychiatric benefits under Medicaid are also limited. If an eligible individual is between the ages of 21 and 65 and is treated in an institution for mental disease, then Medicaid will not pay for these services. There is no age restriction, however, for psychiatric care rendered in a general hospital or for outpatient services. Medicaid is also the final payor for services. All other parties must be billed first, and Medicaid will pay the residual.

By matching patient level-of-care information with Medicaid benefit eligibility data, we found the following percentages of general adult inpatients meeting the age criteria (under 22 or over 64 years of age) for Medicaid entitlement at St. Elizabeths.

Medicaid-Eligible Patients at St. Elizabeths

		Percent of patients		
Level of care	Total patients	Medicaid eligible	Medicaid unknown	Total potentially Medicaid eligible
Level 5	157	25	8	34[a]
Levels 6 & 7	228	40	21	62[a]
Level 8	140	13	4	16[a]
Levels 9 & 10	137	32	12	44
Forensic	297	3	1	4

[a]Does not add due to rounding.

Our Medicaid estimates are based on the total numbers of patients reported as potentially eligible. Because St. Elizabeths did not become a Medicaid provider until December 27, 1982, and because establishing eligibility for patients has been a time-consuming process, many of the patients we reviewed did not yet have Medicaid established. For cases that met the age criteria, we assumed they would become Medicaid eligible because of their age and the long-term nature of their disability.

The table shows that the District will assume most of the costs for indigent patients in levels of care 5 and 8 and forensic patients because so few meet the age restrictions to qualify for Medicaid reimbursements for care at St. Elizabeths. In addition, about 40 percent of the special nursing patients (levels of care 6 and 7) would not qualify for Medicaid reimbursements. Using these percentages of patients potentially eligible for Medicaid reimbursements, we computed that about $17 million of the $60.7 million St. Elizabeths budget would be covered by Medicaid.

Because 90 percent of the acute adult inpatients are under 65 years of age, their treatment at St. Elizabeths cannot be reimbursed by Medicaid. As a result, little information is known on the Medicaid eligibility of the group. We were unable to pinpoint the number of Medicaid eligibles but assume the range of adults eligible to be between 30 and 70 percent based on:

--An analysis of 166 St. Elizabeths acute inpatients as of September 30, 1982. Seven months later, they were still on the hospital rolls. Most had not had current Medicaid benefits determined, but 22 percent had Medicaid, 9 percent had Medicare, 4 percent had both, and 4 percent had Medical Charities eligibility. From this, we estimated that at least 26 percent had Medicaid benefits.

--The outpatient needs assessment survey showing Medicaid eligibles of about 50 percent. About 32 percent of the remaining cases had missing information. Based on these data, an adjusted frequency of Medicaid eligibility of about 70 percent can be estimated.

--An analysis made by the District and St. Elizabeths from a prior outpatient needs assessment survey showing that up to 71 percent of the mental health users between 19 and 64 years of age meet the general income test for Medicaid.

Available information indicates that many of the children and adolescent patients will be Medicaid eligible. A Children's Hospital official told us that about two-thirds of its patients are Medicaid eligible. We assumed that about 70 percent of the child and adolescent patient population will be eligible for Medicaid.

Our estimates for Medicaid reimbursements for outpatient services are based on 52 percent eligibility reported in the outpatient needs assessment survey. We assumed, based on the current situation, that all the community-based services except the contractor-provided services would be Medicaid eligible.

Medicaid is also the important benefit for nursing patients. About 34 and 46 percent of the intermediate and skilled nursing patients, respectively, were eligible for Medicaid. Virtually all remaining patients had no recently established Medicaid information. As a result, somewhere between 40 and 100 percent of the patients could be eligible for Medicaid. We assumed 80 percent would qualify.

Given their long-term disability, we assumed that all the patients placed in CRFs would qualify for Supplemental Security Income, receiving the maximum benefit of $284.30 monthly.

Other insurance and self-pay

Information on the District's current collections for inpatient mental health services indicates that payments from insurance and patients will be extremely limited. District collections for fiscal year 1983 are estimated at about $1.1 million. St. Elizabeths expected to collect about $2.6 million in reimbursements from insurers and self-pay patients in fiscal year 1983, but only $31,000 had actually been received by the end of September 1983. Neither the District nor St. Elizabeths has aggressively sought payments from insurers and patients.

The outpatient needs assessment survey showed that about 13 percent of the patients have some form of insurance alone or in combination with other benefits, but this is difficult to translate into reimbursable dollars.

Considering the limited collections but the degree of insurance, we assumed that third-party insurer and patient payments for inpatient and outpatient services will be about 5 percent for all categories of patients.

Federal beneficiaries

Under our proposal, the cost of care for federal beneficiaries treated at St. Elizabeths will be paid by the federal government. Besides research patients, about 72 federal beneficiaries were in general hospital programs. About one-third of these could be outplaced. An additional 42 patients were under the control of U.S. courts. The following schedule shows by program the percentage of St. Elizabeths patients who were federal beneficiaries on September 30, 1982.

Estimates of Federal Beneficiaries

St. Elizabeths programs	Number	Percent of total
Level 5	12	8
Levels 6 & 7	18	8
Level 8	5	4
Levels 9 & 10	13	10
Forensic	42[a]	15

[a]Estimate from April 30, 1983, based on the number of federal court cases. The federal appropriation would cover the costs of indigent nonresidents sent to St. Elizabeths pending restoration of competency to stand trial or after acquittal by reason of insanity. Because St. Elizabeths had no information on the number of nonresidents, we estimated that all those from federal courts (15 percent) would be reimbursed under the federal appropriation.

SUMMARY OF COSTS AND COST SHARING

Combining the costs developed for each program with eligibility information shows how the costs of the mental health system would be shared. The federal contribution includes Medicare reimbursements, about one-half of the Medicaid reimbursements, and the costs of federal beneficiaries. Individuals, either through insurance or self-pay, will cover 5 percent of the costs. The District will be responsible for the remainder of the costs. The following table summarizes the costs and cost sharing of the mental health system.

APPENDIX IV

Cost Summary for GAO Proposal

	Cost				Major Assumptions[a]	
	Total	District	Federal	Other	Medicaid eligibles	Federal beneficiaries
	(millions)				(percent)	
St. Elizabeths Hospital						
Level 5	$ 8.43[b]	$ 5.98	$ 2.02	$ .42	34	8
Levels 6 & 7	12.63	7.31	4.69	.63	62	8
Level 8	8.78	7.33	1.01	.44	16	4
Levels 9 & 10	9.76	6.28	2 99	.49	44	10
Forensic	21.15	16.90	3.29	.96	(c)	(c)
Subtotal	60.75[b]	43.80	14.00	2.94		
Acute care:						
Adults[d]	18.50[b]	9.64	7.94	.93	70	10[e]
Children[f]	2.32	1.44	.76	.12	70	-
Subtotal	20.82[b]	11.08	8.70	1.05		
Community-based care:						
District I	5.48	3.87	1.34	.27	52	-
District II	2.64[b]	1.86	.64	.13	52	-
District III	3.06	2.16	.75	.15	52	-
Crisis resolution units	2.07	1.46	.51	.10	52	-
Mobile treatment units	1.24[b]	.87	.30	.06	52	-
Contract services	5.29	5.29	-	-	-	-
Subtotal	19.78	15.52[b]	3.54	.72[b]	-	-
Administration	$ 1.0	$ 1.0				
Total	$102.35[b]	$71.40	$26.56	$4.71		
Specialty programs:						
Mental Health for the Deaf	$ 2.33	-	$ 2.33	-	-	100
Research	3.81	-	3.81	-	-	100
Training	6.02	-	6.02	-	-	100
Total	$12.16	-	$12.16	-		
Other program costs:						
Nursing & CRF beds	$4.01	2.04	$1.82	$.15	80[g]	-
Transfer of substance abuse functions[h]	3.40	3.40	-	-	-	-
Total	$7.41	5.44	$1.82	$.15		

[a]Assumes 5 percent of costs are self-pay, or insurance. Federal costs include Medicare, 47 percent of Medicaid contributions, and the cost of federal beneficiaries. The District would pay the remainder of the costs.

[b]Does not add due to rounding.

[c]Cost sharing is based on 4 percent of inpatients and 19 percent of outpatients being Medicaid eligible. Federal beneficiaries are estimated at 15 percent of inpatients and 19 percent of outpatients.

[d]Assumes acute care provided by D.C. General Hospital at $213 per patient day.

[e]Medicare reimbursements.

[f]Assumes care provided by either D.C. General Hospital or St. Elizabeths

[g]Assumes about 80 percent Medicaid for nursing patients and 100 percent Supplemental Security Income for CRF patients

[h]Estimates based on District fiscal year 1984 budget request

INDIVIDUALS AND GROUPS BRIEFED BY GAO ON THE PROPOSED SYSTEM

DEPARTMENT OF HEALTH AND HUMAN SERVICES

1/14/83 - Dr. William Mayer, Administrator; Alcohol, Drug Abuse, & Mental Health Administration (ADAMHA)
4/25/83 - Dr. Mayer, Administrator, ADAMHA
Mr. Trachtenberg, Deputy Administrator, ADAMHA
Mr. Leone, ADAMHA Executive Officer
Mr. Pittman, Executive Officer, NIMH
6/14/83 - ADAMHA Executive Work Group - Messrs. Akins and Pittman
8/24/83 - Ms. Ann Scott, Office of Assistant Secretary for Management and Budget, HHS

ST. ELIZABETHS HOSPITAL

2/4/83 - Dr. William Dobbs, Superintendent
Dr. Bernie Arons, Dixon Office Director
Mr. Mike English, Director, Division of Administrative Services
5/11/83 - Bargaining Unit Representatives
6/16/83 - EEO Advisory Council Members
7/13/83 - Division Administrative Officers
8/11/83 - Dr. Dobbs, Superintendent
Dr. Ponquinette, Assistant Superintendent
Ms. Patricia McCarthy, Director, O'Malley Division
Mr. Raymond Becich, Associate Superintendent for Administration
Dr. Eugene Stammeyer, Director for Psychology
Mr. Curtis Hester, Director for Social Service
Dr. Vallory Lathrop, Director for Nursing

DISTRICT OF COLUMBIA GOVERNMENT

1/18/83 - Ms. Debbie Maise, Research Manager, Office of Policy and Program Evaluation (OPPE)
3/31/83 - Dr. Averett Parker, Administrator, Mental Health Services Administration
Dr. Bannik, Director, South CMHC
Mr. Wheeler, Administrative Officer, North CMHC
Ms. Senior-Fisher, Assistant to the Administrator
Ms. Henderson, Chief, Ugast Center
Mr. Smith, Administrative Officer, South CMHC
Mr. Williams, Associate Center Chief, Adult and Geriatric Services, North CMHC

DISTRICT OF COLUMBIA GOVERNMENT (continued)

4/25/83 - Ms. Betsy Reveal, D.C. Budget Director
Ms. Virginia Fleming, Deputy Director, OPPE
Ms. Debbie Maise, Research Manager, OPPE
6/29/83 - Ms. Joan DePontet, Long-Term Care Administration
Ms. Sheila Joroff, Long-Term Care Administration
8/17/83 - Ms. Virginia Fleming, Deputy Director, OPPE
Ms. Debbie Maise, Research Manager, OPPE
Ms. Marie Danforth, Budget Office
Ms. Lee, Budget Office
8/19/83 - Dr. Ernest Hardaway, Acting Commissioner of Public Health
9/28/83 - Mr. David Rivers, Acting Director of Human Services
Mr. Wilson, Director, State Health Planning Agency
Ms. Jones, State Health Planning Agency

OFFICE OF MANAGEMENT AND BUDGET

4/14/83 - Ms. Barbara Kievamae, Office of Human Resources
8/15/83 - Mr. David White, Office of Human Resources

PROFESSIONAL ASSOCIATIONS

8/16/83 - Dr. Sharpstein, Deputy Medical Director, American Psychiatric Association (APA)
Dr. Jean Spurlock, Deputy Medical Director for Minority/National Affairs, APA
Dr. Carolyn B. Robinowitz, Deputy Medical Director for Education, APA
Mr. Frederick Fedeli, Assistant Director, Government Relations, APA
9/8/83 - Mr. Harry Schnibbe, Executive Director, National Association of the State Mental Health Program Directors
Dr. Stanley Platman, Director, Maryland State Department of Health and Mental Hygiene
9/9/83 - Mr. Walter Batchelor, Program Officer, Health Policy, American Psychological Association (APA)
Mr. Dick Hillberg, Administrative Officer for Professional Affairs, APA
Dr. Maxine Harris, Clinical Psychologist, APA
Dr. Faith Tanney, D.C. Psychological Association
9/20/83 - Ms. Lillian Secundy, President, Mental Health Association of D.C. (MHADC)
Dr. Juliette Simmons, Board of Directors, MHADC
Dr. Gottleib Simon, Social Psychologist, MHADC
Dr. Barbara Tobelmann, Executive Director, MHADC
9/27/83 - Dr. Lawrence Sack, Chairman, Washington Psychiatric Society

PROFESSIONAL ASSOCIATIONS (continued)

9/29/83 - Dr. Raymond Band, Chairman, Mental Health Committee, D.C. Medical Society
Dr. David Joseph, Chairman, D.C. Chapter of Washington Psychiatric Society

OTHERS

American Federation of State, County, and Municipal Employees

4/13/83 - Mr. Albert Russo, Coordinator, Social Services Programs, Department of Legislative Affairs
Dr. Rasmussen, Health Policy Specialist
Ms. Brown, Legislative Representative
8/9/83 - Mr. Russo, Coordinator, Social Services Programs, Department of Legislative Affairs
Mr. Peoples, Administrator, Council #20
Ms. Brown, Legislative Representative

Dixon Implementation Monitoring Committee

4/21/83 - Ms. Gail Marker, Committee Coordinator
Mr. Harry Schwartz, Graduate Student
6/24/83 - Dr. Len Stein, Professor of Psychiatry, University of Wisconsin Medical School
Dr. Joe Bevilacqua, Commissioner, Department of Mental Health and Mental Retardation, Commonwealth of Virginia
Mr. Chuck Morgan, C&P Telephone Company
Ms. Marlene Ross, Director, Mental Health Services, Michigan Department of Mental Health
Mr. Bob Collins, Green Door Member
Ms. Marker, Committee Coordinator
Ms. Dorothy Sharpe, Urban Consultant

Joint Commission on Accreditation of Hospitals

9/15/83 - Dr. John Afeldt, President
Dr. Don Widman, Director of Standards

Ohio Department of Mental Health

4/1/83 & 4/27/83 - Mr. Don Chesser, Special Assistant to the Commissioner of Mental Health

Northern Virginia Mental Health Institute

8/24/83 - Dr. Robert Strange, Director

OTHERS (continued)

State Mental Health Advisory Council

11/16/83 - Ms. Beverly Russau, Chairperson
Members: Ms. June Bland, Ms. Joyce Forest,
Ms. Blanche Beverly, Ms. Alice Dodge,
Ms. Juliette Simons

APPENDIX VI

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

FEB 23 1984

Mr. Richard L. Fogel
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The Secretary asked that I respond to your request for our comments on your draft of a proposed report "A Proposal for Transferring St. Elizabeths Hospital to 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,

Richard P. Kusserow
Inspector General

Enclosure

APPENDIX VI

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GENERAL ACCOUNTING OFFICE'S DRAFT REPORT ENTITLED "A PROPOSAL FOR TRANSFERRING SAINT ELIZABETHS HOSPITAL TO THE DISTRICT OF COLUMBIA," DATED JANUARY 9, 1984

General Concurrence

The Department of Health and Human Services supports the general assumption of the House Committee on the District of Columbia on which the General Accounting Office's (GAO) draft report, "A Proposal for Transferring Saint Elizabeths Hospital to the District of Columbia," is based: The hospital should be integrated into the mental health system of the District of Columbia. Consistent with the Administration's policy, we support the 10 year phase-down of the direct Federal subsidy for District residents at Saint Elizabeths Hospital. Arguments for such an integration and reduction of the Federal subsidy include:

(1) Since 90 percent of the Saint Elizabeths Hospital patient population are District residents, the Federal subsidy should be gradually reduced as the District develops a mental health system consistent with home rule.

(2) Isolation of Saint Elizabeths from mental health services provided by the city prevents the District from offering local residents a true continuum of quality care in which patients receive appropriate treatment in the least restrictive settings.

(3) Fragmentation of fiscal authority between Federal and local authorities has fostered wasteful and potentially inhumane care and treatment patterns. Few incentives under the current "cap" on District payments exist to encourage medically sound outplacement of Saint Elizabeths' patients to community facilities or to discourage inappropriate referrals to the hospital by local law enforcement or human service agencies.

General Comments

The draft report conveys correctly how the current fragmentation of mental health services in the District limits the opportunity of city residents to receive comprehensive care. The report's principal proposal that Saint Elizabeths be quickly integrated into the District's mental health system is generally in accord with the Administration's 10 year phase-down of the Federal subsidy.

Areas of Agreement

In addition to our agreeing with the expeditious transfer of Saint Elizabeths from Federal to local control, the Department supports GAO's proposals that:

(1) The District establish a community mental health service system to be responsible for all outpatient care

We believe appropriate incentives for cost-effective delivery of services can be provided through having the dollars follow the patients and having those funds controlled by the same individuals who determine where the patients can be most effectively treated.

Many of these services should be delivered in the community rather than in an acute care or chronic care institution, which is consistent with current psychiatric practice. The final GAO report should emphasize the absolute need for the District to be responsible for all outpatient care by overcoming management and resource deficiencies that brought about the moratorium on outplacements under the Dixon suit.

(2) The inpatient population of Saint Elizabeths be reduced through appropriate outplacements and relocation of functions

We have long advocated that all patients who could be treated in the less restrictive environments of nursing homes or community residential facilities be transferred out of Saint Elizabeths' inpatient wards.

We support the transfer of alcohol and drug abuse programs now operated by the hospital to city control.

The Department sees potential fiscal merit in the GAO concept that area hospitals assume responsibility for providing acute psychiatric care to District residents. Nevertheless, we believe GAO should explore whether maintaining psychiatric beds in general hospitals is more costly than the current system.

Specific Comments

(1) Federal employees at Saint Elizabeths must be afforded every protection and opportunity as functions are transferred to the District of Columbia

The Department is concerned that a change to the established "transfer of function" process would unfairly disadvantage Federal employees now at Saint Elizabeths. These employees have a right to transfer with their work and, if surplus to the District's needs, to compete with other employees in the District's mental health system. Furthermore, the unique language of any such provision in the transfer legislation would almost certainly be tested through disruptive litigation. In our view, the District's residency requirement need not apply at all. When the District adopted the residency requirement, it exempted employees then on its rolls. It would be reasonable to exempt Federal employees now at Saint Elizabeths because in effect they are not new hires to the District government.

(2) Potential alternative uses for major portions of the Saint Elizabeths "campus" need to be planned and implemented with great care

We concur with GAO that by reducing to 1,000 the inpatient population and by transferring many functions and services performed by the hospital to other sites, much of the campus could be adapted for other uses. The draft report is silent on the Department's renovation activities at the hospital. The Department also notes that the draft report mentions possible impediments to alternative uses of the "campus" among buildings cited for historic preservation. There is a need for further review and discussion on the issue of alternative site use.

(3) Financial estimates need to be calculated carefully

At the core of any real and lasting solution to the problems surrounding mental health services in the District is the issue of funding.

Every proposal over the past 20 years to transfer Saint Elizabeths from Federal to local control, and every round of negotiation between the District and Department officials, has not succeeded because no agreement could be reached on fiscal responsibilities.

The draft report provides a different way of achieving what have long been competing goals--establishing one mental health system under local control and, at the same time, reducing the overall cost of services. We have reservations about certain GAO costs assumptions. Indeed, the GAO proposes that the Federal Government pay more in the short run than it has planned under the Administration's draft corporation proposal, since its proposal would efffectively maintain the Federal payment at the Fiscal Year 1983 level for Fiscal Years 1984, 1985, and 1986.

The Department is also concerned about the formulation of cost for the acute care beds. Although included in the report, references to the contingent nature of cost savings for acute care are scattered. They do not consistently appear when savings are cited. It appears in fact that D.C. General Hospital is the only institution with the potential for offering savings of the magnitude cited in the report, and that use of this facility is contingent on building renovations.

At the core of our concerns over budget is the GAO comparison used to arrive at system and per diem estimates. We have reservations about the States, hospitals, and outpatient-oriented models GAO used as points of comparison.

(4) The transfer of functions is best accomplished through the mechanism of a private nonprofit corporation

The Department believes that the best mechanism for achieving the expeditious transfer of Saint Elizabeths to the District and for developing an integrated system for mental health services is the establishment of a private nonprofit corporation. Such a corporation would provide an objective and effective structure for dealing with the important and sensitive issues of personnel transfers, facility use, and the development of strong and effective local mental health system management.

Conclusion

Converting to local government control a facility that is logically a community responsibility is a positive step toward improving the District's delivery of mental health services. A unified system would assure the continuity of care between the community mental health outpatient centers and inpatient facilities. The unified system would also permit the District to be in a better position to determine its own priorities regarding the degree of use of inpatient and outpatient care. Additionally, a unified system would provide the base on which the District can develop its own integrated, comprehensive mental health system.

The Federal Government recognizes, however, that it cannot immediately remove its support from Saint Elizabeths. Intensive dialogue must now begin for consolidating Saint Elizabeths into a unified system. We believe that the issue concerning optimal governance and financial arrangement can be appropriately addressed through congressional hearings on the Administration's corporation proposal.

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THE DISTRICT OF COLUMBIA

WASHINGTON D C 20004

MARION BARRY JR
MAYOR

9 FEB 1984

Mr. William J. Anderson
Director, General Government Division
U.S. Government Accounting Office
Washington, D.C. 20548

Dear Mr. Anderson:

On January 9, 1984 you sent for my review and comment a draft report on how Saint Elizabeths Hospital can be transferred to the District.

I am aware that the scope of your study as established by the instruction you were given, was to plan a method to transfer Saint Elizabeths Hospital to the District. However, at the initiation of your work I advised the House District Committee that the scope of this study was too narrow, and that a broader set of options needed to be reviewed. We have ourselves undertaken that review over the last six months.

During Congressional hearings on the FY 1984 budget, I made a commitment to provide a viable comprehensive alternative plan for delivering mental health services to District residents, in light of the federal government's determination to close down the service delivery functions of Saint Elizabeths.

You are aware that I recently completed the preparation of such a plan, and announced my intention to develop a comprehensive District-administered system. This plan is the culmination of six months of study by my staff, assisted by the work of a consultant, James Pickman and Associates; the result is the framework of a system tailored to the District's needs and resources, and a plan to implement it.

I am providing this background information to assure you that our comments on the substance of your recommendations are based on extensive prior study of a broad range of issues and alternatives.

APPENDIX VII

In comparing your report with my proposed system design, one can readily appreciate that the objective of each study is the creation of a comprehensive mental health system for the District. However, the methods for achieving that objective are quite different. I am providing with this letter a point-by-point comment on the key aspects of your proposal, and outlining the alternative which I have recommended in each case.

In summary, the October 1, 1985, date for District assumption of all responsibility, and the subsequent two year time frame for total restructuring of the existing system, are highly unrealistic. The recommended reduction by October 1, 1986, of $22 million in federal support for the system not only overestimates the savings potential from reorganization, but assumes that it can be realized at the start of the transition, before any actions have actually taken place. In addition, the phasing out of all federal support by 1988 threatens the potential for success of any proposal, because of the District's limited revenue potential and the extraordinarily high demand for mental health services in the nation's capital.

You propose to transfer all of the patients and employees at Saint Elizabeths Hospital to the District, with only the sketchiest blueprint of how both the census and the employee roster should be reduced to an appropriate size for the District. That would transfer to the District the cost and difficulty of phasing down a national institution which it did not create and should not be required to take over.

We must all recognize that the annual withdrawal of millions of dollars in federal funds from Saint Elizabeths forces program decisions that are not in the best interests of the patients, the staff, and the welfare of District citizens.

I hope that you will carefully consider the clarifications and concerns that I have raised in my response, and will take account of each of them in your final report. I request further that the substance of my own proposals be incorporated in your final report.

When your report is issued, I will be pleased to make it available to my Advisory Committee which is preparing final recommendations to me on a comprehensive District system and transition plan. We want to consider all viable ways to arrive at our common objective before I forward to the Congress our legislative proposals in late April or early May.

Sincerely,

Marion Barry, Jr.
Mayor

APPENDIX VII

Comments on Draft of a Proposed Report

February 9, 1984

A PROPOSAL FOR TRANSFERRING ST. ELIZABETHS HOSPITAL TO THE DISTRICT OF COLUMBIA

GENERAL ACCOUNTING OFFICE (GAO)

Introduction

The GAO was instructed to plan the transfer of Saint Elizabeths Hospital to the District. It recommends that this happen on October 1, 1985 (FY 1986). Its proposal includes these major points:

* That buildings and grounds unneeded by the District Government shall be retained by the Federal government for federal uses.

* That an estimated 2,300 patient care staff shall be transferred to the District, but Congress shall legislate a means for the District to select the 1400 staff it is projected to need, and Congress shall provide an alternative plan for the remaining 900. The alternative was not defined in the report. A plan for the approximately 1000 support staff was not presented in the report.

* That the federal government shall reduce its contribution to the mental health system from $67.8 million in FY 1984 to $40 million at the beginning of the two year "transition period" in FY 86. This would not cause any additional expenditures by the District, due to immediate savings generated by reorganization. The $40 million would be available for two years only. After FY 1987, no direct or predictable federal support shall be available.

* That 1600 of the present 1700 patients at Saint Elizabeths shall be transferred to the District, and in the two subsequent years, FY 1986 and FY 1987, the District shall reduce the Saint Elizabeths population by 600 patients, by purchasing acute care in 200 general hospital beds, outplacing 300 patients, and transferring the 100 bed alcohol and drug abuse program.

* That the District Government shall administer at Saint Elizabeths a chronic care hospital of 670 beds, and a forensic institution for 300 criminally insane, using existing SEH staff and buildings for this purpose.

We comment on the report as follows:

Scope of GAO Study

Proposal

The scope of this study as established by the instruction given to GAO was to develop a way to transfer administrative and financial responsibility for Saint Elizabeths Hospital to the District of Columbia. The report describes a way to carry out that mandate and proposes that the District take over responsibility for Saint Elizabeths Hospital on October 1, 1985.

Comment

It has been and continues to be the position of the District that this study was too narrow in scope. At the initiation of the study we wrote to the committee suggesting that the GAO examine all available options for reorganizing the dual mental health system. To our knowledge, no other alternatives were pursued.

The District is opposed to taking over administrative and financial responsibility for Saint Elizabeths Hospital. The federal government should retain responsibility for this national institution. It was built for a national purpose, and the federal government should determine its future use now that a national mental health hospital is no longer desired.

The District does believe that it should develop a capacity for comprehensive mental health services, including all normal state and local functions. However, we believe it will take a six year transition period to design and implement a workable system.

In the meantime, it is inappropriate for Congress to legislate the design of a local government's mental health system. The District must be given a chance to develop its own capacity now that services will no longer be available in the federally administered national hospital. It is the federal government's decision whether or not to have a national hospital. However, the District must say how it will deliver these services to its residents.

We recommend that the final report reflect the federal government's legal responsibility for the patients, employees and financing for the hospital, and the District's authority to develop its own mental health system.

Transfer of Authority

Proposal

Complete administrative authority and fiscal responsibility for mental health system components should shift to the District Government on a single date: October 1, 1985. During the following two years the District Government should complete the necessary reorganization of patient care, staff, and management.

Comment

The massive and complex task of transforming a large dual system into a unified District administered system cannot be accomplished in such an abrupt manner without disruption to patients, families, staff, and the community.

The reorganization should be accomplished in an orderly sequence of transfers of function over a six year period, consistent with the stated goal of the Office of Management and Budget to end federal administration of state and local functions by 1991. During this period, the federal government should retain jurisdiction over the Hospital. This is a more reasonable and workable approach.

Future Use of Saint Elizabeths Buildings and Grounds

Proposal

The federal government would retain all the buildings and grounds that would not be used for patient care. Transfer of some of the Saint Elizabeths Hospital facilities to the District outright, or lease of facilities by the District, are two options you present in your plan.

Comment

We believe that both of these approaches have merit, and we want to study them further. They are consistent with the District's desire to structure its own system around its own need for facilities and other resources.

Future of Saint Elizabeths Employees

Proposal

The District should take over responsibility for about 2300 patient care employees on October 1, 1985, and should carry out a staff reduction of an estimated 900 persons. Congress should enact legislation to define how District employees should be selected for this future system and what will happen to the remaining employees. No plan is presented for about 1,000 support staff.

Comment

It is the federal governments responsibility to see that its employees are not harmed by its decision to end direct federal mental health care delivery. We believe the District should assume responsibility only for those employees that it needs. The federal government, by means of legislation if necessary, should make it possible for the District to hire needed employees and the federal government should be responsible for the cost and the administrative task of planning for the balance. This is the approach proposed for the facilities and we believe that it is also appropriate for the employees.

Future Federal Financial Participation

Proposal

That direct and predictable federal financial participation should be reduced from $67 million to $40 million in FY 1986; that the $40 million level should be made available again in FY 1987; and that thereafter no future federal support for any part of the mental health system is recommended, unless Congress should adjust its payment to the District in the annual appropriations process.

Comment

The financing proposal for a future District system is totally unrealistic. Without appropriate support from the federal government the District cannot carry out a reorganization or administer the system proposed by GAO, nor its own system.

Congressional restrictions on revenue and taxing authority of the District are a reality which we must live with and plan for. These restrictions must also be reorganized by GAO. Our high tax burden and limited revenue dictate a shared federal-District financial responsibility for mental health services. I have therefore proposed continued financial support following the reorganization of a comprehensive system.

The GAO report is also silent on the issue of the extraordinary volume of demand for services in the District of Columbia, which is far beyond national norms. This demand arises from the unique attraction of the nation's capital, the historic role of a federal hospital offering free care, and the totally urban demography of the District, which is a regional and national magnet for those in need of mental health services. GAO's failure to recognize and provide for these special circumstances is a serious deficiency in the report.

Reorganization of Patient Care

Proposal

Following the assumption of full responsibility on October 1, 1985, the District should in the ensuing two years carry out reduction of the Hospital population by 600 patients by providing for acute care delivery in general hospitals, outplacing an additional 300 patients, and transferring 100 alcohol and drug abuse patients to District care.

Comment

We agree that the delivery of acute short-term psychiatric care now provided in about 200 adult beds and 40 children's beds should be delivered in Medicaid-eligible District general hospitals, whether public or private.

We agree that at least 300 more patients can be placed in less restrictive community settings, and will place 200 such patients in 1984.

We agree that the approximately 100 bed drug and alcohol services now delivered in the Saint Elizabeths Area D program should be transferred to the District. That will take place in FY 1984.

We do not agree, however, that the District should accept responsibility for the care of 1600 patients, and then conduct the transfer or reorganization of patient care to other locations. The federal government should retain responsibility for patient care until each District-administered alternative is prepared, and patients can then transferred into it.

Proposal

The District should administer and finance forensic services for about 300 criminally insane persons now at Saint Elizabeths, using transferred Saint Elizabeths staff and buildings for this purpose, being reimbursed by the federal government for the cost of care for U.S. Court commitments.

Comment

We agree with this approach, and believe this assumption of responsibility should take place as the last step in our six year transition plan.

Proposal

The federal government should, if possible, continue at Saint Elizabeths the national research and training programs and special program for the deaf which it now administers.

Comment

We agree with this approach.

Proposal

The District should administer a chronic care hospital for the remaining 670 long term psychiatric nursing and hospital care patients at Saint Elizabeths, using staff and facilities transferred from that institution for this purpose.

Comment

We seriously question the basis for projecting a need for a continuing chronic care facility for District residents.

GAO identified 670 patients currently at Saint Elizabeths Hospital who require long term psychiatric nursing or hospital care; they assume that the District should therefore take over responsibility for a 670 bed chronic psychiatric institution.

Current admissions data do not support this assumption. Based on current need, the District Government should plan for a chronic hospital of about 200 beds at most. The federal government should retain responsibility for the lifetime care for over 400 patients who have been institutionalized at the national hospital for many years, even decades.

Recreating an oversized hospital, far beyond any present or future need, will prevent the District from building a community-based and cost-effective system. If the federal government goes forward with its plan to conclude the mission of its national hospital, it should not do so at the expense of a local government.

Federal Transition Financial Support Based on Savings Through Reorganization

Proposal

On the date of transfer of authority, October 1, 1986, the federal government should reduce its present $67.8 direct contribution to a level of $40 million. This would not cause any increased expenditures by the District because of $22 million (in FY 1983 dollars) in system savings identified in the GAO proposal.

The transfer of 300 Saint Elizabeths patients to outpatient status and 100 more to District administered drug and alcohol programs, together with changes in staffing patterns throughout the system, will permit an immediate savings of $22 million of $144 million in total FY 83 system costs.

Comment

Any overall system savings which can be realized from reorganization will certainly not be available in the first year that such reorganizations can take place. The reality is that the District would have to direct upwards of $22 million in new resources into the system in FY 1986, and an additional $40 million by FY 1988.

This devastating fiscal impact would endanger the quality of patient care, and would jeopardize the District's ability to create the effective, community-based mental health system which GAO have recommends.

A successful transition plan requires the federal government to maintain its present funding level of $67.8 million through the six year transition.

In addition, preliminary staff analysis indicates that GAO has seriously underestimated the cost of a future comprehensive mental health system for the District. The projections are based on highly unrealistic expectations for acute care costs in general hospitals; on omission of important residential cost factors for hard-to-place adults and for child and adolescent programs; on definitions of outpatient caseloads which are questionable; on omission of any capital costs for developing or maintaining services and institutions; on overly optimistic Medicaid reimbursement expectations; and on understatement of administrative and management costs.

In addition, they have included in a description of future savings in the overall mental health system the cost of transferring nursing home and drug abuse patients from SEH to other District Government programs. These transfers, many of which will occur in FY 1984, add millions of dollars to the District's budget, and cannot be dismissed as "savings".

We will develop our own system cost projections when the Advisory Committee has made its recommendations about the standards and scope of service components. We will therefore not make a more detailed comment on staffing and cost data at this time.

Implementation

Proposal

That legislation be developed and approved during the coming 18 months to accomplish the proposals.

Comment

We agree that legislation should be developed and approved over the coming year and will forward recommended legislation to Mr. Dellums' committee within three months which will identify the legislative actions necessary to the development of a comprehensive mental health system for the District.

Absence of Audits

Finally, as the GAO report points out, there is little data available from the Saint Elizabeths Hospital system which allows analysis of patient data by level of care. Nor is there fiscal data available on which to project future costs adequately. No proposal for reorganization of mental health services can be accepted before an independent fiscal audit, a patient data audit, and a physical plant audit are complete.

Dixon Implementation Monitoring Committee

February 22, 1984

Mr. Richard L. Fogel
Division Director
Human Resources Division
General Accounting Office
Room 6864
441 G Street, N.W.
Washington, D.C. 20854

Dear Mr. Fogel:

Enclosed is a copy of the Dixon Implementation Monitoring Committee's response to the General Accounting Office Draft Report "A Proposal for Transferinng St. Elizabeths Hospital to the District of Columbia."

Thank you for this opportunity to make comments. We would be pleased to answer any questions you may have about our response.

Sincerely,

Gail R. Marker

Enclosure

1801 Columbia Road, N.W. Suite 201 Washington, D.C. 20009 202/332-4288

APPENDIX VIII

Dixon Implementation Monitoring Committee

RESPONSE OF THE DIXON IMPLEMENTATION MONITORING COMMITTEE TO THE GENERAL ACCOUNTING OFFICE DRAFT REPORT "A PROPOSAL FOR TRANSFERRING ST. ELIZABETHS HOSPITAL TO THE DISTRICT OF COLUMBIA"

This memorandum responds to the proposal of the General Accounting Office for the transfer of St. Elizabeths Hospital to the District of Columbia.

For the Dixon Implementation Monitoring Committee,*/ the key issue in the proposed transfer of St. Elizabeths Hospital is whether the 6,000 clients on the combined rolls of the federally operated hospital and the city-run community mental health centers will receive the services they need. The majority of these clients have a chronic mental disability. Most are black and poor and lacking a high-school education. Almost all are unmarried; few are able to support themselves.

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*/ The Dixon Committee was established in 1980 by agreement of the parties in Dixon v. Heckler: the federal government for St. Elizabeths Hospital and the District of Columbia Department of Human Services, as defendants, and the Mental Health Law Project as attorneys for the plaintiffs in this class action. Under a 1975 order by federal district Judge Aubrey Robinson, the Dixon case requires creation of a comprehensive community-oriented service system for the District of Columbia.

The committee is composed of nationally recognized experts in the provision of community-based mental health care and representatives of the local community, serving in an advisory capacity to plaintiffs' counsel. The committee is authorized by the 1980 consent order to evaluate the defendants' reports, to receive complaints, to conduct investigations and to assist the plaintiffs in negotiations with the defendants. It is required to oversee and report to the court on progress made by the defendants in implementing the plan for a mental health services system that is the cornerstone of the Dixon consent order.

1801 Columbia Road, N.W. Suite 201 Washington, D.C. 20009 202/332-4288

These clients have been waiting for mental health services since December 1975, when a United States district court held they were legally entitled to a system of coordinated mental health and support services in the community. They were given hope in April 1980, when the federal and city government jointly pledged to:

> shift the primary locus of care from a large inpatient psychiatric institution to a comprehensive community-based mental health services delivery system...to assure that the full range of inpatient and outpatient services is available to each patient and...to develop adequate residential opportunities and comprehensive community support services so that outplacement can result in an improvement in the quality of life for the plaintiff class. */

They are still waiting today.

The Dixon Committee believes the GAO proposal offers a propitious opportunity to plan the continuum of community-oriented services these clients need but have never received. The cornerstone for success, however, will be a detailed management plan for the entire system.

The next and pivotal step, therefore, is to design the rational stages of action that will achieve the new system. However, the most critical factor in the exploration and implementation of new strategies to develop, coordinate, schedule and finance the new service system must be the needs of its clients -- mentally disabled citizens of the District of Columbia.

A New Direction for Mental Health Services in the District of Columbia: A Change for the Better

The Dixon Committee is above all dedicated to the goal of a single unified mental health system for the District of Columbia,

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*/ Dixon Final Implementation Plan, pp. 1-2.

with the administrative, financial and clinical authority to provide a full range of coordinated mental health care.

The committee therefore endorses the clinical service system outlined in the GAO proposal. Specifically, we concur that:

* The new service system must be managed by a single authority. All of the resources in the present combined system must be at the disposition of this authority to develop a continuum of coordinated mental health services.
* The dollar must follow the client.
* The primary locus of care must shift from St. Elizabeths Hospital to community-based programs, as the clinically preferred treatment setting.
* The community mental health catchment areas should be the focal point of the new service system and should have both budgetary and clinical responsibility for all care provided to their clients.
* Each catchment area must operate a complete community mental health center to provide outpatient, day treatment and case management services; a crisis resolution team trained to evaluate and treat patients in psychiatric crisis and to authorize hospitalization; and mobile treatment teams trained to help difficult-to-treat patients live successfully in the community.
* Acute care could be adequately provided at expanded psychiatric units of local general hospitals.
* A facility is needed to provide long-term care to a small group of patients who, even with the spectrum of community-

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based services available under the new system, cannot survive outside an institution.

* If such a system is put into place, many of the chronic patients now at the hospital could be outplaced and many additional patients could be prevented from becoming chronically mentally ill through timely and appropriate intervention.
* Hospital staff willing to assume new roles in a coordinated service system should follow their clients into the community by being retrained and redeployed into community-based settings.

The Pivotal Step: Implementing Strategies

The GAO report points in the right direction; it shows what an elightened mental health system should look like. Of course, many complex issues remain to be resolved, addressing such areas as the status of current hospital employees and future uses of hospital land and buildings. To achieve the new system and sustain its long-term success, however, requires that the new managing authority -- the District of Columbia, if the GAO suggestion is adopted -- resolve five issues that are critical for client care:

1. Leadership. The key leadership position of the city's Mental Health Services Administration has turned over four times since April 1980 and has been vacant since April 1983. The city's long-term investment in its mental health leadership is a critical variable in the credibility and success of its mental health programs. The current vacancy offers an opportunity to

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hire a person who is dedicated to achieving the unified community-oriented continuum of care outlined in the GAO proposal and who has the clinical and administrative expertise to manage day-to-day operations. Recruiting such a person should be the city's first priority for its mental health delivery system.

2. Existing Service Capacities. A thorough assessment of the strengths and weaknesses of the existing system is necessary. Projected costs and timing for new services will vary considerably, depending on the size of the gap between where the system is now and where it must arrive. A sound management plan for implementing the new system must therefore address existing capacities. The assessment should begin with the city's mental health centers, for they will be the backbone of the new system and are known to have serious service deficiencies.

3. Financing. During the period of transition from a federally operated hospital-oriented system to a city-run community-based system, care will have to be provided on a dual track for a while. A management plan must be developed for both the transitional period and the long term, however, assigning costs and financial responsibility over time to each component of the service system. The Dixon Committee urges the city to make this a top priority. Ultimately, of course, the new system will be more cost-effective. For now, the Dixon Committee will not tolerate further budget reductions in either the hospital's or the city's current mental health resources unless it is collectively agreed that such resources are not needed. Any other justification for budget cuts at this critical juncture would be asking the new system to commit financial suicide.

4. Timing. Some components of the new service system may take longer to implement than others. Accordingly, the management plan should describe in detail the specific action steps that will be taken to put each component into operation. The plan must assign target dates and responsibility for the completion of each step. Once this is done, we will know how long it will take to implement each component of the new system and the system overall.

5. Authority. The Dixon Committee believes there are two legitimate long-term options for managing the new system: (1) management by the District of Columbia and (2) creation of a public corporation. This commentary presumes that, as the GAO proposes, the District will be the manager. This is a logical choice, given the District's continuing obligation under the Dixon court order -- not yet met -- to have developed (by 1982) a network of mental health and support services to serve mentally ill citizens in the community. However, the committee is not persuaded that one option would be inherently better for clients than the other. But the issue of authority has to be resolved quickly. Further, both of these management proposals and any others that are to be given serious consideration must be presented for public scrutiny and comment, along with both prospective authorities' detailed management plans.

Action Steps for the Next 90 Days

To address the five implementation issues outlined above, the Dixon Committee urges completion of the following action steps in the next 90 days:

1. Leadership. The District of Columbia should hire a Mental Health Services Administrator capable of providing substantive guidance and technical assistance to develop and implement a sound management plan for the new service system.

2. Implementation Committee. A working committee should be created immediately, composed of knowledgeable citizens and local and national experts in mental health, to assist the new Mental Health Services Administrator in developing the detailed management plan. This committee should have sufficient staff to develop in 90 days a management plan with specific objectives, target dates and assignments of the responsibility for their implementation.

3. Continued Oversight. At the end of 90 days, the management plan should be open for public comment. If necessary, the GAO could audit the management plan, particularly as to financial considerations. Finally, in light of the city's continuing legal obligations under the Dixon order, the committee will keep the federal district court apprised of progress in developing and implementing the plan.

Conclusion

The Dixon Implementation Monitoring Committee supports the GAO proposal to establish a unified continuum of coordinated mental health services, shifting the primary locus of care from the present hospital-oriented system to community-based settings. The committee further agrees that this system must be managed by a single authority with full control over all administrative, budgetary and clinical decisions.

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The District of Columbia, as the proposed managing authority of the new system, must assume responsibility for resolving critical implementation issues within the next 90 days -- in particular, the hiring of new full-time leadership for the city's Mental Health Service Administration and the development and public acceptance of a sound management plan for the financing, coordination and phasing in of each component of the new system. The 6,000 mentally disabled citizens who have waited since 1975 deserve no less.

AFSCME

American Federation of State, County and Municipal Employees
1625 L Street, N W , Washington, D C 20036
Telephone (202) 429-1000
Telex 89-2376

February 15, 1984

Mr. Richard L. Fogel
Director
U.S. General Accounting Office
441 G Street, N.W.
Washington, D. C. 20548

Dear Mr. Fogel:

The American Federation of State, County and Municipal Employees (AFSCME), a labor union representing more than one million public employees including virtually all support staff at St. Elizabeths Hospital, appreciates the opportunity to comment on the GAO Draft Report on how to transfer St. E's to the District of Columbia.

AFSCME also takes this opportunity to thank your staff for the two briefings which occurred during the last year. I trust that our comments will be included in the final record.

Sincerely,

William B. Welsh
Director of Legislation

WBW:mlm

Enclosure

APPENDIX IX

AFSCME'S RESPONSE:

GAO Report on Transfer of St. Elizabeths Hospital

As the union representing the majority of employees at St. Elizabeths Hospital, the American Federation of State, County and Municipal Employees rejects the GAO report which describes how this facility should be transferred to District of Columbia Government. It is unfortunate, we believe, that the charge given to GAO for this study was not broadened to also include the crucial question of whether St. E's should be transferred to the District Government. Further, as the nation's largest public employees union representing the second largest number of District Government employees, AFSCME is constrained to conclude that the recommendations in the report on where, by whom, and how mental health services are to be provided in the nation's capital city are unrealistic, and unworkable.

Because the ball is now in its court, AFSCME calls upon the Congress to unravel the paradox that St. Elizabeths Hospital has been made to fall into as a result of competing and, at times, conflicting interests and philosophy between the Federal Government and District Government. It is high time to lay to rest the uncertainties that have engulfed the facility, its patients, and its employees and to propose a workable, accountable solution.

GAO has not set the right course. The reasons are:

- Transferring the hospital to the District Government after a brief transitional period (two years) would ill-serve the national interest, the residents of the District and of the surrounding jurisdictions.

  Let's look at the facts.

  The District's mental health program is in a shambles, despite the Mayor's best efforts. Presently, the position of Administrator, Mental Health Administration, Department of Human Services, is vacant. As a result, its mental health program is headed on an acting basis by a controversial Commissioner of Health.

Because of fiscal constraints, the District has reduced mental health staff, compressed its community mental health centers from three to two, has placed an inordinate reliance on contracting out for the delivery of mental health services, and currently has a shortage of nursing and residential facilities.

There is widespread concern in the mental health community about the District's ability to manage and administer the hospital on the basis of its poor record of performance with community services. A contempt motion against it is still outstanding in the U.S. District Court in the Dixon v. Heckler case on the hospital because of its apparent failure to fulfill prior commitments to expanding community-based services.

Unless a dramatic improvement in mental health leadership in terms of national expertise occurs in District Government, unless either a substantial federal subsidy is provided or additional local revenues in excess of $50 million are found, the voluntary or involuntary assumption of responsibility for Saint Elizabeths Hospital would quite likely prove indigestible to District Government.

AFSCME concurs that Saint Elizabeths Hospital, with some modification in its structure, needs to be integrated into a comprehensive mental health system in the District of Columbia. The fact that the present, bifurcal system is fragmented and costly cannot be denied.

GAO recommends that as a critical step in establishing a new system, acute inpatient care be removed from St. E's and that it be purchased from the private hospitals in the City, or be provided at D.C. General Hospital.

None of the City's ten private hospitals have expressed interest in expanding to provide these services. We have no idea if the cost figure for renovation is in the ball-park of reality. The care of indigent psychiatric patients is not even part of the mission of these hospitals.

- GAO recommends scaling down the hospital's inpatient population from about 1,750 to about 1,000. To achieve this, 300 additional patients would be placed in nursing homes and community residential facilities; 86 patients in the substance abuse program would become the responsibility of District Government; the inpatient program for the mentally ill deaf is left in limbo; and responsibility for all outpatient care would be transferred to the District's community mental health centers.

  Only the criminally insane, the intractably ill, and federal beneficiaries would remain, or would be admitted, at St. E's.

  In this process, the level of hospital employees would be reduced drastically by two-thirds. Only vague prospects of possible employment are held out for the enormous number of displaced employees.

  What will be the results?

  There is no assurance whatever that long-term care community facilities are able, or willing, to absorb substantially additional numbers of mentally ill patients. If they were, then this question needs to be raised:

  Why are hundreds of former St. E's patients permitted to predominate the ranks of homeless persons in the nation's capital? It is estimated that nearly one-fourth to one-half of the thousands of homeless persons in the City have histories of mental illness. This tragic trend must be reversed. It cannot be exacerbated by the continuing outplacement of St. E's patients and the repeated breakdown of their community placement plans. Moreover, the quality of care they receive in both non-profit and proprietary long-term community care facilities compares poorly with the services provided by an accredited facility such as St. E's. Only recently, District Government was compelled to discharge the profit-making contractor operating its JB Johnson nursing home because of substandard care. Nearly half of the patients there are former St. E's patients. It should also be noted that this particular facility was renovated at a cost of about $5 million by the Federal Government with the understanding that it would serve as a resource for the outplacement of St. E's patients.

  It is hard to believe that a sure way to establish a comprehensive mental health delivery system is to abolish hundreds of jobs filled by trained and experienced mental health workers and supportive staff. AFSCME insists that any proposal which is intended to redefine the District's

mental health system incorporating St. Elizabeths Hospital into a comprehensive institutional and community-based system must provide for the appropriate retention, retraining where necessary, and placement of Hopsital employees both within the public and private segments of that system. The GAO report fails to do this.

- The residents of the District of Columbia bear one of the highest tax burdens in the nation (the District ranks third nationally on per capita tax). Unlike all other states, the District's taxing power is severely circumscribed by Congressional oversight and interests. For example, the Congress has made it clear that the District cannot impose an income tax on non-residents who work in the City.

  Yet these realities appear to be either avoided or ignored in the GAO report. The fundamental question is, where is District Government going to find the money, in the absence of continuing Federal support, to ultimately take over this 125 old historic Federal facility short of imposing the yoke of intolerable property, income, and consumer taxes upon its already tax-overburdened residents?

AFSCME's Recommendation

Both Federal and District Government have a vital stake and interest in Saint Elizabeths Hospital.

From the Federal standpoint, the facility merits continued Federal support because it serves the national interest. The Hospital's location in the nation's capital; its historic and renown excellence in the field of mental health training and research; the high quality of care it has provided, and continues to provide, should all be properly recognized as manifestations of the nation's commitment to the needs and interests of its mentally ill.

To the residents of the District of Columbia, Saint Elizabeths Hospital has been, and continues to be, the sole source of treatment and care for the medically indigent and mentally ill. Its continued existence is vital to their needs.

Because of the uniqueness of the District of Columbia as the seat of national government and as home to over 600 thousand residents, a well-organized, well-managed, soundly-funded comprehensive mental health system is in the mutual interest of both Federal and local authorities. Each ought to share jointly in the maintenance, governance, and funding of such a system. And St. Elizabeths Hospital must be a vital component within it.

AFSCME believes that the most effective framework for accomplishing this objective is the establishment by the Congress of a Federal corporation whose membership, powers, and functions would be acceptable to the Congress, the Administration, and District Government. The Federal corporation would be subject to Congressional oversight and would be responsible for integrating St. Elizabeths Hospital into a comprehensive public and private mental health system and for funding and governing the system. This corporation, we believe, would set an effective and cost effective national model for mental health care in urban systems. Moveover, it would provide the needed solution to meeting the mental health needs of our nation's capital.

AFSCME urges the Congress to adopt this recommendation.

APPENDIX X

JCAH

Joint Commission on Accreditation of Hospitals
875 North Michigan Avenue
Chicago, Illinois 60611
(312) 642-6061

John E. Affeldt, MD
President

February 24, 1984

Richard L. Fogel
Director
Human Resources Division
United States General Accounting Office
Washington, DC 20548

Dear Mr. Fogel:

This letter is in reply to your correspondence of January 9, 1984, regarding the draft report for transfer of St. Elizabeth's Hospital to the District of Columbia. Although the Joint Commission can only review the proposed transfer of St. Elizabeth's in light of accreditation standards, the proposal on the surface appears to afford greater continuity of care and a more comprehensive mental health system for the District of Columbia than that currently available through St. Elizabeth's delivery system. The proposal indicates St. Elizabeth's would continue to provide long term psychiatric care as well as handle court referred patients while other available resources within the community would provide for short rerm acute psychiatric or outpatient mental health care. With the anticipated reduction in patient population at St. Elizabeth's come changes in the services provided and staffing pattern requirements. Here again, the proposal on paper appears to be in keeping with what we discussed with you and your staff here in Chicago and appropriate to the proposed patient population.

On the other hand JCAH is most interested in how this revised system of patient care if approved, is implemented and any jeopardy that might be created for St. Elizabeth's relative to JCAH accreditation. Consistent with JCAH policy, the hospital would need to notify us upon completion of change in their governance. Depending on the nature and extent of changes in administration, services and staffing associated with change in governance, a follow up accreditation survey may be necessary to assure quality patient care is being maintained for St. Elizabeth's current patients and that transfer of patients to other parts of the mental health system has smoothly transpired. This decision would be made pending our full review of the matter upon completion and notification of change in governance.

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JCAH

If your office or the hospital has questions regarding JCAH policy and procedure in this matter, please do not hesitate to contact us. We look forward to any further assistance we may provide you.

Sincerely,

Myrene McAninch, Ph.D.
Director
Accreditation Program for
Psychiatric Facilities

MMcA:ca

cc: John E. Affeldt, M.D.

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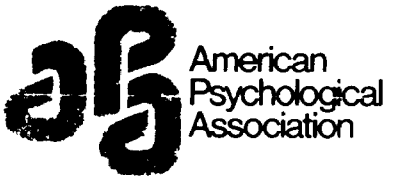

February 9, 1984

Richard L. Fogel
Director
Human Resources Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

On behalf of the American Psychological Association, I appreciate the opportunity to review and comment on your draft report to the Chairman of the House Committee on the District of Columbia on how to transfer St. Elizabeths Hospital to the District of Columbia.

We would like to make a number of general comments, and then go into more specific detail on your report. First, your office is to be commended for undertaking in such an extensive and professional manner one of the more problematic issues in mental health -- the reform of an outdated service delivery system and the creation of an entirely new system. Your task was complicated by the additional factors of combined D.C./Congressional/federal executive branch jurisdiction and involvement, a seeming lack of commitment to this issue (as shown by the lack of resolution of the Dixon case after all these years), a declining commitment to financial responsibility by all parties, and a real lack of substantive health services research into how such a mental health system should be organized and staffed.

Given the complexity of the issues you were asked to address, it is not surprising that there is disagreement on your recommendations. We hope our comments will assist you in revising the report so as to be more comprehensive and responsive to the needs of the mentally disabled in the District of Columbia.

A general comment from each of the psychologists who I asked to review your report for me was the insufficiency of attention to the impact of your proposed changes on the patients in need of care. While patients are proposed to be moved from inpatient wards to nursing home beds or community residential facilities (CRFs), and the positive financial impact of these changes is estimated most carefully, the impact (positive and negative) of these changes on patients is decidely overlooked. Research shows, for instance, that deinstitutionalization is a crisis period in the lives of the mentally disabled. Some research shows that moving individuals from one nursing home to another nursing home is associated with higher morbidity and mortality -- primarily, it seems, because of the stress associated with the change in surroundings, loss of friends, change of staff, etc. These are issues that must be addressed by the GAO in your report.

1200 Seventeenth St N W
Washington D C 20036
(202) 955 7600

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Similarly, while the cost of alternatives to in-patient care are detailed, it is not defined how patients will be receiving mental health care in these nursing homes and CRFs Our advisors suggest that psychological care is at best minimal, and too often non-existant, in such settings. Also, the extent of an individual's mental disability does not automatically improve because of outplacement Therefore, to suggest that placing St Elizabeths' residents in these alternative care settings, without insuring that mental health care will be provided, is to seriously jeopardize the entire GAO model. That is, non-care is not an acceptable alternative to in-patient care.

The use of the Ohio model for planning the D C system is most commendable from our point of view, in that the GAO is using research findings as a basis for public policy. However, we need to ask what the implications of the Ohio model were for patients. Meeting JCAH accreditation standards is important. However, those standards only insure certain life-safety code levels, certain staffing levels, certain quality assurance procedures, etc. They do not -- and JCAH is quick to point this out -- assure quality of outcome in terms of patient care A high quality of care is what we believe is necessary, especially when a new system of care is being suggested.

Treating patients in the community, while probably less expensive than in-patient care, is not cheap Either requires a significant level of expenditure Cost are associated with such items as transportation, outreach services, foster care services, group home care, and so forth. Insuring compliance with contracted services in nursing homes or community residential facilities will require staffing All in all, the District will have to take an agressive approach to patient care if it is to be successful.

Placing all responsibility for patient care at the Community Mental Health Center (CMHC) level seems to be a very positive move -- but there are significant issues here that are not addressed in the GAO report. First, we must question the ability of the area Centers to accept the increased patient load and administrative/coordination responsibilities outlined in the report with an increase of only 29 staff members. Second, those additional responsibilities are not reflected in any proposal for change in staffing patterns -- the notation is made in your report that, since no information was available to the GAO on what the proper mix of professionals should be for outpatient care, the existing staffing ratios and professional mix would be assumed to be appropriate for the new mental health system This analytic lapse was perhaps caused by time pressures on the GAO, but it is nonetheless unacceptable.

Third, we have concerns about the financial incentives built into the system. Is the money to be allocated on a per-capita basis? Is there really an incentive for savings if all of the money, in reality, comes out of the same fiscal pot? Given the real politics of government budgeting, would a CMHC that saved significant amounts of money through reduction of inpatient costs be allowed to "keep" that money the following fiscal year -- or would

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the "spend it or lose it" rule once again come into play? These are problems not addressed in the proposed plan. While we believe these questions need to be answered, we do not question the basic wisdom of the financial incentives proposed, or their basic intent of promoting treatment in the community rather than in the hospital

Fourth, what assurances are made about the realistic possibility of the planned outplacements? We note your statement that "recently, the District's Rehabilitation Center for Alcholics in Northern Virginia was closed and patients were moved to facilities at D.C. General Hospital and to contractor-operated facilities. Space was not available for all patients." (p. 56) (emphasis added) We cannot encourage a similar situation for St. Elizabeths patients.

Your proposals for increased financial contributions from third-party payers, particularly Medicaid, are reasonable. It is truly unfortunate that a patient at St. Elizabeths (defined by Medicaid as an IMD) cannot receive reimbursement but a patient at D.C. General Hospital (defined as a general hospital) can. Given the continued discrimination against the mentally disabled by Medicare and Medicaid, we wonder whether proposals will be made to eliminate coverage for patients in D.C. General as well. Cost-cutting proposals of all types are being given serious consideration by the Executive Branch -- and this is hardly beyond the realm of possibility.

Your proposed staffing levels for inpatient care are drawn from the Ohio model for psychiatric care but are intended to provide for "long-term intensive and rehabilitative psychiatric care, intensive and rehabilitative psychiatric nursing care, and forensic psychiatric care." While we cannot comment on the adequacy of the overall staffing levels - as you say, such data are extremely difficult to obtain -- we can offer some information on staffing levels for psychologists in certain areas. We urge your consideration of these staff to patient ratios, as they are based on our best information on providing intensive and rehabilitative care -- not custodial care.

For inpatient wards servicing patients with some known organic defecit or neurological impairment, patients would need the following: a neuropsychological plan, a program of rehabilitation, and an actual remediation program, including psychotherapy and counseling. Such wards would need one psychologist trained in neuropsychological assessment and treatment for every 25-30 patients.

For forensic units providing pre-trial and post-trial services for minimum security patients, the ratio should be one psychologist for every 25 patients. On post-trial units providing services for maximum security patients, the ratio should be one psychologist for every 35-40 patients. On both pre-trial and post-trial units, the psychological work will include a good deal of

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assessment and psychological screening - much of this mandated by the courts. Additionally, psychologists will have to spend considerable time testifying in court about their assessments. Individual and group psychotherapy will also be involved

For inpatient units providing psychiatric rehabilitation and other services preparatory to returning patients to the community, the need for psychological services is extensive. If you are to effectively prepare patients, the ratio should be one psychologist for every 15-20 patients. The services these psychologists provide include traditional psychological services plus case manager services such as overall coordination of a patient's treatment, liaison work with the community facilities and psychosocial rehabilitation programs, coordination of the patient's placement in the community and supportive and educative work with the families.

We need to point out that the provision of intensive treatment services is shown to be particularly helpful to patients, and beneficial to the system, as movement is made to community-based care However, these services require a high staff-to-patient ratio. Scrimping on staff or services will save money in the short run but will have unacceptably high costs in the long run in terms of money and, more importantly, rehabilitation of patients.

In summary, we commend you for the extensive work your agency has performed. We believe that the careful, planned movement to community-based care will be positive. Such a movement will promote greater access to care and help remove the inappropriate but real stigma of being "a patient at St. Elizabeths." We urge you, however, to revise your report with a central focus on patient care rather than cost. The legitimacy of the mental health system eventually developed will hinge on the clarity of such a focus.

Sincerely yours,

Max Siegel

Max Siegel, Ph.D.
President

WFB/ach

APPENDIX XII

American Psychiatric Association

1400 K Street, N W
Washington, D C 20005
Telephone (202) 682 6000

February 8, 1984

Richard L. Fogel
Director
United States General
Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Fogel:

The American Psychiatric Association, a medical specialty society representing over 28,000 psychiatrists nationwide, is pleased to respond to your request for comments on the recent GAO Draft Report on St. Elizabeths Hospital, another step in the long sequence of efforts to resolve the old and very difficult problem of the most appropriate governance and function of St. Elizabeths.

Unfortunately, the GAO Draft Proposal, perhaps in part because of the constraints of its charge, seriously fails to meet the test of a professionally acceptable resolution of the problem of St. Elizabeths Hospital, which should, in our view, be based on the following considerations:

- the availability in the District of Columbia of a full range of services -- both hospital and community based -- appropriate to the needs of the city's mentally ill;
- the quality of these services at no less than the current best capability of the mental health field;
- service provision through a unified delivery system with upwardly converging lines of professional and managerial accountability;
- ready and flexible access by patients to different combinations of services as their changing clinical and social status may require;

Richard L. Fogel
United States General
Accounting Office

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- flexible deployment of staff, and emphasis on continuity of care consistent with individual treatment plans.

We have had an opportunity to review comments on the GAO Draft Proposal by the Washington Psychiatric Society (their letter to you of February 8, 1984). We concur in this detailed critique and, therefore, shall not repeat here each of the points.

The long-standing impasse between Federal and District interests as to St. Elizabeths Hospital has hinged mainly on questions of financing rather than on the mental health service needs of the city. The GAO Report focuses more on "cost-shifting" than on cost-containment or projections of resources actually required to support a unified system of adequate quality services for the city's mentally ill. While we all recognize that resources are limited, responsibility for providing an acceptable level of mental health services for any population should begin with a clear understanding of the magnitude and nature of that population in terms of its mental health needs, and the range, capacity, and configuration of a service system required effectively to meet those needs. Again, the GAO Draft Proposal is flawed in this respect as noted in the comments by the Washington Psychiatric Society.

Another generic comment about the GAO Report: The Nation's Capital is in many ways a unique urban environment, and great caution must be exercised in drawing parallels as to service needs and funding mechanisms with states or even other cities. Without first ascertaining the particular mental health needs of the District, reliance on such parallels can be seriously distorting.

With regard to research and professional training activities now based at St. Elizabeths Hospital, the GAO Report is disconcertingly superficial and vague, suggesting that those conducting the study were not adequately aware of the nature of these important activities and the consequences of their recommendations. We particularly draw your attention to the comments of the Washington Psychiatric Society in this respect.

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Richard L. Fogel
United States General
Accounting Office

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A final point must be emphasized. Strong Congressional initiative will be necessary to resolve the SEH issue in a manner consistent with an acceptable level and quality of care for the District's mentally ill. The matter is rapidly growing more urgent. The Administration has proposed annual reductions in the Federal appropriation for St. Elizabeths (and in FY 1984 accomplished a first step), on the theory that the District would be persuaded to make off-setting increases in its payment for the Hospital. In FY 1984 the District did not do so, and the consequence was a reduction-in-force of nearly 400 Hospital employees and cutbacks in various program areas. Mayor Barry has indicated that the District cannot increase its support for the Hospital over at least the next six years. If, then, the Appropriations Committees of the Congress proceed with further annual reductions in Federal funding, the Hospital -- and the very ill and vulnerable patients it serves -- will be placed in an intolerable position, leading rapidly to a fatal compromise of the Hospital's function and the "dumping" of its patients on a District mental health system clearly unprepared to meet their needs. In effect, this would be a repudiation and abandonment of the city's most seriously mentally ill, and would likely increase further the city's presently large population of "street people." While financing issues are of great importance, reliance primarily on strictly budget channels to determine the nature of -- and response to -- the District's mental health needs is inappropriate.

We regret that our comments cannot be more positive.

Sincerely,

Melvin Sabshin, M.D.
Medical Director

MS/ff:mm
cc: Washington Psychiatric Society

The Washington Psychiatric Society

A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Executive Director
Grace-Marie Arnett
1400 K Street, N W Suite 202
Washington, D C 20005
Tel (202) 682-6270

February 8, 1984

Richard L Fogel
Director
United States General Accounting
Office
441 G Street, N.W
Washington, D C 20548

Dear Mr Fogel

Thank you for your request for the comments of the Washington Psychiatric Society on your agency's proposed draft report on the transfer of Saint Elizabeths Hospital to the District of Columbia government We note that the American Psychiatric Association also has prepared a response to the report in a letter dated February 8, 1984. We fully agree with the comments contained in that letter and would like through our response to make a more detailed presentation of some of the major points raised by our national association and to bring up others as well. While time does not allow a comprehensive and thorough review of your report, we would like to address some of the problems we have with it

The Draft states that GAO is operating under a constraint that precluded asking "whether the current system needed change or whether transfer was the most appropriate solution to the cost and governance questions," but that it was to assume that "the District would assume both operating and financial responsibility" for Saint Elizabeths. Thus, the basic wisdom of the premises upon which the Draft is founded will not be addressed by the Washington Psychiatric Society at the present time In-stead, we will detail some of the specifics of the Draft that we believe need re-evaluation.

The Draft states that the Chairman of the House Committee on the District of Columbia "specifically asked (GAO) to determine

--the number of patients needing services

--the number of staff needed to operate the facilities

--the land and buildings needed and other uses for unneeded facilities

--the need for community services and

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--the ways of handling national research and training programs now ongoing at Saint Elizabeths"

GAO's answers to these five questions are not convincing for many reasons

NEED FOR SERVICES

In determining "the number of patients needing services," the Draft only addresses the level of care survey of Saint Elizabeths' inpatients, and does not address the many not receiving psychiatric services in Washington For example, a major unmet Washington mental health need is the many mentally ill who are homeless. The Draft says nothing about this population.

--In determining the needs of patients, GAO did not study the needs of those already on the rolls of the District of Columbia Mental Health Services Administration (MHSA).

--In determining "the number of patients needing services" and "the need for community services," the Draft is silent on the patients' own perspectives of their needs. The patients themselves are a valuable resource in any statement about needs

--In determining "the number of patients needing services" and "the need for community services," the Draft is silent on the opinion of relatives as to the services that the patients need. Relatives are a valuable source of what is useful and what needs to be changed in any consideration of a mental health service.

STAFFING

In answering all five of the above questions, the professionals of Saint Elizabeths directing the most effective public mental health services in Washington apparently were not asked how many patients needed services, the staff needed to operate given programs, the best use of the land and buildings that are available or could potentially be available, the need for community services, and the best ways of handling research and training programs now ongoing at Saint Elizabeths. Instead, staffing needs were determined on the basis of an Ohio State formula, and needs for community services were determined on the basis of a program in Madison, Wisconsin.

It is not clear from the Draft that Ohio hospitals actually use the staffing formula in its hospitals and apparently no other state has decided to use that formula either. Additionally, GAO gives no reason for believing that the mentally ill would be better served by

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the Ohio formula than by the present staffing of good programs at Saint Elizabeths and other public or private programs in the District. The Washington Psychiatric Society believes that programmatic and staffing determinations should be based upon proven successes in Washington first before turning to formulae and programs of questionable relevance to Washington needs In determining staffing needs, the Draft seems to say that the GAO team was incapable of evaluating Saint Elizabeths programs and determining clinical staffing needs. The Draft also seems to say that the team was incapable of determining non-clinical staffing needs.

COMMUNITY SERVICES

In determining the needs for community services, the Draft suggests that the psychiatric units of general hospitals can assume the responsibility for acute psychiatric services that are presently being addressed by Saint Elizabeths Hospital, yet the draft fails to note the qualitative differences in patients admitted to Saint Elizabeths versus those admitted to psychiatric units of general hospitals. One half of Saint Elizabeths Hospital's admissions are police emergencies or court criminal cases No District general hospital has admitted either of these two types of patients for at least 20 years

--In determining the need for community programs, the Draft recommends that MHSA have an emergency outreach team GAO finds an experience in Madison, Wisconsin upon which to conclude such a team is needed in the District Such a recommendation has been pursued periodically by MHSA for about 15 years, yet the Draft does not review the long experience of its not being able to develop such a service in Washington. There have been emergency teams developed in the past. In the early 1970s a fleet of buses was bought for each District community mental health center. The program was eventually disbanded In proposing this team, it would seem useful for the Draft to explore the past problems and reasons for failure of this proposal.

--The Draft seems to champion placing more of Saint Elizabeths Hospital patients into nursing institutions such as the J.B. Johnson institution. It would seem important that the Draft focus on the adequacies of the care of such institutions in its report.

--The Draft seems to be saying that it is proposing enhancing continuity of care through having a clinic follow a patient no matter where the patient is. The continuity may be less, however, than Saint Elizabeths Hospital already has for many of its patients. A Saint Elizabeths Hospital patient is followed by the staff of a single division, often in the same building regardless of status. The Draft suggests a more fragmented approach in which the patient's clinic,

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acute treatment program and rehabilitation program would be miles apart from each other

--Among Saint Elizabeths Hospital's most honored clinical programs over the past two decades have been the Area D CMHC Last Renaissance Program for addicts, the Area D CMHC Alcoholism Program, and the Mental Health Program for the Deaf The Draft suggests disassembling the first two and de-professionalizing the third without any statement as to how addicts, alcoholics or the mentally ill who are deaf will benefit The Draft apparently is concerned about "duplication" but actual duplication occurs only when two agencies are both trying to do the same thing for a given patient The word "duplication" should not be used when two similar services are fully busy serving different groups of patients

COSTS

The Draft compares this City's mental health costs with states. Comparing a city with a state is not appropriate, especially a city that attracts many transients from across the country and from other countries. NIMH's data does find that Washington has about five times the number of beds per population than the national average, which makes some sense since NIMH data also shows that Washington's psychiatric admissions are five times the national average.

The Draft suggests that Medicaid is "cheaper" than direct payment to Saint Elizabeths Hospital. Actually, processing the taxpayers' dollars through Medicaid is more expensive because.

a) Saint Elizabeths Hospital is less expensive than D.C. General and far less expensive than other hospitals in the District relative to total costs of psychiatric services,

b) There are administrative costs to process Medicaid payments above and beyond direct payments. There are administrative costs to the District Government, to the Federal Government, and to Saint Elizabeths hospital in processing Medicaid billing. In 1983, clinical units at Saint Elizabeths Hospital lost valuable social workers and other staff because of the need to enhance the staffing of this billing office. Direct payment is the cheapest.

RESEARCH

The Draft suggests continuation of Saint Elizabeths Hospital's research activities only if fully supported by the Federal Government. The National Institute of Mental Health unit at Saint Elizabeths Hospital has evolved into a major division of the Institute's Intramural Research Program and is highly regarded in the scientific

APPENDIX XIII

community for the productivity and quality of its research efforts Whatever the future disposition of Saint Elizabeths Hospital, this intramural NIMH division should be preserved--along with the substantial Federal investment in the physical plant and its research staff--until such time as a realistic relocation may become possible

Equally vital for this research division is continuing access to suitable patients and maintenance of its current 25-bed clinical capacity, an arrangement greatly facilitated by the original agreement between the two Federal entities whereby ongoing responsibility for patient care is carried out by staff under the medical and legal authority of the Hospital superintendent Any proposed transfer legislation, and any agreements entered into with the District of Columbia Government as to the hospital's governance, should clearly provide for viable continuation of the NIMH research unit in the William A White Building

TRAINING

The Draft fails to clarify the importance of both the research and the training programs at Saint Elizabeths Hospital, and it fails to discuss the impact of any changes on the patients that the Hospital serves.

Since at least the turn of the century, professional training programs have been a prominent part of Saint Elizabeths Hospital activities

Trainees receive stipends considerably less than regular staff salaries and devote most of their time to supervised patient care If there were no trainees, additional professional staff would be required to maintain the same level of patient care, so that most training programs are cost-effective.

Additionally, Saint Elizabeths Hospital training programs have been a key recruitment source for permanent staff positions, both at the Hospital and for other public service facilities in the District and surrounding area

The GAO Draft proposes continuation of some or all current Saint Elizabeths Hospital professional training programs only if the Federal Government is prepared to continue to underwrite their cost. This seems to us inappropriate A number of considerations complicate the training issue in terms of the Draft recommendations

--If the Hospital were transferred to the District management, special legislative authority would probably be required for Federal monies to be used to support the District's training activities by direct appropriation It is unlikely that such a proposal would

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receive support from either the Administration or the Congress

--If the future role of Saint Elizabeths Hospital within a District system were to be limited to care for long-term and forensic patients, this would provide an inadequate clinical base for psychiatric (and probably other) training programs For sound training and for purposes of accreditation, such programs would have to involve a much broader range of services, including acute inpatient, outpatient, and community-based activities

--With respect to any Federal support for D C professional training programs, the Administration, and probably the Congress as well, would likely note that with transfer to the District government, the Hospital would compete for Federal training funds from NIMH, likely resulting in few, if any, funds being actually available

The Draft's recommendation failed to address the difficulties that a transfer of the Hospital would entail relative to training It is important to overcome these difficulties because training activities are a significant factor in the quality of care that patients of Saint Elizabeths Hospital receive

CONCLUSION

In conclusion, we appreciate the opportunity to address this Draft, and we look forward to a final document that fully addresses the needs of the mentally ill in Washington as perceived by the patients themselves, by their relatives, and by the professionals who have been serving these patients effectively and humanely

Sincerely,

Lawrence C Sack, M D
President

DAVID I JOSEPH M D
1904 R ST N W
WASHINGTON D C 20009

TELEPHONE 265-3332

February 9, 1984

Mr. Richard L. Fogel
Director
United States General
Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Fogel:

On behalf of the District of Columbia Chapter of the Washington Psychiatric Society, I would like to express my appreciation for the opportunity to respond to the draft of the GAO report on the future of St. Elizabeths Hospital. The District Chapter represents 450 psychiatrists who either work or live in the District of Columbia. Its membership is comprised of psychiatrists from the public, private, and academic sectors and is concerned with insuring that citizens of the District of Columbia receive comprehensive and high quality psychiatric and mental health services. We are aware of comments submitted to you by the American Psychiatric Society and the Washington Psychiatric Society. We concur with the points which they raise and will not address the same issues in our response.

As the cover summary of the report states, the GAO was charged with developing "a plan for transferring St. Elizabeths to the District and integrating the hospital into a restructured mental health care system for District residents. The plan would shift the primary locus of care from St. Elizabeths to community-based programs." As indicated in this quotation, the entire report is based upon a misconception: St. Elizabeths is currently a community based hospital. From either the perspective of geography or treatment delivery, it is difficult to understand how the misconception arose that it was anything else. The hospital is located no further than 40 minutes from the most outlying parts of the city, is well served by public transportation (such transportation will be greatly improved by the completion of the Anacostia line of Metro), and has successfully provided psychiatric care to citizens from every ward of the District. In addition, it has maintained active liaison relationships with the community mental health

DAVID I JOSEPH M D
1904 R ST N W
WASHINGTON D C 20009

TELEPHONE 265-3334

centers which are located in Areas A,B, and C, and has been able to provide regular, comprehensive outpatient services to those previously hospitalized patients unable to receive such care at these mental health centers. The public's memory of large, state hospitals, located many miles from major population centers, with little or no public transportation may have been what those conducting this study for the GAO have in mind when they speak of the need to develop community based hospital services. But, whatever explains their misconception, its overriding influence on the general thrust of the report suggests that their familiarity with the particular problems of the delivery of mental health services to large metropolitan areas is superficial and inadequate.

A second area of concern which we would like to address focuses upon the confusion and mixing of the issues of the administration of the hospital and the health care delivery systems of the District. Important and highly relevant questions regarding the proper role of the Federal government in the administration and financing of St. Elizabeths have been raised for many years. Many specific points regarding the actual figures cited in the GAO report have been explored in the comments of the Washington Psychiatric Society and therefore will not be repeated here. However, we believe it is crucial that the availability of quality mental health services not be jeopardized in the service of either cost containment (which we do not believe will be accomplished by the GAO plan) or administrative restructuring. The mentally ill have always been a poorly understood and too often poorly treated sector of our society. The very nature of their illnesses and the entrenched negative response of society resulted in the warehousing of patients in isolated hospitals not too many years ago. While the GAO report certainly does not attempt to recreate such a situation, the goals of shifting the locus of control to the District and saving admittedly scarce resources will result in even greater numbers of patients being unable to obtain adequate mental health care from a mental health administration which, as Mayor Barry himself

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DAVID I JOSEPH M D
1904 R ST N W
WASHINGTON D C 20009

TELEPHONE 265-3337

has said, is already overburdened and underfinanced. We will then be faced with many of our citizens who are isolated not because the locus of care is so far away, but because their mental illness cannot be adequately treated and because the system cannot assist their reintegration into society. To us, this report uses patients as pawns in a political and financial maneuver. While there are certainly some useful points raised by the report, we can only oppose it in its present form.

Sincerely yours,

David I. Joseph

David I. Joseph, M.D.
Chairman
District Chapter,
Washington Psychiatric
Society

cc: American Psychiatric Society
Washington Psychiatric Society

APPENDIX XV

F.P. FERRARACCIO, Executive Vice President

JOHN J. LYNCH, M.D., President

February 7, 1984

Mr Richard L Fogel
Director
U S. General Accounting Office
Washington, DC 20548

Dear Mr. Fogel:

The Medical Society of the District of Columbia welcomes the opportunity to comment on the General Accounting Office draft relative to the transfer of St Elizabeths Hospital from the federal government to the District of Columbia. Although we just received the lengthy and detailed draft on January 12, we conducted as detailed a review of the document that could be made in the short time allotted.

The Medical Society does not believe that the report has adequately addressed the issue. The entire question of shifting St. Elizabeths Hospital to District of Columbia administration is confused and intermixed with the separate issue of proper care for the mentally ill in the District The issue of who administers and pays for the system is distinct from the one of patient care and its appropriate delivery in this community.

Many statements made in the draft about the availability of beds and the financing prescribed leave much to be desired It is our fear that the mentally ill again will fall between the cracks during the administrative maneuvering. Practically speaking, a substantial portion of the District Government's budget is a federal government budget. So, wherever the ultimate cost is placed it seems that the federal government will have to be vitally involved. We would hope that regardless of who assumes administrative responsibility for St. Elizabeths, the Hospital's administration would be differentiated from the issue of patient care. In our judgment, a

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more comprehensive study including more complete planning for a transfer should be made with greater consultation with the people involved.

Sincerely,

John J. Lynch, M.D.
President

JJL/blb
cc: Robert E. Collins, M.D., President-Elect
Mr. F. P. Ferraraccio, Executive Vice President

APPENDIX XVI

MENTAL HEALTH ASSOCIATION OF THE DISTRICT OF COLUMBIA

2101 Sixteenth Street, N.W. • Washington, D.C. 20009 • (202) 462-1122

Barbara Izaguirre Tobelmann, *Ph D*
Executive Director

February 6, 1984

Mr. Richard L. Fogel, Director
Human Resources Division
United States General Accounting Office
Washington, D.C 20548

Dear Mr. Fogel:

Enclosed are our comments on your draft report to the Chairman of the House Committee on the District of Columbia on the proposed transfer of St. Elizabeths Hospital to the District of Columbia.

We appreciate having had the opportunity to review this report and to comment on it.

Sincerely,

Lillian Secundy
President

Enclosure

APPENDIX XVI

MENTAL HEALTH ASSOCIATION OF THE DISTRICT OF COLUMBIA
2101 - 16th Street, N.W.
Washington, D.C. 20009

February 1984

COMMENTS ON PROPOSAL FOR TRANSFERRING
ST. ELIZABETHS HOSPITAL TO THE DISTRICT OF COLUMBIA

We believe that the proposal is a thoughtful and conscientious response to the charge given its authors We believe, however, that basic restrictions to that charge serious limit its possible application·

1. That the transfer of St. Elizabeths Hospital to the District of Columbia is assumed, and
2. That the authors were not to consider any means by which the present system could be improved nor take into account those aspects of the system which should determine how it should be governed

As a result, at virtually every point, dollars, not patient considerations, determine policy decisions.

The report proposes shifting acute care from St. Elizabeths Hospital to a general hospital or hospitals in the community. Why? Because this makes better treatment sense? No, it is a move to obtain Medicaid reimbursements. It is assumed that Medicaid reimbursements would be forthcoming for all these patients, but this remains to be seen. It should be noted that this is only an apparent cost saving, involving moving the patient from one source of public funding to another Wouldn't it make more sense to simply exempt St. Elizabeths Hospital from restrictive Medicaid regulations and move the dollars rather than the patients?

We foresee St. Elizabeths Hospital as described in the report, stripped of its acute care facilities, and possibly of the Federal training and research components, functioning simply as a warehouse

Another area of serious concern is the District of Columbia's ability to provide effective services for a greatly expanded patient pool at the centers.

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The District now lacks the administrative competence to care for the 1,900 patients currently on its rolls. The District's mental health system would require an administrative renaissance to handle the expanded programs visualized in the GAO report Between the District's demonstrated difficulty in keeping track of its patients and the disincentives for hospitalizing them that the report proposes, we fear a still greater increase in the District's already large homeless population.

Finally, if despite all this one were determined to go ahead with this proposal, it would be virtually impossible to effect the transfer in a two year period. It would require that long just to develop the planning and the personnel needed to implement it responsibly. A much longer transitional period would have to be devised, possibly six years, and the Federal subsidy must be continued throughout that period.

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February 27, 1984

COMMENTS OF THE

STATE MENTAL HEALTH ADVISORY COUNCIL

Comments on the Draft of the GAO Report by SMHAC

Beverly Russau, Chairman
Blanche Prince, L.C.S.W.
Harold Wylie, M.D.

We found the overall quality of this report to be very thorough, well designed and of general excellence with regard to the transfer of patients from St. Elizabeth's to community-based facilities.

We commend the report for using the Ohio and Wisconsin experiences in the planning of the outplacement of the St. Elizabeth's patients. However, of grave concern to us and perhaps beyond the province of the purpose of this report, is the status of the D.C. community-based services and facilities. We consider the success of the transfer process will, in the main, depend on the facilities and services extant for outplaced patients in the D.C. community.

A determination of this will require a comparable thorough evaluation and implementation before action is initiated. Also, we are concerned about the facilities and services for children in D.C. It is not clear from this report how children are included in the mental health program and budget. There is only tangential reference to the establishment of a residential children's center at St. Elizabeth's: a proposal which might result not only in substantial savings, but in better controlled, improved care.

In summary, our major concern pertains to the adequacy of community-based facilities and services available to outplaced patients. It is absolutely essential in order for this suggested program to be implemented that the Mayor appoint a director, of MHSA, to oversee the implementation. Without adequate leadership, we feel there is little chance that this project can be successful.

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