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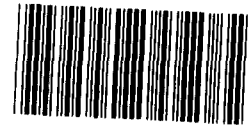
STATEMENT OF
RICHARD L. FOGEL, DIRECTOR
HUMAN RESOURCES DIVISION

BEFORE THE

SUBCOMMITTEE ON FISCAL AFFAIRS AND HEALTH
COMMITTEE ON DISTRICT OF COLUMBIA
HOUSE OF REPRESENTATIVES

ON

TRANSFER OF ST. ELIZABETHS HOSPITAL
TO THE DISTRICT OF COLUMBIA



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Mr. Chairman and Members of the Subcommittee

I am pleased to appear before you today to discuss the results of our study to determine how St. Elizabeths Hospital could be transferred to the District of Columbia. The study was requested by the Chairman, House Committee on the District of Columbia.

On April 19 we provided the Committee with our report entitled "A Proposal for Transferring St. Elizabeths Hospital to the District of Columbia." The report's digest is attached to our statement for your information. We request that the entire report be included in the hearing record.

The report presents a comprehensive plan of how St. Elizabeths could be transferred and incorporated into a restructured mental health care system for District residents. At the direction of the Committee, we took great care to insure that the mental health care system proposed could be capable of providing quality mental health services. In addition, we believe that the system we propose could provide comprehensive services at lower overall costs than the current system.

During our study we consulted extensively with individuals and groups knowledgeable of mental health services and programs in the District of Columbia. We also obtained these organizations' formal comments on our proposal, which have been included in our report.

I have with me today Bill Gerkens and Sue McCrory of my staff who were the leaders of the project. Ms. McCrory will give you an overview of the system we propose, including its costs, staff needed and how it could be implemented. Mr. Gerkens will then provide some comments on the legislative proposals made by the Department of Health and Human Services and the District of Columbia.

Ms. McCrory:

Mr. Chairman, I believe you and the other Subcommittee members will find it useful if I start my presentation by explaining the basic assumptions we used in developing the system we propose.

As shown on our first slide (p. 14), a number of parameters shaped the mental health system we propose.

First, as directed, we assumed that the system would be under the authority of the District of Columbia. Other governance options had been proposed by others. However, rather than evaluating these other options, we focused on how the District system would operate. We believed that as long as the mental health system was consolidated under a single authority, any number of governance options might be adopted.

Second, we assumed the system proposed should be consistent with the mandates of the Dixon Consent Decree. This Decree and the resulting Dixon Implementation Plan set out a number of objectives for the mental health services of the District.

Included are the commitment to consolidate outpatient activities in the community mental health centers and the objective to treat patients in the least restrictive treatment setting. We embraced these goals in our study.

Third, we assumed the system should be organized to minimize total costs and net costs to the District. St. Elizabeths had become a financial concern for both the District and the federal government. In particular, the federal government had been subsidizing District mental health expenditures at St. Elizabeths. Any proposal we developed had to be cost-conscious.

Finally, we assumed the system should use existing resources to the extent possible. In considering mental health delivery options, we hoped to prevent extraordinary upheaval to patients and staff. As a result, we sought ways to use the existing staff and facilities in our proposal.

With these assumptions in mind we developed an initial proposal. We discussed this proposal with many groups both inside the government and in the private sector knowledgeable of mental health services in general and the system currently operating in the District. The system shown on the next slide is the result of our work and the many comments and suggestions we received.

As shown (slide 2, p. 15), the District's Mental Health Services Administration would have overall responsibility for administering the system. Three mental health districts would have responsibility for patient treatment and financing. An

important change that we are suggesting is a system whereby each district would be allocated a budget to provide care for all patients within its service area regardless of where or by whom services are provided. Currently each treatment location is allocated separate budgets for their services. We believe this creates disincentives to outplace patients from St. Elizabeths. By consolidating patient treatment and budget responsibilities, we believe the mental health districts will be encouraged to provide the most appropriate patient care.

In addition to providing comprehensive services through a community mental health center (CMHC), each district would also provide outreach services through mobile treatment teams and crisis resolution services for patients experiencing a psychiatric crisis.

Another important change we are suggesting is the shift of acute psychiatric care from St. Elizabeths to community hospitals. Because St. Elizabeths is an institution for mental disease, patients between the ages of 21 and 65 treated there do not qualify for Medicaid reimbursements. By moving acute care to general hospitals, the District could collect Medicaid for patients within this age group.

Patient flow in our system is shown on our next slide (slide 3, p. 16). The primary location of care would be in the community-based mental health districts. Under our proposal, hospitalization of patients would be a last resort, used only

after the crisis resolution unit is unable to stabilize a patient and only with the unit's authorization.

With comprehensive services being expanded in community-based programs and close monitoring of acute patients by community-based staff, we would anticipate that fewer patients would require long-term care. Even those patients, however, would continue to be monitored by community-based staff to accomplish early return to the community. Importantly, none of the experts and organizations we spoke to took exception to the patient treatment system we propose.

St. Elizabeths would significantly change under our proposal. While it would continue to operate long-term psychiatric, psychiatric nursing, and forensic psychiatry programs, it would no longer offer outpatient services or acute psychiatric care. As a result, as our next slide shows (slide 4, p. 17), about 1,000 beds would be needed at St. Elizabeths.

System staffing was one of the most difficult areas in our study because there are no nationally recognized staffing standards for mental health programs. A system used by the State of Ohio to estimate hospital staffing levels and types of staff needed to achieve accreditation from the Joint Commission on Accreditation of Hospitals was used as the basis for our estimates. We modified our estimates based on comments from various groups and individuals. Finally, we consulted with the Joint

Commission before finalizing our inpatient staffing levels (slide 5, p. 18). As you can see about 900 fewer patient care staff would be needed to operate accredited programs at St. Elizabeths.

Outpatient staffing levels (slide 6, p. 19) were based on standards developed from the Outpatient Needs Assessment Survey done by the District and St. Elizabeths and service standards agreed to by the parties to the Dixon Consent Decree. As shown, about 30 staff in addition to those now providing outpatient services at St. Elizabeths and in the District's CMHCs would be needed to provide outpatient services in the system we propose.

Next, we estimated costs of the system on the basis of staffing needed to operate the system, current employee salaries, and current overhead rates.

The next two slides (slides 7 and 8, pp. 20 and 21) show how the costs of the system will be shared by the District, the federal government, and private payors. We estimate that the proposed system would cost about \$122 million compared to the \$144 million spent in fiscal year 1983.

The District's contribution to the system would be about double the amount paid in fiscal year 1983 (slide 9, p. 22). 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 were continued.

Once the details of our proposal had been developed, we turned our attention to how the system could be implemented. We identified four major implementation issues:

- 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 propose (slide 10, p. 23) that the system be implemented over a 2-year transition period to begin on October 1, 1985, and that the District assume responsibility for the system at the beginning of the period. We believe it would be important to eliminate the dual authority for decision-making early in the transfer. Furthermore, according to HHS, most of the St. Elizabeths renovation program being undertaken to help ensure accreditation would be completed by this date.

To answer the question of how the staff would be transferred, we propose that the District choose staff from among those employed at St. Elizabeths without regard to employee seniority. The District residency requirement would be waived, and employees not selected would be entitled to consideration for other federal positions.

On the financing issue, we propose that the District not incur any additional costs during the transition period. We propose 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. There would, however, be no direct federal appropriation for the system once the transition period had ended. After the transition period, the amount of the federal participation would be determined annually by the Congress when the District's lump-sum federal appropriation is considered.

Finally, we propose that the District evaluate which of the St. Elizabeths buildings it needs and either assume operation of these or lease them from the federal government.

As a result (slide 11, p. 24), the District's major responsibilities during the transition period would be to

- (1) determine where acute psychiatric care would be provided,
- (2) outplace patients who could be cared for in the community,
- (3) transfer all outpatients to CMHCs, (4) determine which employees would staff programs to continue at St. Elizabeths, and
- (5) determine which facilities at St. Elizabeths it wanted.

Mr. Gerkens will now provide our comments on the proposals of the District of Columbia and HHS.

Mr. Gerken:

Mr. Chairman and members of the Subcommittee, I would like to focus on the HHS and District proposals by using the assumptions we used in developing our proposals (slide 1, p. 14). This will allow me to contrast some important aspects of these proposals with ours.

GAO's Views on
HHS' Corporation Proposal

HHS' bill provides for St. Elizabeths Hospital and programs administered by the District's Mental Health Services Administration to be transferred to a private, nonprofit corporation. This corporation would be responsible for providing mental health services to District residents and others.

The corporation would be governed by a 12-member board. The President would appoint five of the original members, and the Mayor of the District of Columbia would appoint four; eventually the entire board (except the three designated ex officio members) would be appointed by the Mayor. Corporation employees would be neither federal nor District employees. Rather, the corporation would develop its own personnel system. Current employees of St. Elizabeths and the District's Mental Health Services Administration would be transferred to the corporation.

Under this proposed legislation, the District would reimburse the corporation for any amounts charged for patients receiving services under order from a District of Columbia court

and for those District residents of limited means. Between fiscal years 1985 and 1991, the federal government would subsidize the District's financial responsibility for indigents on a declining basis. The federal government would be responsible for paying for patients receiving services ordered by a federal court.

Like our transfer proposal, HHS' proposed corporation legislation would consolidate the District's mental health services under a single authority. However, because the corporation would be neither an agency nor an instrumentality of the District or the federal government, we are concerned about accountability of the corporation to these entities. We are also concerned that the corporation proposal does not include incentives to provide appropriate care in the least restrictive treatment settings.

Our analysis indicates that most of the costs for the corporation's services would be borne by the District. Yet the District would not have direct control over the corporation and delivery of services, nor could the District directly control costs. Consequently, HHS' proposal provides for the District to assume the financial responsibility for most of the corporation's budget, yet gives the District only very limited authority in its operation.

Another problem we see with HHS' proposal relates to hospital employee considerations. HHS' proposal includes no provisions regarding employee rights for preferential employment opportunities in the District or federal sectors should a restructuring of the system occur. We believe it is very important to address this matter in any legislation.

It is not possible to comment on whether HHS' corporation proposal is consistent with the Dixon mandates or whether it would use existing resources without a comprehensive plan describing how and where the corporation would deliver services.

GAO's Views on District's Proposal

The District, on the other hand, proposes in its Mental Health Services Clarification Act that St. Elizabeths be established as a national hospital serving federal agencies, the District, and other states and territories. Research and training efforts and special demonstration programs could continue at St. Elizabeths, and the hospital would serve as an interim treatment site for District patients while the District established its own mental health system.

Consequently, the District's proposal endorses two systems--one federally sponsored and one locally controlled. There are provisions in the legislation to enable the District to use federal services at St. Elizabeths by paying subsidized rates until 1991. Likewise the bill includes provisions for the federal government to use available District services for patients for whom it is responsible.

The proposed legislation also defines which patients are the responsibility of the District and which are federal charges. The District proposes that the federal government support all St. Elizabeths patients admitted prior to January 2, 1975, and all patients residing in the District for 1 year or less prior to admission for mental health services. The federal government would also support patients receiving services as a result of a criminal proceeding in a federal court. Unlike our proposal, the District's proposed legislation would continue the current two-provider system. Because the federal government will care for some patients and the District for others, we believe obstacles will continue to exist to providing patients the most appropriate treatment in a cost-effective manner. We would also envision problems outplacng patients such as have occurred in implementing the mandates of the Dixon Consent Decree.

While we understand the District's desire to develop its own mental health system, the legislative proposal is unclear about how and where services will be delivered. Furthermore, the District's bill fails to acknowledge the federal government's desire to stop providing mental health services to District residents. The District's proposal places an unclear demand on the federal sector to continue service to District residents for an undetermined length of time.

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Mr. Fogel

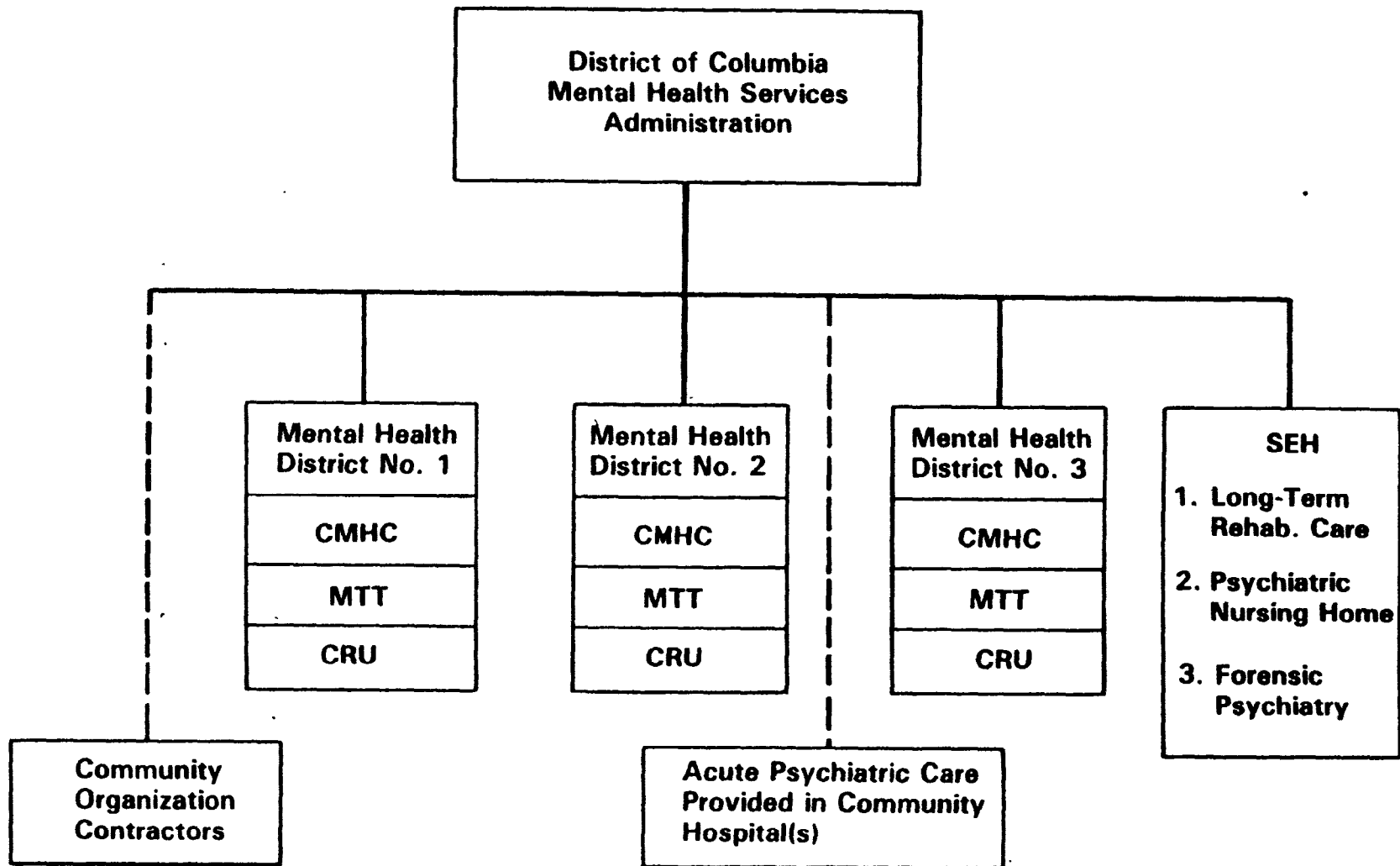
To conclude, we believe it important that the Congress clarify responsibility for providing needed mental health services to District residents. While the several proposals before you present various alternatives for doing this, overall we believe our proposal provides an equitable solution to this difficult problem from the perspective of the District, HHS, employees, and most importantly, persons needing mental health services in the District of Columbia.

We will be happy to address any questions you may have.

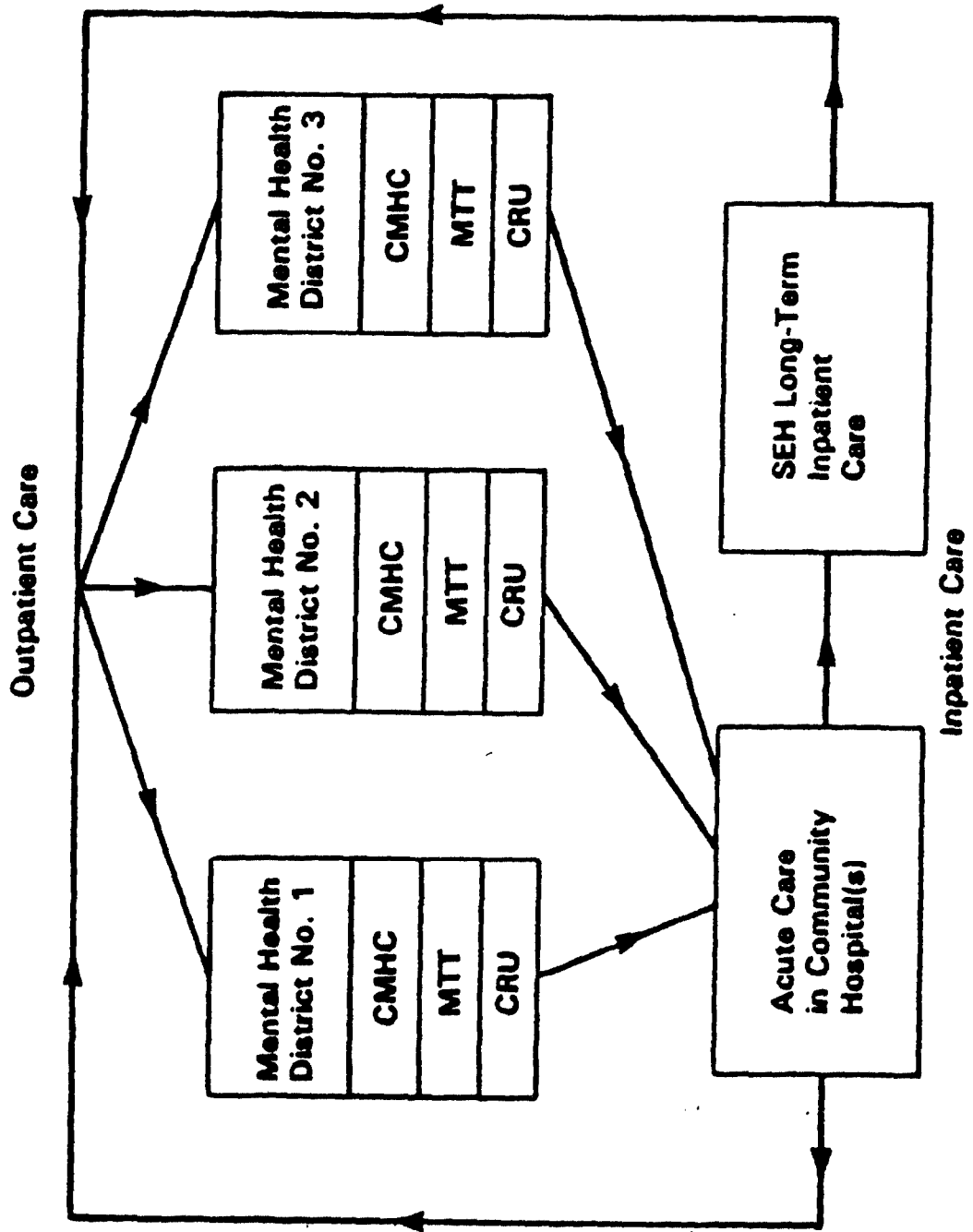
ASSUMPTIONS USED IN GAO STUDY

- 1. The System Should Be Under the Authority of the District of Columbia.**
- 2. The System Should Be Consistent With the Mandates of the Dixon Consent Decree.**
- 3. The System Should Be Organized in a Manner To Minimize the Total Cost of Its Operation and Net Cost to the District.**
- 4. The System Should Use, to the Extent Possible, Existing Resources.**

PROPOSED SYSTEM ORGANIZATIONAL STRUCTURE



PATIENT FLOW IN PROPOSED SYSTEM



PATIENTS TO BE SERVED AT ST. ELIZABETHS HOSPITAL

Number of Patients

Programs:

Rehabilitative Psychiatric	160
Rehabilitative Psychiatric Nursing	230
Intensive Psychiatric	140
Intensive Psychiatric Nursing	140
Deaf	40
Forensic	<u>300</u>

Total	<u>1,010</u>
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PROPOSED SEH INPATIENT STAFF

	<u>St. Elizabeths Fiscal Year 1983</u>	<u>Projected Need</u>	<u>Difference</u>
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	<u>91</u>	<u>36</u>	<u>(55)</u>
Total	<u>2,006</u>	<u>1,088</u>	<u>(918)</u>

PROPOSED OUTPATIENT STAFF

<u>Discipline</u>	<u>St. Elizabeths and District Total</u>	<u>Projected Need</u>	<u>Difference</u>
61 Medical Officers	46	44	(2)
Psychologists	19	31	12
Social Workers	59	62	3
Nurses	131	141	10
Therapists	<u>31</u>	<u>37</u>	<u>6</u>
Total	<u><u>286</u></u>	<u><u>315</u></u>	<u><u>29</u></u>

SUMMARY OF SYSTEM COSTS

	Cost (Millions)			<u>Total</u>
	<u>District</u>	<u>Federal</u>	<u>Other</u>	
Mental Health System				
Administration	\$ 1	\$ —	\$ —	\$.1
St. Elizabeths Hospital	44	14	3	61
Acute Psychiatric Care	11	9	1	21
Community-Based Care	<u>15</u>	<u>4</u>	<u>1</u>	<u>20</u>
Total	<u>71</u>	<u>27</u>	<u>5</u>	<u>103</u>
Specialty Programs				
Program for Deaf	—	2	—	2
Research	—	4	—	4
Training	—	<u>6</u>	—	<u>6</u>
Total	—	<u>12</u>	—	<u>12</u>

SUMMARY OF SYSTEM COSTS (Cont'd.)

	Cost (Millions)			<u>Total</u>
	<u>District</u>	<u>Federal</u>	<u>Other</u>	
21 Other Program Costs				
Income Maintenance & Long-				
Term Care Administration	2	2	—	4
Substance Abuse	3	—	—	3
Total	<u>5</u>	<u>2</u>	—	<u>7</u>
GRAND TOTAL	<u>\$76</u>	<u>\$41</u>	<u>\$5</u>	<u>\$122</u>

COST COMPARISON OF CURRENT AND PROPOSED SYSTEMS

22

<u>Payor</u>	<u>Cost in Millions</u>	
	<u>Current</u>	<u>Proposed</u>
District of Columbia	\$ 37	\$ 77
Federal Government	105	40
Other Payors	<u>2</u>	<u>5</u>
	<u>\$144</u>	<u>\$122</u>

GAO'S PROPOSAL FOR SYSTEM IMPLEMENTATION

- 1. Two-year Transition Period To Begin on October 1, 1985.**
- 2. District Will Assume Total Responsibility for the System at the Beginning of the Transition Period But Not Incur Any Additional Financial Burden During the Period.**

GAO'S PROPOSAL FOR SYSTEM IMPLEMENTATION (Cont'd)

3. During the Transition Period the District Will Need To

24

- Decide Where Acute Psychiatric Care Will Be Provided**
- Outplace Patients Who Could Be Cared For in Community Hospitals and Transfer All Outpatients to CMHCs.**
- Select Which Employees Will Staff Programs To Continue at St. Elizabeths**
- Decide Which Resources It Wants at St. Elizabeths**

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 forensic¹ 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.

¹Individuals 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

	<u>Current</u>	<u>Proposed</u>
I. <u>Programs/services:</u>	<u>Responsibility/location</u>	<u>Responsibility/location</u>
Hospital inpatient:		
Acute psychiatric	Federal/St. Elizabeths	District/General hospital(s)
Long-term	Federal/St. Elizabeths	District/St. Elizabeths
Forensic	Federal/St. Elizabeths	District/St. Elizabeths
Mental Health Program for the Deaf	District/D.C. General 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 Training	Federal/St. Elizabeths Federal/St. Elizabeths	Federal/St. Elizabeths District ^a /St. Elizabeths
II. <u>Patients:</u>	<u>Provider/number</u>	<u>Provider/number</u>
Inpatient	St. Elizabeths/ 1,700	St. Elizabeths/ 1,000
Outpatient	St. Elizabeths/ 2,300 District centers/ <u>1,900</u>	General Hospitals/ 200 District centers/ <u>4,600</u>
Total	<u>5,900</u>	<u>5,800^c</u>
III. <u>Costs</u> (fiscal year 1983):	(in millions)	(in millions)
District of Columbia	\$ 37.0	\$ 76.8
Federal	104.6	40.2 ^d
Other payors	<u>2.6</u>	<u>4.9</u>
Total	<u>\$144.2</u>	<u>\$121.9^e</u>
IV. <u>Direct patient care staffing:</u>	(No. of full-time equivalent employees)	
Inpatient	2,006	1,088
Outpatient	<u>286^f</u>	<u>315</u>
Total	<u>2,292</u>	<u>1,403</u>

^aDistrict would operate if federal funds were provided.

^bSee page 7 for map of Mental Health Districts.

^cDoes not include about 100 substance abuse patients who would be treated in other District programs.

^dIncludes costs of federal beneficiaries, Medicare costs, and the federal share of Medicaid.

^eIncludes 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.

^fIncludes 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 commentators 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 commentators 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 commentators 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 commentators 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 commentator 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 commentators 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.)