

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**The External Quality Review of
Psychiatric Hospitals**



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EXECUTIVE SUMMARY

PURPOSE

To assess the external quality review of free-standing psychiatric hospitals that participate in Medicare.

BACKGROUND

Concerns About Psychiatric Hospitals

Recently, the media has drawn attention to the quality of care in psychiatric hospitals due to deaths attributed to the inappropriate use of restraints and seclusion. This has raised fundamental questions about how care is delivered and overseen in psychiatric hospitals. Medicare requires such hospitals to meet two special conditions of participation (staff requirements and medical records) that apply only to psychiatric hospitals. The Health Care Financing Administration (HCFA) relies upon contracted psychiatric nurses and psychiatrists to assess compliance with these two special conditions. Like general hospitals, psychiatric hospitals are also subject to all the Medicare conditions of participation and can be deemed to meet them through either accreditation (usually by the Joint Commission on Accreditation of Healthcare Organizations) or certification (by State agencies). Currently 611 psychiatric hospitals participate in Medicare; all but 39 are accredited.

This inquiry follows-up our recent series on the external review of hospital quality. In this related inquiry, we focus on the overall system of external review as it applies to psychiatric hospitals. That system includes HCFA's contracted surveyors, the Joint Commission, State agencies, and HCFA itself. We devote particular attention to the review provided by HCFA's contracted surveyors. We based our inquiry on national data on psychiatric hospital surveys, survey observations, and stakeholder interviews, among other sources of information.

FINDINGS

The current system of external review for psychiatric hospitals has some strengths that help protect patients.

The system includes a patient-centered approach aimed at ensuring patients receive active treatment as opposed to custodial care. HCFA's contracted surveyors choose a sample of patients and trace them through the hospital by reviewing their medical records,

observing them on the wards and in sessions, interviewing them, and speaking with their caregivers. Neither State agencies nor the Joint Commission survey with this approach.

It has achieved some balance between the collegial (aiming to educate and improve) and the regulatory (aiming to investigate and enforce) approaches to oversight.

Both HCFA's contracted surveyor and State agency activities lean toward the regulatory approach. The Joint Commission surveys lean toward the collegial approach, with an educational bent. However, the Joint Commission has added some regulatory elements to its approach by increasing its unannounced surveys of psychiatric hospitals and maintaining more control over the selection of medical records.

But the external review system also has major deficiencies.

The extent to which it holds psychiatric hospitals accountable for patient care is questionable. HCFA's contracted surveyors take an in-depth look at patient care, but the two special conditions that guide their survey are limited to medical records and staff requirements. Joint Commission surveyors' approach to patient care is less in-depth, but their official findings are much less limited and more far ranging. State agency involvement in psychiatric hospitals is more episodic and driven by complaints and adverse events, but they too have a broader range of official findings than HCFA's contracted surveyors.

These limitations are particularly apparent with regard to discharge planning and restraints and seclusion. All external reviewers give marginal attention to discharge planning. The Joint Commission gives more attention to restraints and seclusion than HCFA's contracted surveyor or State agencies, but its effectiveness is questionable.

Some psychiatric hospitals are falling through the cracks, rarely being subjected to contracted or State agency surveys. The number of surveys conducted by HCFA's contracted surveyors fell from a high of 413 in FY 1993 to 146 in FY 1998, a drop of 65 percent. The elapsed time between such surveys is growing, and some psychiatric hospitals have not been surveyed in over 5 years.

HCFA's contracted surveyors, State agencies, and the Joint Commission tend to carry out their psychiatric hospital oversight on independent tracks with little coordination. HCFA's contracted surveyors sometimes survey hospitals on the heels of the Joint Commission or State agency. Thus, in short order, a hospital could be visited by each. But HCFA's contracted surveyors rarely have the results of the other reviews.

The contracted surveyors are held just minimally accountable for their performance in overseeing psychiatric hospitals.

HCFA obtains limited information on the performance of its contracted surveyors. Validation surveys, HCFA's main source of information on the performance of external reviewers and hospitals, exclude the two special conditions for psychiatric hospitals. Also, HCFA asks for little aggregate or routine reporting on the contracted surveys.

HCFA provides some feedback to its contracted surveyors, mostly through its review of the survey documentation. HCFA lacks a formal or routine mechanism for providing feedback to its contracted surveyors on their performance. Its feedback tends to be sporadic.

Public disclosure plays a minimal role in holding the contracted surveyors accountable. HCFA makes little information available to the public on the performance of the psychiatric hospitals or the contracted surveyors.

RECOMMENDATIONS

HCFA and Joint Commission responses to the recommendations we posed in our recent series on the external review of hospital quality help address the deficiencies identified in this study. Below we offer five additional recommendations that emerge primarily from the findings in this inquiry, but also draw on those in our previous series, which included acute care hospitals with psychiatric units. Our recommendations call for HCFA to exert its leadership in shaping the external review of psychiatric inpatient care. If enacted, these recommendations will further strengthen external quality review systems intended to protect psychiatric inpatients.

HCFA should deploy its contracted surveyors more strategically and take better advantage of their expertise.

HCFA's 76 contracted surveyors serve as an important resource, providing expertise that HCFA and the State agencies would be hard-pressed to duplicate. To take better advantage of this expertise, we recommend that HCFA strengthen the contracted surveyors' background in the full range of Medicare conditions of participation for hospitals and make them available for:

Responding to complaints and adverse events involving psychiatric care: The contracted surveyors' special expertise should be available to enhance the States' ability to respond appropriately to complaints and events.

Surveying in both psychiatric hospitals and psychiatric units of acute care hospitals: We suggest that the contracted surveyors' expertise would be valuable to these units, which typically receive just a fraction of surveyors' time during an accreditation survey.

We are aware of the resource implications of this recommendation. HCFA currently estimates the costs of each contracted survey at \$8,300. HCFA could use its estimates to seek additional funding or seek authority to establish a user fee to help defray the costs.

HCFA should hold its contracted surveyors more fully accountable for their performance. Toward that end, it should

Conduct periodic observation surveys of the contracted survey process. HCFA now lacks any such oversight mechanism of the contracted survey process.

Obtain timely and useful performance reports. These should cover, at a minimum, the contracted surveyors' activities, such as types of surveys conducted, findings, and trends.

Provide feedback and guidance to the contracted surveyors. Given their part-time status and the decline in scheduled surveys, HCFA should stay in closer contact with the contracted surveyors and consider facilitating a network through a newsletter or website.

Increase public disclosure. HCFA should make more information available on the oversight and performance of psychiatric hospitals by, at a minimum, posting information on the Internet.

HCFA should determine an appropriate minimum cycle for the contracted survey at psychiatric hospitals.

No mandated cycle for these contracted surveys exists. In determining one, HCFA should take steps to strengthen its ability to track all participating hospitals and their survey history in such a way that allows HCFA to easily determine whether the survey was conducted by the contracted surveyors or State agencies. It should also take steps to coordinate the survey activity among the external reviewers.

HCFA should negotiate with the Joint Commission to achieve both a more patient-centered survey approach and a more rigorous assessment of discharge planning.

The Joint Commission does not currently use the patient-tracing approach employed by HCFA's contracted surveyors. The Joint Commission is well-positioned to apply this approach more broadly in psychiatric units as well as psychiatric hospitals. Also, the Joint Commission has a significant base of experience in addressing discharge planning issues in nonhospital settings and is therefore well-positioned to apply this expertise to the hospital setting.

HCFA should consider applying special Medicare conditions of participation both to psychiatric hospitals and psychiatric units of acute care hospitals.

Many experts suggest that psychiatric inpatients face vulnerabilities that warrant greater scrutiny than most other hospital patients. But the external review system that HCFA relies upon falls short in two important ways. First, it does not apply the special conditions to psychiatric units of acute care hospitals, which is where the great majority of Medicare beneficiaries receive inpatient psychiatric care. Furthermore, in psychiatric hospitals, the contracted surveyors are limited to assessing compliance with only the two special conditions (medical records and staff requirements) even though their patient-based review exposes a broad array of treatment issues.

Given this situation, it would appear timely for HCFA to consider special conditions that it would use for both inpatient settings. If HCFA moved in this direction, the following are among the key questions it would have to address:

- Do the proposed Medicare conditions of participation for hospitals and the interim final rule on patient rights provide sufficient authority for the external reviewers to apply the extra scrutiny warranted for psychiatric inpatients?
- Are additional authorities needed for key patient-care issues, including discharge planning?

COMMENTS ON THE DRAFT REPORT

Within the Department of Health and Human Services, we received comments on our draft report from HCFA. Outside the Department, we received comments from the Joint Commission, the National Association of Psychiatric Health Systems, the National Alliance for the Mentally Ill, and Public Citizen's Health Research Group. Below is a summary of those comments followed by our responses, in italics.

HCFA Comments

HCFA concurred with all of our recommendations and noted its ongoing work with the Joint Commission to improve hospital oversight. It is willing to explore more strategic uses of the contracted surveyors and anticipates funding increases that will allow it to reduce the interval between the contracted surveys. It also noted its plans for redesigning its information system to support better reporting of survey trends. Finally, HCFA indicated that it will develop interpretive guidelines, with a corresponding plan for the contracted surveyors to enforce them, for existing regulations that apply to psychiatric units of acute care hospitals, which generally parallel the special conditions for psychiatric hospitals.

We appreciate HCFA's positive response to our report. In implementing the recommendations, HCFA will strengthen the system of external review intended to protect psychiatric inpatients. We have added some text on funding contracted surveys, which is relevant to our call for HCFA

to use the surveyors more strategically as well as to determine an appropriate minimum cycle for surveys. We hope this new text will be helpful to HCFA as it explores further funding increases.

Comments from the Joint Commission

The Joint Commission identified many changes either already implemented or underway that enhance the accreditation process and promote a patient-centered approach to oversight. In particular, it noted its ongoing process to strengthen its standards for discharge planning.

The Joint Commission took issue with how we characterized the authority of the contracted surveyors' ability to hold psychiatric hospitals accountable for patient care issues and our point that Medicare bears the cost of external review either directly or indirectly.

We appreciate the Joint Commission's continued responsiveness to our recommendations. The Joint Commission's leadership on these issues can influence improvements in accredited hospitals. In response to the Joint Commission's concerns, we clarified our discussion of the limits of the contracted surveyors' authority and the extent to which Medicare bears the cost of external review.

Comments of Other External Associations

To varying degrees, the external parties supported our findings and recommendations, but also reflected some concerns. Both the National Alliance for the Mentally Ill and Public Citizen noted their concerns about accreditation and called for increased funding for the contracted surveys. The National Association of Psychiatric Health Systems opposes "widespread dissemination of information [about the performance of hospitals and surveyors] without adequate explanation and protection" whereas Public Citizen expressed its concern that without disclosure, "public discontent will grow."

In its comments, the National Alliance recommended its State organizations as additional resources for the external review of psychiatric hospitals and pointed to other resources on discharge planning in the Substance Abuse and Mental Health Services Administration of the Department.

We suggest that HCFA consider the concerns raised by these stakeholders as it works to improve the system of hospital oversight. They offer perspectives that can be informative to HCFA.

On the matter of public disclosure, we emphasize our position that such disclosure represents an important step toward enhancing the public accountability of the contracted survey process and parallels recommendations we made in our earlier series, "The External Review of Hospital Quality."

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INTRODUCTION

PURPOSE

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BACKGROUND

Concerns about Psychiatric Hospitals

Recently, the media has drawn attention to patient deaths attributed to inappropriate use of restraints and seclusion. In October 1998, *The Hartford Courant* published an investigative series that detailed 142 such deaths from around the country over the past 10 years. Over half of those deaths occurred in hospitals. In April 1999, the television news show *60 Minutes II* highlighted the inappropriate use of restraints and seclusion, lack of trained staff, and questionable record-keeping at psychiatric hospitals in the Charter Behavioral Hospital chain. In response to these concerns, three restraint bills have been introduced in Congress. The bills variously call for restricting the use of restraints, reporting restraint-related deaths and injuries, strengthening protection and advocacy systems, and assuring the rights of individuals receiving mental health services.

In response to requests from members of Congress, the General Accounting Office recently issued a report examining the extent to which restraints and seclusion are used in various inpatient settings.¹ The report found both underreporting of deaths and injuries involving restraints and seclusion as well as variation among State and Federal policies on restraints and seclusion.

This attention has raised fundamental questions about how care is delivered and overseen in psychiatric hospitals.

Inpatient Psychiatric Care

Patients needing inpatient psychiatric care generally receive that care in free-standing psychiatric hospitals or psychiatric units within acute care hospitals. Currently, 611 free-standing psychiatric hospitals operate around the country, all but 39 of which are accredited.² Of about 6,000 acute care hospitals, about 25 percent operate inpatient

psychiatric units. Psychiatric care can also be provided in an acute care bed, outside of a specialized psychiatric unit or hospital.

In 1997, 497,159 Medicare discharges were related to psychiatric care.³ Sixty-six percent of those discharges were from psychiatric units that are part of acute care hospitals, 27 percent were from free-standing psychiatric hospitals. The remainder were from acute care beds outside of specialized hospitals or units.

Medicare Conditions of Participation

When Congress enacted the Medicare Act in 1965, it required hospitals to meet certain minimum health and safety requirements to participate in the program.⁴ Those minimum requirements are called the Medicare conditions of participation. In addition to these conditions that apply to all participating hospitals, free-standing psychiatric hospitals are subject to two special conditions.⁵ One concerns record-keeping and one, staff requirements.⁶ These two special conditions stemmed from Congress' concerns that patients in psychiatric hospitals would be warehoused and receive only custodial care, rather than active treatment.⁷

The Health Care Financing Administration (HCFA) published the Medicare conditions of participation in 1966, revised them in 1986, and, except for the two special psychiatric conditions, are revising them again.⁸ On July 2, 1999, HCFA issued an interim final rule on patient rights, which includes the right to be free from restraints and seclusion as a means of coercion, convenience, and retaliation by staff.⁹ It also calls for hospitals to report restraint-related deaths to HCFA.¹⁰ This interim final rule applies to all hospitals, both general and psychiatric.

External Review of Psychiatric Hospitals for Participating in Medicare

Because the two special conditions for psychiatric hospitals, the Federal government relies on an additional external reviewer for their oversight: a panel of psychiatric surveyors under contract to HCFA (hereafter referred to as contracted surveyors). These contracted surveyors conduct reviews that cover only the special conditions. HCFA does not consider surveys by the Joint Commission on Accreditation of Healthcare Organizations to cover these special conditions. HCFA's contracted surveyors include mostly psychiatrists and psychiatric nurses, but also psychiatric social workers and pharmacists. All are part-time surveyors.

Within the Medicare Act itself, Congress provided that hospitals accredited by the Joint Commission were deemed to be in compliance with the conditions of participation.¹¹ However, the two special conditions that psychiatric hospitals must meet are excluded from that deemed status. Thus, psychiatric hospitals accredited by the Joint Commission are also subject to a review by the contracted surveyors.

Psychiatric hospitals wishing to participate in Medicare without accreditation must go through a Medicare certification process. HCFA funds State survey and certification agencies (hereafter called State agencies) to conduct certification surveys at these hospitals to determine compliance with the Medicare conditions. Although HCFA trains the State surveyors in all the conditions (including the two special psychiatric conditions), the contracted surveyors may be involved in certifying the nonaccredited psychiatric hospitals as well.

Regardless of the route a psychiatric hospital takes to Medicare participation, Medicare generally bears a cost for the external review, either directly by funding State agencies or HCFA's contracted surveyors, or indirectly through hospital charges that include the overhead cost of periodic accreditation surveys.¹²

Accreditation, contracted surveys, and Medicare certification (by State agencies) involve a team of trained surveyors visiting a hospital, interviewing staff, reviewing documents, and inspecting the facility.

Other external parties also have roles in overseeing psychiatric hospitals. Medicare Peer Review Organizations, for example, have broad authority in overseeing the quality of care paid for by Medicare, although they have no responsibilities specific to psychiatric hospitals. Each State also has a federally funded Protection and Advocacy grantee to protect the rights of and advocate for individuals with mental illness. These grantees have the authority to investigate reports of abuse and neglect in all facilities that care for or treat individuals with mental illness, including psychiatric hospitals. And, depending upon the circumstances, even the Department of Justice and the Food and Drug Administration can become involved with patient deaths and abuses in psychiatric hospitals.

Recent Reports by the Office of Inspector General

In July 1999, the Office of Inspector General released four reports that assessed the system in place for reviewing hospitals generally. These reports covered the key roles played by the Joint Commission, the State agencies, and HCFA. See appendix A for a more detailed summary of these reports.

The great majority of psychiatric hospitals are accredited by the Joint Commission, thus, the findings from our recent series apply also to psychiatric hospitals. In our series, we found that Joint Commission surveys are undertaken in a collegial manner and are tightly structured, an approach that fosters consistency but leaves little room for probing. They also provide an important vehicle for reducing risk and fostering improvement in hospitals. The hospitals take the surveys seriously and prepare for them. But the surveys are unlikely to detect substandard patterns of care or individual practitioners with questionable skills.

Likewise, our findings on the role of Medicare certification are relevant to those few nonaccredited psychiatric hospitals, which, without a complaint or adverse event, State agencies are unlikely to survey. In fact, the backlog for surveying nonaccredited hospitals is growing: in 1997 half of all such hospitals had not been surveyed in over 3 years, up from 28 percent in 1995.

We also found that HCFA does little to hold either the Joint Commission or the State agencies accountable for their performance in overseeing hospitals.

In our reports, we called for HCFA to exert leadership in addressing the shortcomings we identified. First, as a guiding principle, we urged HCFA to steer the external review process so that it represented a balance between the educationally oriented approaches of the Joint Commission and the enforcement-oriented approaches of the State agencies. Then we offered two sets of recommendations. In the first, we presented a number of steps HCFA should take to hold both the Joint Commission and the States more fully accountable for their performance in reviewing hospitals. Second, we called for HCFA to determine the appropriate minimum cycle for conducting certification surveys of nonaccredited hospitals. HCFA responded positively to our recommendations by presenting a detailed hospital oversight plan that incorporates our recommendations and an accompanying strategy for hospital performance measurement.

This Inquiry and Report

This inquiry focuses on the oversight of free-standing psychiatric hospitals and, in particular, on the role of HCFA's contracted surveyors. It does not address the implementation of the interim final rule on patient rights. Nor does it address the roles of Medicare Peer Review Organizations, Protection and Advocacy grantees, the Department of Justice, or the Food and Drug Administration. Forthcoming Office of Inspector General reports will address the current Federal and State data systems for reporting patient abuses, particularly those involving restraints and seclusions that occur in psychiatric hospitals.

Our inquiry draws on a variety of sources including: national data from HCFA on its contracted surveys; policies and guidelines on the contracted survey process; interviews with current and former contracted surveyors, HCFA officials, and other stakeholders; survey observations of contracted surveys and Joint Commission surveys in psychiatric hospitals; aggregate data from the Joint Commission; and reviews of laws, regulations, and articles from newspapers and journals, among others. See appendix B for more details on our methodology.

While our findings emerge primarily from the above-noted data sources, we also draw on our observations from our prior reports on the external review of general acute care hospitals, which often have psychiatric units.

We conducted this inspection in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

PROFILE OF PSYCHIATRIC HOSPITAL OVERSIGHT

The table below profiles the roles of the three major external reviewers for psychiatric hospitals. See appendix C for more details on the five-part framework.

Element	HCFA's Contracted Surveys	Joint Commission	State Survey Agencies
Routine, Announced On-site Surveys	<ul style="list-style-type: none"> •Core of contracted surveyor activity •Patient-centered approach that leans toward the regulatory mode •No set cycle for review •No clear policy on announced versus unannounced surveys •Fewer surveys being done •Elapsed time between surveys growing 	<ul style="list-style-type: none"> •Core of accreditation process •Routine presence on a 3-year cycle •Collegial •Significant attention to restraints and seclusion 	<ul style="list-style-type: none"> •Applies to nonaccredited psychiatric hospitals only •Low priority •Mean elapsed time between surveys=3.4 years •55 percent of nonaccredited hospitals have gone over 3 years without a survey; 31 percent, over 4 years; 21 percent, over 5 years
Random Unannounced On-site Surveys	<ul style="list-style-type: none"> •Not Applicable (although some contracted surveys are unannounced, none are random) 	<ul style="list-style-type: none"> •Increasingly aimed at psychiatric hospitals •Customized surveys •Truly unannounced 	<ul style="list-style-type: none"> •Not Applicable
Responses to Complaints	<ul style="list-style-type: none"> •Rarely involved: contracted surveyors responded to a few per year. 	<ul style="list-style-type: none"> •Recent improvements to the complaint process hold promise 	<ul style="list-style-type: none"> •Core activity •Conducted an average of 314 complaint surveys in FY96, FY97, and FY98 •Publicly accountable
Responses to Major Adverse Events	<ul style="list-style-type: none"> •Same as complaints; HCFA makes no distinction 	<ul style="list-style-type: none"> •Approach is oriented toward research and prevention •Relies on self-reporting •Ensures hospital confidentiality •No public accountability 	<ul style="list-style-type: none"> •Core activity in accredited and nonaccredited hospitals •Publicly accountable
Collection and Dissemination of Standardized Performance Measures	<ul style="list-style-type: none"> •Not Applicable 	<ul style="list-style-type: none"> •Not Applicable (core psychiatric measures under development) 	<ul style="list-style-type: none"> •Not Applicable

FINDINGS

The current system of external review for psychiatric hospitals has some strengths that help protect patients.

The system includes a patient-centered approach aimed at ensuring patients receive active treatment as opposed to custodial care.

HCFA's contracted surveyors spend much of their time at psychiatric hospitals following the care of a sample of patients. They choose the sample at the outset of the survey and begin by reviewing the medical records of the chosen patients. Spending an hour or more on a single record, they become familiar with their sample patients' treatment plans, whether they are being implemented, and what outcomes are being achieved. The contracted surveyors follow the record reviews by directly observing patients in different settings, for example on the ward and in activities class. Thus, they can see for themselves the extent to which the treatment plan is being implemented. They also interview the patients' caregivers, thereby eliciting the staff's awareness of the sample patients, such as why they are hospitalized and what their treatment plans are. The contracted surveyors interview the patients themselves, asking them how they are treated, what brought them to the hospital, what their plans for discharge are, and gauging their awareness of their treatment plans. Finally, where possible they observe the treatment team discussions, when the psychiatrist, social worker, and other professionals meet to discuss individual patient's treatment and progress.

Observing Patients in a Substance Abuse Session

A contracted psychiatric nurse surveyor sat in on a substance abuse discussion group, led by a hospital therapist. She chose the session because one of her sample patients, whose medical record she had already reviewed, was a participant. Her review of the medical record revealed the patient's hearing deficiency. She quietly observed the 45-minute session, paying particular attention to whether the therapist appeared to be aware of that deficiency in his interactions with the patient.

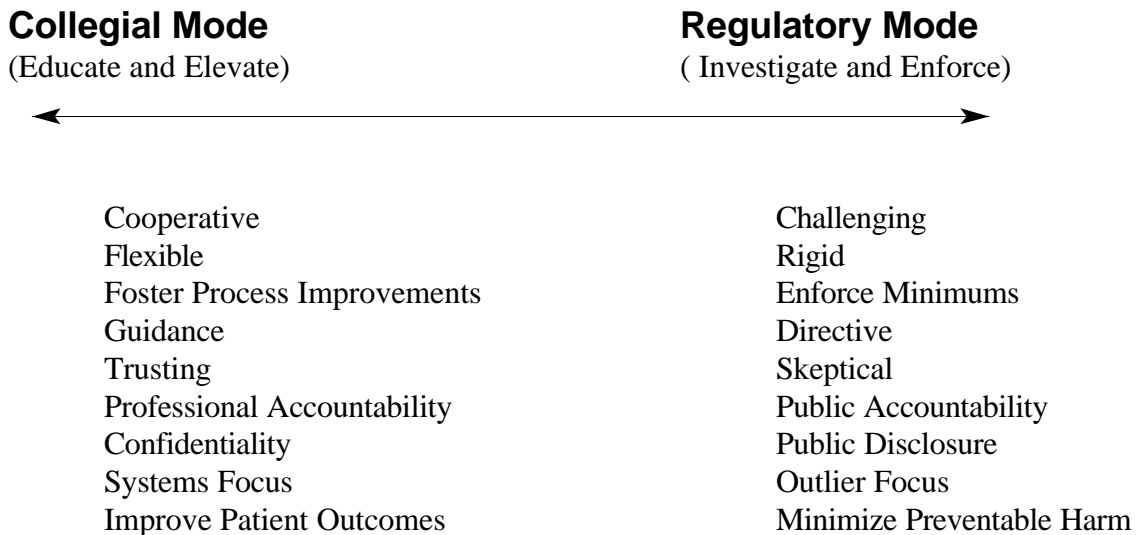
This approach gives the contracted surveyors a picture of the hospital's performance by using discrete patient experiences as lenses. Already experienced as psychiatric nurses, social workers, and psychiatrists, the contracted surveyors use these lenses to identify concerns regarding active treatment ranging from the qualifications and language skills of hospital staff to the participation of the art therapist in treatment team meetings. The focus on active treatment pervades the survey process, with surveyors relying on each

portion of the process--record review, patient observation, and caregiver and patient interviews--to confirm the others.

Neither the Joint Commission nor the State agencies use this approach of tracing the treatment of a sample of patients through medical records, observations, and interviews. While they do involve some patient focus, it is less central to the review process.

It has achieved some balance between the collegial (aiming to educate and improve) and the regulatory (aiming to investigate and enforce) approaches to oversight.

It is helpful to consider external hospital oversight in terms of a continuum, characterized by a collegial approach on one side and a regulatory approach on the other. External reviewers in the collegial mode focus on education and improved performance; those in the regulatory mode focus on investigation and enforcement of minimum requirements. In the continuum below, we list the major characteristics we associate with each side.



Both approaches to oversight have value. HCFA's contracted surveyors, State agencies, and the Joint Commission all have approaches that represent different aspects of the continuum.

The Joint Commission remains the dominant external reviewer for psychiatric hospitals. And it has been grounded on the collegial side of the continuum. Its triennial surveys are announced in advance, giving hospitals time to prepare. Its process is educational: its surveyors share insights from other hospitals and explain the intent and significance of the standards. The surveys focus on performance improvement, giving hospitals opportunities to present improvement projects throughout the visit. Its approach to adverse events stresses research, education, and prevention.

However, while the Joint Commission's approach is still grounded in the collegial mode, it recently made some changes in its accreditation of psychiatric hospitals that mark a shift toward the regulatory mode. Over the summer of 1999, it conducted 38 completely unannounced surveys at Charter psychiatric hospitals in response to the *60 Minutes II* piece on inappropriate restraint use and lack of staff training in Charter hospitals.¹³ The Joint Commission assigned a special team of psychiatric surveyors to these unannounced surveys. During the surveys, the team, rather than the hospital staff, selected the records for review. The Joint Commission recently announced its plans to expand its new unannounced surveys in other psychiatric hospitals and acute care hospitals as well. It is planning tests of an unannounced survey with a focus tailored to the specific hospital and expanded background information for surveyors.

These changes by the Joint Commission, coupled with the regulatory approaches of HCFA's contracted surveys and State agencies, introduce a measure of balance among the external reviewers and their approaches. HCFA's surveys lean toward the regulatory side of the continuum. Their approach is challenging in nature. For example, rather than relying solely on the medical record, they substantiate its documentation with observations and interviews. The contracted surveyors focus on ensuring the minimum requirements for the two special conditions are met. As directed by HCFA, they avoid an educational approach and pay little attention to performance improvement, both hallmarks of a more collegial approach. The hospitals have little opportunity for formally presenting information to the surveyors.¹⁴ The surveyors discourage the hospital's leadership from accompanying them during parts of the survey, such as patient interviews, therapy observations, and ward tours. State agencies are also rooted in the regulatory side of the continuum. Their oversight tends to be driven by complaints and adverse events. Their visits in response to such events tend to be unannounced.

But the external review system also has major deficiencies.

The extent to which it holds psychiatric hospitals accountable for patient care is questionable.

HCFA's contracted surveys provide an in-depth look into the patient care at psychiatric hospitals. Surveyors can uncover problems ranging from the adequacy of the treatment plan to the handling of agitated patients. But their legitimacy in holding the hospital accountable for those problems is far more limited. The two special conditions on which the contracted survey is based are staff requirements and medical records. Thus, despite the far-reaching nature of their inquiry, the contracted surveyors are hard-pressed to hold hospitals accountable for problems outside either medical records or staff requirements. If the contracted surveyors find problems but the conditions are still met, they can refer the problems to HCFA or State agency surveyors, but do not follow-up on the problems themselves.

On the other hand, both the Joint Commission and State agencies (through HCFA and/or their own State authorities) have broader authorities on which to base their survey findings. Indeed, the Joint Commission has several hundred standards grouped across 45 topics, and State agencies can enforce all of the Medicare conditions of participation. However, both lack the in-depth look into patient care that the contracted surveyors have. And State agencies' reviews of psychiatric hospitals tend to be further limited by their episodic nature. They are driven by complaints and adverse events as opposed to regularly scheduled reviews.

Discharge Planning. The limits of the external review system are especially apparent in assessing hospitals' discharge planning.¹⁵ Discharge planning refers to hospitals' efforts to ensure continuity of care for their patients after discharge by linking them with their families, clinics, schools, and residential programs, among other community services. Increasing acuity and decreasing lengths of stay make successful discharge planning increasingly crucial for psychiatric patients.¹⁶ And the external review system--which is hospital-based--only goes so far in assessing how well a hospital links patients with community providers or connects with a patient's family. For example, HCFA's contracted surveyors have just an indirect and narrow window to assess discharge planning through either the medical records or the staff requirements condition. Likewise, the Joint Commission lacks a scheduled session dedicated to discharge planning. Both HCFA's contracted and Joint Commission surveyors review records of discharge planning, which document contacts, but fall short of assessing adequacy. Furthermore, neither HCFA's contracted surveyors nor Joint Commission surveyors know much background about a hospital--such as average length of stay, where the patients come from, the extent of local services, or staff turnover--prior to the survey, making a meaningful assessment of discharge planning unlikely. Surveyors are hardpressed to assess whether hospitals are taking adequate advantage of external services.

Restraints and Seclusion. Like discharge planning, the appropriate use of restraints and seclusion are critically important patient care topics. Unlike discharge planning, restraints and seclusion receive considerable attention from the external reviewers. HCFA's contracted surveyors review restraint logs, ask patients and caregivers about restraints, examine seclusion rooms, and review any documentation in the medical records. But as with discharge planning, HCFA's contracted surveyors have a limited regulatory basis to hold a psychiatric hospital accountable for inappropriate use of restraints.¹⁷

The Joint Commission gives restraints and seclusion more attention, and has for some time. Since 1984, when it first adopted restraint standards, it has been working to improve them: it revised them in 1989, broadened their application in 1991, revised them again in 1993, appointed a Board Task Force on restraints in 1996 and a Restraint Use Task Force in 1998.¹⁸ Even more recently, the Joint Commission held a series of three public hearings on restraint use.¹⁹

Attention to restraints and seclusion pervades the Joint Commission survey process. Surveyors stop orderlies and custodians in the hallways to ask them what they should do if a nearby patient became agitated. They review medical records for proper documentation and personnel records for evidence of proper training. They examine seclusion rooms for safety. In fact, for the past 2 years, restraint-related deficiencies have been among the top five most commonly identified deficiencies in psychiatric hospitals.²⁰

Nevertheless, as evidenced by the *60 Minutes II* segment on restraint abuses in an accredited hospital, the ability of the surveyors to identify such abuses is questionable. Hospitals usually know the Joint Commission is coming and prepare for the survey, thereby perhaps presenting surveyors with only a slice of the hospital's actual operations.

Of course, no system of hospital oversight is foolproof. The continued evidence of abuses concerning restraints and seclusion reinforces that external reviewers serve to reduce risks--not guarantee appropriate treatment. They also serve to reinforce the important safety valve that responding to complaints provides.

Some psychiatric hospitals are falling through the cracks, rarely being subjected to contracted or State agency surveys.

Since FY 1993 the number of contracted surveys at psychiatric hospitals has dropped 65 percent: from a high of 413 to 146 in FY 1998.²¹ This drop reflects the reduced resources available for these surveys. From FY 1993 to FY 1999 the budget for these surveys fell from \$3,000,000 to \$670,000.²² During that same time, the number of contracted surveyors fell from 147 to the current 76. Fewer contracted surveys means psychiatric hospitals go longer without surveys. Since FY 1993, the average elapsed time between contracted surveys has tripled from 14 months to 3.5 years. In fact, we identified 37 hospitals that have gone 5 or more years without a contracted survey, including 3 that have gone 10 years. HCFA relies on input from its regional offices in selecting which

Words of Warning to the Medical Staff

"Psychiatric hospitals are under a microscope...Everyone is upset about how you use restraints. The 60 Minutes Show reflects the peoples' perceptions of your hospital. You are obligated to make them change their minds...It is a challenge to be attentive and thoughtful with restraints. Some hospitals put their staff and physicians in them to see what it is like. And in every case those staff and physicians will be less likely to use restraints. It's a question of dignity. Restraints are dehumanizing. You must ask yourselves: Are you using them only when you've tried everything else?"

-A Joint Commission psychiatrist, in his remarks to the medical staff leadership at a psychiatric hospital, during the triennial accreditation survey (spring, 1999).

psychiatric hospitals to survey each year. But regional participation in that process varies greatly, and no mandated cycle for review of the special conditions exists.

As fewer and fewer contracted surveys have been conducted, HCFA's contracted surveyors are finding more hospitals out of compliance with the two extra conditions of participation. In FY 1993, they found 13 percent of the psychiatric hospitals out of compliance with one or both conditions. By FY 1998, 21 percent were out of compliance.

HCFA's system for tracking psychiatric hospitals often misses hospital mergers, closures, and name changes, making it difficult to accurately and easily identify which hospitals have gone the longest without a contracted survey. The situation is even worse for nonaccredited hospitals. HCFA's records indicate that 65 of the 611 psychiatric hospitals are nonaccredited. However, we determined that 26 of those 65 were, in fact, accredited. Over half--55 percent--of the nonaccredited psychiatric hospitals for which we had data have gone longer than 3 years without a State agency survey; a third, 4 years; and a fifth, 5 years.

HCFA's contracted surveyors, State agencies, and the Joint Commission tend to carry out their psychiatric hospital oversight on independent tracks with little coordination.

HCFA schedules the contracted surveys with little regard for any other external reviewer. Thus a hospital could, in short order, be surveyed by the contracted surveyors, the Joint Commission, and the State agency. This could present a burden to the hospital being reviewed. For example, both of the contracted surveys we observed were at hospitals that had other reviews within 3 to 4 months: one had a Joint Commission survey prior to the contracted survey; the other, a State agency survey to validate the results of the Joint Commission's survey. In neither case did the contracted surveyors have the results of those surveys in advance.

Even in cases of complaints or adverse events, HCFA rarely coordinates with the Joint Commission. For example, a State agency received six complaints about a psychiatric hospital with the highest level of accreditation (accredited with commendation). It received the complaints within 7 months of the Joint Commission's survey. These complaints triggered a series of announced and unannounced surveys over the ensuing 12 months, beginning with a simultaneous State agency complaint investigation and contracted survey. The State agency and contracted surveyors found the hospital to pose an immediate and serious threat to its adolescent patients. Problems ranged from lack of patient supervision, inappropriate use of restraints, and even sexual abuses. Even while the local media picked up the story and the State agency and HCFA's contracted surveyors conducted more surveys and follow-ups, HCFA did not coordinate any of its response with the Joint Commission.

The contracted surveyors are held just minimally accountable for their performance in overseeing psychiatric hospitals.

HCFA obtains limited information on the performance of its contracted surveyors.

While validation surveys represent HCFA's main vehicle for information on the performance of the Joint Commission, they play no role in the oversight of the contracted surveys.²³ Over the past 3 years, 23 psychiatric hospitals ended up in the random sample HCFA draws for validation surveys. But the special psychiatric conditions that the contracted surveyors focus on are excluded from the validation process. Furthermore, HCFA rarely observes the contracted surveyors conducting their surveys as a way to obtain performance information.²⁴

HCFA asks for little in the way of aggregate reporting on its contracted surveyors, despite contractual requirements calling for regular reports highlighting trends in surveys conducted and their results.²⁵ Occasionally, HCFA will ask for special reports, such as its recent request for a rundown on survey activity in Charter facilities. Even HCFA's own data system is ill-equipped to provide insights into psychiatric hospital oversight. For example, the database contains survey dates, but HCFA was unable to readily determine whether the dates entered reflected contracted surveys or State agencies surveys. It was also unable to determine through its database whether surveys were announced or unannounced.

HCFA provides some feedback to its contracted surveyors, mostly through its review of the survey documentation.

Given the drop in contracted surveys conducted, many contracted surveyors conduct only a few surveys each year.²⁶ Thus feedback and guidance from HCFA become important avenues for the contracted surveyors to keep their survey skills sharp. Yet HCFA lacks any formal system for providing feedback to them. Rather, the contracted surveyors submit their survey documentation to HCFA's central office, where one or two staff review the paperwork and provide any guidance or feedback on a case-by-case basis. This feedback focuses on the documentation, not the skills of the surveyors.

Contracted surveyors with whom we spoke expressed interest in receiving more feedback and guidance from HCFA. One remembered an instance over her 10 years of surveying when she received written feedback from HCFA, which she found useful. Others suggested simply knowing more about the current trends in surveyor findings or recent problems surveyors faced would be helpful to them. Although HCFA does convene the contracted surveyors for training, this happens about once every 3 years.²⁷

Public disclosure plays a minimal role in holding the contracted surveyors accountable.

Publicly disclosing information about psychiatric hospitals and their reviewers can convey an assurance that a process exists for the external review of hospitals for which the reviewers are accountable. Public disclosure can spur improvements on the part of the hospital as well as the reviewers. HCFA will disclose survey findings on psychiatric hospitals upon request, but lacks a web page or central number from which to request such information. HCFA has little to disclose on the performance of the contracted surveyors.

RECOMMENDATIONS

HCFA and Joint Commission responses to the recommendations we posed in our recent series on the external review of hospital quality help address the deficiencies identified in this study (see appendix A for more detail on those recommendations). In its response, HCFA committed to an action plan that incorporates most of our recommendations. It identified specific steps it will take to hold the Joint Commission and State agencies more accountable for their performance. It also committed to identifying an appropriate minimum cycle for certifying nonaccredited hospitals. Since the reports came out, the Joint Commission announced that it will increase its unannounced survey visits to hospitals. It also set forth other plans that will contribute to a more challenging survey process.

Below we offer five additional recommendations that emerge primarily from the findings in this inquiry, but also draw on those in our previous series, which included acute care hospitals with psychiatric units. Our recommendations call for HCFA to exert its leadership in shaping the external review of psychiatric inpatient care. If enacted, these recommendations will further strengthen external quality review systems intended to protect psychiatric inpatients.

HCFA should deploy its contracted surveyors more strategically and take better advantage of their expertise.

The 76 contracted surveyors serve as an important resource for HCFA. They are psychiatrists, psychiatric nurses, and social workers with extensive experience with psychiatric patients and facilities. They provide expertise that HCFA and the State agencies would be hardpressed to duplicate. To take better advantage of this expertise, we recommend that HCFA strengthen the contracted surveyors' background in the full range of Medicare conditions of participation for hospitals and make them available for:

Responding to complaints and adverse events involving psychiatric care:

HCFA rarely deploys its contracted surveyors to respond to complaints and adverse events, relying instead on the State agencies as its frontline responders. The contracted surveyors' special expertise should be available to enhance the States' ability to respond appropriately to complaints and events.

Surveying in both psychiatric hospitals and psychiatric units of acute care hospitals: Inpatient psychiatric units in acute care hospitals provide the majority of the psychiatric care paid for by Medicare. We suggest that the contracted surveyors'

expertise would be valuable to these units, which typically receive just a fraction of surveyors' time during an accreditation survey.

We are aware of the resource implications of this recommendation. HCFA currently estimates the costs of each contracted survey at \$8,300. HCFA could use its estimates to seek additional funding or seek authority to establish a survey user fee to help defray the costs.

HCFA should hold its contracted surveyors more fully accountable for their performance.

The contracted surveyors provide expertise and perform an important review of psychiatric hospitals on HCFA's behalf. But they are part-time surveyors who rarely gather as a group and conduct as few as three or four surveys a year. Thus, HCFA should take steps to ensure that its contracted surveyors maintain their survey skills, are well-informed on trends in survey findings, and that in general, they are upholding Federal interests. Toward that end, HCFA should take the following steps that promote accountability:

Conduct periodic observation surveys of the contracted survey process.

HCFA now lacks any such oversight mechanism of the contracted survey process. By accompanying contracted surveyors, HCFA gets direct and immediate information on both the performance of the hospital and the performance of the contracted surveyors.

Obtain timely and useful performance reports. HCFA's tracking of psychiatric hospitals and their survey results is not up to the task of providing a timely, relevant, and up-to-date picture of the external review of psychiatric hospitals, let alone which hospitals are currently accredited. HCFA should improve its tracking and get regular reports that cover, at a minimum, the contracted surveyors' activities, such as types of surveys conducted, findings, and trends.

Provide feedback and guidance to the contracted surveyors. HCFA should provide timely feedback to the contracted surveyors on the basis of its observation surveys. Furthermore, given the contracted surveyors' part-time status and the decline in scheduled surveys, HCFA should consider establishing a newsletter or website to facilitate a network among the surveyors.

Increase public disclosure. HCFA should make the results of the contracted surveys widely available to the public through the Internet or other appropriate mechanisms. It should also make available any performance reports it collects, as described above.

HCFA should determine an appropriate minimum cycle for the contracted survey at psychiatric hospitals.

This recommendation parallels one we made regarding nonaccredited hospitals in our previous series. No mandated cycle for these contracted surveys exists. As with our earlier recommendation, we are aware of this recommendation's resource implications.

In determining an appropriate minimum cycle, HCFA should take steps to strengthen its ability to track all participating hospitals and their survey history in such a way that allows HCFA to easily determine whether the surveys were conducted by the contracted surveyors or State agencies. It should also take steps to coordinate the survey activity (accreditation, validation, State agency certification, and contracted survey) among the external reviewers.

HCFA should negotiate with the Joint Commission to achieve both a more patient-centered survey approach and a more rigorous assessment of discharge planning.

In our previous reports, we recommended HCFA negotiate a number of survey changes with the Joint Commission. Here, we recommend that HCFA negotiate two more changes that are especially relevant to psychiatric inpatients.

The Joint Commission is the primary external reviewer for 94 percent of the psychiatric hospitals that participate in Medicare. As such, it has a routine presence in those hospitals every 3 years. But it does not currently use the patient-tracing approach employed by HCFA's contracted surveyors. Applying such an approach could reinforce a patient-centered approach to the Joint Commission's process. Likewise, the Joint Commission has a significant base of experience in addressing discharge planning issues in nonhospital settings, such as mental health centers and residential treatment centers. That experience could be instructive in strengthening the review of discharge planning in psychiatric hospitals.

HCFA should consider applying special Medicare conditions of participation to both psychiatric hospitals and psychiatric units in acute care hospitals.

Many experts suggest that psychiatric inpatients face vulnerabilities that warrant greater scrutiny than most other hospital patients. But in this respect, the external review system

that HCFA relies upon falls short in two important ways. First, it does not apply the special conditions to psychiatric units of acute care hospitals, which is where the great majority of Medicare beneficiaries receive inpatient psychiatric care.²⁸ Second, in psychiatric hospitals, the contracted surveyors are limited to assessing compliance with only the two special conditions (medical records and staff requirements) even though their patient-based review exposes a broad array of treatment issues.

Given this situation, it would appear timely for HCFA to consider special conditions that it would use for both inpatient settings. If HCFA moved in this direction, the following are among the key questions it would have to address:

- Do the proposed Medicare conditions of participation for hospitals and the interim final rule on patient rights provide sufficient authority for the external reviewers to apply the extra scrutiny warranted for psychiatric inpatients?
- Are additional authorities needed for key patient-care issues, including discharge planning?

COMMENTS ON THE DRAFT REPORT

Within the Department of Health and Human Services, we received comments on our draft report from HCFA. Outside the Department, we received comments from the Joint Commission, the National Association of Psychiatric Health Systems, the National Alliance for the Mentally Ill, and Public Citizen's Health Research Group. We include the full text of those comments in appendix D. Below we summarize the comments and, in italics, offer our responses.

HCFA Comments

HCFA concurred with all of our recommendations. It pointed to the recently expanded regulations on Patient Rights that affect all inpatients, and include the rights of those patients to be free from the inappropriate use of restraints and seclusion. It noted both its planned training of the contracted, regional office, and State agency surveyors on those regulations and its work on a new performance evaluation system for the contracted surveyors. HCFA also indicated its willingness to explore using its contracted surveyors in psychiatric units of acute care hospitals. It expects that recent funding increases to its psychiatric program will allow it to reduce the interval between contracted surveys and notes that it will explore how to further increase the funding. HCFA is committed to a redesign of its system to generate trend reports on psychiatric hospital surveys. Furthermore, HCFA noted it will continue to work with the Joint Commission to improve the oversight of psychiatric hospitals.

Finally, HCFA pointed out that psychiatric units in acute care hospitals that are excluded from the prospective payment system are subject to regulations that generally parallel the special conditions for psychiatric hospitals. It indicated that it will develop interpretive guidelines for these parallel regulations as well as a plan for the contracted surveyors to review them.

We appreciate HCFA's positive response to our report. In implementing the recommendations, HCFA will strengthen the system of external review intended to protect psychiatric inpatients. We also note that the progress HCFA reports making in working with the Joint Commission stemming from our earlier series, "The External Review of Hospital Quality," will further strengthen that system.

We have added some text on funding the contracted surveys, which is relevant to both our call for using the contracted surveyors more strategically as well as for determining an appropriate minimum cycle between surveys. We hope this new text will be helpful to HCFA as it explores further funding increases.

We are pleased with HCFA's commitment to an improved system for generating information on the psychiatric surveys, and we continue to urge HCFA to include reports on recent trends in survey findings in its feedback to the contracted surveyors, through a newsletter or website. Such feedback can enhance the effectiveness of those psychiatric professionals, who survey only a few hospitals each year for HCFA.

Joint Commission Comments

The Joint Commission identified many changes either already implemented or underway that enhance the accreditation process and promote a patient-centered approach to oversight. Among them are the discontinuation of any advance notice for random surveys, enhanced presurvey information for surveyors, revised survey agendas to allow surveyors more time to focus on patient issues, pilot testing of onsite survey activities during evenings and weekends, and a more random selection of medical and personnel records for review. It also noted its process, already underway, to strengthen its standards for discharge planning.

The Joint Commission took issue with how we characterized the authority of the contracted surveyors' ability to hold psychiatric hospitals accountable for patient care issues. It also took issue with our point that Medicare bears the cost of external review either directly or indirectly, pointing out that while costs related to accreditation may have been included in base-year calculations for prospective payment, a hospital's decision to continue to be accredited or not does not affect its Medicare reimbursement.

We appreciate the Joint Commission's continued responsiveness to our recommendations, both in this report and our previous series, "The External Review of Hospital Quality." The Joint Commission's leadership on these issues can influence improvements in accredited hospitals.

In response to the Joint Commission's concerns, we clarified our discussion of the limits of the contracted surveyors' authority and the extent to which Medicare bears the cost of external review.

Comments of Other External Associations

To varying degrees, the external parties supported our findings and recommendations, but also reflected some concerns.

The National Association of Psychiatric Health Systems is opposed to "widespread dissemination of information [about the performance of hospitals and surveyors] without adequate explanation and protection" whereas Public Citizen expressed its concern that without disclosure, "public discontent will grow."

Both the National Alliance for the Mentally Ill and Public Citizen noted their concerns about accreditation and called for an increase in funding for the contracted surveys.

In its comments, the National Alliance for the Mentally Ill recommended its State organizations as a resource to the external review of psychiatric hospitals and pointed to other resources on discharge planning in the Center for Mental Health of the Substance Abuse and Mental Health Services Administration within the Department.

We suggest that HCFA consider the concerns raised by the stakeholders as it works to improve the system of hospital oversight. They offer perspectives that can be informative to HCFA.

On the matter of public disclosure, we emphasize our position that such disclosure represents an important step toward enhancing the public accountability of the contracted survey process and parallels recommendations we made in our earlier series, "The External Review of Hospital Quality."

With regard to the call for increase funding made by the National Alliance and Public Citizen, we note the text added to our recommendation section.

Summary of *The External Review of Hospital Quality Series*

On July 20, 1999, the Office of Inspector General released the four reports named below. A summary of each report follows.

The External Review of Hospital Quality: A Call for Greater Accountability
(OEI-01-97-00050)

The External Review of Hospital Quality: The Role of Accreditation (OEI-01-97-00051)

The External Review of Hospital Quality: The Role of Medicare Certification
(OEI-01-97-00052)

The External Review of Hospital Quality: Holding the Reviewers Accountable
(OEI-01-97-00053)

A Call for Greater Accountability

This report synthesizes the three other reports and includes our recommendations to HCFA.

Continuum of Oversight

In developing this report, we found it helpful to consider external hospital oversight in terms of a continuum, characterized by a collegial approach on one side and a regulatory approach on the other. Oversight in the collegial mode emphasizes trust, professional accountability, and education. Oversight in the regulatory mode emphasizes investigations, enforcement of minimum requirements, and public accountability.

Strengths and Deficiencies of External Hospital Review

- The Joint Commission's strengths are rooted in the collegial side of the continuum, as its surveys focus on education, fostering improvement, and reducing risks. But

these educationally oriented surveys are unlikely to detect patterns of poor care or individual practitioners with questionable skills.

- The State agencies' strengths are more rooted in the regulatory side, as they serve as front-line responders to complaints and adverse events in both accredited and nonaccredited hospitals. But they rarely conduct routine, not-for-cause surveys of nonaccredited hospitals.

Overall, the System Is Moving Toward the Collegial Mode of Oversight

- The Joint Commission, which dominates hospital oversight, is already grounded in the collegial mode, and is leading the movement. HCFA is clearing the way for State agencies to follow with its proposed conditions of participation, which deliberately parallel the Joint Commission's approach.
- The movement toward the collegial mode may undermine patient protections. Both the collegial and regulatory modes have value, but as the system moves too far toward collegial side, it leaves little attention to the investigatory and patient protection efforts that are the core of the regulatory mode.
- The movement in hospital oversight contrasts significantly with the recent movement in nursing home oversight that has emphasized regulatory approaches such as surprise inspections, penalties, and public disclosure of survey results.

Limited Accountability to HCFA for Performance of Joint Commission and State Agencies

- HCFA obtains little information on the performance of Joint Commission or the State agencies. The value of validation surveys, its main vehicle to assess the Joint Commission, is limited. HCFA has piloted a promising new approach, observation surveys, but it has yet to issue any evaluation of the pilot. HCFA does not conduct validation surveys of State agencies and conducts few observation surveys.
- HCFA provides little performance feedback to the Joint Commission and State agencies. In fact, HCFA is more deferential than directive to the Joint Commission. And while it is more directive with the State agencies, it gives them little feedback on how well they perform their hospital oversight work.

- Public disclosure plays only a minimal role in holding the Joint Commission and State agencies accountable. The Joint Commission has been proactive in making hospital survey results widely available, but HCFA has makes little information on hospitals or State agencies available. By contrast, HCFA posts nursing home survey results on the Internet.

Recommendations to HCFA

Guiding Principle: Perform Steering Role to Achieve Balance Between the Collegial and Regulatory Modes

- A credible system of hospital oversight must reflect a reasonable balance between both modes.
- HCFA must recognize the inherent strengths and limits of accreditors and State agencies.
- HCFA must revise the proposed Medicare conditions of participation to (1) affirm the importance of the regulatory role of State agencies, (2) recognize the vital role that State agencies play in investigating complaints and adverse events, and (3) eliminate the suggestion that fewer compliance surveys will be necessary by working in a partnership mode with hospitals.

Recommendation: Hold the Joint Commission and State Agencies More Accountable for their Performance

- Deemphasize validation surveys, reconsider observation surveys, and require performance data.
- Negotiate the following with the Joint Commission to improve accountability and achieve more balance:
 - ▶ More unannounced surveys,
 - ▶ More meaningful accreditation levels,
 - ▶ More random selection of records during surveys,
 - ▶ More background information for surveyors,
 - ▶ More input into survey priorities,

- ▶ More rigorous assessments of hospital improvement efforts, and
- ▶ More attention to complaints.
- Assess periodically the justification for the Joint Commission's deemed status.
- Increase public disclosure on the performance of hospitals, the Joint Commission, and State agencies.

Recommendation: Determine Minimum Cycle for Certifying Nonaccredited Hospitals

- Ensure nonaccredited hospitals are subject to routine external review.

The Role of Accreditation

Announced Surveys

- Announced Joint Commission accreditation surveys are wider than they are deep. They are carried out in a collegial and tightly structured manner, leaving little time to pursue leads or respond to complaints. They serve as a means of reducing risk and fostering improvement. They are unlikely to surface substandard care or to identify individual practitioners whose judgement or skills are questionable.
- Although accreditation results matter enormously to hospitals, the results fail to make meaningful distinctions across hospitals.
- Despite having 6 levels of accreditation, 99 percent of the hospitals surveyed by the Joint Commission between May 1995 and June 1998 clustered in just 2 of those levels: accredited with commendation (16 percent) and accredited with recommendations for improvement (83 percent).

Unannounced Surveys

- The Joint Commission's reliance on unannounced surveys is limited. It conducts 1-day, random unannounced surveys to ensure continued compliance with accreditation standards between triennial surveys. From June 1995 through May

1998, it conducted such surveys, providing 24 to 48 hours notice, on about 5 percent of its accredited hospitals.

Responses to Major Adverse Events and Complaints

- The Joint Commission treats major adverse events as opportunities for improvement. Accordingly, it emphasizes education, prevention, and confidentiality but limits public disclosure on the causes, consequences, and responses to such events.
- The Joint Commission devotes little emphasis to complaints. Although it has mechanisms for receiving complaints both within and outside the survey, its survey process is not particularly geared to dealing with them.

Use of Standardized Performance Measures

- Despite the Joint Commission's early plans to incorporate standardized hospital performance data into its accreditation program, such data remain of limited value to external assessments of hospital quality.

Role of Certification

Announced Surveys

- Routine State agency surveys of nonaccredited hospital are a low priority. The State agencies' limited budget goes to nursing home and home health agency surveys first. Thus the backlog of Medicare certification surveys at nonaccredited hospitals is growing: 50 percent of nonaccredited hospitals had not been surveyed within 3.5 years as of late 1997, up from 28 percent in 1995. Elapsed time between surveys has grown from 1.5 years to 3.3 years.
- HCFA's certification surveys fail to make meaningful distinctions among nonaccredited hospitals, simply resulting in a status of certified or not certified.

From January 1996 to June 1998, HCFA terminated just one hospital based on its certification survey results.

Responses to Major Adverse Events and Complaints

- Complaints and sentinel events drive HCFA's hospital oversight and precede routine surveys in budget priority.

Use of Standardized Performance Measures

- HCFA has not sought to collect or disseminate standardized performance data for nonaccredited hospitals.

Holding the Reviewers Accountable

- The HCFA holds the Joint Commission and the State agencies only minimally accountable for their performance in reviewing hospitals.

Joint Commission

- HCFA's main tools for overseeing the Joint Commission are validation surveys, but these surveys are fundamentally limited because they are based on different standards that are applied at different points in time. They are also expensive to implement and based on a sample that is flawed. HCFA has piloted an observation survey that has promise but remains undeveloped.
- HCFA obtains few reports about the Joint Commission's performance.
- HCFA's own feedback to the Joint Commission is of limited value. In fact, its guidance on policy and procedural matters to the Joint Commission is negligible.
- The Joint Commission has been proactive in making hospital survey results widely available on the Internet and through other means. HCFA, on the other hand, makes little available on the performance of the Joint Commission.

State Agencies

- HCFA conducts no validation surveys and few observation surveys at nonaccredited hospitals to oversee State agencies' performance.
- While it varies by region, nationally HCFA obtains little that reflects on the States' performance specific to hospitals--indeed, it largely relies on States to assess their own performance.
- HCFA gives State agencies limited feedback on how well they perform their hospital oversight activities. However, it does give them considerable guidance, often on a case-by-case basis.
- HCFA makes little information available to the public on the performance of wither hospitals or the States. By contrast, it posts nursing home survey findings on the Internet and Federal law requires nursing homes to post their findings as well.

Methodology

We collected information presented in this report from the following sources:

HCFA

We obtained data on the number of contracted surveys from HCFA's consultant that handles logistical support for the contracted surveyors. These data included the date, type (recertification, follow-up, initial, and complaint), and results of surveys conducted by the contracted surveyors.

We also obtained data from HCFA's Online Survey Certification and Reporting System (OSCAR). These data included surveys based on complaints at psychiatric hospitals and the number of nonaccredited psychiatric hospitals. For the latter, we extracted the identity of nonaccredited psychiatric hospitals and confirmed their accreditation status by visiting the Joint Commission's website.

We also interviewed staff and managers at HCFA's central and regional offices. We reviewed a variety of HCFA documents, including contracts and HCFA's interpretive guidelines for surveys, among others.

Joint Commission on Accreditation of Healthcare Organizations

We interviewed officials from the Joint Commission on Accreditation of Healthcare Organizations. We also reviewed documents from the Joint Commission, including accreditation manuals, policies, the briefing book for members of the Restraint Use Task Force, and hospital survey protocols. We requested and received aggregate data from the Joint Commission on sentinel events involving restraints and seclusion and on survey activity in psychiatric hospitals.

Survey Observations

Based on schedules of upcoming Joint Commission surveys and HCFA's contracted surveys, we were able to observe two Joint Commission surveys and two HCFA recertification surveys. The psychiatric hospitals we observed were located in both urban and suburban locations, with bed sizes ranging from under 50 to over 400. The Joint Commission surveys we observed were an announced triennial survey and a special unannounced survey.

Expert Interviews

We interviewed various stakeholders from around the country. They included mental health officials from various States, practicing psychiatrists, experts in restraints and seclusion, and discussions with surveyors from both the Joint Commission and HCFA.

Other Documents

In addition to the documents referenced above, we reviewed statutes, regulations, legislative history, and a variety of articles from newspapers, journals, and websites.

A Framework for Considering the External Review of Hospitals

The following five components present a framework for considering the external quality review of hospitals. They are intended to complement the internal quality assurance and improvement efforts that hospitals undertake themselves. They are approaches that health care purchasers, such as Medicare and Medicaid, can rely upon to ensure that their beneficiaries receive quality services from hospitals. They can also be of use to beneficiaries and other consumers concerned about the quality of their hospital care.

We present the components to facilitate analysis of the extent and type of external review that is desirable, whether carried out by accreditation bodies, certification agencies, Medicare Peer Review Organizations, HCFA, or others. Each component has strengths and limitations. Moreover, each can be used in support of a review philosophy based on continuous quality improvement, more traditional compliance enforcement, or some combination thereof.

We omitted a sixth component: the retrospective review of medical records to determine appropriateness of care. Formerly a role of the Medicare Peer Review Organizations, such medical record review is no longer carried out on such a large scale. However, some medical record review does occur as part of the components described below.

1. Announced, On-Site Surveys of Hospitals

These involve some combination of observations of facility and equipment; reviews of medical credentials, and other records and documents; and interviews. They result in a pass/fail or some kind of score intended to distinguish level of performance. They can also involve follow-up to correct or improve.

2. Unannounced, On-Site Surveys of Hospitals

The approach is basically the same as above except that the hospital has not had time to prepare. The intent is to gain a clear assessment of the facility as it typically functions and to trigger any necessary follow-up.

3. Response to Complaints Concerning Hospitals

These involve complaints of a particular instance of care or more encompassing matters concerning a hospital's performance. The response to complaints can range from a minimal distant review to a thorough on-site review. The process can trigger corrective actions and system improvements.

4. Response to Major Adverse Events in Hospitals

These involve cases where substantial patient harm resulted from what may be poor performance on the part of the hospital and/or its practitioners. Here, too, the response can range from minimal to thorough and can trigger corrective actions and system improvements.

5. Collection and Dissemination of Standardized Performance Measures

The aim here is to establish the standardized use of measures in ways that enable purchasers, consumers, accrediting bodies, and others to compare hospital performance. The comparisons can focus on a hospital's own performance over time and/or on how its performance compares to other hospitals. The data can be drawn from surveys of patients or providers, billing claims, and the hospitals' own records.

Comments on the Draft Report

In this appendix we present the text of comments of all parties that responded to our draft report. They are:

- Health Care Financing Administration, U.S. Department of Health and human Services
- Joint Commission on Accreditation of Healthcare Organizations
- Public Citizen, Health Research Group
- National Association of Psychiatric Health Systems
- National Alliance for the Mentally Ill



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administration of
Washington, D.C. 20201

DATE: APR 5 2000

2000 APR -7 AM 10:36

TO: June Gibbs Brown
Inspector General

OFFICE OF INSPECTOR
GENERAL

FROM: Nancy-Ann Min DeParle
Administrator

Nancy-Ann DeParle

SUBJECT: Office of Inspector General (OIG) Draft Report: "The External Review of Psychiatric Hospitals," (OEI-01-99-00160)

Thank you for the opportunity to review and comment on the above report. We appreciate the OIG's feedback regarding the current inpatient psychiatric hospital review process by the Health Care Financing Administration's (HCFA's) contract surveyors. We are committed to protecting the health, safety and welfare of patients in psychiatric hospitals and have already taken significant steps to promote quality care. For example, we expanded the Patients' Rights segments of the regulations for all inpatient hospitals, including psychiatric hospitals last year. These new regulations include the right of patients to be free from inappropriate use of restraints and seclusion, and underscore our efforts to ensure basic protections and quality care in all settings. HCFA also sought the commitment of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) to improve its performance in monitoring hospitals, including psychiatric hospitals, to protect patient health and safety. We already have achieved several of our goals, including the Joint Commission's announcement last year that hospitals would no longer be notified of random surveys.

We are pursuing an ongoing effort to continuously improve the psychiatric care and treatment provided by Medicare participating psychiatric hospitals. We provided training updates to HCFA's psychiatric contract surveyors, Regional Office (RO) staff and State Agency (SA) surveyors, including a basic psychiatric hospital training in 1998. All the psychiatric contract surveyors received training within the last two years on Medicare's two special Conditions of Participation (CoP) for psychiatric hospitals (special medical record requirements and special staff requirements). The psychiatric contract surveyors also received training on documentation and identification of immediate and serious jeopardy situations. Further, we plan to provide additional training updates during the next two years on: the new Patients' Rights regulation (including the right to be free from inappropriate use of seclusion and restraints), complaint investigations, and identification of immediate and serious jeopardy situations.

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HCFA agrees with OIG recommendations and the plans for improvement are as follows:

OIG Recommendation

HCFA should deploy its contracted surveyors more strategically and take better advantage of their expertise.

HCFA Response

We concur. In fact, HCFA, already utilizes its contract surveyors in a wide variety of activities including Federal surveys of inpatient psychiatric hospitals. Surveyors also respond to complaints and adverse events. Approximately 10 percent of the surveys conducted this past year were in response to complaints or adverse events. Depending upon the nature of the complaint or adverse event, HCFA selects the contract surveyor with the specific clinical expertise (i.e., gerontology, pediatrics, adolescents, forensic) to conduct an onsite visit to address the complaint or adverse event. HCFA also will explore using the contract surveyors to survey psychiatric units in acute care hospitals.

OIG Recommendation

HCFA should hold its contracted surveyors more fully accountable for their performance.

HCFA Response

We concur. For FY 2000, HCFA is conducting observational performance reviews of these surveyors. HCFA also is in the process of designing a performance based evaluation system to assess the surveyors current level of performance and identify any areas requiring remediation and updated training. Next fiscal year we will have this system in place and peer reviews will be conducted using a standardized performance evaluation protocol developed by HCFA.

HCFA also is committed to redesigning the current in-house system to generate reports identifying trends under the special Conditions of Participation (CoP) for psychiatric hospitals, the number of complaints investigated by the contract surveyors, the number of surveys conducted by these surveyors, their findings and survey outcomes (i.e., termination track, immediate and serious jeopardy). HCFA staff currently provide feedback, guidance and resource information to the surveyors. This is accomplished through telephone conferences, e-mail correspondence, and memoranda sent to the surveyors. Feedback and guidance is given when there are problems with documentation of summary findings, questions from ROs and SAs, or when facilities have questions regarding the survey findings and/or the performance of the survey team.

OIG Recommendation

HCFA should determine an appropriate minimum cycle for the contracted survey at psychiatric hospitals.

Page 3 - June Gibbs Brown

HCFA Response

We concur. With recent funding increases, we anticipate reducing the interval between surveys to three years. Within the last two years, HCFA has increased its funding to the Medicare psychiatric hospital program. For fiscal year 2001, the proposed funding is \$2 million. We will explore how to increase funds for this function in future years.

OIG Recommendation

HCFA should negotiate with the Joint Commission to achieve both a more patient-centered survey approach and a more rigorous assessment of discharge planning.

HCFA Response

We concur. HCFA already is negotiating with JCAHO to strengthen JCAHO's standards and survey process in evaluating important psychiatric services. We will develop and articulate clear criteria for JCAHO performance as recognized accreditors for hospitals seeking deemed status participation in Medicare. In addition, we will work with JCAHO to develop improvements in assessing discharge planning for psychiatric patients.

OIG Recommendation

HCFA should consider applying special Medicare conditions of participation to both psychiatric hospitals and psychiatric units in acute care hospitals.

HCFA Response

We concur. Freestanding psychiatric hospitals must already meet requirements for specialty hospitals at 42 CFR 482.60 through 482.62. These include two CoPs for psychiatric hospitals (special medical record requirements and special staff requirements). In addition, freestanding psychiatric hospitals must also meet the general hospital CoPs at 42 CFR 482.11 through 482.45. Psychiatric units in acute care hospitals are subject to the general hospital CoPs. In addition, for payment purposes and to be excluded from the prospective payment system (PPS), psychiatric units must meet additional requirements at 42 CFR 412.27. These requirements are generally parallel to the special requirements for psychiatric hospitals.

Using these existing regulations, HCFA will develop interpretive guidelines and survey procedures to more rigorously apply these requirements in psychiatric units of acute care hospitals. The worksheets currently used to verify these criteria are met in psychiatric units have no interpretive guidance; the form is simply a checklist. In addition, HCFA will develop a plan to use the contract surveyors to more effectively supplement the survey activities of the State agencies in psychiatric units of general hospitals. Survey activities in these units include: verification of compliance for initial applicants; reverification of compliance for initial applicants; reverification of a sample of PPS-excluded psychiatric units that have attested to continued compliance; and complaint investigations.



Joint Commission
on Accreditation of Healthcare Organizations

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OFFICE OF INSPECTOR
GENERAL

January 31, 2000

June Gibbs Brown
Inspector General
Department of Health and Human Services
5250 Wilbur J. Cohen Building
330 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Draft report: The External Quality Review of Psychiatric Hospitals
Report No. OEI-99-01-00160

Dear Ms. Brown:

Thank you for the opportunity to comment on the draft report on the External Review of Psychiatric Hospitals. The report is an accurate assessment of the oversight process for psychiatric hospitals at the time the study was completed. The report makes a specific recommendation that references the Joint Commission process and includes some background information that should be clarified or corrected.

With reference to the recommendation that HCFA negotiate with the Joint Commission to achieve both a more patient centered approach and a more rigorous assessment of discharge planning we would provide the following comments.

The Joint Commission's Board of Commissioners established an Oversight Task Force for Accreditation Process Improvements last year to identify and recommend to the Board needed enhancements to the accreditation process. The task force was charged with redesigning the accreditation process to make it more relevant and credible. The task force is continuing to assess our survey process to insure that it is effective in identifying issues in the delivery and quality of patient care. The changes that are being considered and those now being put in place include many of the aspects of the "patient centered" approach and go beyond it in enhancing the survey process. The first set of changes resulting from this efforts are consistent with the recommendations made in this report as well as the prior OIG reports on hospital oversight. Specifically with reference to the recommendation in this report, effective with January 2000 we have made the following changes:

- 1) Advanced notice of random surveys will be discontinued, these surveys may be conducted at anytime between nine and 30 months after the triennial full survey.
- 2) Surveyors will receive an enhanced presurvey information packet that will provide them with more information about the provider being surveyed, including complaint history and ORYX (i.e., performance indicators) data.

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American College of Physicians
American College of Surgeons

American Dental Association
American Hospital Association
American Medical Association

June Gibbs Brown
January 31, 2000
Page 2

- 3) The agenda for the conduct of the survey has been revised to allow surveyors more time to focus directly on patient issues, to address in depth organization-specific performance issues and facilitate a survey process that is increasingly data driven and individualized to a particular health care organization.
- 4) Pilot testing of on-site survey activities during evening, night and weekend periods (which began during the last quarter of 1999) will continue in the first quarter of 2000.
- 5) In addition the process started in 1999 of the surveyors selecting at random personnel and patient medical records for review will be continued as a regular part of the process.

Finally, we would agree with the need to strengthen the standards for discharge planning in behavioral health facilities. We have underway a process of reviewing the requirements in our various programs with the intention of developing a more comprehensive set of standards to achieve improvements in discharge planning for patients.

With reference to the information in the report requiring clarification or correction, at page 15, the report states that the extent to which a psychiatric hospital is held accountable for patient care is questionable because HCFA contract surveyors find problems outside the scope of the "special conditions" and can't address them. On page 16 you state that HCFA's contracted surveyors lack regulatory authority to hold a psychiatric hospital accountable for inappropriate use of restraints. This is not correct. HCFA at all times retains the authority and the responsibility for responding to information it has regarding problems with the quality of care, including the use of restraints. Issues not coming under the purview of the "special conditions" can and should be reported by the contracted surveyors to HCFA. HCFA should then determine if the State agency or the accreditor is the appropriate party to follow up and resolve these issues or concerns. It is incorrect to imply that because of the deemed status relationship HCFA lacks the authority or the responsibility for following up on this information. In addition, HCFA by sharing these findings with the Joint Commission would provide us with additional information to facilitate the identification and correction of problems in the delivery of care or in the use of restraints by these providers.

At page 9 of the report you note that Medicare bears the cost of external review, directly by funding either State agencies or HCFA's contracted surveyors, or indirectly through hospital charges that include in the overhead the cost of accreditation. Where Medicare reimburses a provider on a cost basis, Medicare does cover a part of the cost of the accreditation, i.e., the amount paid is in the same proportion as the volume of Medicare patients to non-Medicare at the provider. However, where the provider is reimbursed under a prospective payment system (PPS) Medicare does not contribute to the cost of the accreditation. The providers cost related to accreditation may have been included in the base year calculations in determining the amount to

June Gibbs Brown
January 31, 2000
Page 3

be paid under PPS. However, once those rates are established, whether a provider elects to continue to be accredited or not does not change the amount the provider receives from Medicare. Accordingly, one of the values of deemed status to Medicare is to allow HCFA and the States to concentrate their resources on those providers that are either unable or unwilling to provide quality care, allowing the accreditation process to monitor the other providers and bring about the ongoing improvement in the quality of care. As noted in your previous reports the Joint Commission process has a history of effectiveness in improving the quality of care in the providers it accredits.

We thank you for the opportunity to comment on this report and look forward to working with you and HCFA in achieving improvements in the process of the oversight of psychiatric hospitals and the appropriate oversight of the deemed status process.

Sincerely



Anthony J. Tirone
Director, Federal Relations

**Comments by Peter Lurie, MD, Deputy Director
and Sidney M. Wolfe, MD, Director
Public Citizen's Health Research Group
on the Draft Health and Human Services Inspector General's Report:
The External Quality Review of Psychiatric Hospitals (OEI-01-99-00160)
January 31, 2000**

The Inspector General's report does a respectable job of documenting the particular problems in the oversight of psychiatric institutions in the United States. However, when the report summarizes these problems, it tends to downplay their dangers and then generates a list of recommendations that, while individually reasonable, fail to collectively address the enormous inadequacies the report has documented.

The problems identified by the report are widespread and confirm, as did the Inspector General's previous reports on non-psychiatric hospital oversight (The External Review of Hospital Quality; July 20, 1999), that the public is poorly protected by the current system. These problems fall into the categories of conflict of interest, failure to identify individual questionable doctors, infrequent inspections and lack of public accountability.

Conflict of interest

There are three major elements to the external quality review system for psychiatric hospitals in the United States. Most oversight of psychiatric hospitals that participate in Medicare is conducted by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). In some instances, unaccredited hospitals will elect to be monitored instead by the state rather than by the JCAHO. In addition to the criteria that the JCAHO and the states apply to all hospitals, the Health Care Financing Administration (HCFA) requires that psychiatric hospitals meet two special conditions for participation in Medicare: staff requirements and medical records. Compliance with these two conditions is monitored by specially contracted psychiatrists and psychiatric nurses known as contracted surveyors.

The earlier reports confirm that the JCAHO surveys are undertaken in a collegial manner and that "Overall, the system is moving toward the collegial mode of oversight," an approach the reports concluded "may undermine patient protections." This approach "leaves little attention to the investigatory and patient protection efforts that are the core of the regulatory mode." As the present report acknowledges, "the findings from our recent series [on external review of all hospitals] apply also to psychiatric hospitals."

At its core, the JCAHO is riven with conflict of interest: "corporate members" comprise 75% of its board (they pay \$20,000 for the privilege), hospitals hand-pick the medical records to be reviewed and hospital surveys are generally announced months ahead of time. This collegial approach cannot adequately protect patients; there is no reason to believe this system works any more effectively for psychiatric patients. For years we have advocated the abolition of the JCAHO's legislatively deemed

authority to accredit hospitals for Medicare participation. The organization's pathetic performance in psychiatric care provides further justification for doing so.

The conflict of interest problem is much less an issue for the HCFA contractors and the state inspectors, because they are direct contractors to the federal government and take a regulatory rather than a more collegial approach to quality review.

Failure to identify individual questionable doctors or address specific dangerous practices

The report makes clear that the patient-centered approach of the contracted surveyors provides a comprehensive picture of how patients are actually treated, an approach shunned by the JCAHO, which relies primarily on a paper review. Indeed, the present report makes clear that "The [JCAHO] surveys are unlikely to detect substandard patterns of care or individual practitioners with questionable skills." This is in part because the JCAHO pays little attention to interviewing patients or caregivers.

But even if the contracted surveyors unearth significant problems, the fact that the surveyors' reviews are technically restricted to the two special conditions undercuts the surveyors' effectiveness. Even if major problems are identified, therefore, the surveyors' have to rely upon the ineffective HCFA or the states for actual enforcement. According to the report, "Thus, despite the far-reaching nature of their inquiry, the contracted surveyors are hard-pressed to hold hospitals accountable for problems outside either medical records or staff requirements."

The limited authority of the contracted surveyors especially undercuts their effectiveness in two critical areas: discharge planning and use of restraints. And while the JCAHO process does pay attention to the use of restraints, warning hospitals that a survey is imminent allows them to "clean up their act" in time for the site visit. Obviously, these announced site visits were not sufficient to prevent the abuses of restraints so well documented in the 60 Minutes II segment on Charter Hospitals. Nor were they sufficient to prevent a particularly tragic case documented in the previous Inspector General's reports: "[I]n the Spring of 1996, the Joint Commission awarded one hospital its highest level of accreditation: accreditation with commendation. That Fall, the hospital experienced an unexpected death, triggering the State agency to investigate. In the Spring of 1997, more unexpected deaths occurred, and the agency returned. After a 3-week investigation, that agency found systemic problems in both quality assurance and medical staffing."

Infrequent inspections

For two of the three elements of the psychiatric external quality review system, inspections occur far too infrequently. The present report notes that between Fiscal Year 1993 and 1998 the number of contracted surveys fell from 413 to 146. The average time between surveys increased from 14 months in Fiscal Year 1993 to 3.5 years in 1998. Three psychiatric hospitals had not undergone contracted surveys in more than ten years. There is no mystery as to the cause of this: between Fiscal Year 1993 and 1999, the HCFA budget for these surveys fell from \$3 million to \$670,000 and the number of contracted surveyors from 147 to 76.

Previous Inspector General reports also documented infrequent inspections by the states. From 1995 to late 1997, the percentage of nonaccredited hospitals that without a survey in the previous 3.5 years grew from 28% to 50% and the average time between surveys rose from 1.5 to 3.3 years. In part this is because states concentrate their inspection efforts among hospitals with complaints or adverse events.

Lack of public accountability

HCFA at least has a mechanism for monitoring JCAHO inspections: the validation surveys done by the state health departments. (These were described as being of "limited" value in the earlier reports.) But the agency does not even conduct similar surveys for the contracted surveyors and so is restricted to occasional special reports by the contracted surveyors and direct observations. These are grossly insufficient to assure psychiatric hospital quality. Moreover, the contracted surveyors receive little feedback from HCFA and are retrained by the agency only every three years.

As the report documents, "public disclosure plays a minimal role in holding the contracted surveyors accountable." HCFA does not even maintain a web site or central telephone number from which quality assurance findings can be obtained. In the earlier reports, the Inspector General used almost identical language to describe the lack of adequate public disclosure of the JCAHO and state inspections.

In a climate of lack of public disclosure, public discontent will grow. This was reflected in the public response to the 60 Minutes II piece. CBS received approximately 1500 comments on the piece, most of which were supportive. Over 100 of these were from workers reporting serious problems with patient care, mainly at other Charter hospitals (Malmgren H, CBS News, January 24, 2000).

The 60 Minutes II experience also proves that even so conflict-ridden and ineffectual an organization as the JCAHO is capable of reacting to public pressure. Two days after the piece aired, JCAHO teams conducted unannounced inspections at 18 Charter Hospitals. All had some deficiencies and three received failing grades, a rarity for an organization plagued by grade inflation. Since the 60 Minutes II piece, Charter has closed 13 hospitals, plans to sell 40 more, became the focus of both Justice Department and an Inspector General investigation, lost referrals from three major managed care networks and underwent a change of ownership. Because it took a national television program to jolt the JCAHO into action, it is not likely that these after-the-fact inspections represent a systemic change of heart in the organization. More likely, the industry-friendly pseudo-inspections that have characterized JCAHO inspections to date will again become the order of the day.

Recommendations

In general, the findings of the present Inspector General report are consistent with the findings in the previous reports. The fact that generally similar problems persist even in psychiatry, an area in which abuses of patients are particularly well documented, argues for stronger recommendations than in the previous reports. Yet the present report is content for the most part to adopt a less aggressive approach

-- one that takes HCFA's promises after the previous reports seriously, even though the agency's history is one in which it has consistently neglected its duties and deferred to the JCAHO.

The fundamental problem in psychiatric (and other) hospital oversight is that the JCAHO has repeatedly been demonstrated to be so close to the industry as to be incapable of providing meaningful oversight. The Department of Health and Human Services should immediately pursue legislation that would revoke the JCAHO's ability to accredit hospitals and should delegate these responsibilities instead to the states, with HCFA oversight.

In the event that HCFA does not seek the dismantling of the JCAHO, we would reiterate the following JCAHO-specific recommendations that we made when commenting on the previous reports:

- a. Increase the number of unannounced surveys (the JCAHO has claimed it will now do this but appears to be referring to the 5% of inspections which were previously described as "unannounced," but which actually involved one or two days advanced notice. The other 95% of inspections are likely to continue to have weeks, if not months, notice);
- b. Randomly select the medical records to be reviewed instead of allowing hospitals to select favorable records;
- c. Incorporate information gathered confidentially from hospital employees and patients; and
- d. Disclose the results of the surveys publicly.

The contracted surveyors should retain their roles in the review of psychiatric hospitals, but their role needs to be greatly expanded so that their findings are acted upon more consistently. In the present circumstance, they too often identify problems outside the two special conditions and then are powerless to see them addressed.

Moreover, the contracted surveyors have authority only over free-standing psychiatric hospitals. Yet 66% of Medicare discharges are from psychiatric units that are part of acute care hospitals. The present report suggests meekly that "the contracted surveyors' expertise would be valuable to these units." The report also states that "it would appear timely for HCFA to consider special conditions for both [freestanding psychiatric hospitals and inpatient psychiatric units in acute care hospitals]." These are toothless recommendations for a problem of this magnitude. Clearly the authority of the contracted surveyors should include these psychiatric units.

Although the Inspector General's report recommends "an appropriate minimum cycle" for reviews by contracted surveyors, it is silent on the length of such a cycle. In our view, since even the JCAHO seems to be able to adhere to a three-year cycle, this should be required of the contracted reviewers' inspections as well.

Finally, the present report neglects to make the most obvious recommendation: because the number of inspections by contracted surveyors has declined due to decreased funding, HCFA needs to, at a minimum, restore the funds deleted from this line item in the recent past.

*The National Association of
Psychiatric
Health
Systems*

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January 11, 2000

Ms. June Gibbs Brown
Inspector General
Office of Inspector General
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. Brown,

Thank you for the opportunity to review and comment on the draft of the report entitled "The External Quality Review of Psychiatric Hospitals." The members of the National Association of Psychiatric Health Systems have extensive experience working with all components of the system of oversight for psychiatric hospitals that you define in the report. Our organization is committed to advocating for a process of external review that makes it possible to deliver responsible, accountable, and clinically effective treatment to patients. We will organize our comments to parallel the headings used in the recommendations section of the draft report.

USE CONTRACTED SURVEYORS MORE STRATEGICALLY

We support the value of the contracted surveyors as a resource to HCFA. Our members have considerable experience with the patient-centered survey approach and have realized that **the successful application of this approach is directly related to the expertise of the surveyors.** When experienced and clinically prepared surveyors use the process, it can work well. However, surveyors who do not have adequate training or experience (as can be the case with state agency surveyors) are not consistently able to make the independent clinical judgments that it requires. We support your efforts to have highly competent surveyors responsible for implementing the process. We also hope that the contract surveyors not be directed to function totally as "regulators" to the point that they are unable to provide the consultation that is so valuable to providers in their efforts to comply with the special conditions.

There are many ways the expertise of contracted surveyors can be put to the best advantage. These might include such things as using the contract surveyors as a resource to states (perhaps one contract surveyor with other team members from the state agency); to focus on problematic facilities; and, as you suggest, to investigate complaints and adverse events.

Page 2 – NAPHS

HOLD CONTRACTED SURVEYORS MORE ACCOUNTABLE

We support the recommendation that there be periodic observations of the contracted surveys, a method of tracking surveyor performance (we suggest also providing surveyed organizations with the opportunity to provide feedback about the survey process and surveyors), regular guidance and feedback to surveyors, and ongoing education. These actions should also apply to state agency surveyors. However, we are concerned about the inclusion in this section of the very general statement about making more information available to the public about performance of hospitals and the performance of contracted surveyors. We value the public's right to information, and the determination of compliance is public information. However, **we do not support widespread dissemination of information without adequate explanation and protection.** We do not support disclosing information to the public about the performance of individual contracted surveyors. It is the responsibility of HCFA to determine that the surveyors are performing well.

DETERMINE AN APPROPRIATE MINIMUM CYCLE FOR THE CONTRACTED SURVEYS

Not knowing what to expect with regard to the frequency or type of surveys is a source of anxiety for providers. We agree that HCFA should have a way of tracking all participating hospitals and their survey history. In working with the very limited resources in the current environment, it seems impossible to expect that contracted surveyors will be able to survey all participating hospitals (or that all regional offices will request their assistance), even on a rotating basis. We support the continuing development of criteria that identify the facilities most in need of the expertise of the contracted surveyors. It seems that facilities that are not accredited should have high priority as should facilities that have been identified as problematic (through such things as complaints or significant change in JCAHO status). Tracking all facilities should make it possible to determine when surveys had been done, by whom (contracted surveyors or state agencies) and the results. **A plan could then be developed to determine an appropriate minimum cycle, based on identified priorities.**

We agree that every effort should be made to coordinate the survey activity of accreditation, validation, state agency certification, and contracted surveys. **We support all efforts to integrate the strengths of each body into a coherent experience for providers.** This includes sharing of information and avoiding multiple and duplicate surveys.

The decreasing number of surveys conducted by HCFA and state agencies is striking. In order for contracted surveyors to do more surveys and to be available for the other functions that have been proposed, **the funding of the contract must obviously be increased.** States must also recognize their responsibility to adequately support the work of the state agencies (through funding and qualified personnel).

We also want to call to your attention the importance of coordinating survey information among the facility, the state agency, the regional office, HCFA central

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office, and the contract surveyors. Communication at the time of survey between the state agency, the regional office, and the facility is essential for the satisfactory resolution of potential deficiencies. The regional office also needs access to the HCFA central office (who can then contact the contract surveyors if necessary) if there are questions about survey findings.

NEGOTIATE WITH JCAHO

We note with interest your focus on the areas of discharge planning and restraint and seclusion as areas of limitation in the external review process. **The special conditions address discharge planning in elements B134 and B135.** The interpretative guidelines appear to give the surveyors significant direction in assessing for compliance with these elements.

We have been actively involved in the current national dialogue about restraint and seclusion and in working with both HCFA and JCAHO in framing standards that will effectively protect patient rights in this area. **We have been impressed with the commitment JCAHO has shown in addressing the very difficult issues related to rigorously surveying for compliance with the standards.** We are confident that their current course will assure all stakeholders that the use of restraint and seclusion is being carefully monitored and that patients for whom these modalities are used are cared for safely.

APPLY MEDICARE CONDITIONS OF PARTICIPATION APPROPRIATELY

We think it is important to be clear about the difference between the hospital conditions of participation and the special conditions (as well as the responsibilities of the various groups for assessing compliance). As you know, hospitals are deemed to meet the hospital conditions of participation (HCOPs) if they are JCAHO accredited or, if not accredited, if they are surveyed for the HCOPs by the state agency.

To choose some of these conditions (such as the patient right's condition) to be surveyed a second time for psychiatric facilities is both duplicative and unfair. The same objection would apply if the special conditions of participation for psychiatric hospitals were expanded to include additional requirements such as patient rights. **We do not support adding requirements under the special conditions.** The special conditions were developed thirty years ago to address a very specific need to document the provision of active treatment in a psychiatric environment in order to comply with title XVII and XVIII of the Social Security Act. **Any new or revised conditions should apply to all facilities and should be part of deemed status.**

As we have expressed in other forums, we have specific objections to one provision of the interim final rule on patient's rights. Our concern is with A 786 (the "one hour rule"). We think the requirement to have a physician or LIP see a patient who is or has been restrained or secluded face-to-face within one hour of the initiation of the intervention is overly prescriptive and not grounded in clinical practice or research. **A visit within one hour is one of many possible interventions designed to address the safety of patients who are restrained or secluded.** It is not the only or, necessarily the best, way to ensure such protections. We strongly encourage HCFA

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to rely on JCAHO, within the framework of its deemed status relationship, to use its standards for the determination of compliance with the hospital conditions of participation (including restraint and seclusion). To begin to choose elements for special survey undermines the integrity of this process.

Thank you very much for the opportunity to comment on the draft document. Please do not hesitate to contact me directly if you have any questions. My phone number is 202/393-6700, Ext. 16.

Sincerely,



Mark Covall
Executive Director

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[Effective January 10, 2000, NAMI has a new office address.]

January 13, 2000

June Gibbs Brown
 Inspector General
 U.S. Department of Health and Human Services
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 330 Independence Avenue, SW
 Washington, DC 20201

Dear Ms. Gibbs:

NAMI – the National Alliance for the Mentally Ill – appreciates the opportunity to review your draft report, “The External Quality Review of Psychiatric Hospitals” (OEI-01-99-00160). Your report should be very helpful in improving the quality of care in psychiatric hospitals.

Our comments emphasize the current inadequacies of deemed status through JCAHO, recommend your consideration of another form of external quality review, and refer you to a resource within HHS (not cited in your report) on discharge planning problems.

Current Inadequacies of JCAHO Deemed Status

Previous OIG reports issued July 20, 1999, particularly OEI-01-97-00050 and OEI-01-97-00051, cite the overall problems with deemed status.

Attached is our August 11 letter to JCAHO President Dennis O’Leary. JCAHO devoted several years to developing a Comprehensive Accreditation Manual for Behavioral Health but no psychiatric hospital in the nation is evaluated through these standards. All psychiatric hospitals are surveyed through the Comprehensive Manual for Hospitals. This is false advertising. JCAHO declares that they have specialty behavioral healthcare standards yet they do not use them. The “general” hospital standards are just that – “general.” Trade press coverage of this letter is also attached. Psychiatric hospitals prefer the less rigorous general standards.

Attached is our August/September 1999 *NAMI Advocate* article summarizing an open forum with JCAHO officials at the NAMI annual convention. Though JCAHO requires that facilities inform the public when JCAHO surveyors arrive for a survey and though JCAHO requires a public meeting as part of the survey process, usually the facility runs a short announcement in the classified advertising section of the local paper to meet this

1

requirement. JCAHO does not require facilities to outreach to known advocate, consumer, family, and patient groups within the community. This is another example of a JCAHO less than rigorous effort to have facilities meet JCAHO requirements.

The OIG report cites the *Hartford Courant* series and observes that JCAHO surveys often miss important events within a facility. Attached is the October 13, 1998 Courant article on Gloria Huntley of Central State Hospital in Virginia. JCAHO commended Central State with its highest ranking. The day after the award of this highest ranking, Gloria Huntley, in restraints for 558 hours during her last two months of life, died in restraints. This example just affirms the OIG observation.

Attached is NAMI's December 2, 1998 letter to JCAHO President Dennis O'Leary objecting to their reversal of their announced sentinel event policy. Here is an example of the Commission announcing a very constructive policy, only to change it when hospitals, which dominate the JCAHO governing board, complain.

Attached are the November 22 comments submitted to JCAHO by the Advocates Coalition for the Appropriate Use of Restraints, reacting to their draft revised standards on the use of restraints and seclusion. The advocates coalition, chaired by NAMI, is alarmed that HCFA's legal agent – JCAHO through deemed status – would develop standards which contradict and undermine HCFA final interim regulations. If JCAHO has deemed status under the law, how can they develop standards which contradict and undermine HCFA regulations? Obviously, the hospitals are using their dominance on the JCAHO governing board to use the Commission to undermine national HCFA standards. Attached is a January 3, 2000 trade press article on this dynamic. JCAHO is quoted as saying that HCFA and JCAHO are basically equal partners who discuss how to resolve differences. It seems an interesting attitude by the legal agent of a governmental agency, particularly an agent controlled by the regulated industry.

Last I attach NAMI's January 4, 1999 letter to HHS Secretary Donna Shalala which cites Section 1875 (b) of the Social Security Act. This is the section of the act authorizing deemed status. Section 1875 calls for the Secretary to continually study the validation of JCAHO processes. NAMI doubts whether HCFA is performing this obligation.

Another Form of External Quality Review

Four state mental health agencies – Delaware, New Hampshire, Oklahoma, and Pennsylvania - use NAMI state organizations as independent and external consumer and family facility monitoring teams. Consumer and family volunteers who are trained in monitoring review, who are authorized access to facilities (24 hours a day, 7 days a week, some unannounced, some without facility companions), and who sign confidentiality agreements, are used in state psychiatric hospitals. In September 1999 NAMI conducted a briefing at HCFA headquarters on how these teams operate. Information is available from me at NAMI, from the four state NAMI organizations, and the four state mental health authorities. We would like the OIG report to acknowledge the potential role such

consumer and family monitoring teams can play in enhancing both quality and accountability in psychiatric hospitals.

HHS Discharge Planning Resource

Dr. Larry Rickards at the Center for Mental Health Services/SAMHSA/HHS has convened and authored two reports on problems with psychiatric hospital discharge planning. Internal CMHS reports were prepared in 1992 and 1997. Little positive accomplishment occurred in the nation between 1992 and 1997. The reports provide detailed information on problems as well as suggest possible policy solutions to identified problems. Information is available from Dr. Rickards at 301-443-3706.

NAMI hopes that these reactions are helpful as you proceed to finalize the report. We appreciate your seeking our comments.

We would also like to share these comments with colleagues within both HCFA and CMHS. May we do so now? Please advise.

Sincerely,



E. Clarke Ross, D.P.A.
Deputy Executive Director for Public Policy
703-312-7894
fax: 703-524-9094

c.c. George Grob, Deputy Inspector General for Evaluations and Inspections
Elise Stein, Office of the Inspector General

Endnotes

1. U.S. General Accounting Office, *Mental Health: Improper Restraints and Seclusion Use Places People at Risk*, GAO/HEHS-99-176, September 1999.
2. According to HCFA's Online Survey and Certification Reporting System (OSCAR), 65 psychiatric hospitals are nonaccredited as of August, 1999. However, we determined that 26 of those hospitals are, in fact, accredited.
3. These data are based on the four most common psychiatric DRGs in Medicare according to the 1997 HCFA Customer Information Set: DRG 430 (psychosis), DRG 429 (dementia), DRG 426 (depressive neurosis), DRG 427 (neurosis except depressive), and DRG 428 (disorders of personality and impulse control).
4. P.L. 89-97.
5. Psychiatric units in acute care hospitals are not subject to these extra conditions.
6. 42 C.F.R. 482.60-62.
7. United States Code, *Congressional and Administrative News: Legislative History*, First Session 1965, p. 1970.
8. HCFA published its proposed hospital conditions of participation on December 19, 1997 (62 Fed. Reg. 66,726).
9. 64 Fed. Reg. 36,070, July 2, 1999.
10. Ibid., 36,089.
11. Congress also provided that hospitals accredited by the American Osteopathic Association could be considered in compliance, but only to the extent that the Secretary deemed appropriate. (Social Security Act, sec. 1865, 42 U.S.C 1395bb.)
12. Costs associated with accreditation may or may not have been included in the base-year calculations under the prospective payment system, depending on the hospital's accreditation status at that time. Accreditation is voluntary, and whether or not a hospital elects to be accredited does not change its reimbursement from Medicare.

13. As of May 2000, the Joint Commission reported that of the 38 Charter hospitals subject to an unannounced survey, it accredited 2 with commendation, 29 with type 1 recommendations, 3 with conditional accreditation. Another four were not accredited. Since the unannounced surveys, 17 of the 38 hospitals have closed and 3 were sold.
14. Current HCFA policy, as outlined in the State Operations Manual §2042, is to announce surveys at psychiatric hospitals. However, practices vary across HCFA regions, with some regional offices announcing and some not announcing upcoming surveys. In some cases, then, the hospitals have no advance knowledge that the contracted surveyors are coming and thus are unlikely to have presentations prepared for the contracted surveyors. HCFA is in the process of clarifying its policy on announcing such surveys.
15. We recognize that current Medicare conditions of participation require discharge planning but spell out no requirements for the execution of that plan, thus hospitals cannot be held directly accountable for that process. However, inadequacy of the discharge plan's execution could be related to inadequacies in its planning.
16. According to the American Hospital Association, the length of stay in psychiatric hospitals dropped 80 percent: from 204 days in 1974 to 41 days in 1997.
17. On July 2, 1999, HCFA issued an interim final rule on patient rights, which covers the use of restraints. That interim final rule is outside the purview of the contracted surveyors.
18. Joint Commission on Accreditation of Healthcare Organizations, *Restraint Use Task Force Meeting: Agenda and Materials*, May 26, 1999.
19. The Joint Commission held these hearings in early 1999: March 29 in San Francisco, April 6 in Atlanta, and April 13 in Washington, D.C..
20. In 1997, Joint Commission surveyors found the standard for time-limited orders for restraints out of compliance in 16 percent of the psychiatric hospitals surveyed that year. In 1998, they found that same standard out of compliance 10 percent of the time. (Data as reported by the Joint Commission).
21. We based this analysis on the recertification surveys of the two special conditions, which represent the majority of the surveys conducted by the contracted surveyors. Our analysis excluded follow-up, initial, and complaint investigation surveys conducted by the contracted surveyors.

22. According to HCFA, the FY 1993 amount of \$3,000,000 funded the contracted surveys for 7 months, from September 19, 1992 through March 1993. In April 1993, HCFA modified the contract and budgeted an additional \$1,187,370 for the next 12 months, taking the contract through the remainder of FY 1993 and into FY 1994.
23. Validation surveys are on-site reviews of hospitals that are conducted some time after the accreditors' or State agencies' own visits.
24. HCFA did observe the contracted surveyors at a psychiatric hospital in late summer, 1999. That observation resulted in no written report nor formal performance assessment.
25. HCFA has a contract with Romain Consulting to provide logistical support for the contracted surveyors. Romain schedules surveys at psychiatric hospitals, assigns surveyors, arranges travel, and tracks the survey activity. HCFA's contract with Romain calls for the following major routine reports: (1) monthly progress reports, (2) monthly summary of meetings with HCFA, (3) quarterly expenditure reports, and (4) draft and final year-end reports. During the course of our inquiry, we asked to review samples of the monthly reports as well as the year-end reports. HCFA responded that no such reports existed, referring us instead to Romain. Romain likewise kept no such reports.
26. In FY 1997, 54 percent of the contracted surveyors conducted 3 or fewer surveys; In FY 1998, 42 percent. To date in FY 1999, 58 percent of the contracted surveyors conducted 3 or fewer surveys (based on data reported by Romain Consulting).
27. According to HCFA, it trained all the contracted surveyors in January 1992, June 1995, and April 1998. It provided training for newly recruited surveyors in both November 1992 and March 1999.
28. According to 1997 HCFA Customer Information Set data, 66 percent of the 497,159 psychiatric discharges were from psychiatric units in acute care hospitals and 27 percent were from free-standing psychiatric hospitals.