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Providing Medical Care in State Psychiatric Hospitals

Susan Saik, MD; Brian B. Sheitman, MD; Scott Mann, MD; Walter W. Stelle, PhD; James W. Osberg III, PhD

Abstract

Background: *Dorothea Dix State Psychiatric Hospital (DDH) was cited by regulatory agencies in 1999-2001 for serious deficiencies in providing medical care to psychiatric patients. This resulted in a change in the discipline responsible for providing medical care. We report here how clinical staff and regulatory agencies evaluated the change. In addition, we sought to determine how medical care is currently provided at other state hospitals across the nation.*

Methods: *A transition occurred whereby the responsibility for medical care (direct care and supervision of physician extenders) was changed from psychiatrists to internists. We surveyed psychiatrists and nurses about their impressions of the change and calculated the number of citations from regulators pre-and post-changeover. In addition, a survey was sent to all 212 state psychiatric hospitals.*

Results: *Response rates were: 100% for DDH psychiatrists, 42% for DDH nurses, and 67% for state hospitals. At DDH, clinicians favorably viewed the changeover with 23 (96%) of the 24 psychiatrists reporting a preference for internists having overall responsibility for medical care. There was also a marked reduction in deficiencies cited by regulatory agencies, with 10 prior to the change and only one after the change. Responses to the State Psychiatric Hospital survey revealed that psychiatrists currently provide or are responsible for at least some portion of the medical care at 69% of all facilities.*

Limitations: *DDH staff evaluated a change from a system that had not been in place for 3 years. Quality of care measures were not available. How these data generalize to other state hospitals is unknown.*

Conclusions: *Having internists responsible for medical care was well received by staff and regulatory agencies. Currently, state psychiatric facilities use different approaches to provide medical care. Further research is needed on how quality of care, and ultimately patient safety, may be impacted by these different service delivery models.*

Key words: *Inpatient psychiatry, state hospitals, medical comorbidity*

Introduction

Patients with psychiatric and/or substance abuse disorders have an increased prevalence of comorbid medical disorders compared to the general population.[1-4] A recent report on the physical health of the 1500 schizophrenia patients enrolled in the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study showed that over 40% had signs and symptoms consistent with the metabolic syndrome.[5] This syndrome is characterized by insulin resistance and associated with an increased risk of diabetes and cardiovascular disease. In addition, among patients hospitalized for either a medical or surgical condition, those patients with schizophrenia, when compared to those without the condition, had significantly more complications, with their average length of stay 10 days longer.[6] The reason for the increased prevalence of medical problems is less clear and likely multifactorial.[7-10] A reduced commitment/ability to maintain overall good health, side effects of prescribed psychotropic medications, an increased neuro-developmental vulnerability, increased use of tobacco products, and some combination of all

Susan Saik, MD, is chief of medical services and assistant clinical director at Dorothea Dix State Psychiatric Hospital in Raleigh, NC and clinical associate professor in the Department of Medicine at the University of North Carolina at Chapel Hill. Dr. Saik can be reached at Susan.Saik@ncmail.net or Dorothea Dix Hospital, 820 South Boylan Avenue, Raleigh, NC 27603.

Brian B. Sheitman, MD, is chief of adult psychiatry and associate director of clinical research at Dorothea Dix State Psychiatric Hospital and clinical professor in the Department of Psychiatry at the University of North Carolina at Chapel Hill.

Scott Mann, MD, is an attending internist at Dorothea Dix State Psychiatric Hospital and clinical assistant professor in the Department of Medicine at the University of North Carolina at Chapel Hill.

Walter W. Stelle, PhD, is currently retired and was the prior hospital director at Dorothea Dix State Psychiatric Hospital.

James W. Osberg III, PhD, is hospital director at Dorothea Dix State Psychiatric Hospital.

the above have been suggested. Recent recommendations acknowledging the increased medical comorbidity among schizophrenia patients now call for mental health providers to offer physical health monitoring in primary care settings for those patients who do not routinely receive ongoing physical health monitoring.[11]

How to best provide medical care for psychiatric inpatients in state facilities or freestanding psychiatric hospitals (not affiliated with a general medical hospital) has received limited systematic investigation. Given Dorothea Dix Hospital's (DDH) history of regulatory problems directly related to the proper medical care of patients on the psychiatric units, a decision was made in 2001 to change the professional medical discipline responsible for providing and supervising all medical care from psychiatrists to internists. The purpose of this report is to describe the impressions of clinical staff (psychiatrists and nurses) and outside regulatory agencies on how they evaluated the changeover to the current system. In addition, we conducted a survey of all state psychiatric hospitals in the United States, whereby we requested information on which medical disciplines are responsible for providing medical (nonpsychiatric) care to the patients on the psychiatric units.

Methods

Part I. This study was conducted at DDH in Raleigh, North Carolina. The hospital maintains both Joint Commission on Accreditation of Hospital Organizations (JCAHO) and Centers for Medicare and Medicaid Services (CMS) certification. The hospital is the primary off-site training location for the University of North Carolina at Chapel Hill (UNC-Chapel Hill) Department of Psychiatry. Psychiatric residents and medical students rotate through the adult and adolescent admission wards. In addition, all psychiatric residents spend two months of their medicine rotation on the DDH medical unit. All of the teaching attending physicians have faculty appointments at either the UNC-Chapel Hill Departments of Psychiatry or Medicine.

DDH serves adolescent, adult, and geriatric patients. The hospital also has both a Pre-trial Evaluation Unit and a 90-bed Forensic Treatment Program. There is a separate medical unit that provides a scope of service capable of handling most acute medical problems (ie, with capabilities similar to a general hospital non-Intensive Care Unit bed). There are approximately 4500 admissions per year to the hospital and an average daily census of about 320. The hospital serves both acute patients and those requiring extended stays. The primary diagnoses among the acute admissions patients are substance abuse disorders (60%) and the major mental illnesses (40%), consisting of schizophrenia, schizoaffective disorder, and bipolar disorder. The longer stay patients are primarily diagnosed with a major mental illness.

A transition in the provision of direct medical care began toward the end of 2001. Internists were made responsible for these functions rather than psychiatrists who had previously been providing direct medical care and were also supervising the physician extenders. The change was fully implemented by the end of the year 2002.

Management believed the changeover was remarkably successful and that almost everyone was pleased with the new system. However, data was not systematically collected to verify this opinion. Therefore, in the winter of 2005, a survey was conducted of all psychiatric and nursing staff. The survey was conducted anonymously for nursing staff, but not for the psychiatrists. Conducting the survey anonymously for psychiatrists, as well, was considered but decided against due to the difficulty of achieving true anonymity given the relatively small number of psychiatrists employed (n=24).

The investigators developed the survey and designed it to be brief. The psychiatrist survey consisted of 6 questions, with 5 of the 6 questions requesting a selection of the best response out of 3 or 4 choices (ie, yes, no, not sure). The other question, "What do you like or not like about the way medical care is provided to psychiatric patients at DDH," instructs the psychiatrist to select as many of the listed responses that are applicable. There is also a space left to write in responses. The authors did not formally assess the validity of the instrument before using it. The surveys were sent directly to all psychiatrists, and their supervisor was responsible for following up to see that it was completed. Completed surveys were sent to the clinical director's office. The nursing survey consisted of 3 questions. Similar to the psychiatrists' survey, the nurses' survey included a question asking what they liked or disliked about how medical care is provided at DDH. The nursing surveys were distributed from the director of nursing to nursing supervisors, who then distributed the surveys to the individual nurses. Nursing staff were instructed to send the surveys back to the director of nursing's office. Surveys were sent one time only, though supervisors were asked to remind nurses to respond. No incentives were offered to those who responded. At the time of the survey, there were 24 staff psychiatrists at the hospital, of which 21 were diplomates of the American Board of Psychiatry and Neurology Board (ie, board certified) with the remaining 3 board eligible. Sixteen psychiatrists had worked at either DDH or another state hospital where psychiatrists were directly responsible for providing medical care. There were 155 nurses employed at the time of the survey.

Part II. The Centers for Medicare & Medicaid Services (CMS, formerly known as the Health Care Financing Administration or HCFA) facility and compliance survey records were reviewed for two 3-year periods: 1999-2001 and 2003-2005. All regulator-cited deficiencies specifically related to the medical care of patients for each period were recorded. To be counted as a deficiency, there needed to be a specific reference in the CMS record to care that did not meet either the element, standard, or condition of care as required by CMS. If the same deficiency was cited in more than one place (ie, cited as deficient on multiple elements, standards, or conditions) it was only counted one time.

Part III. Due to the impression of how successful the changeover had been at DDH and to the anecdotal stories of the many different ways medical care was provided in other state hospitals, we sought to systematically collect data on this issue. Therefore, a list of all state psychiatric hospitals (n=212),

including chief executive officers (CEOs) and addresses, was obtained from the National Association of State Hospital Program Directors (NASHPD) website in 2006. A brief survey was developed by the investigators consisting of 5 questions with instructions to choose the best answer from a list provided or to write in a response if the response choices did not fit their institution. The survey was then sent to each hospital's CEO with instructions to please forward the survey to the person at the institution who could best answer questions about which disciplines were providing medical care on the psychiatric units. Questions addressed both normal business hours and off–hours coverage since many institutions use "moonlighting" providers (ie, licensed physicians either within or outside of their specialty who typically work nights or weekends, in addition to their regular jobs, to earn additional compensation). The survey was sent one time only and no incentives were provided.

Given the types of data collected, only descriptive statistics were used for all data analyses.

Results

Survey of psychiatrists and nurses at Dorothea Dix Hospital

Psychiatrists

All 24 psychiatrists responded to the survey. All except one (96%) preferred having internists provide and be responsible for the medical care of patients. One (4%) psychiatrist wasn't sure. The most common reasons sighted for this preference were:

a. Reduces my concern about missing a serious medical problem 100%
b. Gives me more time to focus on psychiatric issues 96%
c Reduces my potential medical legal risk 83%

Psychiatrists described their working relationship with the internists and the physician extenders as follows: excellent 92% (n=22), good 8% (n=2), fair and poor 0%.

Nurses

Of the 155 nurses who were sent surveys, 65 (42%) responded. All except four (94%) stated that they preferred the current approach. Forty-seven nurses had worked at DDH for more than 4 years and had experience with both service delivery systems. The most common reasons sighted for their preference were:

a. I feel more comfortable having a medical provider address medical issues.....................................88%
b. I prefer to contact the person who will specifically address the problem, rather than often being asked to make more than one call................................71%

Deficiencies Cited by CMS

During the period 1999-2001, there were 10 citations identified by regulators that were directly related to the medical care of patients. Thus, the hospital was found to be out of compliance with the "Conditions of Participation" and needed immediate plans for correction to avoid losing federal funding. During the period 2003-2005, there was one citation related to medical care. This was corrected by the time regulators visited, so there were no requirements for additional follow-up.

Survey of State Hospitals

Responses were received from 145 (67%) of the state hospitals and included the following:

1. Medical (nonpsychiatric) care during business hours was provided as follows:
   Psychiatrists 65/143 (45%), physician extenders 58/143 (41%), physicians other than psychiatrists 137/143 (96%). Note: Many hospitals reported that multiple disciplines provided coverage; therefore, the numerator does not add up to 143.
2. If physician extenders were used, who was responsible for their supervision?
   Physician extenders were used in 70/143 facilities (12 facilities reported using physician extenders as moonlighters). They were supervised by psychiatrists in 35/70 (50%) of facilities and internists in 66/70 (94%) of facilities.
3. Off-hours coverage was provided by moonlighting physicians in 68/143 (48%) of the facilities. Psychiatrists provided this coverage in 42/68 (62%) facilities, nonpsychiatric physicians in 52/68 (76%), and physician extenders in 13/68 (19%).
4. Nonpsychiatric physicians solely provided medical care in 44/143 (31%) facilities, while psychiatrists were responsible for medical care by either directly caring for patients during regular business hours, supervising physician extenders, or providing moonlighting coverage in 99/143 (69%) of the facilities.

Discussion

These data suggest that the transition from psychiatrists to internists went very well at DDH. Both psychiatrists and nurses overwhelmingly endorsed the current system with most having experience working in the previous model. Psychiatrists unanimously endorsed that the change reduced their concern about missing a serious medical problem. In addition, despite some concerns that there would be an emergence of "turf" battles between psychiatrists and nonpsychiatric physicians, relationships between the two disciplines were described as excellent by 22/24 psychiatrists and good by the other two psychiatrists. Nurses also overwhelmingly reported that they preferred having a medical provider address medical issues and preferred directly contacting the person who would address the problem. Moreover, there was a marked reduction in the number of regulator-cited deficiencies in the medical care provided to patients.

The data received from the survey of all the facilities would suggest that there is currently no consensus on which disciplines should be providing medical care to patients in state facilities. Though psychiatrists do not provide medical care at our facility,

this remains the case at 69% of the facilities. Psychiatrists provide direct medical care during business hours in 45% of hospitals, are responsible for supervision of physician extenders in 50% of facilities that use them, and are responsible for medical care while moonlighting at 62% of hospitals where moonlighting occurs.

We were in favor of the change from psychiatrists to internists because we felt that staying current with the latest psychiatric advances is a full-time job, and it is unrealistic to expect psychiatrists, no matter how competent, to keep up with the internal medicine literature as well. Interestingly, the Psychiatry Board recertification exam contains no questions directly related to internal medicine. Anecdotal accounts suggest that having "split" treatment (ie, mental health care treatment by a psychiatrist and nonmental health care by a nonpsychiatrist) seems to be the way most outpatient psychiatrists operate their practice. Furthermore, the larger issue of how to best provide medical care to a patient hospitalized for a different indication is not only relevant to psychiatric inpatients. A recent publication described a project whereby a hospitalist-orthopedic team worked together in a collaborative model with orthopedic surgery patients, as opposed to the traditional consultant model used in academic medical centers.[12] They reported a reduction in minor postoperative complication rates, with no statistically significant differences in length of stay or cost. Both the nurses and surgeons strongly preferred the comanagement hospitalist model.

This report has its limitations. The survey data are comparing two different time periods and are limited to "satisfaction" with the change, not differences in specific quality of care measures. In addition, psychiatrists were not surveyed anonymously, which could have biased their opinions, and only 42% of the nurses responded. DDH also has a medical unit with a scope of service beyond what some other state hospitals may have, and it also has a strong affiliation with an academic medical center located relatively close to it. Nevertheless, we believe this is a very important topic for the medical field. Currently, state psychiatric facilities use different approaches to provide medical care for patients. These data suggest that further research is needed on how quality of care and, ultimately, patient safety may be impacted by these different service delivery models in order to eventually make best practice recommendations. **NCMJ**

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