SAFE STAFFING

CRITICAL NEED FOR IMPROVED OUTCOMES

NURSING REPORT FINDINGS

AND PROPOSED SOLUTIONS

GARY MARGULIS M Ed MSN

Dear Representative Bradford:

I greatly appreciate your allowing those who represent the front line of health care the opportunity to speak to you. We as nurses have the most responsibility for patient care and least ability to obtain even the basic things we need to do our job effectively. The management in the state system as well as in the community sector has left many nurses looking for jobs elsewhere. This is not because we cannot care for the patients, but because of the daily strife that management has created. I will attempt to point out some of the more severe issues and hope that with your help we can achieve safe and consistent staffing so we can actually provide continuity of care for our mentally ill population effectively.

Author Note

I had worked for the State of NJ and I am currently working at Norristown State Hospital in PA. I also serve as an adjunct professor for Rutgers Univ - Camden. I have no particular affiliations with any particular political party or any special interest groups. My advanced training was in Evidenced Based Practice so my views and beliefs are based upon outcomes and dollars spent to achieve those outcomes. I wish to acknowledge those states where difficult decisions were made to spend tax dollars so as to improve services to their populations of physically and mentally ill. The positive outcomes for that population were significant. It is particularly important to fund state facilities adequately because they are the only type of hospitalization where long term rehabilitation can take place. Community hospitals only provide short term stays and band aid approaches. Community services remain fragmented and many times they are insufficient for the needs of the mentally ill. Relapse issues are frequent and the cost to the taxpayers is large. I can be reached at gmargulisrn@yahoo.com.

I have added a supplement to the end of this paper to further show why legislation is needed to improve outcomes of heath care. It provides some shocking statistics on how much in “hidden costs” there are for understaffing and poor management at various hospitals.

General History

I have been at Norristown Hospital for almost 10 years. I have worked for several major hospitals as a clinical instructor. With a total of over 20 years experience in two states, I will attempt to provide insight as to the need for safe staffing as a means to help control operational costs. Since mental health is my specialty I will focus most of my attention to Norristown Hospital and Torrance hospitals. I know of Torrance because of the nursing leaders and I have been involved with various campaigns to obtain staffing that reflects competency of the nurse as well as adequate numbers to effectively provide care for this high risk population. To date, there has been a steady decline in ability to staff units effectively. We have only 1 nurse assigned to our most volatile units in the forensics building. Our civil side fares better with usually two nurses assigned per unit except for weekends. On the weekends there are 3 nurses for two units. State hospital patients are notoriously volatile and require frequent monitoring and assessment for changes in behaviors. To emphasize how volatile a mental patient can be, the only injury I ever received as a nurse from a patient occurred in the forensic building at Norristown Hospital. I had attempted to make this short staffing issue known to Harrisburg previously. Below are some examples of my effort to gain attention to this matter.

Greetings Senator Vance:

I am writing to you at the suggestion of my peers because of your ability to bring bills to the floor for a vote. I am asking for your help in passing SB1081 as soon as possible. At stake are patient lives as well as the safety of the staff who provide care for these volatile population of patients. The multiple attempts to get management to recognize staffing as an issue has fell upon deaf ears and blind eyes. As a direct result of poor staffing we have patients being injured almost daily. Fortunately most injuries are minor and so these go underreported. There are however times when injuries require helicopter transport from our front lawn area to local hospitals. Of course there are those who merely require an ambulance for transport as well. In addition to patient to patient violence there is patient to staff violence. It is sad that management has seen fit to short staff the forensic units in spite of the overwhelming data that shows they are being penny wise and millions of dollars foolish. The reasoning provided by management to short staff forensic units is 'a patient is a patient and no additional nursing staff is required other than a single RN on a unit'. Unlike the civil side where almost every unit has two

RNs on duty except on weekends and holidays, Forensic units are only staffed by a single RN. In addition, management recently added more duties to forensic nurses. These changes make it the sole responsibility of the staff RN for all staff and patients on the ward. Not only is this impossible, but ironically makes it infinitely easier for management to avoid being responsible if there is any adverse outcomes on the unit. Training provided to Forensic staff (FSE) consists of intensive 3 months in the areas of security of building as well as custody and control procedures when dealing with the inmates (patients only while at hospital). The forensic nurse receives 2 hours of basic training via 10 read and sign modules. We debated that a single Forensic RN cannot be expected to pour meds, prepare paperwork, provide treatments, attend meetings and also monitor every inmate, and staff on the unit. In the forensic units there is at least one event (fight, injury, incident, etc) per shift. What is one nurse supposed to do by themselves. Management has been rabid in their accusing the forensic nurse in lack of due diligence. We have filed numerous grievances against this accusatory practice. Recently a FSE had their nose bit by an inmate to the extent that the bite went clear to the bone structure. Management once again sought to blame the RN for the incident rather than own up that short staffing was the primary underlying cause. The state already has issues recruiting and retaining RNs. This is due to changes in benefits and pensions such that most major hospitals offer the same or better working conditions and pay. In addition to recruitment, there has been an increase in exodus because of the hostile work conditions and lack of management response to serious issues. I know of one RN I represented in a grievance who was accused of patient abuse when in fact he was preventing the patient from burning himself and staff. The nurse was with the state less than a year and decided that the job was not worth the aggravation that management was putting him through. He is now working at a major hospital and happy where he is. This is one of many other examples of those who left the state to work elsewhere instead of putting up with mismanagement at the state hospital.

If you were going to choose a hospital for you or your loved one to go to, would you choose one with high turnover, low morale, and frequent injuries to staff and patients? Do you know of any hospital that becomes a leader in the industry with a vast majority of staff who have few years on the job, work under hostile work conditions and an administration that has a lack of concern about safety? We are concerned professionals who need relief from the poor management we currently work under. In my almost 20 years as an RN working as an employee or instructor at many hospitals (public, county and state) I had never had an injury due to a patient attacking me. In contrast to this, I was severely injured while working on a forensic unit (in less than 3 months on duty) at Norristown State Hospital by a patient who was not well controlled.

I have sent this package of information to you because even though it is a compressed version of what was presented by myself and Ms. Shepler to management as well as HR. It was too extensive to send via E mail. Over a year ago Ms Shepler and I brought forth all our data to HR representatives to show how dangerous understaffing forensic units are. We had shown the data on injuries to staff and patients as well as the burn out of staff. We recently met with Ms. Spotts who is the head of HR in Harrisburg. We spent over 5 hours reviewing the lack of training as well as lack of adequate nursing staff and how that negatively impacts on patient care. In the end we felt betrayed by those whose duty is to safeguard staff and patients. The only hope now is to have SB1081 pass before many more become injured. Injuries, overtime and need to recruit new staff to take over those who leave costs the states millions of dollars every year. This money would be better spent in safety improvement and retention. I wish to thank you in advance for your attention to this plea for help. I will make myself available to meet with you as you see fit. Ms Shepler and I hope that you find our information helpful and that SB1081 becomes law in the near future. The lives and monies saved will more than compensate any inconveniences made to management so that safe staffing becomes practice across the state system.

Dept of Human Services

Bureau of Human Resources

Attn: Ms. Spotts Dept Head

Dear Ms. Spotts:

I received your response to the grievance on 6/21. I have to say not only was I taken by surprise at the casual response to the serious issues we presented to you in your office. Your response not only ignored the issues and the possible options we presented, it completely overlooked the implications of the ongoing issues we face attempting to care for a volatile population. Prior to management unilaterally deciding to artificially change the previous job descriptions we as RN's had more than we could handle on a regular basis. Now that you decided to heap even more responsibilities upon an overworked staff there have been serious issues manifesting. A recent issue was a FSE had his nose almost completely bit off by a patient. There was only **ONE** RN the unit at that time. We have the civil liberties of our patients being violated on a frequent basis due to lack of the RN being able to:

1) pour meds

2) complete treatments

3) attend treatment team (days / evenings)

4) attend to emerging issues

5) charting

6) monitor patient behaviors

7) daily paperwork

8) now - having to monitor the FSE

The patients deserve better than minimum professional staffing. On any given day, on any given shift if there is so much as anything that deviates from a normal day, there is extremely limited professional response available to aid the patient or staff. This was why Jeanine and I came to you. We explained that the original job description had none of these new duties in them. We also explained how if we were to acquire these new responsibilities we would need additional RN's to do so. Also we pointed out to you the MAIN reason the management wanted the FRN to evaluate the FSE was they wanted to get around the contract with PSCOA which stated that only a FRN supervisor could evaluate the FSE. We also explained to you that we do not have security and control training and to hold the FRN accountable to evaluate an FSE whose job we do not know fully is ludicrous. This is all smoke and mirrors and if this decision is final, we plan to take it to the next step. The grievance continues to stand as is and with merit. I am deeply disturbed that the oversight committee to which you belong does not care about the patients we care for. If this was a public hospital, the public would be up in arms over the lack staffing and ability to protect the patients the hospital oversees. I am confident that when I present our case to others who are vested in patient care by public facilities there will be enough outcry to have our case heard at the next level. I am truly dismayed over the contents of the letter dated 6/17/16 but remain open for discussion during the process of going forward with this case.

Sincerely yours,

Gary Margulis M Ed MSN

Dear Senator Fontana:

I want to thank you in advance for reviewing this letter and providing feedback. My name is Gary Margulis and I am an M Ed MSN working at Norristown State Hospital. A colleague of mine who works at Torrance State Hospital is Jeanine Shepler RN. We went to Harrisburg to Jennifer Spotts to voice concerns about an ongoing unfair staffing practice and sought to have the issue rectified. We spent over 5 hours detailing our collective concerns to her and brought documentation to support our positions. It was with great heart ache that I received a decision via a letter dated 6/17/16 stating that the concerns we raised about safe staffing and patient care were ignored. To give you a perspective of what the various issues are I will attempt to concisely present our case to you.

The state system provides two levels of patient care. One level is the civil side where the patient is either ready for discharge to community or is working towards that goal. The patient is relatively stable and can be taken care of without a great security risk. The second tier of care is the forensic unit. These are patients coming from various prisons and jails who have mental illness issues. These patients are usually not stable and present with various security risks. The forensic centers are actually like mini prisons where the patient is still considered an inmate. The goal of the forensic unit is to stabilize the patient and help them progress back to prison for a competency hearing or go forward to civil side where the focus is more on recovery and community living post discharge. Under the current situation, the forensic side is an unsafe area to work due to poor management. We are top heavy with management and front line nurse short. As a result of this imbalance there is almost a daily incident of injury to staff and / or patients on these units. I can personally attest to at least 20 staff being injured during my brief time working in the forensic center of Norristown. We have brought up this inequity of staffing in labor management meetings and were "poo pooed" when we asked that the staffing in the forensic center have at least two RN's on each unit due to the high acuity. Recently the management sought and now has won the ability to continue to short the units of needed RN's and worse yet, hold the front line nurse for any incident that takes place. This is a travesty that if any public hospital did, there would be protests and outrage from the community.

I am asking you to help put patient care first. Those who come to the forensic unit deserve better care than to live in fear of being attacked or worse yet neglected due to lack of professional staff being available to care for them. A minor change in staffing has the potential to improve working conditions for staff and living conditions for the patients. We also asked for training that was on par with the one that the FSE receive. This way an RN could actually comprehend if the FSE was or was not doing

their jobs as per management directives. It was interesting to note how Ms Spotts ignored that aspect and stated that presenting the aspect of no adequate training to her was not the right forum to present that information. So in essence she blatantly ignored we were short staffed and not trained, yet it was allowable that management arbitrarily change our job descriptions to include more duties so the supervisors had less responsibility.

This is ludicrous, dangerous and places front line staff at high risk for injury and discipline under management's broad policy of "failure to follow" which has been used to suspend people for absurd charges. In the end, the state loses almost all the discipline cases, people are hostile towards management, people get injured and tend to have no motivation to return to work and patient care suffers. If anyone took the time to measure the loss to the state it would be millions each year in losses. At this junction there is an opportunity to break this vicious cycle. I am asking for your help in righting this wrong and put the state system on the path that indicates a proactive leadership style instead of the punitive one that we currently have. I thank you for your time and hope that we have the opportunity to discuss this along with other issues we as state employees face daily.

Sincerely yours,

Gary Margulis M Ed MSN – Norristown Hospital

856-904-0463

Janine Shepler RN- Torrance Hospital

Outcome

As you can see, there is little support for those of us who deal with difficult populations. The frustration over poor management leads to burnout and that costs millions each year. Last publication I received indicated that the state spent over 5 Million dollars to treat injuries from employees. If we had more trained and regular staffing most of that issue would be eliminated. On any given day we have staff out of work. Some due to injuries others due to so called investigation post intervention with a violent patient. To give you an example of what this costs the state, we have had as many as 44 people off the unit but still getting paid in our forensic building alone. Adequate staffing would cut a large percentage of this population out and return them to the unit to work.

Examples of Failure

Norristown Hospital

We recently had a working out of class employee on a unit where he was filling in as a patient assistant (PA / tech). He did not respond to a psychotic patient fast enough and was severely beaten by that patient. I was there after he was hit. It was gut wrenching to see a person convulsing, non verbal and fighting for his life. The outcome was he was diagnosed with possible permanent damage to his brain and may have seizures for the rest of his life. The cost of this injury will most likely reach the million dollar mark and the state of PA will be paying that bill.

Several months ago we had a suicidal patient who would attack others so that they would beat them. When they realized their plan was not working they decided to inflict self harm. The call for a more adequate placement and the use of restraints were denied by administration. The patient was successful in killing himself and that is just one of the many statistics we have at our hospital alone. The use of restraint chairs is well documented in other hospitals and effective when a patient is out of control. The use of this chair would have saved this person's life as well as saved the state monies spent for therapy for the staff who had witnessed the event.

Without regulations to stop this abuse there is little wonder why the state spends 5,000,000 each year in injury payments (as of posting PA 2017). That is why many of the forensic injuries last for such long periods. We need to put into place a sanity that makes it safer to go to work and help the state save money.

People who have left to work elsewhere, in addition for increased numbers to replace those needed in forensic units has lead to enormous OT (over time)needs. People call out because of mental and physical fatigue which leads to unit shortages on a regular basis. Upper management has consistently lagged behind staffing needs. Most of the upper management is so far removed from daily issues that if only supervisors ran the hospital, our staffing issues and morale and performances would actually go up.

Norristown Hospital

Another example of issues we face as front line health providers is the recent drainage of our regular staff to become forensic employees (FSE). It is interesting to note we have people coming from recreation, social services and other areas just to fill in PA (tech) slots. Our ability to hire is limited because I was informed by the DON that we have to use a contractor (Genesis) to help supply us with new staff. No other facility I know of is locked into this ridiculous arrangement. Other hospitals where I work have all used inside recruiter s to obtain the best candidates for the job.

It is interesting to note that we violate our own policy (20-10E) on a regular basis. We cannot practice safe work habits, assess and report unsafe procedures with ever changing assigned staff to a single unit. If you do not know a patient, how can you assess for anything? It is interesting to note that the policy also states that "all supervisory, management and administrative staff will aid and support improving the safety of our facility" but that almost never happens.

On an almost daily basis I start my shift with all my staff coming from working a previous shift. This means my unit is not covered with any staff on the 3-11 roster during 3PM. Most come in at 3:30PM. Many times a few staff arrive 3:35 and I can begin to assign that staff to my 1:1 patients and eventually one person to do accountability. Not only is this dangerous because the reason a person is on a 1:1 is self harm or worse, but there is no one there to help out if any issue arises! This is the best case for patient abuse I can make to date. We fail to adequately provide for high risk patients. It is nerve wracking as charge RN to deal with this almost daily occurrence.

Current Needs

What is urgently needed is a more defined ratio of working front line staff to patient ratios. We need to exclude: supervisors, management, and other ancillary staff as part of that ratio. We also need to hold management responsible for obtaining new staff prior to taking regular staff from the various units. We need a plan to have back up agency or reserve nurses to staff units that are currently understaffed.

Our population responds well to consistency so that there is continuity of care. How can we provide consistency when the people caring for them change almost daily? It is time for those who make the laws to look at our situation and set parameters for management to follow. Management has made up the rules as they have gone along and it negatively impacts our patient population as well as those who work to provide care.

It is time for a change. We need legislative support to help provide appropriate care to our patients. We need enough consistent staff so we can effectively handle emerging issues and the ever changing needs and challenges of our patients. Safe staffing laws would be a great help in saving lives and saving millions each year. I am asking for a law that requires at least 2 RNs per unit in our state hospitals to help lower assault and injuries. Based upon finding in other research studies, It will also lower the percentage of failure to rescue as well.

Results in Community Settings

I would like to include findings from a Scientific American report July 14,2015 called Widespread Understaffing of Nurses Increases Risk to Patients. This particular article provided a wide view of outcomes across the spectrum of nursing and did not focus on only a single aspect. This article provided a non biased approach to viewing the multiple issues nurses face from various sectors of employment.

According to the US health Resources and Services Administration: “hospital administrators do not want to spend the money needed for ample staffing, although almost everywhere there has been a surplus of educated nurses for years.”

As per Linda Aiken – Director of the center for health care outcomes and policy research at the University of Pennsylvania (level 1 trauma center and a large employer for the area).
“We have more nurses in the US than we ever had before but there is a lack of budgeted positions in hospitals.” Hospital administrators are reluctant to hire more nurses because it is not seen as cost effective, but “it’s costing us more to not have adequate staffing because all the excess costs that they are getting from these poor outcomes”, such as patients who return, postsurgical infections and other consequences of short staffing.

Critical Care Medicine in March of 2015 had findings that when they compared a diverse group of hospitals worldwide, those with a higher nurse to patient ratio correlated with lower patient deaths in intensive care units.

A study by The Lancet journal (2014) found that an increase in a nurse’s workload by one additional patient over 4 increased the likelihood of a patient in that hospital dying by 7%. “In every single country and states within countries, there’s a tremendous variation in nurse staffing in hospitals. Along with that variation in nurse staffing is variation in every other patient outcome, from mortality to falls with injuries, to patient safety events to patient satisfaction”

A report by ACH which was released March 1, 2015 was cited. ACH is an independent reporting agency on medical issues. The release dealt with issues about nurse fatigue. The report went on to state the following:

Risk managers should adopt strategies to reduce fatigue caused by scheduling, overtime, and excessive workloads.

High turnover rates among nurses can be an indicator of fatigue risks. Creative scheduling can reduce nurse fatigue.

The article cited Richard C. Boothman, JD chief risk officer and executive director of clinical safety at the University of Michigan Health System in Ann Arbor Michigan. “fatigue poses a huge threat to patient safety. The health care industry has not connected the dots between how clinical and business pressures can fatigue nurses to the point of threatening patient safety. Fatigue is a pretty well documented concern, but it is not often assessed in nurses. There is no reason to think nurses are immune to the same problem and in some ways it’s worse.” He went on to state that since nurses have the most hours of direct patient contact, a fatigued induced error of oversight can initiate a chain reaction of improper care. He went on to cite an infamous case where a fatigued nurse gave the wrong meds to a pregnant woman. The woman died but they were able to save the baby.

An additional article that also focused on nursing issues was Hospital Nurse Staffing and Patient Mortality, Nurse Burnout and Job Dissatisfaction (JAMA 8/25/14). The article used a large scale analysis (232,342 patient outcomes during a single year) of PA patients in order to assess various health factors. The data was obtained from 168 different hospitals. The purpose of the study was to measure risk adjusted mortality and failure to rescue within 30 days of admission and nurse reported job satisfaction and job related burnout. What I particularly liked about this article was that they went as far as to look at various sub types of specialty nursing. They found that “Direct measurement (of data) also avoided problems with missing data common to the AHA’s annual Survey of hospitals.” This report only assessed 20% of PA hospitals and their staffing issues.

The study focused on outcomes for 232,342 patients between ages of 20 and 85 who had general surgical, orthopedic or vascular procedures completed in one of the 168 hospitals reviewed. Hospital patients ranged from 75 to 7746 per hospital for that year. The study looked at 30 day post discharge mortality, failure to rescue (deaths within 30 days of discharge). The study separated out complications from pre existing conditions. Risk adjustment of mortality and failure to rescue were calculated using

133 variables (age, sex, surgery types, chronic preexisting conditions, etc). The risk adjustment model used represented a .89 correlation. This is a very significant ratio to have achieved.

The study focused on outcomes for a nurse who had 4, 6 or 8 patient assignments. The study used standardized patient characteristics for the comparison.

Findings of Research

Of the respondents, 94.1% of nurses were women. Only 39.6% were BSN or higher degree. The mean average of experience was 13.8 years

Of the workforce 31% worked in medical and surgical general units, 19.6% worked in intensive care units, and 9.8 worked in perioperative settings.

As for job related issues it was found that 43% of nurses had a high burnout scores and an almost same number were dissatisfied with their jobs.

Patient data revealed of the 232,342 patients studied, 53,813 (23.2%) experienced major complications not present upon admission. In addition, 4,535 died within 30 days of admission and the death rate for patients with complicates was found to be 8.4%.

Of those patients undergoing surgery 51.2% were orthopedic classification, and 36.4% were digestive and hepatobiliary types.

Controlling for hospital environment and nurse assignments it was found that a relationship between staffing and burnout emerged. It was found that when a nurse had a ratio of 8:1 there was a 2.29 multiplier for burnout as a nurse who had a 4:1 ratio. It was also found that 43% of those nurses who reported high burnout intend to leave their jobs over the next 12 months. Results of outcomes also found that for every patient over 4:1, there was an additional increase of 7% mortality for the patient being cared for by the same nurse.

Report by Nurses of PA Article: Breaking Point Sept 2017

The significance of this report is that thousands of nurses form all types of hospitals in PA were polled. The responses reflect the concerns that affect every patient in every type of health care facility. This means it could be your loved one, you or a friend who is being cared for whether it is at a local hospital

or state facility. We can ill afford to ignore the needs of the patients who come to hospitals in order to regain their health. Too often adverse outcomes are blamed on something not related to the actual cause. In the 1990's hospitals decide that could save money by "cross training" staff to do multiple tasks. The end result was hundreds of people died due to lack of proper care. The results prompted hospitals to go back to having staff become "specialists" in specific areas of care. That lead to a decline in mortality rates and in the end actually saved the hospitals money.

Findings of Breaking point

Staffing decisions made by facilities regarding both nurses and support staff and the ability to retain qualified nurses have fueled a crisis in patient care

94% of nurses report that their facility does not have enough nursing staff and 87% report that staffing levels affecting patient care are getting worse.

About 84% of nurses report that a high turnover rate among nurses is a problem in their facility.

About 79% of nurses report that since they began to work at their present job, the rate of turnover is increasing.

Nurses' report that the lack of time to be able to spend with their patient has lead to increased medical costs due to lack of ability to address issues of the patient in a timely manner.

Paperwork is crippling the ability of the nurse to effectively complete their job in a timely manner. Here at Norristown we have to document everything on paper. This means that a single report has to be written in as many as 4 different places (24 hr report, chart, note to MD, lab, etc, incident report, sick call book). In this age of computers why not use them? Other major hospitals use electronic charting.

Numerous other studies have shown that there is a direct relationship between higher nursing staffing levels and improved outcome of care. This took into account lower mortality rates, less antibiotic use, fewer infections and lower hospitalization rates.

A study of 168 hospitals in PA found that risks of patient mortality increased by 7% for each additional patient added to a nurse's workload beyond the baseline of 4 patients.

Cost factors associated with current practice

Hospital acquired infections add additional days of hospitalizations. They also add to readmission days as well as mortality rates. One study showed that of 7,062 patients there were 1245 that had to be readmitted within 30 days. Of that population, about half were readmitted within 10 days discharge. American Journal of Infection Control 44(2016) 500-6

Several studies focused on the workload of nurses and outcomes related to overload, stress, fatigue, etc. One study found that 86% of nurses reported that they left one or more care activities undone due to time constraints. Although all statistics were significant in nature the more pressing ones cited were that 47% responded they omitted developing and updating care plans. A study went on to review outcomes of a major hospital. It found that in a two year period there was an average of 400-1200 more fatalities than statistically expected. The study cited 102 previous research studies that indicated that higher RN staffing levels are associated with lower levels hospital related mortality and adverse patient events.

With hospitals that have higher mortality and morbidity it was fond that a failure to properly observe and respond to patient deterioration (failure to rescue) was identified with low staffing. The study went on to state unfinished care by RNs or 'missed care' can be used as an indicator of overall quality. This factor was found to account for 40% variation in care quality ratings in a US study. What I found most pertinent was that the study realized that the role of the RN as being complicated as well as demanding. They listed:

Adequate patient surveillance	adequate documentation of nursing care
Administration of on time medication	comforting / talking to patients
Developing / updating nursing care plans	educating patients / families for post discharge
Ensuring changing positions to avoid skin break down	pain management
Planning care for length of stay	skin care (treatments) / procedures

BMJ Qual Saf2014;23:116-125

The US Government Accountability Office

They looked at 4 of their centers (of which one was in Delaware). Their findings were that private sector facilities had provided better incentives for nurses, reduced pool of nurses in rural areas who had advanced training and the number of employees who were dissatisfied with their jobs. The VA report found that the nurse skill mix was an important factor in hiring "as the level of education and training for each nurse position determines the types of services that can be provided." Another important finding of this report was that "officials from one medical center and it's union reported high levels of nurse dissatisfaction with medical center leadership" The national average for turnover RN rates was found to be 7.9%. At the facility in the report they had a turnover rate of 12% NP (nurse practitioners), 30% nursing assistants, and a "high turnover" (undisclosed number) and nurses on administrative leave.
VA Health Care: Oversight Improvements Needed for Nurse Recruitment and Retention Initiatives Sept 2015

Discussion of findings

Until we change how we staff, educate and support our health care providers we will continue to spend millions in injuries, millions in turnover costs and millions in overtime. We need to stop the madness and take an evidence based approach to the way staffing is done at state hospitals. Most major hospitals have significantly less turn over, spend less money per patient and have better outcomes. State and Federal government agencies lag far behind other major hospitals. The bottom line is that if we choose to continue as we have been, then nothing will change. If we choose to embrace evidenced based practice we can solve most of our most pressing issues and save money in the process. I for one will stand up and be heard. I have worked in many different mental health hospitals and can attest from personal experience that we can do better. Many like me have the education and training that could make significant improvements to the system we currently have, but we will need the authority to implement that change. The current management tends to be socially promoted, reactionary and lack the ability and motivation to move the system forward. We need forward think leaders who have the respect of the staff they supervise. Labor – management meetings lead to little open discussion. Promises of "looking into" complaints lead to few results. When front line staff complain to people outside our management system (as per letters above), there are no checks and balances for complaints made to Harrisburg. We are dedicated health care professionals who want to provide holistic care to our patients but we cannot do so under current parameters.

As an advanced practice RN, I can attest to the cost factors associated with inefficient staffing. I have witnessed those issues first hand. If we can make even some adjustment to what we currently have as legislation now, we can realize millions in cost savings. I realize it is a difficult task as a legislator to champion a cause that is shrouded in various aspects of varying facts. In spite of variations, the most common theme of all research papers that indicate success and maximum patient efficiency is due to: the years of experience of the RN, the more stable the staffing is and the more the RN is aligned with the specialty they perform. Clinical evidence indicates that having more than a 6 patient to 1 nurse ratio in a community hospital leads to an increase in mortality of over 20%. We at the sate and other similar types of settings require 2 nurses per unit to service up to 30 patients effectively. We have to fight management almost daily to obtain that meager number.

Although the California law did not accomplish as much as it was theoretically supposed to do, there is multiple evidence that other factors such as; years experience, stability of staffing on the unit and support by management that decreases negative outcomes and improves care of the patient. If legislation only considers the latter part of the argument which is to support front line nurses by hiring those nurses with appropriate education and training, allowing them to have the adequate time to perform their functions, and have staffing dictated by patient needs and fluctuations in those needs, I believe that positive outcomes that were previously clouded by considering mandating specific numbers of RNs only will be realized. The state would do well to begin the safe staffing act with their own facilities as well as regulate community staffing. If we change to a 2 RN to unit (range of 22-30 patients per unit) policy the state would realize savings from decreased turnover, better patient outcomes, less assaults and injuries, and less staff out due to injuries and assaults. I do realize that legislation does not fix all woes. As an evidenced based practitioner, I am seeking a balance between dollars spent and outcomes.

SUPPLEMENT

Fraud, Waste, and Excess Profits

November 18, 2015 | Cultural Psychiatry, Career, Psychiatry Compensation
By E. Fuller Torrey, MD

On September 28, I co-authored a report estimating that between 10% and 20% of state mental health funds—$4 to $8 billion—are being lost to fraud, waste, and excess profits to for-profit managed care companies.[1] This loss is important because even $4 billion, if it was not being lost, could buy 3 months of hospitalization for 112,000 individuals, 1 year of supported housing for 335,000 individuals, or 1 year of clozapine treatment for 667,000 individuals. There is thus a direct connection between such losses and the deterioration of public services for individuals with serious mental illnesses.

It was not always this way. At one time state mental health authorities directly controlled almost all of the states' mental health expenditures because the money was spent on state-owned mental hospitals and, in states such as New Hampshire, on state-owned mental health centers. As recently as 1981, 63% of the state funds were still going to state hospitals. By 2009, however, the percent of state mental health funds going to state hospitals, and thus directly controlled by the state, had decreased to 26%, and in the intervening years it has continued to further decrease. Thus, the vast majority of state-controlled mental health funds, which in 2012 totaled $40 billion, support community mental health services mostly through Medicaid, Medicare, not–for-profit organizations and, increasingly, for-profit managed care companies.

What kind of fraud are we talking about? For Medicaid and Medicare fraud carried out by mental health providers, our study identified almost $1 billion in false claims in media studies reported in 2014 alone. A social worker in Charlotte billed for 64 hours of therapy in a single day. A mental health center in Baton Rouge billed Medicare for $258 million in fraudulent partial hospitalization claims; following a trial in 2014, one of the center's owners was fined $43.5 million and sentenced to 7 years in jail. A psychiatrist at a mental health center in Miami was convicted for being part of a $55 million Medicare fraud; he was sentenced to 12 years in prison. In 2012, the former administrator of the Centers for Medicaid and Medicare Services estimated that approximately 10% of all Medicaid and Medicare funds are lost to fraud.[2]

In 2014, the former Inspector General of the federal Department of Health and Human Services claimed that "many health care fraud investigations believe mental health care givers, such as psychiatrists and psychologists, have the worst fraud records of all disciplines."[3]

Torrey F, et al. Fraud, waste and excess profits: the fate of money intended to treat people with serious mental illness. *Mental Illness Policy Org*. 2015. http://www.mentalillnesspolicy.org/national-studies/wastereport.pdf.

In addition to Medicaid and Medicare fraud, our study identified other examples of waste of mental illness funds. A recent example of such waste was in California where in 2004 voters approved a special tax specifically to help individuals diagnosed with serious mental illness. The tax has produced over $1 billion per year. However, some of the money was diverted to activities such as yoga, line dancing, therapeutic drumming, and community gardens. As the *San Francisco Examiner* noted: "Unfortunately, $1 out of every $5 may be funding mildly therapeutic programs for people who do not remotely suffer from serious illness—or may even be funding frivolous perks for government employees."[4]

Perhaps the largest amount of state-controlled mental health funds, however, is being lost through excess profits taken by for-profit managed care companies. Such companies have proliferated since the 1980s when most states assigned health care responsibilities for Medicaid recipients to them. In 1995 the *Wall Street Journal* called for-profit managed care companies "extremely profitable" with "plenty of potential for additional growth."[5] Studies have reported that the administrative costs of for-profit psychiatric hospitals are 32% higher than non-profit psychiatric hospitals and 83% higher than public psychiatric hosptials.[6] According to data from the Kaiser Family Foundation, there are currently approximately 20 for-profit managed care companies that manage psychiatric (called "behavioral health") patients, usually those receiving Medicaid, under state contracts in 39 states.

Scandals involving for-profit psychiatric care companies have been common. In Rhode Island, United Behavioral Health Systems was fined $100,000 for paying incentive bonuses to the company's chief psychiatrist contingent on the company's profits. In Iowa, Merit Behavioral Care was paid a "commission" of $880 for each adult who applied for, but was denied admission to, a psychiatric unit.

WellCare is an example of such a company. It began in 1985 with a contract for the managed care of Florida's Medicaid patients. Under what is known as Florida's 80/20 law, WellCare was required to spend 80% of the Medicaid premiums on mental health services but could keep the remaining 20% for administrative costs and profits. According to court documents, WellCare "allegedly set up a subsidiary to hide money from Florida regulators and falsified information on payments to doctors and mental health centers."[7,8] This criminal behavior came to light when a WellCare financial analyst became a whistleblower and began secretly recording conversations with WellCare executives. One company vice president was recorded claiming that WellCare was in fact keeping 50% of the Medicaid premiums. In 2007, the FBI raided WellCare's headquarters in Tampa, and fraud charges were brought against the company's top executives. In a 2013 trial, 3 were convicted and sentenced to prison. WellCare has also paid over $400 million

in restitution and fines. Despite WellCare's past criminal behavior, it has continued in business, with Medicaid contracts in 9 states, including Florida.

In addition to WellCare, we examined some of the psychiatric activities of United Health Group, Centene, and Magellan Health Services in our report. We have no information, however, that would suggest that these companies are any better or worse than other for-profit managed care companies that are managing state contracts for psychiatric care.

So what can we learn from the loss of these mental health funds through fraud, waste, and excess profits? First, the loss of these funds is one reason why public mental health services in the US are so inadequate and appear to be getting worse. As noted above, even $4 billion can buy many needed services, including 1 year of Assertive Community Treatment team care for 267,000 individuals; 1 year of Fountain House clubhouse psychiatric services and rehabilitation for 364,000 individuals; or 1 year of Assertive Outpatient Treatment (AOT) for 800,000 individuals who have exhibited a need for such services. Such AOT services would cover the entire 350,000 individuals with serious mental illness in jails and state prisons as well as the 216,000 individuals with serious mental illness who are homeless.

Second, the main reason why the public mental illness system is failing so badly is that the incentives are all wrong. For states, the main incentive is to save state money by discharging patients and closing state hospital beds. Once patients are in the community, they are eligible for federal funds under Medicaid, Medicare, Supplemental Security Income, and Social Security Disability Insurance; the major portion of the cost of their care has thus effectively been shifted from the state to the federal government. A generally unrecognized fact about the deinstitutionalization movement is that not only were patients deinstitutionalized, but state funds were deinstitutionalized as well.

Many discharged patients in the 39 states where for-profit managed care companies operate receive outpatient care from these companies. But for-profit medical companies, by their nature as investor-owned enterprises, usually place the interest of their shareholders above the interest of patients in order to maximize their profits and stock price. As one critic phrased it, "What's good for the shareholders is bad for patients."[9]

Under most state contracts, for-profit companies receive a specified amount of money each month for each psychiatric patient assigned to them. This incentivizes them to provide treatment for the easiest and least expensive patients to treat and to provide as little treatment as possible for the most difficult and thus most expensive patients to treat. In practical terms, this means patients with depression, eating disorders, and anxiety disorders may receive good treatment, but those who have paranoid schizophrenia with poor medication compliance, or recurrent mania with substance abuse, are ignored whenever possible. If such patients end up homeless or incarcerated—as is often the case—they then cost the company nothing, since the company has already been paid for their care. And if the managed care company is not providing the services it should, states have little incentive to find this out because they would then have to either find another company or provide the services themselves. This is why states often are oblivious to egregious failures by managed care companies. The states' motto is see no evil, hear no evil, and speak no evil.

Finally, the problem with the public mental health care system is not just a money problem, as is almost universally alleged. According to annual data collected by the National Association of State Mental Health Program Directors, the money available to state mental health agencies in 2012 was 36% more, in constant dollars, than was available in 1981. Thus, simply throwing more money at the problem will not necessarily solve it. The issue is not just how much money is available but rather how it is spent.

So what should be done? Our report makes several recommendations. The federal Health Care Fraud Prevention and Enforcement Action Team (HEAT Task Force) should be significantly expanded, since it has been shown to pay for itself. State mental health agencies should also exert active, assertive oversight over community programs. This should include vigorous examination of Medicaid and Medicare claims, unannounced audits of community mental health programs looking for theft and waste, and a prohibition on the use of for-profit managed care companies. Such corrective actions are unlikely to happen unless mental health advocacy groups and the public in general demand it.

Office of Inspector General

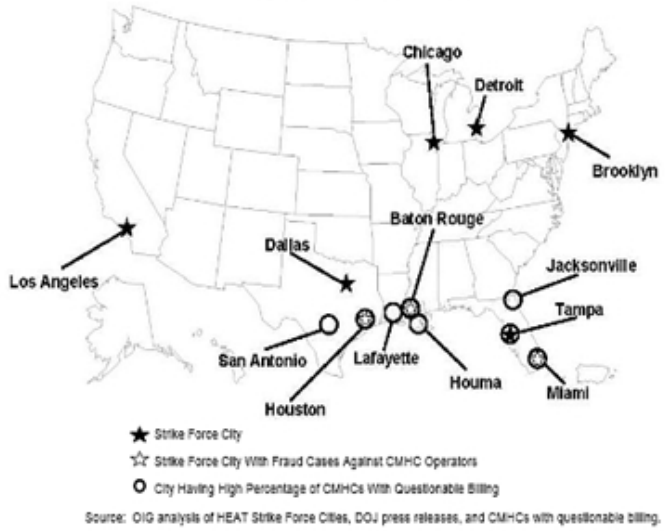
Spotlight On...
Fighting Fraud at Community Mental Health Centers

Lethal Weapon. Tootsie. Ghostbusters. Batman. You may think these are great movies—some might argue they're classics—but do they qualify as psychotherapy? Patients at Diagnostic and Behavioral Health Clinic watched these films for entertainment and participated in other recreational activities, such as playing games and going on field trips, while the clinic billed Medicare for mental health services. Therapists also charged for 1-hour sessions when patients were in-and-out the door in 15 minutes. As a result, the clinic improperly billed Medicare over $4 million. OIG's investigation of this case led to the 1999 convictions of the owner and another employee.

Over a decade later, OIG and our law enforcement partners found that employees at another facility—American Therapeutic Corporation —concocted a $205 million fraud scheme involving fictitious companies, fabricated patient files, patient recruiters, kickbacks, and elaborate cover-ups. They also illegally prescribed unnecessary psychotropic medications. Prosecutors for the case charged dozens, and the three owners/operators received a combined 120 years in prison (additional information below).

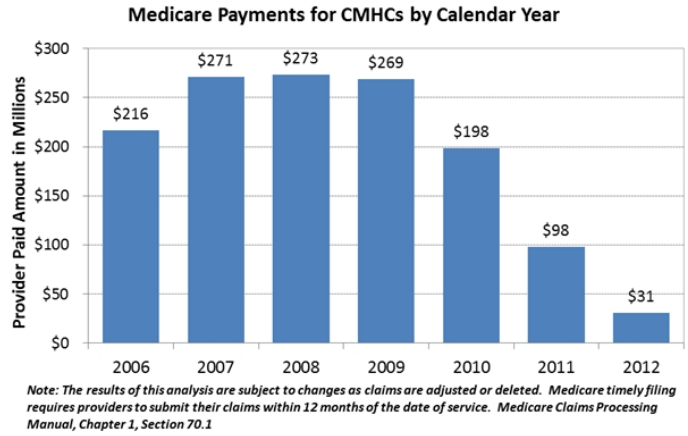
Besides committing fraud, the facilities in these two examples have something else in common: both are Community Mental Health Centers (CMHC), a type of facility that provides mental health services to individuals who reside in a defined geographic area. Fraud at CMHCs is not new, and OIG studies on CMHCs show that it isn't isolated. For example, the report Questionable Billing by Community Health Centers found approximately half of CMHCs had unusually high billing for at least one of nine questionable billing characteristics. These characteristics include billing for patients with no mental health diagnoses, billing for patients who participated in CMHCs outside their own communities, or billing for patients who were not referred by health care facilities. While there are procedures in place for detecting and deterring fraud involving CMHCs, another OIG report - Vulnerabilities in CMS's and Contractors' Activities to Detect and Deter Fraud in Community Mental Health Centers - identified a number of shortcomings in oversight of CMHCs and found the extent to which Medicare contractors engaged in anti-fraud activities varied considerably.

Figure 1: Fraud-Prone Areas



Source: OIG analysis of HEAT Strike Force Cities, DOJ press releases, and CMHCs with questionable billing.

However, through programmatic recommendations, data analytics, and geographically targeted fraud-fighting efforts, OIG and partners have made significant progress cracking down on CMHC fraud. For example, an October 2013 final rule on CMHCs cited findings from OIG's Questionable Billing report and enacted our recommendation to finalize CMHC conditions for participation in Medicare. Furthermore, by analyzing payment trends, OIG agents determined the areas where suspicious billing by CMHCs is most rampant. As shown in Figure 1, our principal target areas - known as Strike Force cities - overlap with the cities identified in OIG's report as home to approximately two-thirds of the CMHCs with questionable billing. We deployed our Strike Force teams to investigate CMHCs with excessive Medicare billing and prosecute fraud. This focused law enforcement crackdown sent fraudsters to jail and sent the message that CMHC fraud will not be tolerated.



And the data suggests this message made an impact. Total national Medicare payments to CMHCs peaked in 2008 at $273 million. Targeted enforcement activities - centered in Miami, Baton Rouge, and Houston - also began in 2008, and major enforcement actions occurred in all three cities from 2010 - 2012, some of which are described below. As seen on the graph, payments to CMHCs dramatically decreased during and after this period. In 2012, payment

levels fell to $31 million, a difference of over $240 million. This may suggest that the large-scale CMHC fraud convictions not only eliminated some of the "bad actors" but could have also deterred other "would-be" fraudsters.

Our CMHC work is a clear example of how devoting resources to fraud-fighting can pay off. But it's also important to consider the challenges that still exist. For example, while billing dramatically decreased in the targeted areas, criminals may have moved into other types of fraud. Furthermore, OIG investigations continue to identify scenarios where CMHCs bill for mental health services but instead provide, at best, recreational adult day care. This not only clogs the system for those in need of legitimate care, but could also drive up overall health care costs. As mental health services are expanding under the Affordable Care Act, the task of rooting out fraud, waste, and abuse will only become more vital. Therefore, OIG will continue to use every tool in its arsenal - inspections, audits*, data-analytics, law enforcement partnerships, and more - to fight fraud and protect Medicare mental health services.

*OIG is currently reviewing the appropriateness of Medicare payments for partial hospitalization program psychiatric services in hospital outpatient departments and community mental health centers. For more information on this upcoming audit, see page 22 of our 2013 work plan.

CMHC Fraud Cases in Strike Force Cities

American Therapeutic Corporation - American Therapeutic Corporation (ATC), an umbrella organization that managed seven CMHCs owned by Lawrence Duran, along with American Sleep Institute (ASI), another of Duran's companies, submitted more than $205 million in false and fraudulent claims to Medicare for services that were medically unnecessary, not eligible for Medicare reimbursement, or were never provided. Duran and his co-conspirators created a massive criminal operation in which they paid large kickbacks in exchange for Medicare beneficiaries who claimed to receive ATC and ASI services. To fund these kickbacks, the defendants created fictitious identities, set up various corporations, and utilized multiple individuals to launder money. Additionally, evidence showed that ATC medical directors signed patient files without reading them; did not see patients; and changed, removed, or placed patients on psychotropic medications without medical evaluation, all in an effort to conceal the fact that many of the patients did not qualify for reimbursement. Twenty four defendants have been sentenced to a combined total of more than 200 years in prison for crimes related to this scheme. Duran was sentenced to 50 years and ordered to pay $87 million in restitution.

Biscayne Milieu - Claiming to operate as an intensive treatment program for individuals with severe mental illness, this Miami-based CMHC devised a $55 million Medicare scheme involving patient recruiters, kickbacks, billing for services not provided, and billing for ineligible patients. For example, Biscayne Milieu billed Medicare for patients who were not mentally ill, but rather soliciting false diagnoses so they could be exempt from portions of their U.S. citizenship application. The fraud scheme also involved elaborate cover-up efforts, including fake case managers and phony medical records. Biscayne Milieu, its owners, and more than 25 other defendants either pled guilty or were convicted at trial. The three owners were jailed for a combined 77 years.

Spectrum Care P.A. - Based in Houston, TX, this CMHC is charged with submitting $97 million in claims to Medicare for services that were unnecessary or not provided. Spectrum allegedly paid kickbacks in the form of cash, gifts cards, and even cigarettes in exchange for delivering Medicare patients who were willing to sign files documenting services they never received and/or were not qualified to receive. Meanwhile, the patients allegedly enjoyed playing bingo and watching movies. Eight were indicted in this case, which is scheduled to go to trial in 2014.

Health Care Solutions Network - The clinical director at the Florida location of this CMHC submitted claims to Medicare using her personal Medicare provider number for individual therapy she claimed to provide, while knowing that the CMHC was simultaneously billing for services for the same patients. In addition, the CMHC paid kickbacks to a local assisted living facility for referring patients, many of whom weren't even eligible for the services. Employees forged records to support the $56 million in fraudulent claims submitted to Medicare and Florida Medicaid. In total, 12 defendants were sentenced to a combined 70 years in prison and ordered to pay $186 million in restitution.

https://oig.hhs.gov/newsroom/spotlight/2013/cmhc.asp

Universal Health Services (UHS) Skewered (Again) by New Report

By John M. Grohol, Psy.D.
~ 7 min read

Universal Health Services (UHS), America's largest psychiatric hospital provider, was skewered last week in an investigative journalism report by Rosalind Adams and published by BuzzFeed News. This wasn't some hastily thrown together hit piece, but rather an in-depth look — talking with 175 current and former staffers at UHS hospitals and 120 additional interviews with patients, experts, and investigators into the claims brought against the company.

The report paints a picture of certain hospitals within the UHS system that seem to have significant problems and deficits. Worse yet, the company apparently has its head in the sand, denying any problems exist in its facilities, and spinning data that appears to show the company emphasizes money over patient care.

This report should act as a wake-up call for the entire inpatient psychiatric hospital industry.

This is a story we've heard before in the healthcare industry — one where certain hospitals prioritize profit over patient care. This new report from BuzzFeed News is the latest in-depth investigative piece of journalism that has delved into the problems at Universal Health Services (UHS). After the report was released, the price of the company's publicly traded stock dropped nearly 12 percent. But this isn't the first time UHS has been the target of investigative journalism and state investigations — see the end of this article for links to similar reports in recent years from across the nation.

UHS, which is based in King of Prussia, Pennsylvania, runs over 240 psychiatric, in-patient hospitals across the United States. These hospitals are, oddly enough, not branded with the UHS name (which is what you would typically find at a hospital chain treating medical diseases). Instead, they hide behind the folksy, local names of the individual hospitals themselves — names such as Millwood, Roxbury, Palmetto, Suncoast, and Highlands.[1]

UHS is a huge, for-profit corporation with nearly $9.7 billion in revenues resulting in over $600 million in annual profits. Not bad for people who are supposedly in the business of helping people with the most serious mental health issues get better.

UHS & Medicare Fraud

UHS seems to have some big problems looming on its horizon:

UHS is under federal investigation into whether the company committed Medicare fraud. The probe involves more than 1 in 10 UHS psychiatric hospitals. Three are being investigated criminally — including one facing allegations that it routinely misused Florida's involuntary commitment law to lock in patients who did not need hospitalization.

In March last year, the federal criminal investigation expanded to include UHS as a corporate entity, the company told investors.

That seems like a pretty significant issue, when 1 in 10 of your hospitals appears to be under investigation for Medicare fraud. And when an investigation expands to include the corporate parent of the hospitals it is investigating, that strongly suggests the investigation is turning up problematic practices that are potentially systematic (and not just affecting one or two outlier hospitals).

The fact that this is not the first time UHS has been investigated for issues in its hospitals is also suggestive, in my opinion, of a corporate culture that emphasizes profit over positive patient outcomes.

Suicidality Determined by Person with Conflict of Interest

One of the most significant problems for psychiatric hospitals is that the person making the determination as to whether or not to admit you is incentivized to err on the side of admitting you. The more people an intake professional admits, the more the hospital keeps its census up —

and its profits rising. It's a clear conflict of interest for these hospitals, yet they rarely even acknowledge this is a problem (that could be easily corrected).

Worse yet is that these intake coordinators or directors are usually not doctors, physicians, or psychologists. They may be a master's-level individual who has only minimal training or understanding of severe mental illness and suicidality. Why do these hospitals employ lower-trained professionals for such a sensitive position? (Hint: It's not because they are interested in providing the best, most-thorough patient assessment possible.)

In short, a poorly-qualified professional with a clear conflict of interest can readily relieve you of your protected civil rights and freedom in America, without you ever seeing a physician or psychologist. If you think I'm kidding, walk into any psychiatric hospital (especially in certain states, such as Texas) to see for yourself.[2]

Treatment Can be Lacking

One of the open secrets of many psychiatric hospitals is that during the day, treatment programming may be, ah… lacking. Patients rarely see an attending psychiatrist or psychologist, or if they do, it is only for a few minutes at a time. Instead, patients in many psychiatric hospitals spend their time in "activity therapy" groups, run by mental health "techs" who may have nothing more than a high school diploma.

"I've never been trained to run a group," said a mental health technician at Havenwyck Hospital, "so those poor ladies leave my groups more confused than when they come in."

Kevin Ball, a former tech, said he screened My So-Called Life during group sessions. "My degree was in parks and recreation," he said, so "I was just as clueless as the kids."

Mostly, patients "just sat around," one former patient at Millwood recalled. You "spent most of your day in your room."

I can vouch first-hand that this isn't just a problem at UHS, but a problem across many psychiatric hospitals in the industry. There simply aren't enough structured, therapeutic activities — led by actual mental health professionals who are well-trained — scheduled for most of the day for most patients. (While targeted, specific types of activity therapy might be beneficial for certain groups of patients, there is little research to suggest it is an effective therapeutic modality for nearly all inpatients at a psychiatric hospital.)

Money Makes the World Go Around

For-profit hospitals, as a group, have a profit-driven incentive to keep their uninsured patient populations low. And then to discharge uninsured patients as quickly as possible, compared to their paying patients. UHS is apparently no different:

At the company's Florida hospitals between 2013 and 2015, 55% of self-paying patients were discharged within three days, compared with just 30% of patients with commercial insurance.

(Other for-profit psychiatric hospitals had a similar disparity, but not-for-profits showed almost no difference.) In California, a similar pattern was found.

Asked about this discrepancy, a UHS representative said a patient's length of stay is based on his or her individual treatment plan. The representative denied that a patient's insurance is a factor and said a discharge is "a clinical decision; it's not a business decision."

Research shows those without insurance — the homeless and poor — tend to have worse prognosis and often present with more difficult, chronic disorders to treat. If these were purely clinical decisions, it would stand to reason that such patients would likely be admitted for similar or slightly longer periods of time as their paying counterparts. Yet that's not what the data show. (Worse yet, a 2011 meta-analysis shows that, for clinical depression at least, psychological interventions administered in an inpatient setting have a minimal positive impact compared to a control group [Cuijpers et al., 2011].)

This audit of one of UHS's facilities shows professionals copying and pasting parts of patient's charts (time-saving laziness?), lack of training by staff, lack of oversight by appropriately trained professionals, and more. All of which paints a picture of a hospital appearing to not really giving much more than lip service to offering the highest level of patient care.

Psychiatric Hospitals: A Bad Reputation?

It's no wonder that so many psychiatric inpatient facilities seem to have bad reputations. While one could argue this investigative report cherry-picked its data, highlighting some of the most egregious, anecdotal examples of problems at specific hospitals, there are data in the report that are hard to explain away so easily (like the above example of discharge rates among the uninsured).

There is a simple hierarchy at most psychiatric hospitals that starts with the owner or corporate finance people who demand certain ratios, metrics, and weekly goals be met (in terms of admissions, length of stay days, etc.). This bubbles down to the directors, head clinical staff (psychiatrists and psychologists), and intake personnel, because you're not going to ignore the marching orders from the folks who sign your paycheck. Staffing levels are kept as low as allowed by regulations, which vary from state to state.[3]

Sadly, the staff who end up spending the most time with patients aren't highly-trained, well-qualified psychiatrists, psychologists, and clinical social workers. They are the lowly paid "mental health techs," folks who may have had little formal training and hold nothing more than a bachelor's degree or high school diploma. These are the well-meaning, unsung heroes of inpatient psychiatric hospitals — staff who make running such hospitals even possible. These are the people most patients remember most, because they are the ones they spend the most time with. This report should act as a wake-up call to all psychiatric hospitals in the U.S. to get their house in order. As patients become more educated, they're learning that you'd better be offering the highest level of clinical assessment and care possible (with actual trained mental health professionals, not just mental health techs). Or the next investigation may be the one at your hospital.

For further information

Read the full BuzzFeed News investigation (long, but worth your time): **Intake: Locked on the Psych Ward**

Read UHS's response: Myth vs Fact

Dallas Morning News 2016's story: Danger in the psych ward

The Boston Globe's 2013 story: National reviews of centers rare in mental health

Chicago Tribune's 2015 story: Lawmakers urge faster action to protect youths at residential treatment sites