MEMORANDUM

TO : William J. Thompson, Interim Superintendent AMHI

FROM : The Primary Care Study Group

SUBJECT: Primary Medical Care at AMHI

DATE : 09-12-89

A study group consisting of representatives from the hospitals in the consortium presently advising the Augusta Mental Health Institute (AMHI) was convened to address the following question:

How well is AMHI organized to meet its primary health care needs?

Procedure:

A preliminary meeting was held at AMHI and the charge of the committee as well as the general structure and function of the Augusta Mental Health Institute were reviewed. Arrangements were made to tour the facility and review several medical records. Basic demographic data including admissions, discharges, length of stay, patient characteristics and medical needs were also reviewed. After this, one day was spent interviewing individuals employed at AMHI. This included two physician extenders (P.A.'s), two primary care physicians, the psychiatrist working on the admission unit, the unit directors, Vera Gillis who works in nursing, and two representative from the patient advocate office. This report has been formulated following these interviews.

This report must, by necessity, be limited in its scope and is meant only to address the primary medical care needs at AHMI. To better interpret our recommendations, it is important to understand certain recent trends at AMHI. Until very recently, the number of admissions has been climbing. This has resulted in increased numbers of medical patients and the workload for all at the institute has subsequently increased. It is also likely that the number of patients admitted and evaluated with medical problems has increased. This is in part due to an increasing number of patients with geriatric problems. In addition, the institution recently lost JCAH accreditation and has been publicly scrutinized. Several patient deaths have been extensively investigated, morale has been low, and staffing has been barely adequate.

There have been several responses to the aforementioned difficulties and our understanding is that improvements have already been implemented. The difficulties arising from the high census, high admissions and low staffing have begun to be addressed. The Legislature has helped by granting new positions to the institution. The Bureau of Mental Health and Retardation has allocated special funding to be used to help divert patients from AMHI to other psychiatric facilities within the State. This has eased some of the pressure since the admission rate to AMHI has dropped from highs of greater than 120 patients a month to an average of about 60 patients per month at this time. Clearly, these are short-term answers and long-term solutions are being planned. Our recommendations are based on the assumption that the patient population and admission rates will stabilize with an average number of admissions approximating 60 per month. If these conditions do not hold true, then increases in medical staff will be needed in order to maximize

and ensure good medical care.

CONCLUSIONS AND RECOMMENDATIONS:

1) There is need for more aggressive leadership within the institution.

There should be a clinical director to oversee the overall health needs of the patient population and there should be a medical director to oversee the medical care. The clinical director should be a dynamic individual, able to integrate both psychiatric and medical care, and ideally would be board certified in psychiatry and internal medicine or family practice. This individual should have administrative capabilities and be a "people person" who can look for solutions to problems. The medical director also needs good administrative abilities and should report to the clinical director. It is important that both these individuals be interested in continuing education. If the clinical director does not have a strong primary care background, then the medical director's position becomes even more important. Clearly, the medical director and clinical director must be compatible and be able to communicate effectively.

2) The nursing administration should be reorganized and a nursing administrator position should be created. This individual should work closely with the clinical and medical director to establish standards of care.

Primary health care is vitally dependent on good and thorough nursing care. Therefore, there needs to be lines of communication between nursing and physicians. This could be better achieved by developing a nursing administration with direct lines of responsibility for the nursing department.

3) The number of primary care physicians should be increased.

Increasing the number of medical doctors would help to provide continuity of care. We feel that five primary care physicians will be needed to care for the medical needs of the patients admitted to AMHI. Medical evaluations should be available 24 hours a day. This will require the physicians to develop an on-call schedule for off hours and weekends. The off-hours coverage should either be on site or within 1/2 hour of the hospital so that quick response time is possible. In the future, if the workload or the acuity of the medical problems increases, it will be necessary to have 24 hour a day onsite coverage. The night time P.A.'s should not be on-call without easily available medical backup. Psychiatric on-call from home should also be available to the covering P.A.'s.

4) The Medical Service needs to be reorganized.

Daily rounds with an attempt to integrate medical and psychiatric care should be encouraged. These rounds would ideally occur in the separate units of the facility. They should involve individuals from nursing, the medical departments, including both physicians and physician extenders as well as psychiatrists. This could provide the framework for meaningful discussions between all caregivers responsible for each patient. To provide medical care in each of

the units would require providing rooms for examinations that are well equipped for basic medical care. The clinic would still function and be available for routine follow-up examinations and any other specialized problems. As part of this reorganization, more efficient charting systems, medication lists and problems lists should be developed for the medical charts.

5) Within the framework of a reorganized medical service, continuity of care and primary preventive medical care should be encouraged.

Patients presently have a yearly physical, but little is provided beyond this for preventive care. Patients from AMHI require close observation and follow-up. This is especially true on the "chronic ward". To provide appropriate follow-up, medical records will need to keep information centralized and easily available to the physicians and nurses so that health maintenance screens can be done.

6) Emergency medical care in off hours needs to be strengthened.

This would ideally be best accomplished by establishing better lines of communication between the Augusta Mental Health Institute and the Kennebec Valley Medical Center. The primary care physicians at AMHI should be qualified to be credentialed at Kennebec Valley Medical Center. The physicians could have admitting privileges so that they could follow their patients after admission for acute problems. For the same reasons, arrangements can be made to have lab work and x-rays available during off hours on an as needed basis. This could possibly be arranged by contract with Kennebec Valley Medical Center.

7) A physician directed quality assurance program needs to be developed.

Quality assurance is the key to providing quality medical care and is a requirement by JCAH and most other reviewers. Physicians need to be reviewing physician charts and actions within the hospital. Presently, physicians are only minimally involved and allow the nurses to do most of the quality assurance review. This is not acceptable to JCAH and should not be acceptable to the medical staff. As part of quality review, doctors privileges should be reviewed by a quality assurance and credentials committee and privileges should be granted using these reviews every two years.

8) Until a more structured quality assurance program is in place and functioning properly, outside peer review and quality assurance should continue.

9) There needs to be better integration of the psychiatric and medical care and this should be reflected within the charts.

This could be accomplished by establishing better communication between these disciplines and utilizing combined team conferences. Presently, the psychiatrist orders psychotropic medicines, but complications and follow-up is provided by the primary care physicians. Patient care is thus fragmented and continuity is lacking. Medical records should be changed so that pertinent information can be transmitted and retrieved easily and caregivers

can readily identify problems. To provide more continuity of care, there needs to be a sign-out system for patients to the on-call physician that is formalized and mandatory so that problems in the various units can be addressed and understood prior to physicians leaving for the day. Likewise, a system of formalized intake rounds in the morning should continue.

10) There needs to be improved relationships with the community hospitals.

Guidelines for admissions to AMHI must be developed and implemented and transmitted to the referring community hospitals. There must be sharing of information between institutions. Medical records from other institutions need to be readily available and present on transfer of patients. One method of doing this would be to use a FAX machine. Internal records also need to be easily available for the physicians at AMHI and computerization of the system would improve the availability of past medical records and problem lists. Statistically, 77% of the admissions to AMHI occur in the off hours. Most of these occur early in the morning. The reasons for this should be thoroughly investigated and attempts made to increase the number of patients admitted in day time hours. It will, though, be necessary for patients to be admitted throughout all shifts and the hospital should endeavor to provide quality medical care on a continuous basis.

11) Continued medical education and staff development is clearly needed.

This could involve support and sharing of information with other state psychiatric institutions. Continuing education is needed throughout the system and should involve mental health workers, nurses, ancillary support staff, primary care physicians, and psychiatrists (ie: all members of the health care team). State psychiatric patients often present with very difficult and demanding medical problems and, it is, therefore, mandatory that well trained, competent individuals be available. Inservice education, especially in the recognition of acute medical problems should be stressed.

12) If the number of admissions increase, then the psychiatrists should be available during off hours to help screen patients and determine the appropriateness of admission to AMHI.

At the current admission level, "one or two patients at night", it does not seem necessary to have a psychiatrist present on the grounds, but if the admission rate doubles, as it has in the past, and admissions increase to between four and ten patients per night, then psychiatric, in-house, coverage should be appropriate. Presently, only physician extenders are in the institute at night. It is essential that both psychiatric and medical back-up be available.

13) A medical environment dedicated to quality health care delivery must be established and maintained.

To recruit and retain new doctors, institutional support for research would be very important. To this end, it would be

advantageous to network with the residency programs in Portland for psychiatry and in Augusta with the Maine Dartmouth Family Practice Residency for primary care. In this manner, primary care and psychiatric care could develop in a teaching atmosphere and provide for increased opportunities to recruit and retain interested and active medical staff.

14) New medical equipment should be obtained.

It is apparent that much of the medical equipment available is outdated and when medical staff is increased new equipment will be necessary. This could be best accomplished by creating a primary care medical team to evaluate present equipment availability and necessary and desired needs.

15) An ethics committee should be established.

Difficult socio-medical issues such as "do not resuscitate" orders need to be addressed and continuously monitored. Restraining of patients and the need for consent for procedures are other issues an ethics committee could address.

16) Better access to specialty physicians is needed.

These could include, but not be limited to, physicians trained in gerontology, geriatric psychiatric care, pediatrics and child psychiatry and other primary specialties as needed. These relationships could be contractual with physicians in the community.

We hope that the recommendations in this report will provide a broad and useful set of guidelines that will help in the development of quality primary medical care at the Augusta Mental Health Institute. Due to the time constraints necessary to complete this project, these recommendations are not meant to be exhaustive. More study of the problem would be useful. We would like to stress that the medical care needs at AMHI are complicated and solutions will not come quickly. It would be helpful to have a "cooling off period" in which changes can be implemented and AMHI is not under such stringent public scrutiny. We feel the problems can be solved, but will need the staff at AMHI to be given the time and resources to implement these suggestions. We realize that many changes have already been made at AMHI. When the facility has a new superintendent, we expect more changes will be likely.

We would like to take this opportunity to thank all those at AMHI that helped us and made our visit fruitful. We found all individuals to be open, cooperative and pleasant. We all learned a great deal about AMHI. We hope you find our comments useful.

Respectfully submitted,

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