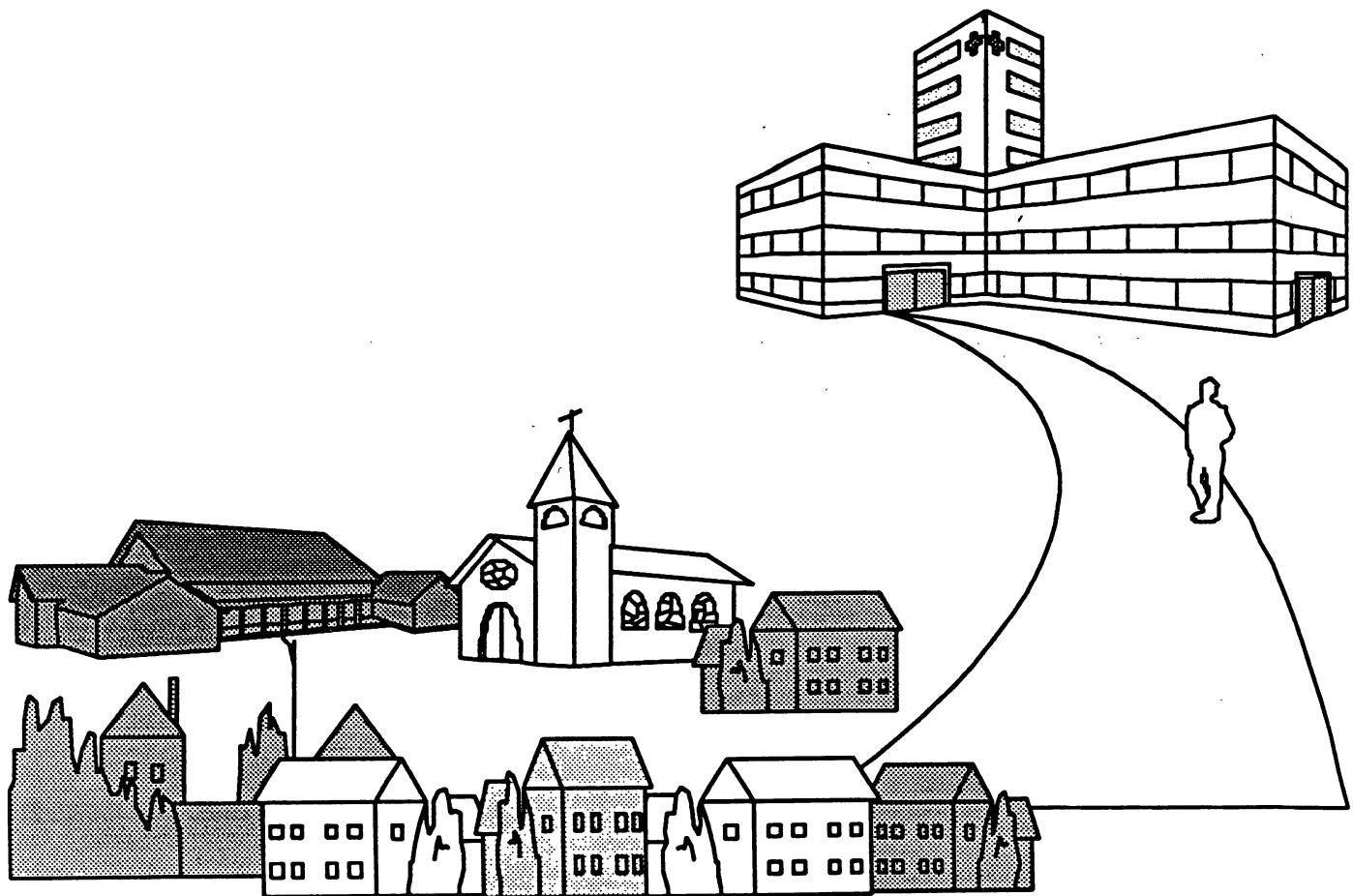


Discharge Planning Practices of General Hospitals: Did Incentive Payments Improve Performance?



New York State Commission on Quality of Care
for the Mentally Disabled

April 1993

Discharge Planning Practices of General Hospitals: Did Incentive Payments Improve Performance?

Clarence J. Sundram
CHAIRMAN

Elizabeth W. Stack
William P. Benjamin
COMMISSIONERS

April 1993



**NYS COMMISSION
ON QUALITY OF CARE
FOR THE MENTALLY DISABLED**

Acknowledgements

The Commission would like to acknowledge the assistance of the administrators and staff of the departments of psychiatry at the ten hospitals selected for inclusion in the sample of the study. These individuals graciously accommodated Commission staff during our on-site data collection activities, and many were also enormously helpful in explaining their units' operation. The Commission also wants to thank the staff of the many outpatient clinics and programs who took time from their busy schedules to comply with specific requests for information and to share a general overview of their services and relationships with inpatient psychiatric units.

The Commission is also appreciative of the significant assistance provided by the staff of the Office of Mental Health's Bureau of Financial Planning who provided data on hospital and outpatient utilization for the period studied and generally assisted the Commission in examining the impact of the new rate methodologies on mental health inpatient and outpatient services.

The Commission also owes a special debt to the 100 individuals in the sample and many of their families. Many of these individuals and their family members made special efforts to share their experiences upon discharge and their opinions and concerns with Commission staff. Through the perspectives and experiences of these individuals and their families, the Commission was able to gain a personal and powerful perspective of what it is like to be hospitalized and then discharged to pick up one's life again in the community.

Finally, as the Commission was preparing this report, many individuals and organizations, including the Greater New York Hospital Association, the NYS Mental Health Services Council, the Association of Community Mental Health Centers, the New York Association of Psychiatric Rehabilitation Services, and the Mental Health Action Network provided valuable comments and insights, for which we are very grateful.

Table of Contents

Acknowledgments	ii
List of Figures	v
Research Staff	vii
Executive Summary	ix
Chapter I: Introduction	1
Chapter II: The Individuals, Their Hospital Stays, and Their Discharges	7
Chapter III: Life in the Community	25
Chapter IV: The Rehospitalized Individual	39
Chapter V: Impact of the New Rate Reimbursement Methodologies	49
Chapter VI: Conclusions and Recommendations	63
Appendix A: Responses to the Draft Report by	

**New York State Office of Mental Health
Greater New York Hospital Association**

List of Figures

Figure 1: Actual and Projected Admissions to State Psychiatric Centers (1988 - 1993)	2
Figure 2: Key Features of the New Inpatient Medicaid Rate Methodology	3
Figure 3: Key Features of the New Outpatient Medicaid Rate Methodology	4
Figure 4: Sample Hospitals	5
Figure 5: Sample Outpatient Providers	6
Figure 6: Sample Profile	8
Figure 7: Admission/Discharge Diagnoses	9
Figure 8: Length of Stay	10
Figure 9: Challenges to Treatment	11
Figure 10: Improvements in Discharge Planning	14
Figure 11: Individual Involvement	15
Figure 12: Family Involvement	16
Figure 13: Residential and Aftercare Service Referrals	19
Figure 14: Outpatient Needs Identified	21
Figure 15: Six-Month Postdischarge Outcomes	26
Figure 16: Individuals in Contact With Services	27
Figure 17: Total Number of Aftercare Programs and Contacts in the Six-Month Postdischarge Period	28
Figure 18: Aftercare Referrals Versus Attendance in Six-Month Postdischarge Period	29
Figure 19: Drug/Alcohol Abuse Service Provision in Six-Month Postdischarge Period	30
Figure 20: Family Relationships Predictive of Better Outcomes	32
Figure 21: Availability of On-Call Crisis, Weekend and Evening Services	33
Figure 22: Positive Life Events Postdischarge	36
Figure 23: What the Individuals Said	38
Figure 24: Cost of the Rehospitalizations of the 38 Individuals	39
Figure 25: Month of First Readmission for Rehospitalized Individuals	41
Figure 26: Rehospitalized Versus Nonrehospitalized Individuals	42
Figure 27: New Rate Methodologies Were an Rx for	49
Figure 28: Implementation Problems	50
Figure 29: Total Rate Premiums Earned by Phase 1 Hospitals (January 1991, July 1991, January 1992)	52
Figure 30: 1992 Rate Premiums Earned by Outpatient Provider Agencies	52
Figure 31: Improvements in Discharge Planning	53
Figure 32: Lengths of Psychiatric Inpatient Stays	54
Figure 33: Census Change in NYS Psychiatric Centers (1984 - 1992)	55
Figure 34: Psychiatric Discharges from General Hospitals (1989 - 1991)	56
Figure 35: Number and Percent of Persistently Mentally Ill Discharges from General Hospitals (1989 - 1991)	57
Figure 36: Percent of Discharged Psychiatric Patients Making Outpatient Contact Within 10 Days	58
Figure 37: Rehospitalizations Within 30 Days as a Percentage of Total Discharges	59
Figure 38: Other Reforms	61

Research Staff

Project Director

Nancy K. Ray, Ed.D.

Research Coordinators

**Natalie J. Russo, M.A., R.N.
Cheryl A. Ouimet, C.S.W.**

Research Staff

James Barnhardt	Thomas R. Harmon
Mindy T. Becker	Stephen Hirschhorn, C.S.W.
Barbara A. Beebe, C.S.W.	Randal L. Holloway
Peter Behm	Gary Masline, J.D., M.S.W.
Patricia Bush, R.N.	Mark E. Rappaport, M.S., R.N.
John E. Donohue	Victoria L. Rinere, M.S.Ed.
Craig A. Freis	Harriet Rubenstein, C.S.W.
Jacqueline García, M.S.W.	Kathy A. Serino, R.N.
	Sylvia Wheeless, A.C.S.W.

Production Staff

**Gail P. Fetsko
Joyce A. Salazar
Kathleen A. Runkle**

Executive Summary

The functioning of the mental health system is a matter of keen public interest. Not only does this system attempt to respond to some of the nation's most difficult health problems — in providing treatment for mental health disorders which are not fully understood — but it also must cope with poverty, homelessness, alcohol and substance abuse, and the lack of social supports, which are often experienced by persons with mental illness. The mental health system's response to these formidable challenges is the regular subject of critical evaluation by constituency groups, legislative committees, advocacy organizations, and the Office of Mental Health.

Among the many aspects of the mental health system that receive regular scrutiny, there are two recurrent concerns. The first is the ready availability of inpatient hospitalization to persons whose mental illness either endangers their own welfare or creates a danger to others. The second is careful discharge planning for persons who have been hospitalized to assure their access to continued mental health treatment, appropriate housing, and necessary rehabilitation services and supports to live successfully in the community.

Background to the Study

Five years ago, in response to these concerns and at the request of the State Legislature, the

Commission undertook a study of admission and discharge practices of psychiatric hospitals.¹ That study found a significant degree of overcrowding in acute psychiatric units and psychiatric emergency rooms of general hospitals, and an absence of necessary services in the community that could both prevent the unnecessary reliance on expensive inpatient hospitalization and provide adequate supports to patients upon discharge. As a result, a significant percentage of inpatient psychiatric beds were "blocked," or essentially unavailable to patients who needed admission, because they were being inappropriately used by patients no longer requiring hospitalization, but for whom needed community services were unavailable.

In 1989, the Legislature commissioned a second study to examine the nature, costs, and availability of outpatient mental health services in the community.² This study concluded that, although the state's annual expenditure for outpatient mental health services totaled approximately \$745 million in 1986, the system was dominated by clinical services offered at outpatient clinics, and it provided little in the way of the rehabilitative, vocational, and social supports that patients and families said they wanted and needed to live in the community. By 1992, these costs had risen to \$1.07 billion.

The 1989 study also concluded that there was little management of the system to assure

¹ See, *Admission and Discharge Practices of Psychiatric Hospitals, A report to the New York State Legislature Pursuant to Chapter 50 of the Laws of 1987, NYS Commission on Quality of Care for the Mentally Disabled*, April 1988.

² See, *Outpatient Mental Health Services, NYS Commission on Quality of Care for the Mentally Disabled*, July 1989.

that the needs of individuals with persistent mental illness were being prioritized or that outpatient services were available and accessible to them. Finally, the study found there was an absence of fiscal accountability for the programs, leading to great differences in the costs of delivering the same service among programs.

New Initiatives

These studies by the Commission confirmed similar conclusions being reached by the Office of Mental Health. In response, the Office of Mental Health took a number of actions to eliminate overcrowding in inpatient facilities, to improve access to services for persistently mentally ill persons, and to restructure the outpatient mental health system and initiate a new emphasis on psychiatric rehabilitation in community mental health services.

One of the initiatives begun by the Office of Mental Health was to use reimbursement rates for both inpatient and outpatient mental health services to create fiscal incentives to change clinical behavior and provider practices in order to:

- increase access of persistently mentally ill patients³ to inpatient psychiatric care when needed;
- shorten excessive lengths of stay in acute psychiatric hospitals;
- assure that discharged patients were linked with an outpatient mental health program and continued to receive necessary outpatient services; and
- reduce the rate of rehospitalization of discharged patients.

Commission Study

In the fall of 1989, the implementation of the inpatient rate methodology was approved by the State Hospital Review and Planning Council on a pilot basis for 27 of the 100 hospitals with psychiatric units in New York. A second batch of 25 hospitals was allowed to participate in the methodology in 1991. However, at this time, both the Office of Mental Health and the State Council requested that the Commission on Quality of Care conduct an evaluation to determine whether the fiscal incentives created by the new inpatient rate methodology, as well as the new outpatient methodology, which had been instituted statewide in 1989, had any adverse impact upon patients.

In responding to this request, the Commission designed a study that closely examined the practices of psychiatric units in ten hospitals in five counties across the state and the experiences of 100 randomly selected patients. The ten hospitals selected were in five closely matched pairs, in which one hospital participated in the rate methodology and the other did not. The Commission interviewed inpatient and outpatient providers of service to these 100 patients in attempting to determine the nature of the services they had received as inpatients and outpatients and how they had fared in the community during a six-month period following their discharge.

Findings

The findings of the Commission's review are sobering. On the positive side, there is little evidence that the new rate methodologies have contributed to any adverse impact upon patients. Overcrowding in psychiatric

³ The reimbursement formula classified patients as "persistently" mentally ill based on the duration of their prior mental health history or the recency of their past hospitalizations.

emergency rooms and acute psychiatric hospitals has also been virtually eliminated as a result of initiatives implemented by the Office of Mental Health.

Some aspects of discharge planning have improved greatly since they were last studied by the Commission in 1988.⁴

- More patients had a clearly identified discharge plan in the hospital record (86% vs. 54%) (Report, p. 15).
- More patients were given a referral to an outpatient program with a specific appointment upon discharge (80% vs. 40%) (Report, p. 15).
- Housing arrangements were made for all patients upon discharge (100% vs. 96%) (Report, p. 15).

At the same time, many other unsatisfactory conditions did not change. Inpatient stays continue to be used largely for crisis stabilization, rather than conducting more comprehensive assessments of patients' strengths and needs for assistance upon discharge (Report, pp. 19-23). Patients and families are usually not meaningfully involved in the preparation of discharge plans or provided with much voice or choice in services to be provided (Report, pp. 15-18).

The types of service that patients express a desire for — vocational, rehabilitative and social programs — generally don't exist in sufficient quantity.

- Patients are typically referred to clinics that on average provide them one to one and a half hours of service per month (Report, pp. 27-29).
- Only 10% of the patients with diagnosed alcohol and substance abuse problems received any services targeted to these problems (Report, pp. 29-30).

- Only about one-third of the patients received any rehabilitative or vocational services (Report, pp. 30-31).

Once discharged, patients almost never received any follow-up services to assure the implementation of discharge plans (Report, pp. 23-24). Instead, patients are typically left on their own to negotiate a complex web of human service programs operated by multiple state, local, and private agencies.

- Only 6% of the discharged patients studied received case management services to assist them in this process (Report, p. 29).
- Approximately one out of four patients received no outpatient services whatsoever in the six-month period (Report, pp. 27-28).

Not surprisingly, many of the discharged patients did not fare well in the community in the six months following their discharge.

- Thirty-eight (38) percent were rehospitalized, 13% on two or more occasions. The average additional inpatient costs per rehospitalized individual was \$36,750 (Report, pp. 39-41).
- Thirty-four (34) percent had severe financial problems, and 24% had a serious physical illness (Report, p. 36).
- Nine (9) percent were homeless for some period of time, 7% had problems with the law, 5% had gone without sufficient food or clothing, and 2% died (Report, p. 36).

Conclusions

The Commission concluded that the incentive payments contained in the rate methodologies, which resulted in the expenditure of approximately \$20 million in FY 1992, failed to

⁴ See, *Discharge Practices of Inpatient Psychiatric Facilities*, NYS Commission on Quality of Care, August 1988.

influence changes in provider practices as intended. While the Commission found several positive changes as described above, most were attributable to other factors and influences, including policy changes initiated by the Office of Mental Health, clinical leadership at hospitals, and court decisions (Report, pp. 60-62). In most of the areas of positive change, hospitals not participating in the rate methodologies performed better than those eligible for the incentive payments (Report, pp. 53-59).

During the time that these methodologies have been in effect, key measures of desirable performance have not improved.

- Patients with persistent mental illness are not gaining greater access to inpatient hospitalization at participating hospitals (Report, pp. 56-57).
- Rehospitalization rates have actually increased by about 20% (Report, pp. 59-60).
- The linkage rate of discharged patients to outpatient services remains unchanged despite specific incentive payments (Report, pp. 58-59).
- The number of patients who remained in contact with the outpatient service system six months after discharge was also unchanged (Report, pp. 58-59).

As described in this report, the methodologies failed because they were too complex, they paid too little money to individual providers, and they paid the money in a confusing and delayed fashion that masked their effects. Additionally, the methodologies were generally overshadowed by more dramatic changes in hospital reimbursement rates (Report, pp. 60-62).

Recommendations

The Commission agrees with the policy goals that the Office of Mental Health sought to achieve. We believe, however, that several fun-

damental changes need to occur to improve outcomes for patients as intended.

First, this study provides a strong imperative to involve patients and families meaningfully in treatment planning, in identifying the types of services needed upon discharge, and in providing supports to assist patients in their reintegration into the community.

Second, listening to the voices of patients and families will inevitably require greater emphasis on making available vocational, social, and psychiatric rehabilitation services rather than continuing the almost exclusive reliance on low levels of clinical services. It will also require more emphasis on consumer-directed services and family support programs. These services may provide the strongest hope of helping sustain individuals with serious mental illness (discharged patients) in the community (Report, pp. 65-66). However, since there is unlikely to be a significant amount of new money available to create such services, the mental health system must confront the harsh reality of reallocating its existing funding (Report, pp. 67-68).

Third, notwithstanding the findings of this study, the Commission believes that using fiscal incentives in the mental health system to change provider behavior and practices in ways that are desired should continue to be explored. However, it is clear that for such incentives to work, they must: (1) be clear; (2) be visible to the person whose behavior is to be changed; (3) be substantial enough to induce the desired change; and (4) produce readily measurable beneficial results for patients that are closely monitored through quality assurance oversight.

For example, fiscal incentives to reduce the high rate of rehospitalizations, to assure patient and family participation in the discharge planning process, and to provide follow-up services promoting the implementation of a discharge plan may very well prove to be cost-effective measures that also improve quality of care (Report, p. 69).

This report represents the unanimous opinions of the members of the Commission. A draft of this report was sent to several agencies including the New York State Office of Mental Health, the Greater New York Hospital Association, as well as the directors of psychiatry of

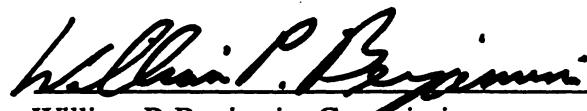
the ten general hospitals included in the study sample. Responses to a draft of this report from the New York State Office of Mental Health and the Greater New York Hospital Association are attached as Appendix A.



Clarence J. Sundram, Chairman



Elizabeth W. Stack, Commissioner



William P. Benjamin, Commissioner

Chapter I

Introduction

In 1988, the Commission on Quality of Care (CQC) published two reports that examined discharge practices in selected state psychiatric centers and acute psychiatric units of general hospitals in New York State (*Admission and Discharge Practices of Psychiatric Hospitals*, April 1988; *Discharge Practices of Inpatient Psychiatric Facilities*, August 1988). This report takes a second look at the discharge practices of acute psychiatric units of general hospitals, and it describes how things have changed for individuals leaving inpatient psychiatric units of general hospitals over the past four years.

Rationale for the Study

Impetus for this follow-up study came from a joint request by the New York State Office of Mental Health and the State Hospital Review and Planning Council to provide an independent evaluation of recent changes in the inpatient and outpatient Medicaid rate reimbursement methodologies for psychiatric services. As discussed in this chapter, these rate methodologies have many features, but overall, they sought to promote greater service accessibility and improved quality of service delivery for individuals with serious and persistent mental illness.

While the revised outpatient reimbursement methodology was implemented statewide in October 1989, the new inpatient reimbursement methodology was implemented on a pilot basis (Phase I) in October 1989 in a select group of 27

of the 107 general hospitals statewide which have a certified psychiatric unit. In approving Phase II of the new psychiatric inpatient methodology, which allowed 25 new hospitals to participate in the spring of 1991, the State Hospital Review and Planning Council asked the Commission to conduct a review to ensure that there had been no adverse impact upon patients. The Council hoped to use the findings of the Commission's review in making its determination for the full Phase III implementation of the methodology scheduled for the late spring/summer of 1992.¹

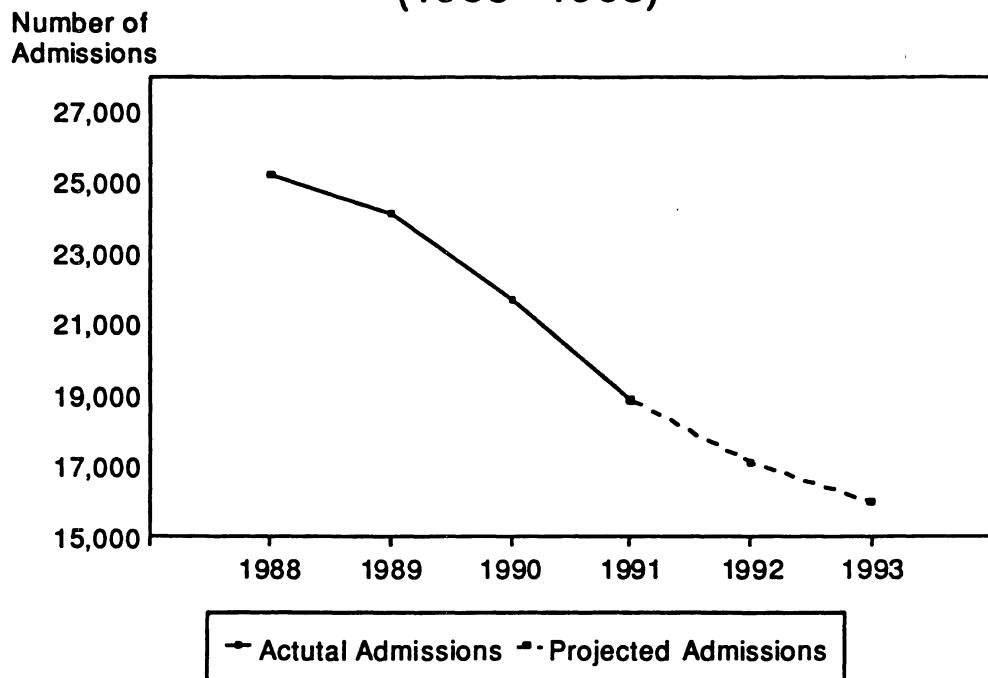
In addition to the evaluation of the new rate methodologies, the Commission, the State Council, and the Office of Mental Health were also interested in learning more about discharge planning, aftercare service provision, and rehospitalization rates for psychiatric inpatients of general hospitals. In recent years, the Office of Mental Health has encouraged an expanded role for psychiatric units of general hospitals in serving persons with serious and persistent mental illness. Simultaneously, it has sought to reduce the state's reliance on expensive, and largely non-Medicaid-reimbursable, acute psychiatric services provided by state psychiatric centers.² This effort has resulted in a dramatic reduction in direct acute admissions to state institutions (Figure 1).

Although pleased with this outcome, the Office of Mental Health and the Commission were aware that regulatory oversight of inpa-

¹ Subsequently, and due in part to the preliminary findings of this study, Phase III of the implementation of the new inpatient rate methodology was deferred by the Office of Mental Health in October 1992.

² Inpatient stays in state psychiatric centers, classified as "institutions for mental disease," are not reimbursable through the Medicaid program for individuals between the ages of 21 and 64.

**Figure 1: Actual and Projected Admissions
To State Psychiatric Centers
(1988 - 1993)**



Data provided by OMH.

tient psychiatric units of general hospitals—especially related to discharge planning practices—was minimal. An important concurrent objective of this study, therefore, was to provide a baseline assessment of the quality of discharge planning and follow-up services by these inpatient units, as well as an analysis of how these practices may be associated with aftercare outcomes.

New Inpatient Rate Methodology

Fiscal incentives in the inpatient methodology rewarded hospitals for serving a greater percentage of individuals who were classified as persistently mentally ill, by paying a slightly higher rate (104% of the base rate) for treating

these patients. The methodology also adjusted payments to discourage very short inpatient stays, by paying a slightly higher rate (107%–115% of the base rate) for the first 10–14 days of hospitalization. Conversely, the new methodology discouraged long lengths of stay, by paying a lower “extended care” rate (85%) for days billed after the first 23–31 days of hospitalization for all individuals diagnosed with a psychotic disorder or classified as a “persistent” patient³ (Figure 2).

With regard to both case mix and length of stay, the methodology also had a specific allowance which rewarded hospitals for continuing good performance. This allowance sought to ensure that hospitals which had independently achieved benchmarks of good performance re-

³ For individuals admitted with a nonpsychotic diagnosis, the reduced extended care rate becomes effective after the first 13 days of a hospitalization. And, for individuals classified as “persistent” patients, the extended care rate is not instituted until after their first 29 days of hospitalization. Additionally, children are reimbursed at the extended care rate only after the first 31 days of their stay.

Figure 2: Key Features of the New Inpatient Medicaid Rate Methodology

- ✓ Higher base rate (104%) for individuals classified as persistently mentally ill
- ✓ Higher base rate (107% to 115%) for first 10-14 days of hospitalization
- ✓ Lower base rate (85%) for longer lengths of stay
- ✓ Rewards to hospitals for maintaining established good performance
- ✓ Fiscal disincentive for rehospitalizations within 30 days
- ✓ \$65 payment for discharge plan and aftercare linkage within 10 days of discharge
- ✓ Waiver of DOH penalties for increasing bed utilization and increasing case-mix severity
- ✓ A “hold-harmless” clause — no hospital could lose \$\$

lated to length of stay and serving persons who were persistently mentally ill prior to the institution of the new rate methodology would be equally rewarded for maintaining their good performance.

There was also a fiscal disincentive for rehospitalizations of individuals within 30 days of their discharge. Additional hospitalizations within this period would be reimbursed as if they were a continuation of the first stay, resulting in most days being billed at the lower “extended care” rate.

The new methodology was also designed to promote better discharge planning. Hospitals were awarded a \$65 “bridging fee” for each individual discharged from a psychiatric unit if a discharge plan was prepared *and* the individual made contact with an outpatient mental health program within ten days of leaving the hospital.

Finally, because a major objective of the methodology was to increase psychiatric inpatient capacity, hospitals participating in the methodology were exempted for psychiatric patients from the NYS Department of Health’s (DOH)

case mix and volume rate adjustments. The Department of Health’s case mix adjustment penalizes hospitals for increasing inpatient service, including seriously mentally ill persons, by using service intensity weights which are lower for psychotic patients than for other patients. The Department of Health’s volume adjustment, targeted to reduce hospital bed utilization statewide, penalizes hospitals for increasing the number of individuals served, and it rewards hospitals for decreasing their service volume compared to their performance in the base year of 1987.

Since the Office of Mental Health sought to increase the inpatient psychiatric capacity of general hospitals, it was important to ensure that hospitals participating in the methodology would be relieved of these Department of Health disincentives for increasing psychiatric volume. In so doing, these hospitals were also made ineligible for the Department of Health incentives for reducing psychiatric bed days. For many hospitals participating in Phase I, however, these waivers backfired, as many hospitals actually decreased their psychiatric bed days in the latter part of the evaluation period (contrary to expec-

tations), and they lost the Department of Health's premium for reducing volume.

Also, as reflected above, the fiscal incentives in the inpatient methodology, while complex, were not very large. Office of Mental Health officials had originally proposed more significant fiscal incentives and disincentives, but these were ultimately "negotiated" with the State Hospital Review and Planning Council. Finally, in the last stage of these negotiations, a "hold harmless" guarantee, offered to all hospitals that agreed to participate in the methodology during the phase-in process, eliminated any financial risks to the hospitals.

New Outpatient Rate Methodology

The outpatient rate methodology was a "late companion" to the inpatient rate methodology. Reportedly, final approval of the inpatient rate methodology was held up by the State Hospital Review and Planning Council until a companion outpatient rate methodology, which would comparably reward outpatient providers for services to persons who were "persistently mentally ill," was instituted.

In accord with these parameters, the new outpatient rate methodology sought to reward intensive mental health outpatient service provi-

sion to psychiatric patients in the first 30 days after their discharge from a hospital stay—and also to reward (at a somewhat lower rate) continued aftercare services to persons classified as "persistently mentally ill" during the remainder of the first year after their hospitalization (Figure 3). A 40% rate premium was offered (for each billed visit) for serving outpatients within the first 30 days of their discharge from an inpatient psychiatric unit; and a 20% rate premium (for each billed visit) was offered for serving persons who qualified as "persistently mentally ill" for the remainder of the first year.

Although these rate premiums offered in the outpatient methodology appear much larger than those offered by the inpatient rate methodology, it should be emphasized that recently discharged individuals and individuals classified as "persistently mentally ill" account for only a small percentage of most outpatient programs' total units of service. As a result, for the vast majority of outpatient providers, these premiums, too, reflect only a small portion of a program's overall Medicaid revenue.

Study Sample

The study's design involved 6-month follow-up assessments of 100 individuals dis-

Figure 3: Key Features of the New Outpatient Medicaid Rate Methodology

- ✓ A 40% rate premium per billed visit for all individuals discharged from inpatient care within 30 days.
- ✓ A 20% rate premium per billed visit for all individuals classified as persistently mentally ill during months 2-12 subsequent to discharge from inpatient care or to individuals receiving intensive case management services.
- ✓ No possibility of loss of revenue.

charged from the psychiatric units of ten general hospitals located in five counties across New York State (Bronx, New York, Nassau, Onondaga, and Erie Counties). The ten hospitals included five matching pairs of hospitals where one hospital participated in Phase I of the new psychiatric inpatient rate methodology and one hospital did not. The two hospitals in each matching pair were located in the same county, and to the extent possible, the hospitals were of similar sizes, had similar inpatient psychiatric bed capacities, and served a similar percentage of indigent individuals (Figure 4).

Ten individuals discharged from the psychiatric units of each of the ten hospitals in May/June 1991 were included in the total sample of 100. Only individuals whose care was reimbursed by Medicaid and who had a major psychiatric diagnosis on discharge were eligible for inclusion in the sample. Within these criteria, sample individuals were selected randomly from lists of discharged patients from each of the ten hospitals.

Figure 4: Sample Hospitals

Participating Hospitals

- (1) Metropolitan Hospital - New York County
- (2) Bronx Lebanon Hospital - Bronx County
- (3) Mercy Hospital - Nassau County
- (4) University Hospital - Onondaga County
- (5) Erie County Medical Center - Erie County

Nonparticipating Hospitals

- (1) Harlem Hospital - New York County
- (2) North Central Bronx Hospital - Bronx County
- (3) South Nassau Hospital - Nassau County
- (4) St. Joseph's Hospital - Onondaga County
- (5) Buffalo General Hospital - Erie County

Data Collection Steps

The Commission focused its data collection efforts on following up on the 100 discharged individuals. After reviewing each of the individuals' inpatient records, discharge plans, and discharge summaries, Commission staff contacted and interviewed all identified aftercare providers, staff of any hospitals where the individuals had been rehospitalized, and where possible, the individuals themselves and involved family members.

To encourage participation, individuals were offered a \$10 stipend for participating in a brief telephone interview or completing a brief written survey relating their perceptions of their inpatient treatment, discharge plans, aftercare service, and general well-being upon leaving the hospital. In total, 40 of the 100 individuals in the sample and 21 family members participated in this part of the study.

In addition to these efforts, Commission staff took advantage of their time on-site to learn more about the inpatient and outpatient mental health providers in the county. These visits and interviews focused on the hospitals' discharge planning practices, other services designed to help patients transition to the community (e.g., follow-up services, family support, previsits to aftercare programs, etc.), and the nature and extent of coordination and cooperation among mental health service providers in the county. Hospital and outpatient providers in the county were also interviewed to assess their understanding of the Office of Mental Health's new inpatient and outpatient reimbursement methodologies and the impact of these methodologies on their services and the Medicaid reimbursement they received.

At each hospital in the sample, Commission staff conducted a structured interview with senior hospital management staff (e.g., the senior vice president with oversight of psychiatric services, the director of psychiatric services, the

senior financial officer with oversight of psychiatric services, etc.) and a separate interview with senior administrative and clinical staff directly associated with the hospital's inpatient psychiatric service (e.g., the director of inpatient service, the chief psychiatrist, supervising social worker, the nursing supervisor, etc.).

Additionally, senior management and clinical staff of the psychiatric outpatient program(s) of each of the ten hospitals were also interviewed. Interviews were also conducted at three other freestanding mental health outpatient agencies which offered aftercare services for psychiatric individuals discharged from each of the ten hospitals.

In total, the Commission visited and interviewed senior staff of 39 outpatient mental health providers, including eight different providers in four of the five geographical areas represented in the sample, and seven providers in the fifth area. This sample assured that the Commission met with all major providers of mental health outpatient services in these geographic areas (Figure 5).

Organization of the Report

Data findings of the study are presented in three chapters. Chapter II provides a clinical profile of the 100 individuals and their inpatient hospitalizations and discharge plans. Chapter III follows the 100 individuals to the community and traces their utilization of psychiatric inpatient and outpatient services and other aftercare services in the six months following their discharge, as well as their general life experiences. In Chapter IV, the Commission looks more closely at the 38 individuals in the sample who were rehospitalized for psychiatric treatment during the 6-month follow-up period. Information related to the impact of the inpatient and outpatient rate methodologies for psychiatric services is presented in Chapter V.

Conclusions and recommendations are presented in Chapter VI.

Figure 5: Sample Outpatient Providers (N = 39)

New York County

Harlem Hospital Outpatient Mental Health
Lincoln Hospital Outpatient Services
Upper Manhattan Mental Health Services, Inc.
Manhattan Psychiatric Center Outpatient Community Services
Metropolitan Hospital Outpatient Department
Federation Employment and Guidance Service
Post-Graduate Center for Mental Health
St. Luke's Outpatient Department

Bronx County

North Central Bronx Hospital Outpatient Department
Riverdale Mental Health Center
Morrisania Mental Health Center
Soundview-Throgs Neck Community Mental Health Center
Bronx Lebanon Hospital Center Outpatient Department
South Bronx Mental Health Council, Inc.
Bronx Center for Community Services
Fordham Tremont Community Mental Health Center

Nassau County

South Nassau Communities
South Shore Association for Independent Living
Catholic Charities - St. Anthony's Guidance Clinic
Long Beach Memorial Hospital Mental Health Clinic
Mercy Hospital Outpatient Mental Health Clinic
North Shore University Hospital - Day Treatment Center
Jewish Community Services for Long Island
Pilgrim Psychiatric Center - Progress House

Onondaga County

St. Joseph's Hospital - St. Francis Hall
Onondaga Case Management Services
University Hospital Adult Mental Health Clinic
Onondaga Pastoral Counseling Center
Hutchings Psychiatric Center Outpatient Department
Transitional Living Services of Onondaga County, Inc.
The Alliance Advocacy Center

Erie County

Buffalo General Hospital Outpatient Department
Horizon Human Services
Lake Shore Community Mental Health Center
Spectrum Human Services
Erie County Medical Center Adult/Child/Family Outpatient Clinic
Buffalo Psychiatric Center Outpatient Services
Northwest Corporation
Mid-Erie Mental Health Services

Chapter II

The Individuals, Their Hospital Stays, and Their Discharges

Clinical data on the 100 individuals, their hospitalizations, and their discharges were obtained from reviews of their clinical records. These records generally included admission notes, substantial clinical progress notes, as well as assessments, individualized treatment plans, and discharge plans and summaries.

Consistent with the practices of JCAHO and HCFA,⁴ the Commission relied exclusively on record documentation in evaluating the sample individuals' hospitalizations and discharges.

Overview

As detailed in this chapter, the study found that the discharge planning practices of psychiatric units of general hospitals have improved in several areas since the Commission's 1988 study. As compared to the findings in the 1988 study, the individuals in the current study were much more likely to have comprehensive discharge plans (86% versus 54%) and to have a specific appointment for mental health aftercare services arranged prior to their discharge (80% versus 40%). Hospital staff follow-up after discharge continued to be the exception rather than the rule in the current study, but here too there was some improvement (15% versus 2%).

In other significant areas, hospital performance had not changed since 1988. Documentation of efforts to involve individuals substan-

Eliza

Eliza is a 29-year-old African-American woman who was admitted involuntarily to an upstate hospital in May 1991, with somatic complaints, delusional behavior, and emotional lability. Upon admission, she appeared obese and unkempt, of below average intelligence, and was diagnosed as a schizophrenic, chronic residual type, and as having a schizoaffective disorder. This was not Eliza's first psychiatric admission; she has a lengthy psychiatric history which dates back to when Eliza was 13 years of age.

Eliza is unmarried; she lives with her mother. She has two daughters, ages 8 and 5, who are cared for by her mother and sister, respectively. Although Eliza finished high school, she has not been able to hold down a job for at least the past two years.

After a ten-day inpatient stay, Eliza was discharged to a continuing treatment program that reportedly provides Eliza with medication management, verbal therapy, crisis intervention, task/skill development, and social/recreational activities.

Eliza's long-range goal is to obtain employment, to become more independent (of her family), and to regain custody of and to care for her two children. Eliza summarized her situation best when she said the best thing the continuing treatment program could do for her would be "teaching me to take care of myself."

⁴ The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is the primary national accreditation service for psychiatric inpatient providers, and the Health Care Financing Administration (HCFA) is the federal agency responsible for certifying public psychiatric institutions and general hospitals for the receipt of federal Medicare and Medicaid revenues for inpatient treatment.

tially in making choices for aftercare service was present in only 30% of the records, and although families of 65% of the individuals were in contact with their relatives during their hospitalizations, there was documentation of family involvement in discharge planning for only 41% of the individuals.

Additionally, and perhaps most importantly, referral patterns for aftercare services had hardly changed over the past four years. In the vast majority of cases, individuals were referred only for mental health clinic services, with only 20% of the individuals referred for mental health day program services and less than 5% referred to day hospitals, intensive case management, or supported work programs. Referrals to address the individuals' special problems with alcohol and drug abuse were also infrequent, as were referrals to psychosocial clubs and other consumer directed programs designed to help individuals build friendships and other social skills.

Profile of the Individuals

The 100 individuals in the Commission's sample were evenly distributed between men (49%) and women (51%); they were young (66% were 40 or younger); and a majority were nonwhite (58%) (Figure 6). Only 19% of the individuals had been regularly or periodically employed in the year prior to their hospitalization, and almost two-thirds of the individuals (62%) had not been employed for the past two years. Notably, however, over half of the individuals had a high school education, including one-fourth (27%) who had attended or graduated from college.

For the vast majority of the individuals (85%), this was not their first psychiatric hospitalization.

- One-fifth (24%) had one or two prior psychiatric hospitalizations; 61% had three or more prior hospitalizations.
- Thirty-nine (39) percent of the individuals had five or more prior psychiatric hospitalizations.

**Figure 6: Sample Profile
(N = 100)**

Average Age	36.6 years
Percent Female	51%
Percent Minority	58%
Percent With High School/ College Education	54%
Percent Unemployed During Year Prior to Admission	81%
Percent Admitted Involuntarily*	54%
Median Number of Prior Psychiatric Hospitalizations **	4.0

* 34% remained on involuntary status for entire hospitalization.

** Calculation based on n = 85.

Data analysis further showed no significant demographic or clinical differences between the 50 individuals in the sample from hospitals participating in the new rate methodology and the 50 individuals in the sample from nonparticipating hospitals. In addition, on all key demographic and clinical variables, the Commission's sample of 100 individuals was similar to larger samples of inpatients with major psychiatric diagnoses who have been profiled in recent NYS Office of Mental Health studies.

Reasons for Admission

Slightly more than half of the individuals (54%) were admitted on involuntary status, and approximately one-third (34%) remained on involuntary status for the full period of their hospitalization. For most individuals, several reasons were offered in the record to justify their admissions, but the five most common were

"dangerous to self" (45%), "hallucinations" (43%), "suicidal ideation" (37%), "delusions" (30%), and "bizarre thoughts or behaviors" (40%).

In contrast, less than 20% of the individuals' admissions were justified with notations of "dangerous to others" (13%), "could not provide for basic needs in the community" (16%), "suicide attempt" (14%), or "physically assaulted someone" (10%). In no case was "fire setting" or "sexual assault" listed as a reason for admission.

At the time of admission, families of one-fifth of the individuals (21%) also reported that they could no longer manage the individual at home. Similar notes were entered for another 6% of the individuals living in adult homes or community residences.

Additionally, although in only 16% of the cases was not being able to provide for one's basic needs in the community documented as a reason for admission, an additional 9% of the individuals were described at the time of admission as being homeless, without adequate clothing, without a regular means of getting three

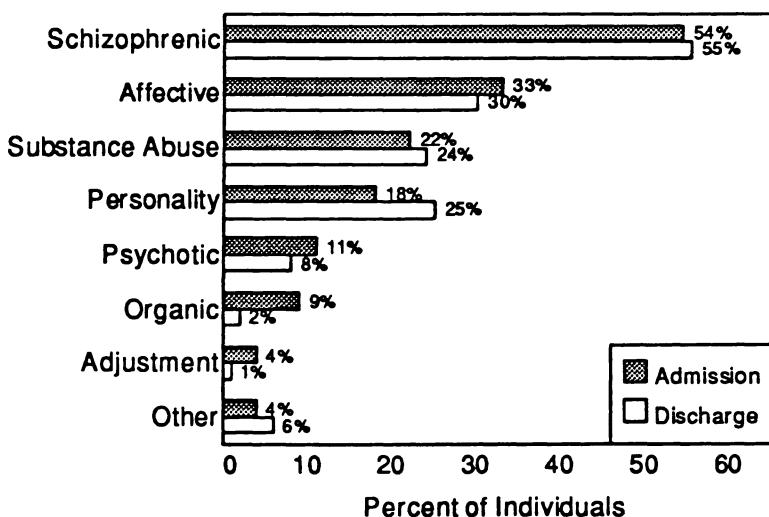
meals a day, malnourished, or needing medical care. Finally, clinicians' notes attributed the unstable mental health conditions of almost one-third of the individuals (30%) at the time of their admission, at least in part, to their recent non-compliance with psychotropic medications or other clinical treatment.

Psychiatric Diagnoses

In completing its record reviews, the Commission staff recorded the documented clinical diagnoses of individuals on admission and on discharge. This review indicated that changing and multiple Axis I and Axis II diagnoses were common for many of the individuals in the sample (40%), but the overall diagnostic profile of the sample individuals was not significantly different at the time of admission and the time of discharge.

Upon admission, over three-fourths of the individuals carried a diagnosis of a schizophrenic/psychotic disorder (65%) and/or an affective disorder (33%) (Figure 7). At the time of discharge, 63% of the individuals were diag-

Figure 7: Admission/Discharge Diagnoses*
(N = 100)



*Categories are not mutually exclusive.

nosed with a schizophrenic/psychotic disorder, and 30% of the individuals were diagnosed with an affective disorder. The only exception to the general stability of the sample's diagnostic profile was that more individuals received a diagnosis of a personality disorder at the end of their inpatient stay than at the time of their admission (25% versus 18%). Admission profiles of 22% of the individuals also included a diagnosed alcohol or substance abuse disorder.⁵

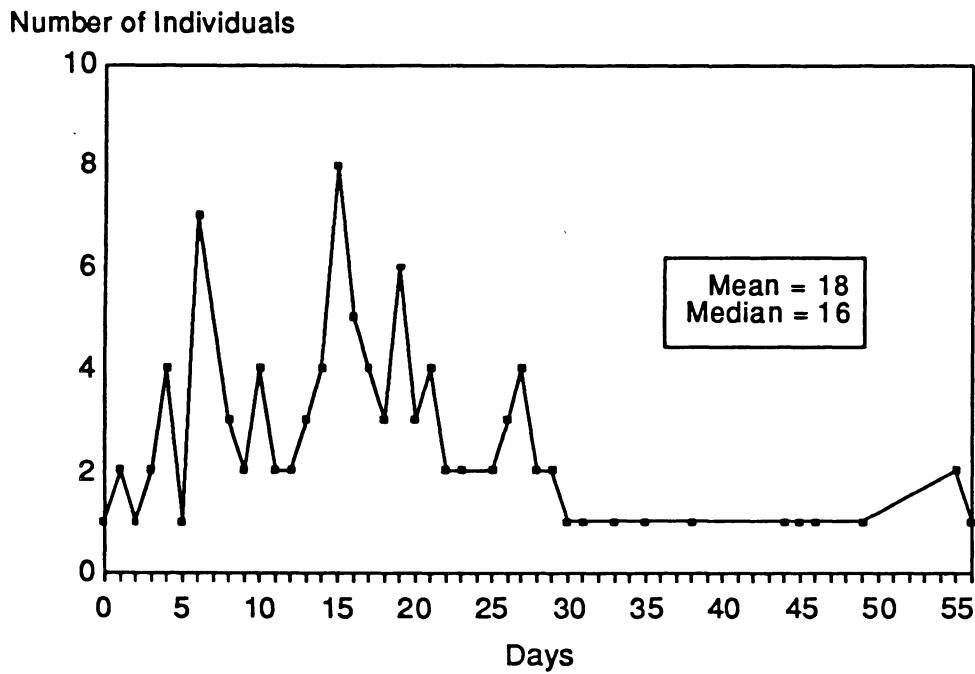
Hospital Stays

The median hospital stay for the 100 individuals was 16 days, with two-thirds of the sample (67%) having lengths of stay of less than 21 days (Figure 8). On the extremes of the

distribution, 17% of the individuals had lengths of stay of less than seven days, and 16% of the individuals had lengths of stay of 28 days or longer.

Although the Commission's study did not include an assessment of inpatient treatment, review of the individuals' records, as well as observations on the inpatient units, indicated that the primary treatment intervention across the ten hospitals was psychotropic medications, followed by individual therapy sessions (30 - 60 minutes) held several times a week. Outside of these interventions, most hospitals had weekday schedules of several brief group activities, often an arts and crafts project or a discussion of current events, which individuals attended selectively.

**Figure 8: Length of Stay
(N = 100)**



⁵ As discussed later in this report, approximately 41% of the individuals appeared to have a problem with drug or alcohol abuse, as evidenced by an inpatient diagnosis of these problems or reports by their outpatient therapists.

Although two hospitals stood out as exceptions, offering a very structured day of group activities for individuals, for the most part, inpatient stays were focused on stabilizing the individual and arranging for his/her discharge. In this context, hospitals provided "safe havens" for individuals where their acute medical and mental health needs, as well as their basic needs for clothing, shelter, and three meals a day were assured. This observation was also confirmed by the consumer responses to the Commission's survey where the majority of the respondents ($n = 40$), stated that they benefited from their hospital stay because it afforded them *a much needed rest*.

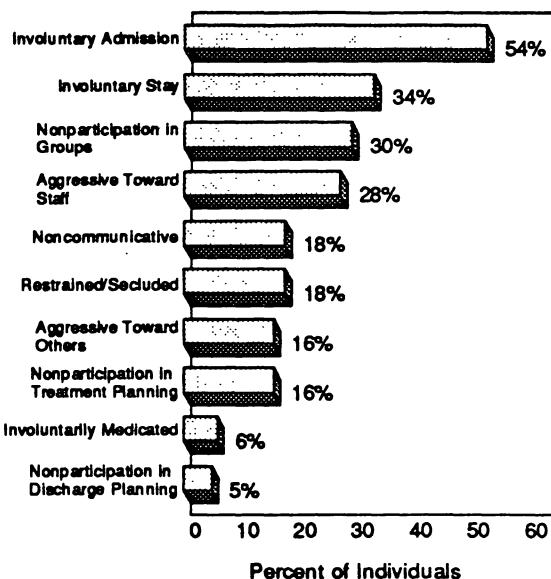
Most of the psychiatric units were not staffed or designed to provide more comprehensive psychiatric rehabilitative assessments targeted toward identifying the patients' strengths and needs in making a successful transition to community living. As discussed in more detail later in this report, the limited availability of outpatient psychiatric rehabilitation services was also a disincentive to hospital staff in considering such comprehensive assessments.

Treatment Challenges

As noted above, for over half of the individuals (54%), their hospitalization was involuntary, and 34 of these 54 individuals remained on involuntary status for the duration of their hospital stays. Other record notes further confirmed that many individuals did not adapt easily to their hospitalization and psychiatric treatment (Figure 9).

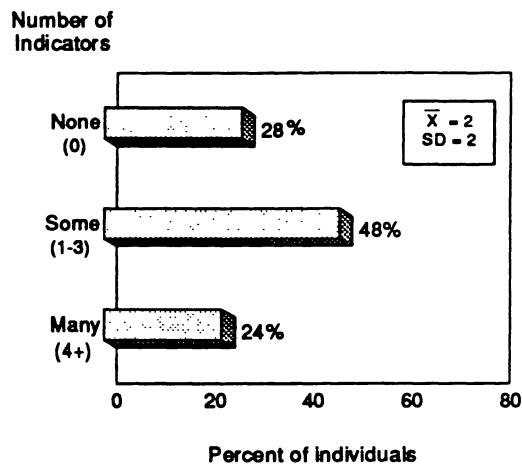
- Approximately one-third of the individuals (30%) reportedly refused to participate in group activities while in the hospital.
- Twenty-eight (28) percent reportedly displayed aggressive behavior toward staff.
- Approximately one-sixth of the individuals displayed aggressive behavior toward other individuals (16%) and/or were

Figure 9: Challenges to Treatment*
($N = 100$)



*Categories are not mutually exclusive.

Treatment Challengers
($N = 100$)



non-communicative (18%) during their hospitalizations.

- Sixteen percent (16%) of the individuals refused to participate in treatment planning, and 5% refused to participate in discharge planning.

Kathy

Kathy, age 55, is single, and lives at home with her 80-year-old mother. For many years Kathy worked at a bank, but she lost her job five years ago. Kathy has a long history of mental health problems, including numerous psychiatric hospitalizations and a consistent pattern of noncompliance with outpatient services.

Kathy was admitted to an upstate New York hospital in the spring of 1991 after she became verbally unresponsive at home, with increased anxiety, agitation, and insomnia. In the hospital, Kathy was noncommunicative, hostile to staff interventions, and resistant to participating in treatment planning and group activities. By the time of her discharge 20 days later, however, Kathy had agreed to attend the mental health center that she had sporadically attended prior to her hospitalization. She was given a clinic appointment for three weeks postdischarge, and she returned home to live with her elderly mother.

Kathy kept her intake screening appointment at the mental health center, but subsequently refused all outpatient services. Kathy's sister, who responded to the Commission's survey, complained that although she visited Kathy daily while she was in the hospital, inpatient staff never spoke with her about Kathy's discharge plans or possible methods for addressing Kathy's pattern of rehospitalizations and refusal to take prescribed medications and follow through with aftercare referrals.

During the six months following her hospitalization period, Kathy did not receive any mental health services. Her sister reports that Kathy spends all day in the house, neglects her personal hygiene, and has stopped taking her psychotropic medications. It seems that Kathy is destined to repeat her pattern of rehospitalizations until outpatient service providers find a way to engage her in treatment.

- Nearly one-fifth of the individuals (18%) reportedly displayed dangerous behaviors that resulted in the use of physical interventions, mechanical restraints, or seclusion during their hospitalization, and 6% were medicated with psychotropic medications involuntarily.

Searching for a better overall indicator of an individual's level of "challenge" to inpatient treatment, the Commission created a ten-point scale which summed positive responses to each of the above indicators, as well as involuntary commitment status on admission and continued stay on involuntary legal status. This analysis indicated that while the majority of the individuals (64%) posed no or few challenges to inpatient treatment, over one-fourth of the individuals had positive indications on four or more of the treatment challenge criteria.

- Over one-fourth of the individuals (28%) scored "0" indicating no positive responses on the treatment challenge indicators, and another 36% of the individuals had relatively low scores, with positive responses on only one to two indicators.
- Over one-third of the individuals (36%) scored higher than two on the scale, the sample's mean inpatient treatment challenge score, and 24% of the individuals had treatment challenge scores of four or more.

Treatment Challenge Associated With Outcome Measures

Looking more closely at the individuals who presented above average inpatient treatment challenges (scores of four or more), it became clear that several challenge indicators were almost exclusively present among this subgroup. Almost all of these individuals (92%) were noted to have shown aggressive behaviors toward

Mark

Mark at age 30 was homeless, living in the subways, and had been experiencing hallucinations for the past six months. In the spring of 1991, Mark was admitted involuntarily to a NYC hospital. Mark had one known previous psychiatric admission in 1990, although no known history of outpatient mental health treatment.

During the first week of Mark's inpatient stay, he was noncommunicative, and he occasionally refused medications. Mark's treatment plan focused on his medication management and finding him a place to live. While in the hospital, Mark's involuntary status was converted to voluntary status.

Two days prior to his discharge, Mark's medication was increased, and record notes indicated that he continued to need acute care, as he still had racing thoughts. On the same day, Mark's record indicated his mother told the treatment team, "Mark cannot live with me because of his personality. We've tried, but we just do not get along."

After spending 22 days in the hospital, Mark submitted a letter requesting his release, and two days later, Mark was discharged to his mother's home, apparently against her wishes. Upon discharge, Mark was given a specific appointment with the hospital-affiliated outpatient clinic, but he never kept this appointment. Per clinic policy, Mark was sent a letter with a new appointment for the following week, but after missing two appointments, his case was closed at the clinic.

Over the six months after Mark's discharge, a Commission staff person spoke with Mark's mother who stated that Mark never followed through with any aftercare services.

inpatient staff compared to only 8% of the other sample individuals. Similarly, records of over half of these individuals (58%) documented aggressive behaviors toward their peers compared to only 3% of the other sample individuals. And, although over half of this group (54%) had

been restrained or secluded at least once during their inpatient stay, this was true for only 7% of the other sample individuals.

This analysis took on more meaning, as the Commission also found that individuals who had high treatment challenge scores (overall scores of four or more) fared significantly less well during the 6-month follow-up period. More than half of these individuals (58%) were rehospitalized in the 6-month follow-up period compared to only 32% of the other sample individuals. In the community, individuals with high treatment challenge scores were also much more likely to have limited informal supports (88% versus 58%, $\chi^2 = 5.79$, df = 1, p < .05), and they were less likely to use their leisure time productively (4% versus 30%, $\chi^2 = 5.45$, df = 1, p < .05).

Other analyses showed that individuals with high treatment challenge scores, although similar to other sample individuals demographically and clinically in most ways, were significantly different on a few readily identifiable variables. For example, as compared with individuals who scored low or average on the treatment challenge scale, high scoring individuals were:

- more likely to be treated in a hospital located in New York City (67% versus 32%, $\chi^2 = 7.95$, df = 1, p < .01);
- more likely, upon admission, to have been reported as unmanageable by their family (38% versus 16%, $\chi^2 = 3.96$, df = 1, p < .05).
- more likely, upon discharge, to have been judged by their treatment team/primary therapist as not ready for discharge (42% versus 13%, $\chi^2 = 7.57$, df = 1, p < .01); *not* to have been referred to live at their own home (33% versus 17%, $\chi^2 = 24.63$, df = 8, p < .01); and *not* to have been referred to an outpatient program that they had attended previously (58% versus 29%, $\chi^2 = 5.62$, df = 1, p < .05).

Overall, these findings indicate that it is possible to identify patients presenting unusually high inpatient treatment challenge using a rather simple listing of indicators. Easily assessed from an inpatient record, these measures also appear to be relevant in predicting the individual's success and specific difficulties upon discharge. Given the high cost of rehospitalization, this risk prediction could be particularly valuable to care systems attempting to reduce inpatient costs and to make more funds available for community services. More specifically, these findings may be helpful to states in making decisions regarding the allocation of scarce intensive case management services.

Readiness for Discharge

Clinical records of 44% of the individuals did not include an affirmative statement of dis-

charge readiness *at least three days prior* to the individual's discharge, and 29% did not contain such a statement at the time of the individual's discharge.⁶

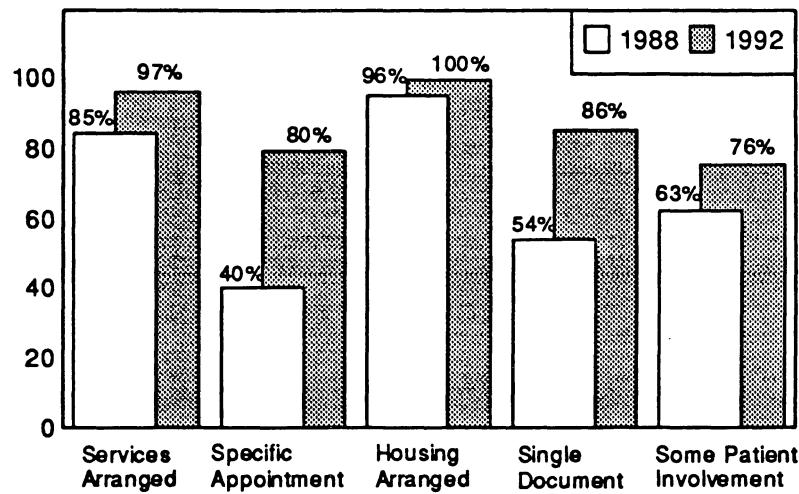
Notwithstanding this absence of affirmative record documentation of discharge readiness, however, records of only four individuals documented incidents or circumstances proximate with their date of discharge which suggested they clearly were not ready for discharge. In these few instances, individuals were described as delusional, confused, or agitated to the point of requiring chemical restraints and/or seclusion within three days of their discharge.

Discharge Plans

On many specific indicators of appropriate discharge planning, the hospitals in the sample scored well (Figure 10).

**Figure 10: Improvements in Discharge Planning*
(N = 100)**

Percent of Individuals



* Categories are not mutually exclusive.

⁶ Individuals who were discharged directly to a state psychiatric center (n = 7) and individuals who left the facility without medical consent (n = 5) were excluded from these analyses, as the facility had clearly determined that these individuals were not ready for discharge.

- For 97% of the individuals, there were record notes indicating that residential and outpatient treatment service arrangements were made for the patient prior to discharge, and for 86%, there was a single document in the record which provided a comprehensive listing of these arrangements.
- These documents or notes also usually specified a housing arrangement (100%) and a specific appointment soon after discharge with a mental health outpatient provider (80%).

For most individuals (83%), there was also documentation that discharge planning had begun within one week of their admission and, for 76% of the individuals, there was documentation that they had been involved in some discussion(s) regarding their aftercare services.

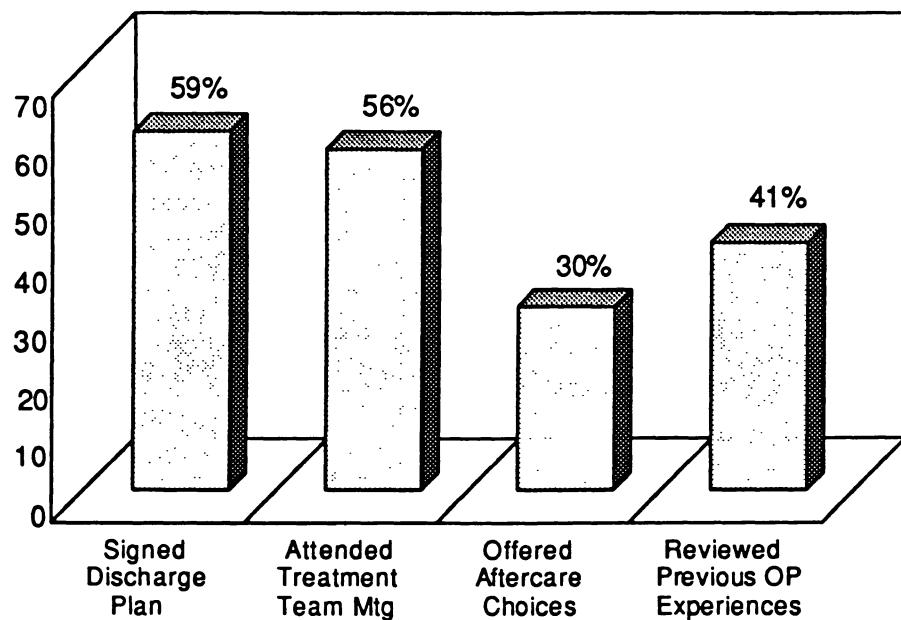
Limited Individual and Family Participation

Although three-fourths of the records documented some discussion between patients and staff of aftercare service plans, many individuals in the sample had not actively participated in their discharge planning process (Figure 11).

- Only 59% of the individuals actually signed their discharge plans, and records of only 56% of the individuals documented their attendance at discharge planning meetings.
- In addition, records documented the offering of aftercare services "choices" to only 30% of the individuals, and records of only 41% provided explicit reference/review of the individual's prior positive

**Figure 11: Individual Involvement
(N = 100)**

Percent of Individuals



or negative experiences with mental health outpatient programs or services.⁷

Family participation in discharge planning was also frequently not documented in the individuals' records (Figure 12). The records indicated that family members of 77% of the individuals were aware of the individual's hospitalization, and that family members of 65% of the individuals made contact with them during their hospitalization. In contrast, however, records documented that family members of only 41% of the individuals were involved in any discussions related to discharge planning.

When individuals left the hospital to go home to live with their family, it was also not always clear from the record whether these family members had been contacted about discharge plans or their concurrence with them.

- For 15 of the 41 individuals (37%) returning home to live with family mem-

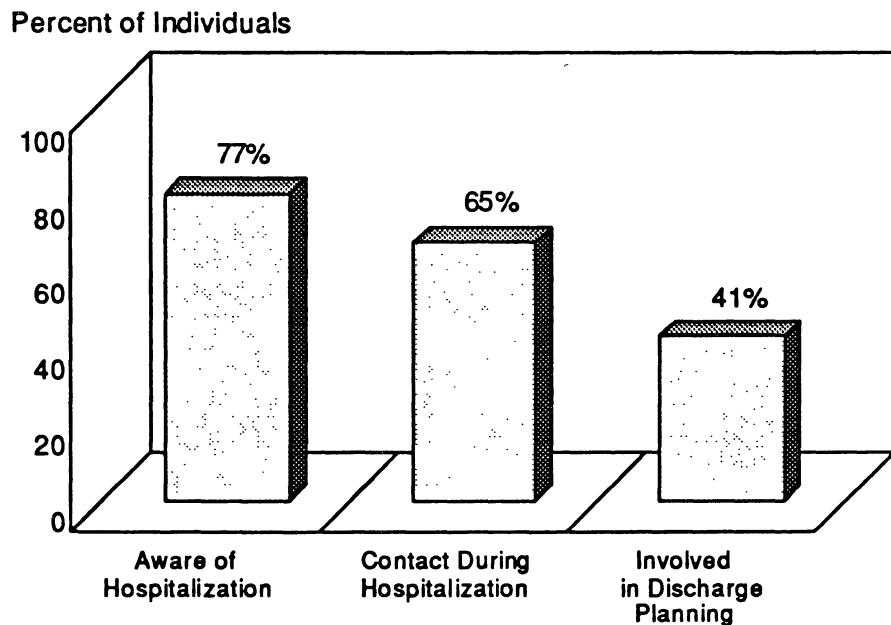
bers or a spouse/significant other, records provided no documentation that the family member, spouse or significant others agreed to the discharge home.

- Additionally, for 14 of these 41 individuals (33%), there was no record documentation that the family had been notified at least 48 hours prior to the individual's discharge that he/she was on the way to their home.

Practices Trail Expectations

In contrast to these findings, psychiatric unit staff at all ten hospitals articulated explicit requirements that individuals would document their concurrence with aftercare service arrangements in the record and that individuals would actively participate in aftercare service decision making. Psychiatric unit staff at all ten hospitals also reported that, with the individual's permis-

**Figure 12: Family Involvement
(N = 100)**



⁷ Records of 7 of the 100 individuals indicate no prior contact with a mental health aftercare service provider.

sion, they would elicit participation of involved family members in discharge planning.

Despite these expectations, however, many hospitals had difficulty engaging individuals

Tom

Tom, age 34, was admitted to a downstate hospital in May 1991 for treatment of severe agitation, paranoia, and auditory hallucinations. Tom has a long history of mental problems, and since 1984 he has had four psychiatric hospitalizations and one stay in a substance abuse detoxification program. He lives in an apartment with his aunt, and he has been receiving disability benefits since he stopped working as a security guard two years ago.

After a 19-day hospital stay, Tom was discharged to live with his aunt, and he was given a specific appointment at the same mental health clinic he had been attending prior to his hospitalization. Tom's inpatient record included no documentation of his involvement in discharge planning discussions. In response to the Commission's consumer survey, Tom also rated the services he received from hospital staff as "quite bad," stating that staff did not discuss his treatment goals with him, the reasons for taking medications, or the aftercare services that were available in the community.

Despite the lack of involvement in his discharge planning, Tom attended all of his clinic appointments between May and December 1991. During this time period, clinic staff helped Tom with problems involving his financial entitlements and his landlord. On several occasions, clinic staff accompanied him to the SSI office, and, on one occasion, they visited Tom's home to help him and his aunt resolve problems with their landlord.

As of six months postdischarge, Tom was doing well. He spends most of his time visiting family members, shopping, and cooking. His therapist believes that with continued support and supervision Tom will be able to live independently in the community and that he will eventually find employment.

and family members in substantive discussions of discharge planning.

- Seven of the ten hospitals acknowledged that less than half of their patients took an active role in shaping their discharge plans by stating the types or nature of services they needed or wanted.
- Only two of the ten hospitals reported that families of at least half of their individuals took an active role in shaping discharge plans by affirmatively stating the type and nature of services that their relative needed or desired.

The Commission also found that, although hospital administrators readily acknowledged this gap between stated expectations and actual practice, none of the hospitals visited reported having formal staff training programs or other initiatives geared toward meaningfully improving individual and family involvement in discharge planning.

Family Assessments

Family member responses to the Commission's survey ($n = 21$) also indicated that a significant minority of family members believed that they were not adequately involved or considered in discussions of their relative's care or discharge planning.

Three-fourths of these family members (76%) indicated that hospital staff had invited them to meetings or discussions to talk about their relative's treatment, and most (67%) also believed that hospital staff had been responsive to their concerns and suggestions. Family members, however, were less positive about their involvement in the discharge planning process. Less than half of the family members (43%) gave discharge planning services an overall rating of "really terrific" (10%) or "quite good" (33%), and almost one-fourth rated these services as "quite bad" (10%) or "really awful" (14%).

About half (52%) of the families specifically indicated that hospital staff had not asked their input for aftercare service needs for their relative or explained the progress that their relative would need to make before he/she was ready for discharge. The actual comments of the family members who answered these questions clarify their dissatisfaction.

I went over to visit her for 21 days. . . . I only spoke with the nurse; she was uncooperative; she did not show any interest.

They [hospital staff] never listened.

I was not asked for any input.

No one listened to us; we had to do everything

ourselves and nine out of ten people we spoke to didn't know what they were talking about.

[My son] called me himself and told me he was leaving. In his next admission, nobody called me about his discharge plans.

Doctors don't listen to the patient or parents!

I was invited to a meeting with the psychiatrist. . . . I told him that I wouldn't take [my son] home and I didn't hear anything more. . . . My son called me when he was being discharged and asked me to let him come live with me because he was being discharged to a shelter.

We had very little contact with the clinicians. I only spent one and one-half hours with the therapist.

Allen

Allen, 48, was voluntarily admitted to a New York City hospital. In the hospital emergency room, he reported that voices were telling him to jump in front of a train, and he requested psychotropic medication. Allen presented as malnourished, disheveled, and dirty, and he had body lice.

Allen had a long history of psychiatric problems with eight prior psychiatric hospitalizations. Allen also had pulmonary tuberculosis. Allen told staff that he had his own apartment and that he had been attending an outpatient program. Although record notes indicated that staff doubted the veracity of these statements, the record provided no indication that anyone attempted to find out what Allen's prior housing and mental health service arrangements actually were.

A meeting with Allen's sister was scheduled during his six-day inpatient stay, but it was cancelled by the hospital. Regrettably, a family meeting was not rescheduled prior to Allen's discharge, which was precipitated by Allen submitting a 72-hour letter requesting his release. Although the day before Allen's discharge record notes stated that he was still actively psychotic, a day later two psychiatrists documented that he was not psychotic or dangerous, and they approved his discharge.

Allen was sent "home" to live, and he was referred, without an appointment, to the outpatient clinic he said he had been attending. Upon Commission follow-up, the clinic staff reported that they had not seen Allen for nearly a year. Allen's sister responded to the Commission's family member survey. She stated that Allen had returned to his rent-subsidized apartment, but that it was not a safe place and Allen had been attacked and robbed. Allen also had problems at home, and his sister reported that once she needed to call the police. He also had significant health problems, and he had been rehospitalized at least once for health care.

Allen's sister stated that both the medical and psychiatric hospital staff consistently failed to involve her in Allen's discharge planning. She had not been able to discuss her concerns ". . . about my brother's safety in the streets. People would beat him up and take his money on the first of the month, then he would have to beg or eat from garbage cans until the first of the next month." She added, ". . . sometimes the family can put a light on the patient's problem if the doctor would just talk to them. I could have."

Four months after his Allen's discharge in September 1991, Allen died from complications associated with his health problems.

Residential Referrals

Like the 1988 study, the current study found that the largest single subset of individuals (40%) was discharged home to live with other adult family members/significant others (Figure 13). In addition to these individuals, another 29 of the 100 individuals (29%) returned to their own home either living alone or with children under the age of 18. Much smaller percentages of individuals were discharged to community residences (8%), adult homes (5%), homeless shelters (5%), state psychiatric centers (7%), and boarding facilities (3%). For 3 of the 100 individuals, no place of residence upon discharge was documented in the record.⁸

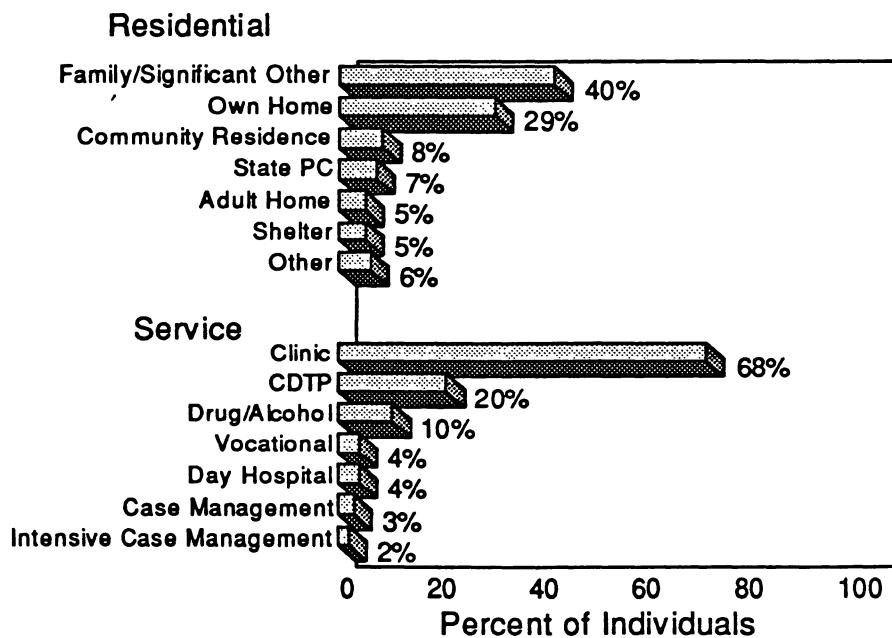
These data substantiate the significant role of family members, spouses, and significant others in caring for and supporting many persons with serious mental illness when they leave

the hospital. They also identify the significant minority of persons who return home with no adult support immediately available. Finally, these data indicate that less than 10% of the individuals in the sample leaving psychiatric units of general hospitals gained access upon discharge to a supervised mental health residential program.

Outpatient Service Referrals

As in the 1988 study, the Commission found that the most common aftercare service referral for the individuals in the sample was to mental health clinics (68%). Much smaller percentages of the sample individuals were discharged with a specific referral to a continuing day treatment program (20%), a day hospital (4%), or a vocational program (4%); and very few individuals (5%) were referred for case management services or intensive case management services.

**Figure 13: Residential and Aftercare Service Referrals
(N = 100)**



⁸ Five (5) individuals, including all three with no documented postdischarge residence, were discharged against medical advice.

It appeared that the clinical service referrals were the most common, largely because clinics were the most accessible aftercare community service statewide. In almost all communities, hospital and outpatient providers confirmed that appointments with traditional clinic programs could be arranged within two weeks of the patient's discharge, and usually these appointments could be arranged within a few days of a patient's discharge. Indeed, at several hospital-based and freestanding outpatient providers visited, new policy mandates requiring timely appointments for individuals being discharged from an inpatient stay had been put into place during the past two years.

In contrast, there was universal indication that obtaining residential services, including residential drug and alcohol abuse services, including intensive case managers, and appropriate outpatient programs for individuals who have a concomitant drug and alcohol abuse problem was difficult and entailed long waits in almost all communities. Particularly in New York City, waits for residential services and intensive case management services were so lengthy that many clinicians who spoke with the Commission simply did not view these as viable discharge service options for their patients.

Unmet Service Needs

In most of the communities visited by Commission staff, many other rehabilitation-oriented services, including continuing day treatment programs, vocational programs, supported work programs, educational programs, and psycho-social clubs also had no or very brief waiting periods (less than two weeks) for enrollment. It appeared that the low referrals to these programs were not constrained by service availability as much as by the tendency of hospital staff to overlook these service needs in the discharge planning process.

In conducting its review, the Commission sought to assess objectively whether discharge

Marsha

Last May, Marsha sat motionless in her apartment, staring into space, speechless for two days. Finally, one of her three young children called an ambulance, and Marsha was involuntarily admitted to the hospital. Marsha has had numerous psychiatric hospitalizations during her 40 years, and her noncompliance with psychiatric treatment is well-known among clinicians who have treated her.

Marsha is separated from her husband, and although her mother lives in the same apartment building, she is not a support to Marsha and she is not involved in Marsha's psychiatric treatment. Marsha has a high-school education, but has no history of employment. During Marsha's four-week hospitalization, she was diagnosed with schizophrenia, catatonic type; she steadfastly refused psychotropic medications and profusely complained about the lack of familial support and unmanageable stress in her life.

Upon discharge from the hospital, Marsha was given an appointment with the hospital's outpatient clinic. Hospital staff also notified the Child Welfare Authority of their concerns that Marsha may not be able to care for her children adequately.

Marsha did not show up for her first clinic appointment. A letter with a new appointment was sent to Marsha's address, but Marsha also missed that appointment. Subsequently, Marsha was discharged from the clinic for her failure to attend.

Neither the discharging hospital nor the outpatient clinic made any attempt to personally contact Marsha, other than the letter mentioned above. Marsha also did not respond to the Commission's survey. At the time of the Commission's six-month follow-up, it could not confirm Marsha's whereabouts or obtain any information about her well-being.

plans adequately addressed all the individuals' needs. In practice, this was a very difficult task, as inpatient assessments were often focused on the individual's psychiatric condition and dis-

charge planning at most hospitals centered on the individual's stabilization and return to his/her prior place of residence or outpatient service provision. Clinical records typically did not reference a functional evaluation of what individuals would need to make an optimal adjustment to community living or to compensate for specific problems that had preceded their hospitalization.

Only two service needs were identified for the majority of the 100 individuals in the sample—outpatient mental health treatment (96%) and psychotropic medications (86%). As shown in Figure 14, most other needs, and especially needs related to basic skills for community living, were documented only for a minority of the individuals. Other study data on the 100 individuals in the sample clearly challenged the overall "accuracy" of these need assessments.

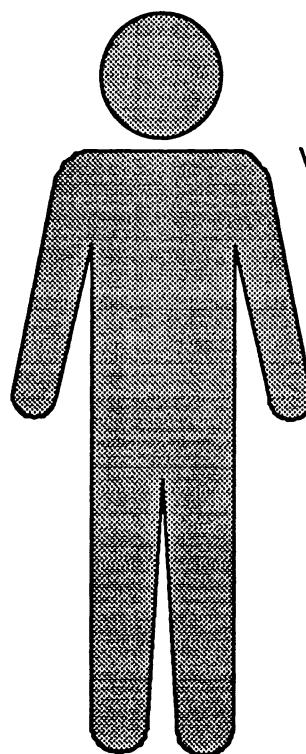
- Although 81 of the 100 individuals had not been regularly employed prior to their hospitalization, and 70 of these individuals were also under age 51, only 24 of the 100 individuals were identified as having a need for vocational/employment services. Discharge plans of only 13 of these 24 individuals actually referenced some service arrangement to address this need. Only nine individuals actually received vocational services at any point during the 6-month follow-up period.
- Despite the fact that almost all of the individuals had a history of prior psychiatric hospitalizations and/or treatment noncompliance (89%), only 25% were identified as needing case management services, and discharge plans for only

**Figure 14: Outpatient Needs Identified
(N = 100)**

Mental Health Treatment 96%
Psychotropic Medication 86%

Medical Treatment 43%
Drug/Alcohol Treatment 33%

Education 16%
Nutritional Counseling 14%
Leisure Activities 11%



Case Management 25%
Daily Living Assistance 24%
Voc/Employment Assistance 24%
Housing 22%
Peer Support 22%
Financial Assistance 21%

Money Management 7%
Child Care 6%
Physical/Occup Therapy 5%
Transportation 3%

20% of the individuals actually referenced some arrangements attempting to address this need. Only five of the individuals in the sample, however, actually received case management or intensive case management services at any one point in time during the 6-month follow-up period.

- Thirty-seven (37) percent of the individuals in the sample lacked a high school education and 76% of these men and women had also been unemployed for at least two years. Assessments and discharge planning notes, however, identified educational needs for only 16% of the individuals in the sample and only 5 of the 37 individuals with less than a high school education. Service referrals for education were noted in discharge plans of only 12 of these 16 individuals. Only nine individuals in the sample actually received any educational services over the 6-month follow-up period.

Other well-documented rehabilitation needs among persons who are seriously and persistently mentally ill were also rarely addressed in assessments or discharge planning. Less than one-fourth of the individuals were identified as needing skill training in the activities of daily living (24%), money management (7%), peer relationships (22%), and using leisure time productively (11%). In addition, even for the few individuals for whom these needs were identified, there was no certainty that the service need would actually be addressed in their discharge plan.

These needs assessments, as reflected in the individuals' discharge plans, also conflicted with the predominant responses by the individuals themselves ($n = 40$) on the Commission's consumer survey. The most common consumer responses to the survey indicated that their most important self-perceived needs on discharge were healthier housing, education, a job, and a supportive group of friends.

As reflected in these data, at most of the hospitals visited, discharge planning did not mean a comprehensive assessment of the individuals' needs, but rather stabilization and a quick turn around to "return the patient" to the outpatient program that he or she had been attending. Upon discharge, 81% of the individuals in the sample with a prior outpatient service linkage returned to the outpatient treatment program(s) that they had attended prior to admission. The few exceptions to this general rule were individuals who stridently objected to returning to their previous program or individuals who had "burned their bridges" as a result of their behavior prior to their hospitalization.

Appropriateness of Referrals

Although the data indicated that most outpatient providers (90%) usually believed that hospitals referred individuals who were appropriate for their programs, they were less unanimous in their belief that hospital staff referred individuals who really wanted what their program(s) had to offer.

- Only half of the outpatient providers interviewed (50%) stated that hospital staff "usually" referred individuals who wanted outpatient services. The remainder (45%) indicated that this statement was "sometimes" true.
- Less than half of the outpatient providers interviewed (42%) said that hospital staff "usually" provided individuals with reliable descriptions of the services available from the program to which they were referred. Again, most of the other respondents (45%) indicated that this statement was "sometimes" true.

Other comments indicated that hospital and outpatient provider staff were not universally familiar with one another's services, and that while hospital referrals were usually judged "clinically correct," they may not have been based on any

personal knowledge of the program or its services, or on any consideration of how the program would meet the individuals' needs.

- Less than half of the outpatient providers (48%) reported that they visited inpatient psychiatric units of general hospitals in their communities at least annually to familiarize themselves with the services and activities offered.
- Only one-third of the outpatient providers (34%) reported that hospital staff visited their programs at least annually.

Outpatient providers, as a general rule, also did not take affirmative steps to meet with new patients before they were discharged from the hospital to introduce them to their programs.

- Only 26% of the outpatient providers stated that they would "usually" ensure a meeting with new patients prior to their hospital discharge. An additional 45% of the providers said that this would "sometimes" occur.
- Only 16% of the outpatient providers said that they would "usually" ensure that new patients visited their outpatient programs prior to their hospital discharge. An additional 37% of the providers said that this would "sometimes" occur.

Follow-Up After Discharge

One of the weakest aspects of discharge activities at all ten of the hospitals visited was the follow-up by hospital staff subsequent to the individual's discharge. In total, hospital records documented postdischarge follow-up with only 15 of the 100 individuals.

Notably, there was not a single documented case where hospital staff provided follow-up directly with the individual after discharge, and in only two cases did hospital staff follow up with the family. In the relatively infrequent cases where follow-up did occur, it usually involved

Norman

In April 1991, 31-year-old Norman was brought to an emergency room of an upstate hospital by his elderly mother. He had not been sleeping; he had received six speeding tickets in a week; and he had been destroying furniture at home. Voicing delusions of grandeur and paranoid ideation in the emergency room, Norman was involuntarily admitted with a diagnosis of paranoid schizophrenia.

Norman, who suffered head injuries in a car accident at age 19, has had at least five previous psychiatric admissions. He is unmarried and lives at home with his elderly parents. Although Norman has a high school diploma and attended college for a year, he has not been able to maintain employment.

After a 21-day stay in the hospital, Norman was discharged to his parents' home in rural upstate New York. Norman and his parents were involved in developing the discharge plan, which included a referral to a local mental health clinic he had previously attended.

During the six months post-discharge, Norman attended his weekly clinic appointments, but he initially made little progress toward his treatment goals of finding some work and feeling more satisfied with how he was spending his time. With the help of the Office of Vocational and Educational Services for Individuals with Disabilities, Norman was referred to a workshop, but he dropped out twice. He also dropped out of a psychosocial club.

Finally, several months later, out of frustration, Norman's therapist asked him to "come up with something to do on his own," and, Norman did just that.

As of December 1991, Norman was a part-time volunteer dispatcher for a rural transportation program. He had utilized the program's free transportation service, and he felt this was a way to pay them back. Norman also volunteered at the local auxiliary fire department, cleaning the firehouse and attending department meetings. Norman is very proud of these activities, and he feels good about the contributions he makes to both organizations.

hospital staff contact with the individual's designated mental health aftercare provider to ensure that the individual made contact (12 of the 15 cases).

Structured interviews with psychiatric inpatient staff of the ten hospitals confirmed limited expectations for follow-up with individuals after discharge. Only two of the ten hospitals reported an expectation that inpatient staff would

contact an individual within one week of his/her discharge, and eight of the ten hospitals stated they usually had insufficient resources to follow up with individuals at some point during the 30 days after their discharge. Despite these acknowledgments, senior staff of these eight hospitals also affirmed that failing to follow up with discharged patients adversely affected linkages with aftercare providers for many of their patients.

Chapter III

Life in the Community

The Commission's review looked most closely at what happened to the 100 individuals after their discharge. We were interested in understanding more about the services the individuals received in the six months after their discharge; whether they had remained psychiatrically stable for the period or if they had been rehospitalized; and the quality of their lives, including their positive achievements and specific difficulties, since their discharge.⁹

Data for this aspect of the review came from several sources. Commission staff interviewed primary clinicians and professionals of all known mental health and non-mental health aftercare service providers who had served the individual during the six months after his/her discharge, as well as hospital staff if the individual had been rehospitalized. In addition, the individuals who had been discharged were offered an opportunity and a \$10 stipend for completing a mail survey or participating in a telephone interview with Commission staff. And, when records clearly indicated that family members of the individual had been involved in treatment or discharge planning during his/her hospitalization, these relatives were also given the opportunity to respond to a mail survey or to participate in a telephone interview with Commission staff.

Basic Indicators

As an initial perspective, the Commission looked at basic quality of life and aftercare

Mike

Although only 22 years old, Mike already had led a very troubled life before his first psychiatric admission to a Long Island hospital in June 1991. Physically abused and then abandoned by his mother at age seven, Mike was placed in foster care, and he had received mental health services during most of his childhood. Known to abuse drugs and alcohol, he was also periodically violent.

At the time of Mike's involuntary admission to the hospital, he was homeless; he admitted to current abuse of cocaine and alcohol; and he told staff, "I want to do myself in." Mike was diagnosed as having a major depressive disorder, a substance abuse disorder, and a borderline personality disorder. During his five-day inpatient stay, he was cooperative with treatment and accepted referrals with specific appointment times to an outpatient alcohol/drug treatment program and a mental health clinic. Housing was a more difficult problem to address, as Mike's foster mother said she could not take him in, but later relented, stating that she would allow him to stay at her home one night until emergency housing could be arranged.

Six months later, we found that Mike had not kept his appointments at the substance abuse program or the clinic. Neither the hospital nor the mental health clinic staff had followed up with Mike, and their staff knew nothing about his whereabouts. Clinic staff reported that he was probably homeless and using drugs again.

⁹ For a number of issues discussed in this report, the term "known" is used. The Commission was unable to obtain any follow-up information for 11 of the 100 individuals in the sample. These individuals made no known contact with an aftercare service provider, and neither they nor their family members responded to the Commission's inquiry. It is possible, and even likely, that some of these "lost" patients also encountered particular problems that are discussed, but these problems were not "known."

service indicators. These data revealed that a majority of the individuals did reasonably well in the six months after their discharge. Most individuals in the sample maintained contact with mental health services for the full 6-month follow-up period (60%), were not rehospitalized for their psychiatric condition (62%), and had maintained their initial postdischarge housing arrangement. Almost half (48%) had also reportedly maintained a stable relationship with their family during the follow-up period.

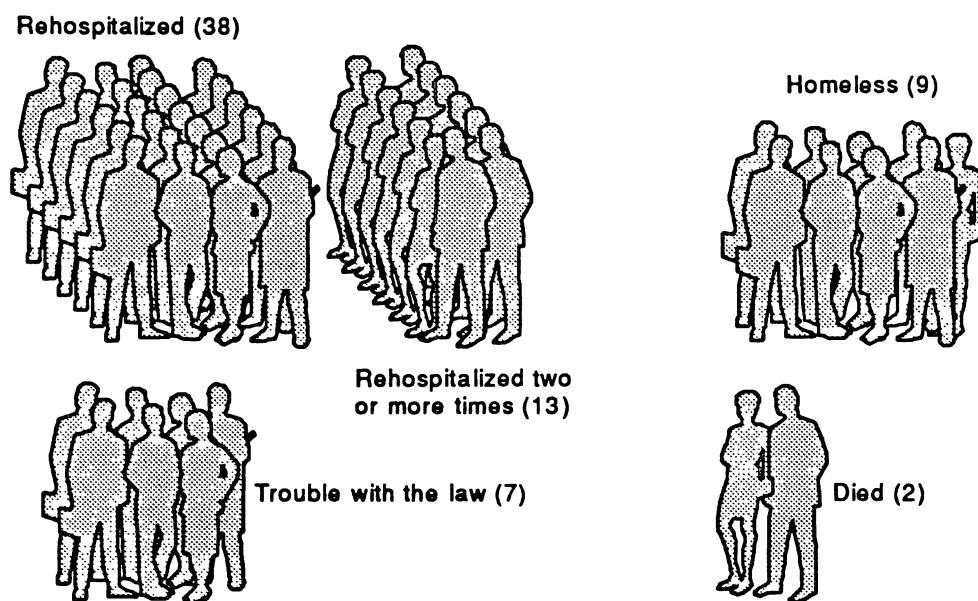
In contrast, however, approximately 4 out of every 10 individuals in the sample (38%) were rehospitalized for psychiatric problems at least once during the 6-month period, and 13% were rehospitalized two or more times. Nine (9) of the 100 individuals were known to have been homeless for at least part of the period; 7 of the 100

individuals had encountered problems with the law; and 2 of the 100 individuals had died (Figure 15). And, although almost all the individuals in the sample had limited financial means and were dependent on financial assistance and/or entitlements, one-third (34%) were known to have experienced significant financial problems during the 6-month period, and 5% of the individuals were known to have been without an adequate supply of food and clothing at some point during the period.

Staying in Contact With Services

Maintaining contact with mental health services has been identified in the literature as a key criterion for evaluating discharge planning. The data showed that more than half of the individuals discharged were in contact with at least one

Figure 15: Six-Month Postdischarge Outcomes*
(N = 100)



mental health provider at the end of the 6-month follow-up period, but that 40% of the individuals had dropped out (Figure 16).¹⁰

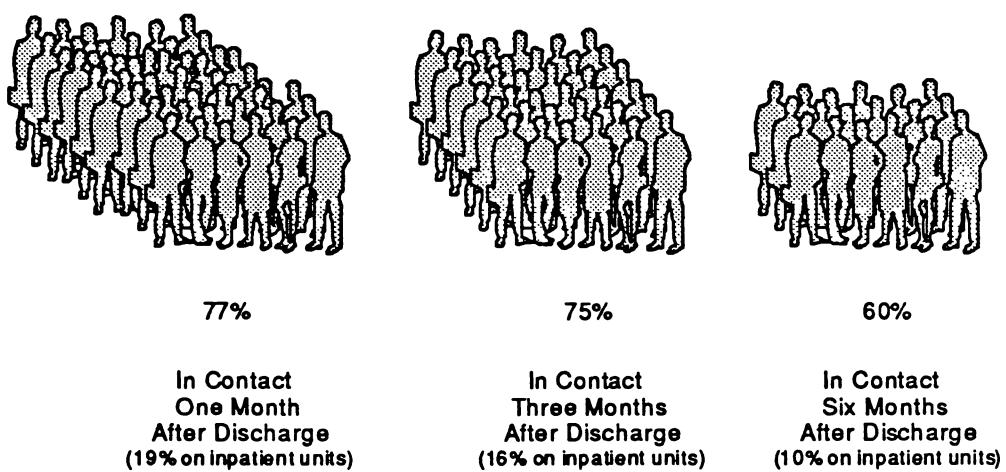
- Three-fourths of the individuals (77%) maintained contact with at least one mental health provider through the first 30 days after their discharge.
- Although the percentage of individuals still in contact at three months after discharge had dropped only slightly to 75%, this percentage dropped off more significantly to 60% by the sixth month after discharge.

The data also indicated that most individuals who did not maintain contact with a mental health service provider over time, actually never made contact at all. In total, 22 of the 40 individuals (55%) who were not in contact with services by the end of the 6-month follow-up period had never made initial contact. This finding reinforces the importance of ensuring initial contact shortly after discharge.

Limited Service Contact, Usually at a Clinic

Making and maintaining service contact did not, however, usually imply that the individuals

**Figure 16: Individuals in Contact With Services
(N = 100)**



¹⁰ Ten (10) of the 60 individuals still in contact with mental health services at the end of the follow-up period were in a hospital being treated for a psychiatric condition. Four (4) of these 10 individuals had been transferred to a state psychiatric center directly upon discharge from the general hospital and remained there for the full 6-month follow-up period. Thus, 4 of the 60 individuals described as "still in contact" with services essentially never left inpatient care during the 6-month period.

were in frequent contact with outpatient services (Figure 17). Almost half of the individuals had no or infrequent service contact (10 or fewer contacts), usually exclusively with a mental health clinic, in the six months after their discharge. The typical individual in the sample who participated in services was only enrolled in a clinic program and attended only 12 appointments during the full 6-month follow-up period. Given that clinic appointments are usually only 30-45 minutes long, these observations indicate that about half of the individuals in the sample received less than 8-10 hours of services during the entire 6-month follow-up period.

- Twenty-two (22) percent of the individuals received no aftercare services during the 6-month period, and another 26% had 10 or fewer service contacts during this period.
- One-fourth of the individuals (24 of the 100) had between 11 and 30 service

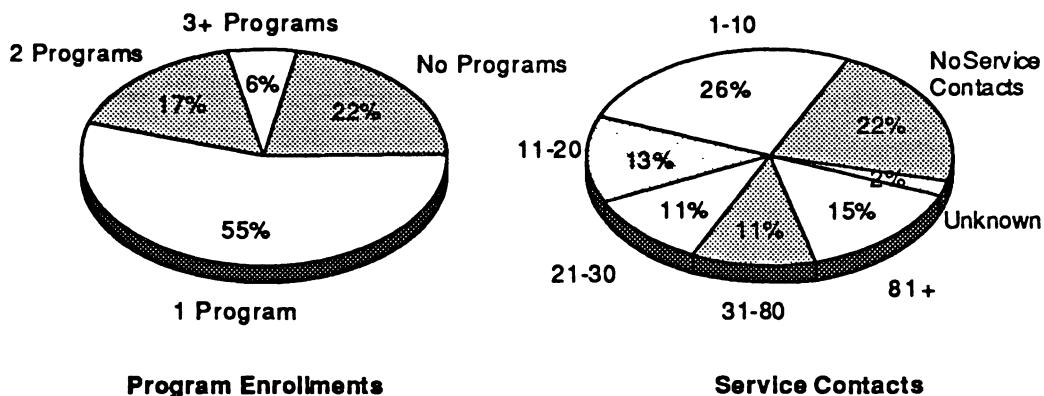
contacts in the 6-month follow-up period.

- Only 26 of the individuals had more than 30 service contacts, and only 15 individuals were intensively served, with more than 80 service contacts during the follow-up period.

Only 23 of the 100 individuals were enrolled in two or more service programs during the follow-up period, and only ten of these individuals were enrolled in two programs at the same time for some or all of the follow-up period. Almost all of these 23 individuals (83%) were enrolled in at least one clinic program, and multiple program enrollment for 3 of the 23 essentially involved changing clinic programs one or more times over the period.

Half of the individuals in the sample (56%) made contact with at least one mental health clinic during the six months following their discharge, while only 22% made contact with a continuing day treatment program. Only 6 of the

**Figure 17: Total Number of Aftercare Programs and Contacts in the Six-Month Postdischarge Period
(N = 100)**



100 individuals received regular case management services (3 individuals) or intensive case management services (4 individuals)¹¹ in the 6-month period, and only 4% joined a psychosocial club (Figure 18).

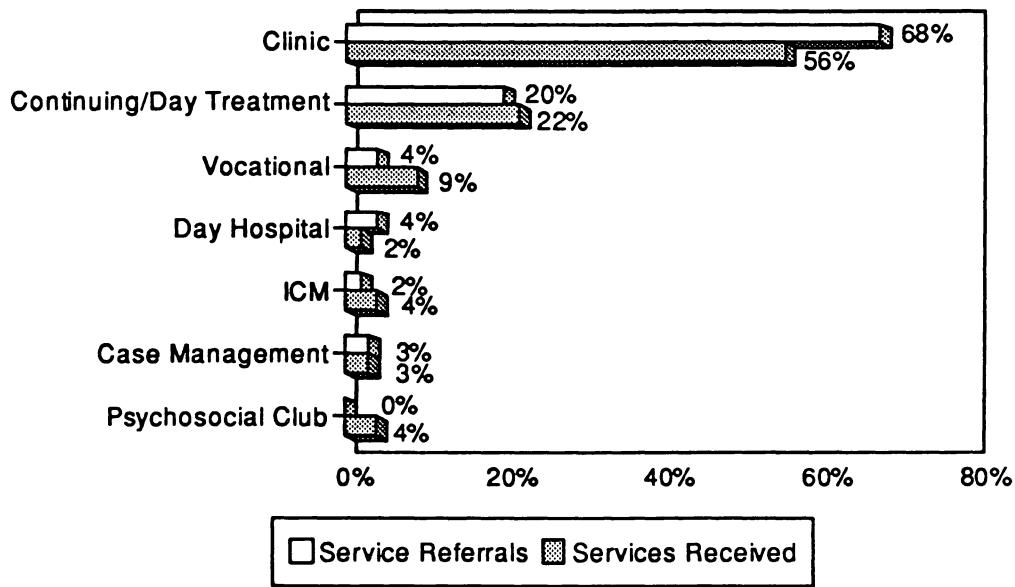
Thirteen (13) of the 15 individuals who were intensively served (more than 80 service contacts) were primarily served by continuing day treatment/day hospital programs (10) and vocational programs (3). In contrast, the data indicated that clinic enrollees tended to be among the least intensively served individuals. Over half of the 56 individuals (54%) enrolled in a clinic program(s) had 10 or fewer total service contacts in the 6-month period, and only 11 of

these individuals (20%) had more than 20 service contacts in the follow-up period.

Drug/Alcohol Abuse Services

In total, 28 of the 100 individuals were identified during their hospitalization as having a problem with drug or alcohol abuse, while outpatient therapists identified 23 individuals known to have abused drugs or alcohol during the 6-month period following their discharge. Combining these two lists of individuals, the Commission noted evidence of drug or alcohol abuse problems on admission assessments and/or in discharge plans for 41% of the individuals in the sample.

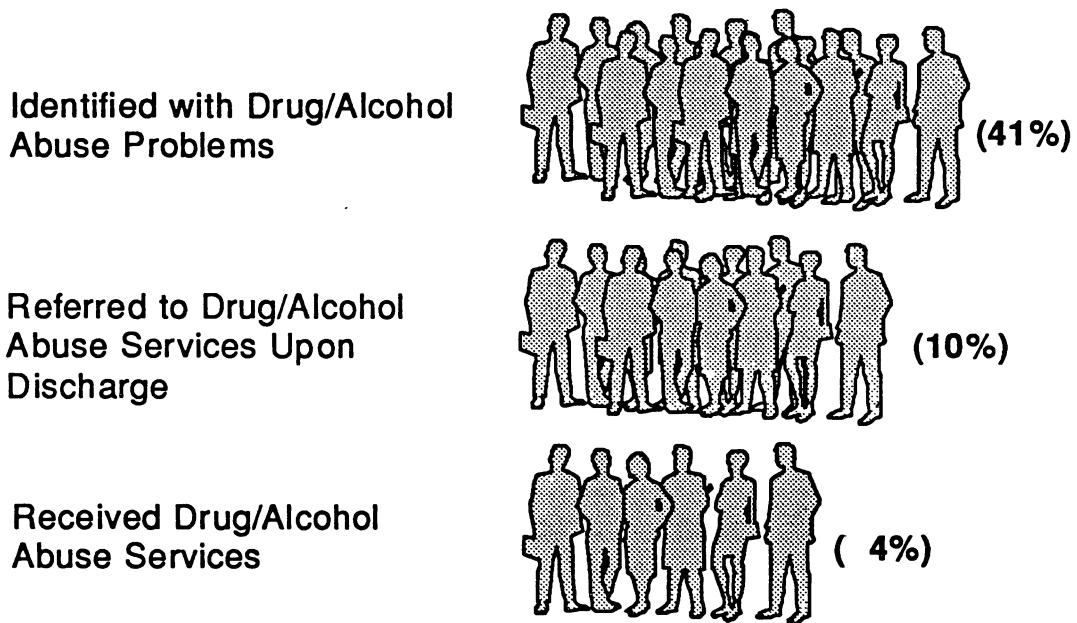
**Figure 18: Aftercare Referrals Versus Attendance
in the Six-Month Postdischarge Period*
(N = 100)**



*Categories are not mutually exclusive.

¹¹ One of the four individuals who received intensive case management services during the 6-month follow-up period also received regular case management services.

**Figure 19: Drug/Alcohol Abuse Service Provision
in the Six-Month Postdischarge Period
(N = 100)**



Treatment for drug and alcohol abuse problems, however, was not common (Figure 19). Discharge plans of only 10 individuals included aftercare referrals to drug or alcohol abuse services, and only four of these individuals were known to have received any drug or alcohol abuse services during the entire 6-month follow-up period.

Many inpatient and outpatient providers reported that appropriate drug and alcohol abuse treatment services for their patients who were also seriously mentally ill were very difficult to find.¹² In many communities, there were extended (and sometimes endless) waiting lists for a residential drug or alcohol abuse program

placement for individuals with a serious mental illness, and many providers noted that existing outpatient drug and alcohol programs were not sufficiently structured or intensive to meet the needs of their clients.

Psychiatric staff at 7 of the 10 hospitals visited also reported that more accessible and appropriate drug and alcohol abuse services would make "a great deal of difference" in helping discharged patients live more comfortable and healthy lives in the community. Additionally, 4 of the 10 hospitals reported that licensed mental health outpatient programs in their communities were reluctant to serve the mentally ill chemical abuser, creating another

¹² This observation that drug and alcohol abuse services are not readily available for individuals who also have mental health problems has also been documented in previous Commission studies, *Outpatient Mental Health Services*, July 1989; *Admission and Discharge Practices of Psychiatric Hospitals*, April 1989; *Discharge Practices of Inpatient Psychiatric Facilities*, August 1988; *The Multiple Dilemmas of the Multiply Disabled: An Approach to Improving Services for the Mentally Ill Chemical Abuser*, September 1986.

significant obstacle to effective discharge planning for these patients.

Although all of the 38 outpatient providers visited indicated that their programs served persons with drug and alcohol problems and 16 of these providers also reported sponsoring at least one drug or alcohol abuse program, one-fifth of the outpatient providers interviewed (21%) reported that patients' continued abuse of drugs or alcohol was a significant factor related to their difficulties in the community.

Psychiatric Rehabilitative Services

As stated above, most of the individuals in the sample were enrolled in traditional clinically oriented mental health outpatient programs. In total, only one-third of the individuals in the sample were known to have gainful employment or to have participated in some supported work, sheltered work, educational or rehabilitative activity at any time during the 6-month follow-up period.

- Only one-fourth of the 100 individuals in the sample had a job (6 individuals), participated in any form of vocational or supported work program (9 individuals), or attended an educational program (9 individuals) during the 6-month follow-up period.
- Only 15 individuals attended a day treatment program or a day hospital program at least 30 times during the 6-month period.

As mentioned in the previous chapter, service availability did not appear to be the primary barrier to individuals receiving these rehabilitatively oriented services. In almost all communities visited, outpatient program providers indicated that these programs had short or no waiting lists, and that admissions could be arranged within two weeks of a request.

Barry

Barry is 23 years old; he has cerebral palsy and uses a wheelchair. During May 1991, Barry was hospitalized 31 days for treatment of an exacerbation of the manic features associated with his bipolar disorder.

Once released from the hospital, Barry returned to his family's home and began attending a local continuing treatment program. Unfortunately, Barry's physical and psychiatric setback precluded his return to competitive employment.

Barry's therapist noted progress in Barry's awareness and understanding of his illness which he attributed to Barry's attendance at the continuing treatment program, but Barry would like to have a job again. In the meantime, Barry has involved himself in a consumer self-help group where he is learning to use computers and is regaining work skills.

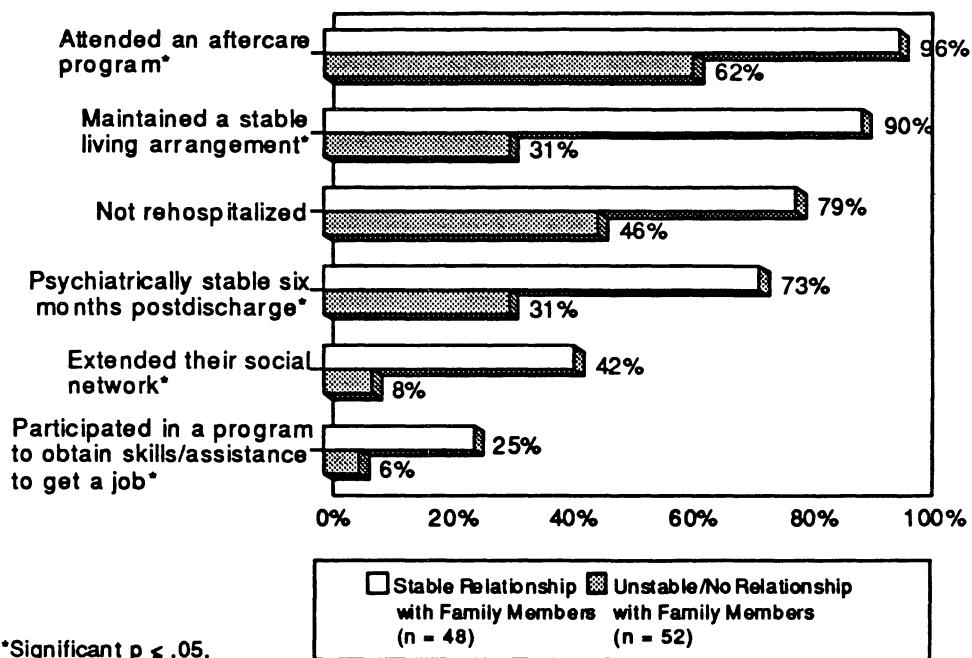
Barry's opinion of his day treatment program is that it is ". . . basically geared for the elderly and I'm only 23. I personally get bored sometimes with their activities." Barry, however, is optimistic about his future and poignantly relayed his hopes to ". . . move on to bigger and better things. I want to help other people the way they've helped me [and] pay back my debt."

Other Supports

Only 11% of the individuals in the sample benefited from regular or intensive case managers, psychosocial club attendance, and/or participation in support groups during the 6-month follow-up period. The individuals in the sample were more likely to have informal supports than to participate in these organized support services.

According to their inpatient records and/or their outpatient therapists, three-fourths of the individuals (77%) had some informal support network. Two-thirds of the individuals (63%),

Figure 20: Family Relationships Predictive of Better Outcomes



had supportive relationships with family members, and 40% had supportive friends or significant others.

Outpatient therapists further indicated that almost half of the individuals (48%) had maintained supportive and stable relationships with family members and significant others during the six months following their discharge and that 24% of the individuals had expanded their social network and made friends during this period.

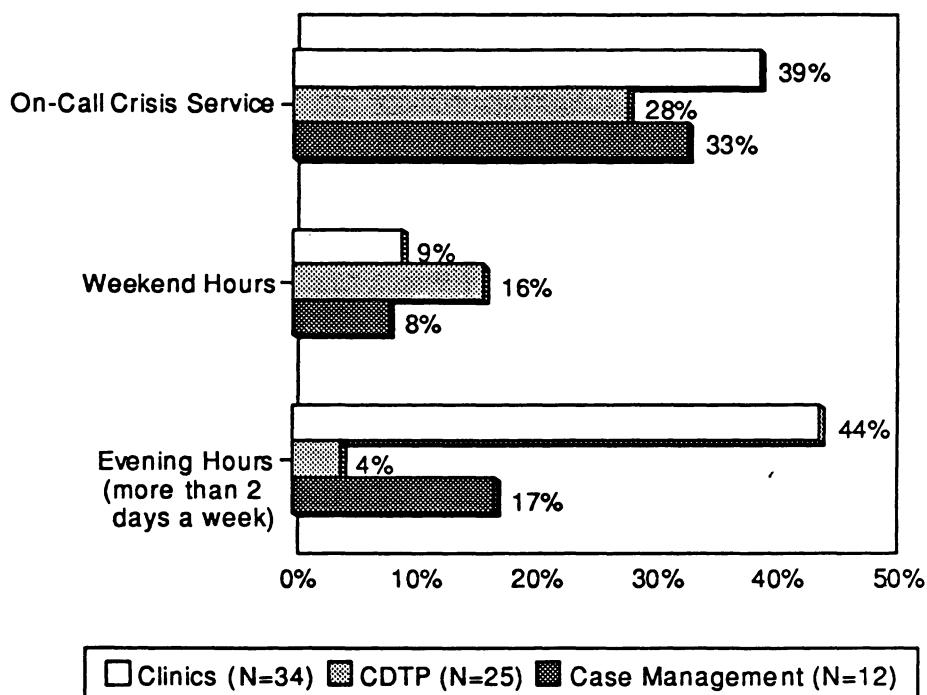
Perhaps most critically, data analyses showed that the presence of informal supports, and especially maintaining a stable relationship with family members, was associated with many positive postdischarge outcomes. For example, these individuals were more likely to attend services, not to be rehospitalized, to maintain a stable housing arrangement, and to expand their social networks (Figure 20).

Crisis Services

Based on reports by their outpatient primary therapists, 29% of the individuals in the sample accessed crisis services at least once during the 6-month follow-up period. Twenty (20) of these 29 individuals were also rehospitalized, either proximate with the time of seeking crisis services, or at some other point during the 6-month follow-up period.

For almost all of the individuals in the sample, crisis services were provided in an emergency room of a local hospital, as crisis, weekend, and evening services were not regularly available from the outpatient providers in their communities (Figure 21). Only 26% of these 38 outpatient providers visited by the Commission reported that they offer a 24-hour on-call service, which is staffed by one of their personnel. Most of the providers reported that their answering service

Figure 21: Availability of On-Call Crisis, Weekend and Evening Services



provides a taped message referring individuals to the local hospital emergency rooms if they need services after hours or on weekends.¹³

Additionally, most of the outpatient providers visited reported that their programs offer no weekend hours. Across the 38 outpatient provider agencies visited, only 16% of the 25 continuing day treatment programs, 9% of the 34 clinic programs, and 8% of the 12 regular case management programs offered any weekend hours. Although more programs reported offering hours after 5:00 p.m. on weekdays, less than half of the clinics offered evening hours more than two days a week. Only 17% of the case

management programs and 4% of the continuing day treatment programs were open more than two evenings during the week. Only intensive case management programs routinely offered evening and weekend services. As noted earlier only 4% of the individuals received intensive case management services.

Noncompliance With Outpatient Treatment

Noncompliance with outpatient psychiatric treatment seemed to be the rule, rather than the exception, for the vast majority of the individu-

¹³ Many of these outpatient providers also do not offer a real "on-call" staff person for hospital emergency room staff who may encounter one of their patients. Thus, if an individual presents at an emergency room at 5:00 p.m. on a Friday, it is unlikely that hospital staff will be able to contact his/her outpatient therapist or obtain any information until Monday.

Stephen

Stephen, age 21, is unemployed, lives with his family, and has a history of drug abuse. In April, Stephen was admitted to a Long Island hospital after attempting to stab his sleeping brother with a knife. Prior to his admission, Stephen had stopped taking his medication, and he had become increasingly psychotic. At this time, Stephen was also on probation for a sex offense.

After a 21-day inpatient stay, Stephen was discharged back to his parents' home and was given appointments at two continuing day treatment programs. His parents had been involved in discharge planning, and when interviewed by Commission staff, they responded that the arrangements made by the hospital staff were "quite good" and that the family's concerns were addressed and incorporated in the plans.

Stephen was typical of individuals who change services frequently and do not appear satisfied with available options. Although hospital staff actually enrolled Stephen (and arranged visits) in one continuing day treatment program prior to his discharge, he did not attend the program for five

weeks. In the interim, he "tried out" the other continuing day treatment program to which he had been referred, but never enrolled.

The therapist at the day program he finally attended stated that Stephen had been discharged for noncompliance after approximately four months. Stephen reportedly had attendance problems, was difficult to control, needed constant reminders about program rules, and had recently grabbed another woman enrolled in the program. Upon discharge, Stephen was referred to a third continuing day treatment program.

After four appointments for intake, Stephen decided not to attend the new continuing day treatment program, and he was then referred to a psychosocial club. According to staff, this referral was contingent on Stephen's agreement to attend a clinic run by the same agency for medication management.

Thus, six months after his hospital discharge, Stephen had tried out three programs; one program had rejected him and he had rejected the other two. He was now on his way to try out two more, one of which he apparently was being compelled to attend.

als in the sample. As noted previously, discharge plans of almost all of the individuals in the sample (97%) included a referral and/or a specific appointment (80%) for outpatient services. Follow-up indicated that 22 of these 97 individuals (23%), however, did not make contact with this or any other mental health outpatient provider during the entire 6-month follow-up period.¹⁴

Noncompliance with outpatient care also seemed to persist for a significant minority of the individuals who had made some contact with aftercare services.

- Almost one-third of the 78 individuals (29%) who attended an outpatient mental health program had been subsequently discharged from a program for failing to keep appointments or to comply with program rules or participation requirements.
- One-third of the 56 individuals who attended a mental health outpatient clinic program (32%) missed more than three clinic appointments during the 6-month follow-up period.

¹⁴ Although the patient subsamples are small, almost twice as many patients who received only a general referral with no specific appointment ($n = 16$) failed to make contact with an aftercare provider than patients who had a specific appointment prior to discharge ($n = 80$) (41% versus 23%). The four individuals who remained inpatients at state psychiatric centers for the full 6-month period are excluded from this analysis.

- Over half of the 38 individuals who attended some other mental health program (55%) missed more than three scheduled appointments or sessions during the follow-up period.
- Primary therapists reported that 42% of the 83 individuals discharged with a prescription for a psychotropic medication were known to have been noncompliant with their psychotropic medication regimen over the follow-up period.

Outpatient providers interviewed by the Commission accepted patient noncompliance as a “fact of life,” and most had established protocols (95%) for follow-up with individuals who missed appointments, with 82% usually following up by phone and 50% usually following up with a letter. Less frequently, outpatient providers reported following up with patients who missed appointments by assigning a case manager (21%) or by making a home visit (8%). A few providers had also instituted “automatic discharge” guidelines for individuals who had missed three or more appointments. These providers would allow these individuals to reenroll, but only after going through another intake assessment.

Few outpatient providers, however, had taken more proactive steps to promote patient compliance and investment in services. When the Commission asked providers what they had done to promote patient involvement in services, few providers identified initiatives that encouraged ongoing consumer involvement in shaping or influencing the operating practices or services of their programs, and only 8% had any formal vehicle for consumer evaluation of services.

Overall Quality of Life

The Commission also attempted to assess the quality of life of the individuals in the sample in the six months after their discharge. Data for this

section of the report have several limitations. On the one hand, there was some inevitable subjectivity in the choice of the positive and negative indicators assessed.

For a minority of individuals in the sample (11%), the Commission was not able to make contact with any service provider who had served the individual or to contact the individual himself/herself to obtain information about their lives. For others, reports were sometimes incomplete as the service provider was not in contact with the individual for the full 6-month follow-up period. Finally, only 40% of the individuals in the sample completed a consumer survey or agreed to be interviewed by Commission staff. Thus, direct reports from the individuals were not always available for the individuals in the sample.

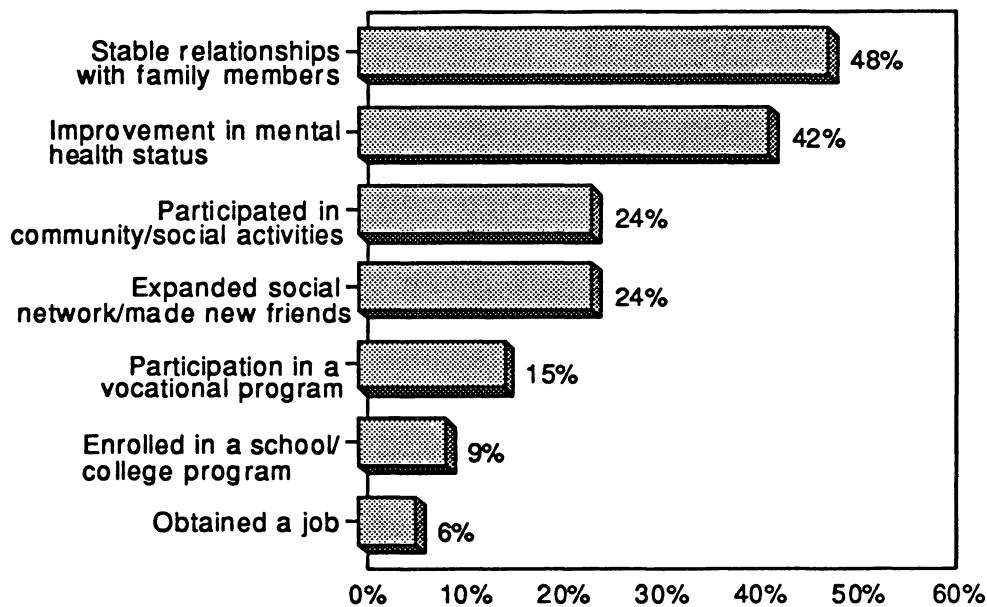
Given these limitations, it is fair to say that the data findings below probably offer an incomplete portrait of both the positive achievements and the difficulties experienced by the individuals in the sample. Notwithstanding these limitations, however, they do provide some interesting observations.

Many Positive Achievements

Most of the individuals had attained some positive achievements during the follow-up period (Figure 22).

- Nearly half (48%) reportedly maintained supportive, stable relationships with family members and/or significant others.
- Forty-two (42%) percent were judged by their primary therapists as experiencing an improvement in their mental health status.
- One-fourth of the individuals (24%) had participated productively in community, volunteer, and social club activities.
- One-fourth of the individuals (24%) had expanded their social network and made new friends.

**Figure 22: Positive Life Events Postdischarge*
(N = 100)**



*Categories are not mutually exclusive.

- Finally, 15 of the individuals had participated in a program to obtain skills or to assist them in getting a job; 6 had actually obtained a job; and 9 individuals had enrolled in a school or college program.

In total, 66% of the individuals in the sample had at least one of the above positive achievements areas, and 40% had a positive achievement in two or more of the areas.

Adverse Events and Circumstances

The data also indicated that most of the 100 individuals experienced adverse events or circumstances during the 6-month follow-up period. As referenced earlier, 9% had been homeless, 5% had gone without sufficient food or

clothing, and one-third (34%) had experienced significant financial problems. And, exacerbations in psychiatric conditions of 38% of the individuals had resulted in their rehospitalization at least once during the 6-month period.

Almost one-fourth of the individuals (24%) suffered a serious physical illness or medical condition, and two had died. Smaller percentages of the individuals were also known to have had problems with the law (7%), lost a job (5%) or a financial entitlement (3%), divorced or separated from a spouse (7%), or experienced the death or serious illness of a spouse, family member, or significant other person in their lives (12%), and a significant 25% of the individuals had moved from their place of residence at least once during the 6-month follow-up period.

Leah

Leah is 31 years old and unmarried, and she has a seven-year-old son. A high school graduate with two years college education, Leah has been unemployed for the past several years.

In May 1991, Leah was involuntarily admitted to a hospital in upstate New York because she was unable to concentrate, was delusional, and confused. Leah was diagnosed with a psychotic disorder, not otherwise specified. Leah was in the hospital for only eight days when her family removed her against medical advice for reasons of "family business."

Consequently, hospital staff were unable to arrange a specific aftercare service appointment for Leah, but they did recommend that she call the local clinic for an appointment. Notably, just one day prior to Leah's departure, an entry in her hospital record indicated that "...she needs acute care."

Upon discharge, Leah did make an appointment at the clinic, but she did not keep it. When clinic staff called Leah after she missed the appointment, they found her to be delusional, hostile, and resistive to their intervention and suggestions.

Leah also told them that she was using alcohol and drugs, that she was unable to find work, and that her telephone service was being shut off. Since Leah flatly refused to come to the clinic, staff alerted the clinic's mobile crisis team to Leah's situation and suggested that they follow up on Leah in the community.

Two months later, Leah showed up at the clinic without an appointment and was seen by a psychiatrist who believed that she was in a psychotic state. He tried to encourage Leah to attend the clinic program, but was met with hostility and rejection from Leah. As a final and desperate attempt to reach out to Leah, clinic staff again notified the local crisis services program and the local Social Services Department's Child Protective Unit of Leah's condition and living situation, and requested that these programs make another attempt to contact Leah.

Approximately two months after Leah's discharge, the clinic staff had no further information about her whereabouts or the outcomes of their other referrals. Leah also did not respond to the Commission's survey.

In total, 74% of the individuals were known to have experienced at least one of these negative events or circumstances, including 50% who experienced two and 27% who experienced three or more.

Self-Assessments on Quality of Life

The self-reports of the individuals in the sample who responded to the Commission's survey were generally positive, both in regard to their overall well-being since their discharge, and their satisfaction with discharge planning and outpatient services.

- Of the 40 individuals who responded, more than half indicated that they had

been doing "just great" (8%) or "pretty good" (45%) since their discharge. Only 15% indicated that they had "lots of problems," and only one individual said things had been "horrible."

- Thirteen (13) of the 40 individuals (33%) rated the hospital's services in getting them ready for discharge as "really terrific," and an additional 38% rated them as "quite good." Only 16% rated them as "quite bad" (8%) or "really awful" (8%).
- Nearly half also rated the outpatient services they received as "really terrific" (13%) or "quite good" (35%). Only 13% rated them as "quite bad" (8%) or "really awful" (5%).

Figure 23: What the Individuals Said . . .*

(N = 40)

What did they need to do before discharge from the hospital?

Needed to . . . calm down, take medications, and attend in-house activities.

Were they ready to leave at the time of discharge?

Yes, but I could not have left sooner because I got a much-needed rest.

How did hospitalization help them?

It helped in a limited capacity. Appointments were set up and referrals were made, but they didn't see to it that you got somewhere and they didn't go with you.

How have they been since discharge?

Good (50%), Not Bad (30%), Horrible . . . Lots of Problems (20%)

What do they want in the community?

. . . healthier housing, transportation, education, a job, and a supportive group of friends.

* Results are based on quotations of the most frequent responses to the survey items.

Although this was a small sample of consumers, their narrative comments were also helpful in gaining a more concrete understanding of what may be most important to consumers (Figure 23). For example, despite the fact that there was a high rate of involuntary admissions in the sample (54%), most individuals responding stated that their hospitalization had helped them, especially in providing a much-needed rest and assuring service referrals. The most common criticism of hospital services was that hospital staff did not help patients in following through with referrals. As one consumer put it—
. . . appointments are set up and referrals are made, but they don't see to it that you get somewhere and they don't go with you.

Many of the consumers, despite their overall reported satisfaction with the services that they were receiving, also had recommendations for how to make the service system better, and there was striking constancy in their responses—
. . . healthier housing, transportation, education, a job, and a supportive group of friends.

Chapter IV

The Rehospitalized Individual

As noted in the previous chapter, almost 4 of every 10 discharged individuals in the sample were rehospitalized in the next six months, and 13 of these 38 individuals were rehospitalized two or more times.

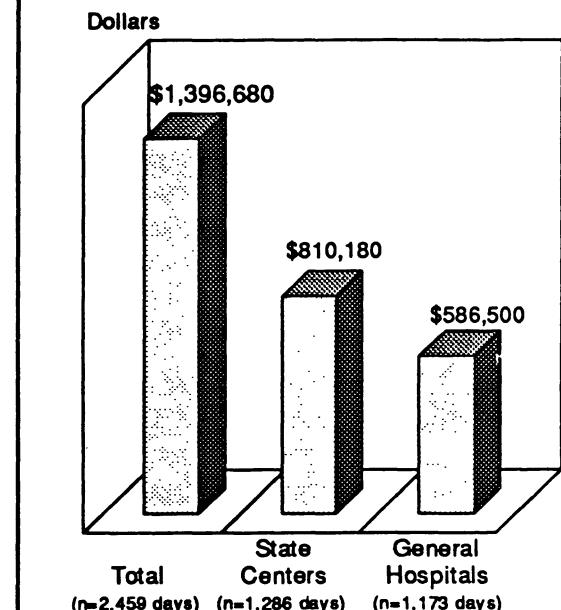
In total, the 38 rehospitalized individuals spent 2,459 days on psychiatric wards of general hospitals or state psychiatric centers during this 6-month follow-up period. The average rehospitalized individual spent 65 days of the 6-month follow-up period on an inpatient psychiatric ward; the median length of rehospitalization stays was 33 days.

Costs of Rehospitalizations

Based on average reimbursement rates for psychiatric units of general hospitals and state psychiatric centers, the rehospitalizations of these 38 individuals in the 6-month period cost approximately \$1,396,680, or about \$36,755 per individual (Figure 24). Approximately 58% of this estimated cost (\$810,180) reflects the cost of rehospitalized patient days in state psychiatric centers. Reflecting both their lower number of rehospitalized patient days (1,173 versus 1,286) and their lower average per diem rate (\$508 versus \$630), general hospital costs comprise only 42% or \$586,500 of the total.

The state share of these costs is also high, largely because of the limitations on federal fiscal participation in reimbursing care in state psychiatric centers for patients between the ages of 21 and 64. As mentioned above, on average, state psychiatric centers also have a 24% higher

Figure 24: Cost of the Rehospitalizations of the 38 Individuals*



*Based on average Medicaid per diem reimbursement rates.

per diem rate than general hospital psychiatric units.

The state share of the rehospitalization costs in state psychiatric centers alone was \$769,671 or 95% of the total cost of these rehospitalizations. The total state/local share of the rehospitalization costs for general hospitals was \$293,250.¹⁵

Going Back to the Hospital

Almost two-thirds of the rehospitalized individuals (62%) were readmitted to a hospital within the first three months of their discharge.

¹⁵ The state government assumes 50% or more of this state/local share of general hospitals, with the exact percentage determined by the local government's Medicaid overburden payment. There is no local government share for state psychiatric centers.

Jerry

Jerry, age 32, was an unusual individual in the sample, as he had no prior history of psychiatric hospitalization. However, over the 6-month period since his first hospitalization in April 1991, he was rehospitalized three times.

Jerry had been receiving mental health outpatient services for about four years, when in August 1990 he separated from his wife of nine years and his two children, ages seven and nine. At this time, Jerry moved in with his parents, but immediately prior to his first hospitalization he had moved out on his own. Living alone was not easy for Jerry, and he became increasingly despondent over his separation; he binged on alcohol daily; and one week prior to his first admission, he took an overdose of prescription medication.

During Jerry's first hospitalization, he was involved in many discussions about needed after-care services, including clinic follow-up, supportive housing, and participating in parenting classes and Alcoholics Anonymous meetings. Despite these discussions, after a 21-day hospital stay, Jerry left the hospital with only a clinic appointment.

Within one month, Jerry experienced his first rehospitalization for recurrent depression and al-

cohol abuse. Upon discharge, Jerry was again referred to the clinic he had attended for years, and he was also assigned a case manager to assist him with his financial problems.

Jerry was rehospitalized again a month later and then again within 45 days of this discharge. Only after this fourth hospitalization in five months was Jerry referred for alcoholism treatment. Unfortunately, he did not follow up with this referral or return to the clinic. In September 1991, shortly after his last discharge from the hospital, Jerry was discharged from the clinic for failing to keep his readmission appointment. The next month, he was sent a letter explaining that he would have to go through the entire intake process again to be accepted back into the clinic.

In response to the Commission's survey, Jerry minced no words. He said that he has been "horrible and had lots of problems, especially during the last three months of 1991." Jerry added, "I have had a lot of trouble remembering my appointments and, as a matter of fact, they dropped me when I missed an appointment. Now I have to start with intake again and go without medicine."

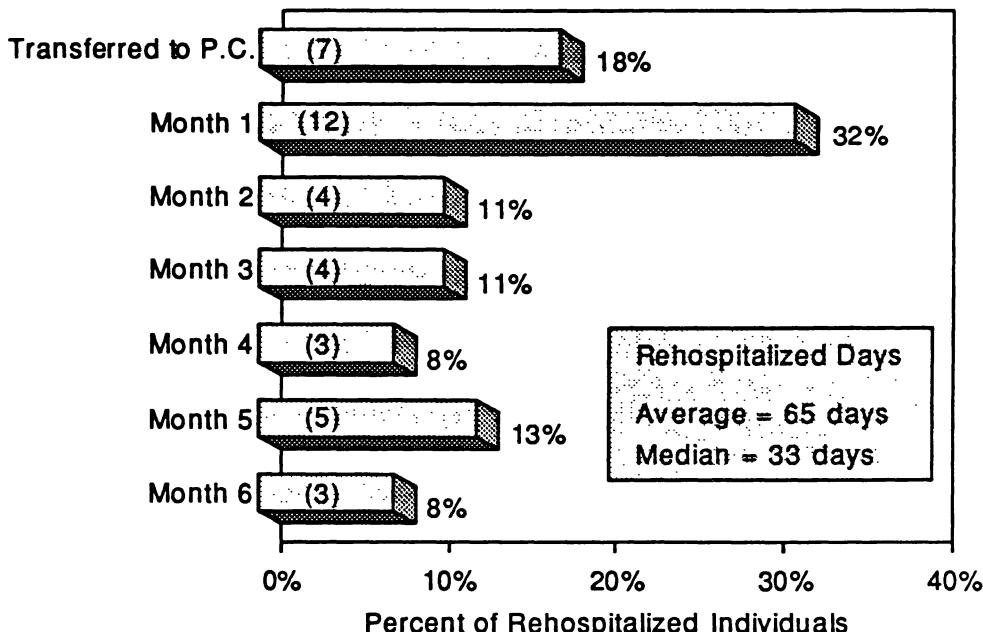
Half of these individuals were on an inpatient unit within 30 days of their discharge. Seven of the 38 rehospitalized individuals (18%) were transferred upon discharge directly to a state psychiatric center, and another 12 (32%) were rehospitalized for the first time within 30 days of their discharge.

Eight other rehospitalized individuals (22%) went back to the hospital for the first time 31 to 90 days after their discharge. In contrast, only 11 of the 38 individuals (29%) were rehospitalized for the first time more than 90 days after their initial discharge (Figure 25).

In total, the 38 individuals had 56 rehospitalizations during the 6-month follow-up period, with 34% of these individuals accounting for two or more rehospitalizations each. Further analysis showed that although 77% of the rehospitalizations occurred in general hospitals, rehospitalizations in state centers were typically of much longer duration.

Four of the seven individuals in the sample who transferred to a state psychiatric center directly upon discharge stayed there for the full 6-month follow-up period. Two other individuals who were admitted to a state psychiatric center

**Figure 25: Month of First Readmission for Rehospitalized Individuals
(N = 38)**



during the 6-month follow-up period had lengths of stay over 150 days. Only half of the individuals rehospitalized in state centers had lengths of stay less than 60 days. In contrast, the average length of rehospitalization per person in general hospitals was 28 days, and only 5 of the 43 rehospitalizations in these settings were over 60 days.

These variances in lengths of stay are consistent with the state's initiatives to redefine the role of the state centers as intermediate and long-term treatment settings, leaving acute care to the general hospitals. On the other hand, the high percentage of individuals (50%) with stays in state centers over 150 days was surprising.

Comparative Profile Overview

Comparative profiles of the rehospitalized and nonrehospitalized individuals indicated some significant differences, but as noted in this chapter, these two groups of patients also had much in common. For example, there were few significant demographic differences between the two groups of individuals, and there were also few differences between the rehospitalized and the nonrehospitalized individuals in terms of the outpatient services they received.

Notwithstanding these similarities between the rehospitalized individuals and the nonrehospitalized individuals, the Commission found it remarkable that the rehospitalized individuals were clearly distinguishable on two key

and readily identifiable traits: documented treatment challenge upon admission and during their hospital stay, and the lack of any informal support network of family or friends (Figure 26).

- Rehospitalized individuals were more likely to have had two or more prior hospitalizations and to be identified, upon admission, as dangerous to others and noncompliant with psychiatric treatment.
- Rehospitalized individuals presented significantly more "treatment challenges" during their hospital stays.
- Rehospitalized individuals were less likely to have an informal support network of friends or family, and they were less likely to have been discharged to their own or family home.

Rehospitalized individuals were also not significantly different on most outpatient noncompliance variables, and there was virtually no differ-

ence between the two groups of individuals in terms of their likelihood to be in contact with mental health services (inpatient or outpatient) at the close of the 6-month follow-up period.

Downstate Location

Rehospitalization was significantly more common for individuals served in the six downstate (NYC and Long Island) hospitals in the sample versus those served in the four upstate hospitals. One-half (50%) of the individuals served in downstate hospitals were rehospitalized compared to one-fourth (24%) of the individuals served in upstate hospitals ($\chi^2=5.74$, df = 1, p<.05).

With the exception of this geographical difference, however, there were no significant demographic differences in age, sex, race, education, or employment histories which distinguished the rehospitalized and the nonrehospitalized individuals.

Figure 26: Rehospitalized Versus Nonrehospitalized Individuals

**Rehospitalized
Individuals
(N=38)**

92%	Two or more prior hospitalizations*
24%	Upon admission, dangerous to others*
37%	Scored above average (4 or higher) on Treatment Challenge Scale*
63%	Informal support network in the community*
26%	Maintained a supportive and stable relationship with family members**
45%	Discharged to their own home or their family's home

**Nonrehospitalized
Individuals
(N=62)**

66%
7%
16%
89%
61%
79%

* Significant p<.05

** Significant p<.01

Hospital Stays

Rehospitalized individuals and nonrehospitalized individuals were similar in terms of their likelihood to have been admitted on involuntary status (58% versus 52%). Additionally, similar percentages of the two groups manifested specific psychiatric symptoms upon admission (e.g., suicide attempt, depression, delusions, hallucinations etc.).¹⁶

There was evidence, however, that rehospitalized individuals presented more chronic and serious problems upon admission and during their hospitalization.

- Rehospitalized individuals were significantly more likely than nonrehospitalized individuals to have had two or more prior psychiatric hospitalizations (92% versus 66%, $\chi^2 = 7.35$, df = 1, p<.01).
- Upon their initial admission, rehospitalized individuals were more likely to be described as dangerous to others (24% versus 7%, $\chi^2 = 4.75$, df = 1, p<.05) and to have been noncompliant with psychiatric treatment (21% versus 3%, $\chi^2 = 6.46$, df = 1, p<.05).

Joann

Joann is 29, and she has a history of psychiatric problems dating back to age 16, with at least three previous psychiatric admissions. In May 1991, Joann's mother sent her to the emergency room of a New York City hospital, where she was admitted with a diagnosis of paranoid schizophrenia.

While in the hospital, Joann was reportedly very aggressive and she was both physically and chemically restrained. She also refused to participate in treatment or discharge planning. Four days after her admission, Joann eloped from the unit.

Staff contacted Joann's mother to inform her of the elopement and to encourage her to bring Joann back to the hospital or to arrange outpatient services. Joann refused to return, and she was given an appointment at a clinic for the following day.

Joann did not keep her initial appointment, but was seen on a walk-in basis two weeks later; however, she refused to arrange another appoint-

ment at the clinic. Approximately six months later, Joann was readmitted to the same hospital due to agitated and violent behavior. At this time, she was also 20 weeks pregnant and homeless.

Joann was hospitalized for eight days and then discharged to a shelter for unwed mothers. She was also referred to another (nonhospital-affiliated) clinic for aftercare services. Shortly thereafter, however, Joann was asked to leave the shelter for not conforming to rules and expectations. When contacted by the Commission, the clinic staff reported that Joann never had a scheduled appointment at the clinic, and she had never been seen.

In January 1992, Joann turned up again as a walk-in client at the first clinic she was referred to in May 1991. At this time, Joann was living with her mother, and she was receiving prenatal care (baby was due in February). Joann's mother works outside the home, and she is concerned that Joann may not be able to take care of a baby. Joann's mother said that she mentioned this concern to clinic staff; however, they said they would deal with it at a later time.

¹⁶ Contrary to expectations, there was no significant difference between the rehospitalized and the nonrehospitalized individuals in terms of their likelihood to have an alcohol or drug abuse problem. There were also no significant differences between the groups in the reported incidence of drug or alcohol abuse in the 6-month follow-up period. This latter finding may be suspect, however, as most of the individuals studied had relatively infrequent and brief contact with outpatient mental providers, and self-reports of alcohol and drug abuse, especially in this context, are unlikely.

Most critically, on the ten-point scale of inpatient treatment challenge, rehospitalized individuals were more likely to score four or more, or at least one or more standard deviations above the mean (37% versus 16%, $\chi^2 = 4.46$, df = 1, $p < .05$). Although the between-group differences were not usually statistically significant on individual indicators of treatment challenge, rehospitalized individuals were especially more likely than nonrehospitalized individuals:

- to have been aggressive to staff (40% versus 21%);
- to have refused to participate in groups (40% versus 24%);
- to have refused to participate in treatment and discharge planning (24% versus 11% and 13% versus 0%, respectively);
- to have been involuntarily medicated (13% versus 2%); and
- to have required physical interventions (26% versus 13%).

Reflecting their more serious and difficult clinical portrait, the rehospitalized individuals also had significantly longer average *initial* lengths of stay on the inpatient psychiatric units than nonrehospitalized patients ($\bar{x} = 22.1$ days and 16.7 days, respectively). Their longer lengths of stay appeared to be due both to the hospital staff's recognition of these individuals' more complex problems and to many of these individuals' greater objection to inpatient treatment.

Discharge Planning

Overall, there were few significant differences in the discharge planning services offered to rehospitalized versus nonrehospitalized individuals. Neither group was significantly more or less likely to have discharge planning start within one week after their admission, to have a comprehensive discharge plan, or have a specific appointment for aftercare services prior to discharge.

John

John is 28, unemployed, and he lives at home with his parents. In the four years prior to the hospitalization under study, John had five psychiatric hospitalizations. He attempted suicide two years ago, and he has a history of crack cocaine abuse.

In March 1991, when John was hospitalized at a New York City hospital, he had been noncompliant with medications, physically assaultive, paranoid, and he had been hostile and difficult with family members at home. While in the hospital, John displayed hostile behavior toward staff and other patients, he required physical and chemical interventions to control his behavior, and he refused to participate in treatment planning and group activities.

After a 46-day hospital stay, John willingly accepted a referral back to the clinic program he had attended prior to his hospitalization. Despite John's long track record of failing to attend scheduled appointments at this program in the past, there was no indication that he was offered other aftercare options. Although John was discharged to his parents' home, his mother reported that she was overwhelmed by his recent aggressive behavior, but felt obligated to care for him.

Within two weeks of his discharge, John was rehospitalized. Again, during this hospitalization, John was resistant to treatment and medications, and he was ultimately medicated under a court order. In response to the Commission's survey, John's mother noted that a family meeting was held with inpatient staff who listened to her concerns, but that they were not responsive to her suggestion that John be referred to a different outpatient program, as he was refusing to return to the clinic program he had attended in the past.

Despite John's stated refusal and his mother's request, he was referred back to the same aftercare provider. As John's mother aptly commented on her survey form, "... needless to say he hasn't followed through with outpatient services there."

Discharge planning documentation did indicate that records of more of the rehospitalized individuals documented problems with non-compliance with treatment (50% versus 24%, $\chi^2 = 5.89$, df = 1, p<.05) and independence in daily living (37% versus 16%, $\chi^2 = 4.46$, df = 1, p<.05). Despite these documented needs, rehospitalized individuals were not significantly more likely to have received services (e.g., case management, other daily living skills assistance or training) postdischarge to address these needs.

Reflecting these needs of the rehospitalized individuals, as well as their postdischarge plans, it was noteworthy that 7 of the 38 rehospitalized individuals (18%) compared to only 2 of the 62

nonrehospitalized individuals (3%) were reportedly homeless at some point during the 6-month follow-up period. It was also interesting that although only 15 individuals in the total sample received any follow-up services, these services were provided to 10 of the 38 individuals who were subsequently rehospitalized (26%), but only to 5 of the 62 individuals who were not rehospitalized (8%) ($\chi^2 = 4.81$, df = 1, p<.05).

Receipt of Aftercare Services

The rehospitalized and the nonrehospitalized individuals did not differ in terms of their actual receipt of aftercare services. More specifically,

Richard

Richard, age 28, has been receiving mental health services for many years. In June 1991, Richard presented in an emergency room stating, "I've been depressed for six months and I can't shake it." Although extremely vague about other symptoms, he appeared tense, uncooperative, mistrustful and somewhat hostile to staff.

A day after his admission, however, Richard requested his release from the hospital and, as he was not dangerous to himself or others, he was discharged. Upon discharge, Richard went to live in an apartment in a neighboring town, and he agreed to contact the continuing treatment program he had been attending.

Nine days later, Richard was readmitted to a different hospital due to suicidal ideation. He stayed in the hospital for 21 days and then was discharged again to the same continuing treatment program and to his own apartment.

After only four days, Richard was rehospitalized again for suicidal thoughts and concern that he would burn down his apartment building. This time Richard stayed in the hospital 74 days, and on discharge he was assured more supports. Again, he was referred back to his continuing treatment program, but he also was placed in a supportive apartment and he was assigned an intensive case manager.

Since his discharge in October 1991, Richard has done well. The supportive apartment staff help him pay his bills and deal with his landlord; a county case manager helps him with his financial entitlements and transportation; and his intensive case manager is working with Richard on vocational issues. Reportedly, Richard infrequently attends his continuing day treatment program, but he has become a regular at the local psychosocial club.

In responding to the Commission's survey, it was clear that although much had been going better for Richard, he wanted a fuller life. He wrote, "I still have too much time on my hands, no place to go, and at day program you just sit around and watch movies and they treat you like a kid. . . . There's a lot of stigma being idle, I'd be a whole lot better if I could be productive and support myself."

When asked what services would "best" help him live in the community, Richard added, "Besides people getting a check, they should have a place to go and work, [to] become more responsible and less dependent, and [to] get some kind of self-respect back. I wish they had something like they had in the Depression, like a camp where you worked on the roads, slept in trailers, where you'd be active and productive."

rehospitalized individuals were not distinguished by their likelihood to use (or not use) clinic, continuing treatment, or vocational services, nor were they distinguished by their total number of service contacts during the 6-month follow-up period.¹⁷

The rehospitalized individuals also did not differ from the nonrehospitalized individuals on most indicators of outpatient service resistance (e.g., missing three or more clinic or other outpatient appointments, being dismissed from an outpatient program due to service noncompliance or breaking program rules, or noncompliance with medications).

Lack of Informal Supports

The most consistent significant differences between rehospitalized and nonrehospitalized individuals related to informal supports. From many perspectives, rehospitalized individuals appeared to have fewer informal supports than nonrehospitalized individuals.

- Rehospitalized individuals were *less likely* to have an informal support network of any nature (63% versus 86%, $\chi^2 = 5.43$, df = 1, p<.05); they were also less likely to have a supportive family relationship (47% versus 73%, $\chi^2 = 5.39$, df = 1, p<.05).
- Rehospitalized individuals were *less likely* to have been discharged to their own home (to live independently or with children) or to their family's home than nonrehospitalized individuals (45% versus 79%).
- Rehospitalized individuals were *less likely* to have maintained a supportive

Mel

Mel's psychiatric problems started when he was 14 years old. During the past 14 years (Mel is 28 years old), Mel has dropped out of high school, has had several psychiatric hospitalizations, and has been unable to hold down a job.

Prior to Mel's May 1991 hospitalization in an upstate facility, he broke up with his girlfriend, abused alcohol and drugs, and expressed suicidal ideation. During his ten-day hospital stay, Mel refused to participate in any group activities or treatment planning, and he staunchly refused to have his parents involved in any of his treatment.

Once discharged from the hospital, Mel was rehospitalized within a week for treatment of an alcohol and drug overdose, never having made it to his mental health clinic appointment. During the six months postdischarge, Mel was also rehospitalized two more times—once for another alcohol and drug overdose and once for a medical condition. During his third rehospitalization, Mel left the hospital without medical consent prior to linkage with aftercare services.

At this time, Mel lost his room at a local rooming house because he assaulted the manager, and his private psychiatrist refused to take Mel back as a client. Mel's parents were sympathetic with his plight and allowed him to return to their home, where he was arrested twice for assaulting his father and threatening his mother with a knife.

Aftercare service providers in the community reported that since Mel's release from jail, he has been calling all the aftercare service providers in the county requesting mental health services. Since local providers became aware of a judge's order for Mel to participate in a drug/alcohol detoxification program, they have been reluctant to enroll him in any mental health program until he complies with the judge's order.

¹⁷ This latter finding is somewhat surprising given that the average rehospitalized patient was actually in the hospital for 65 days of the 6-month follow-up period, and thereby not eligible for outpatient services for this period of time. It would have been reasonable to expect that rehospitalized individuals, because they had spent less time in the community, would have made fewer outpatient contacts. Actually, for the time spent in the community, rehospitalized individuals surfaced as being more intensely served.

Sophie

Sophie is only 23 years old, but she has already experienced numerous psychiatric hospitalizations, incarcerations, prostitution, drug addiction, and serious medical conditions. Sophie lives in New York City, where she is one of six children of alcoholic parents. Many of Sophie's problems started at the age of 14 when she began using drugs. Sophie never finished high school, and she has never been continuously employed.

In April 1991, less than three months after an inpatient stay at a state psychiatric center, Sophie was brought to a local hospital emergency room by ambulance from her parents' home. According to her mother, Sophie had been missing for seven days, and when she finally came home, she was dirty, partially clothed, and acting bizarrely. While in the emergency room, Sophie was treated for a facial laceration and then admitted to the psychiatric unit.

During her hospitalization, Sophie was diagnosed as having schizophrenia (chronic, undifferentiated), a personality disorder, and as being cocaine dependent. While an inpatient, Sophie frequently refused to participate in group activities. She also displayed resistive behavior toward staff interventions and hostility toward other pa-

tients. In addition, Sophie was very preoccupied with her daily planning to buy drugs in the community. After spending ten days at the hospital, Sophie eloped to her mother's house.

According to her inpatient record, prior to her elopement, hospital staff were considering transferring Sophie to a state psychiatric center. Subsequent to her elopement, record notes specified a preset hospital staff agreement to transfer Sophie to a state psychiatric center immediately if, and when, she showed up in the emergency room again.

One week later, Sophie was brought to the hospital emergency room by the crisis team due to her bizarre behavior, and she was transferred to the state psychiatric center. Once there, Sophie escaped from the center every chance she got. Sophie was assigned an intensive case manager whose primary job seemed to be returning Sophie to the center upon her elopements.

Sophie's intensive case manager and primary therapist are very concerned about her well-being. Whenever Sophie elopes to the community, she is known to abuse drugs and engage in prostitution and high risk sexual behavior. She also requires regular medication for complications of a terminal physical condition.

and stable relationship with family members and significant others during the 6-month follow-up period (26% versus 61%, $\chi^2 = 10.19$, df = 1, p<.01).

- Rehospitalized individuals were *less likely* to have had contact with their family during the studied hospitalization (55% versus 71%, nonsignificant).

These findings provide substantial evidence that informal supports are critical in assisting persons with serious mental illness return successfully to the community after a hospitalization. They reinforce the need for hospital staff to be attentive in nurturing informal supports for

individuals while they are hospitalized. The findings also suggest that hospital and outpatient staff should help individuals who may not have informal supports of family or friends to develop them through services like psychosocial clubs and Compeer Programs.

These findings are also consistent with the nature of the "treatment challenge" patient. Many of these individuals present similar challenges to their family and friends as they do to hospital staff. These challenges ultimately erode family support and weaken friendships, leaving these individuals with few informal supports in the community.

Chapter V

Impact of the New Rate Reimbursement Methodologies

This study also evaluated the new Medicaid rate reimbursement methodologies for inpatient and outpatient psychiatric services instituted in 1989 by the Office of Mental Health. As discussed in Chapter I, these new rate methodologies were developed to encourage specific changes in practices intended to improve service quality and access for persons with serious mental illness (Figure 27).

In conducting its evaluation of the rate methodologies, the Commission relied on:

- statewide data from the Medicaid (MMIS) files, as well as the Department of Health's SPARC's database;
- its own study data comparing the experiences of the 50 individuals discharged

from hospitals participating in the new inpatient rate methodology and 50 individuals discharged from hospitals which were not; and

- interviews with administrators and executive directors of the hospitals and outpatient programs visited.

Where data were available, the Commission also compared its 1992 study findings with the findings of the discharge practices study it had conducted in 1988 (*Discharge Practices in Psychiatric Facilities*, 1988). Although there were methodological differences in the two studies—as the earlier study focused only on downstate facilities (NYC, Westchester, and Long Island) and its sample included state psychiatric centers, as well as psychiatric units of general hospi-

Figure 27: New Rate Methodologies Were an Rx for . . .

- ✓ Increasing the psychiatric inpatient capacity in general hospitals
- ✓ Increasing inpatient and outpatient services to persons who are persistently mentally ill
- ✓ Reducing inpatient lengths of stay
- ✓ Reducing rehospitalization rates
- ✓ Better discharge planning
- ✓ Timely contact with aftercare services for discharged patients
- ✓ Long-term aftercare contact for persons who are persistently mentally ill
- ✓ Better coordination between inpatient and outpatient providers

tals—this comparison provided one of the only available benchmarks of how practices may have changed since the introduction of the new methodologies.

Implementation of the Rate Methodologies

Although the new outpatient methodology was immediately implemented statewide in October 1989, the new inpatient rate methodology was gradually phased in, with an initial subgroup of 27 of the state's 100 general hospitals with psychiatric units enrolling in October 1989. Another group of 25 hospitals enrolled in the methodology in July 1991. It was anticipated, if all went smoothly, that all hospitals in the state would enroll in the new methodology by the summer of 1992.¹⁸

Several other points about the actual implementation of the two methodologies are also important (Figure 28). First, the 27 general hospitals enrolled in Phase I of the new inpatient rate methodology were not randomly selected. Selected from a larger group of 52 hospitals that volunteered to participate, Phase I hospitals included an overrepresentation of large hospitals, teaching hospitals, and hospitals serving many indigent patients. Additionally, only hospitals already certified to admit involuntary psychiatric patients (under §9.39 of the Mental Hygiene Law) were eligible to participate in Phase I. Similarly, the second group of 25 hospitals that enrolled in Phase II were also not randomly selected.

Second, although the first two rate premium payments to Phase I hospitals and to outpatient providers were paid in a relatively timely manner, the third and fourth rate premium payments (due in July 1991 and January 1992, respectively) were each paid about four months late.

Figure 28: Implementation Problems

- Hospitals participating in the new inpatient rate methodology were not a random or representative sample.
- Rate premiums were often paid late.
- Paying premiums as overall rate adjustments obscured the fiscal rewards earned by providers.
- OMH training sessions for providers were late and limited.
- Many providers and front-line clinical staff reported a lack of understanding of the reimbursement methodologies.
- Few providers had monitoring systems capable of tracking changes in their clinical practices, pursuant to the methodologies.

The Office of Mental Health projects that the payment due in July 1992 will also be at least four months late. In addition, as of October 1992, no payments had been made to the 25 hospitals that joined the inpatient rate methodology in July 1991 as they too are awaiting their payment in the delayed July 1992 adjustments. According to Office of Mental Health officials, delays in payments have been caused by delays in the receipt of data from the Department of Health and delays in payment approvals from the State Division of the Budget.

Third, the method of rate premium payments also confused many providers and tended to

¹⁸ Subsequently, and due in part to the preliminary findings of this study, in October 1992 Phase III of the implementation of the new inpatient rate methodology was deferred by the Office of Mental Health.

obscure their earned financial rewards from the methodologies. To save administrative time, the Office of Mental Health determined to pay all rate premiums to hospitals and outpatient providers as overall rate adjustments, rather than as quarterly or semiannual bonus payments. Although efficient, this payment method, which took the premium earnings of hospitals and outpatient programs and distributed them over all billed inpatient days or outpatient visits, further camouflaged the fiscal rewards of the methodologies. As one outpatient provider told Commission staff, "For a few pennies a visit, it is hardly worth it to me."

Fourth, there were also limitations in the training offered to hospital and outpatient provider staff on the new rate methodologies. Training for the staff of the 27 hospitals that enrolled in Phase I in October 1989 did not start until February 1990, and training for all of these hospitals was not completed until May 1990, seven months after their enrollment in the methodology. Training for the outpatient methodology was restricted to single half-day training sessions in each of the Office of Mental Health's five regional offices. Although Office of Mental Health officials reported that these sessions were well attended, they acknowledged that representatives of many of the approximately 900 certified outpatient programs may not have attended.

These features appear to have influenced the ultimate impact of the new rate methodologies. In interviews with the Commission, most hospital and outpatient providers stated that they did not fully understand the multiple features of the methodologies. Senior administrators and staff at most of the participating hospitals and outpatient providers visited by the Commission in the fall 1991 and winter 1992 also reported that they were uncertain what, if any, financial rewards their hospital or program had gained from the methodologies. Most importantly, almost all providers visited complained that they could not relate

their rate adjustments to changes in their clinical practices, in part, because the incentive formulas for the methodologies, and especially the inpatient methodology, were complex, and also because the providers did not have monitoring systems capable of tracking their own changes in practice.

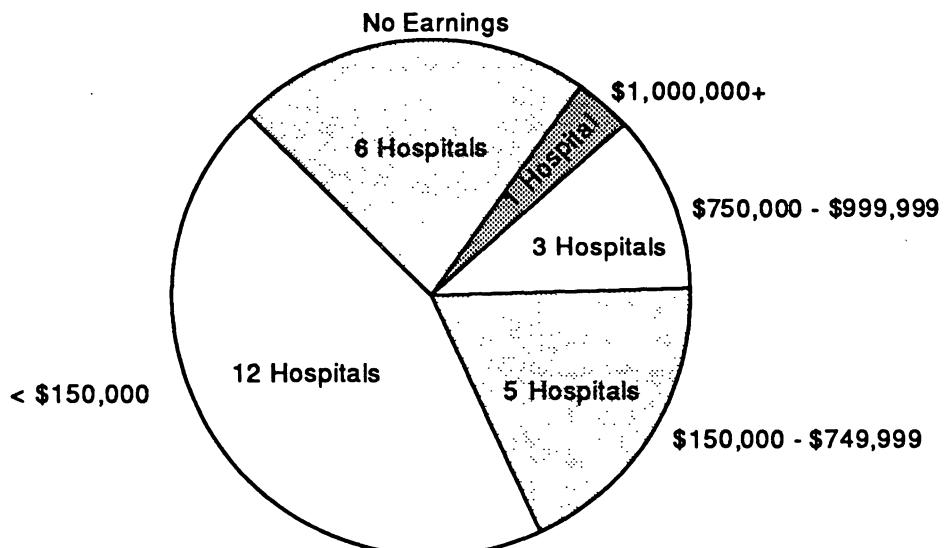
Marginal Fiscal Rewards for Most Providers

The actual impact of the new methodologies is perhaps best measured by how providers' practices changed vis-à-vis the intended objectives of the two new rate reimbursement schemes. These changes may be measured by the fiscal rewards providers received due to the new methodologies' incentives.

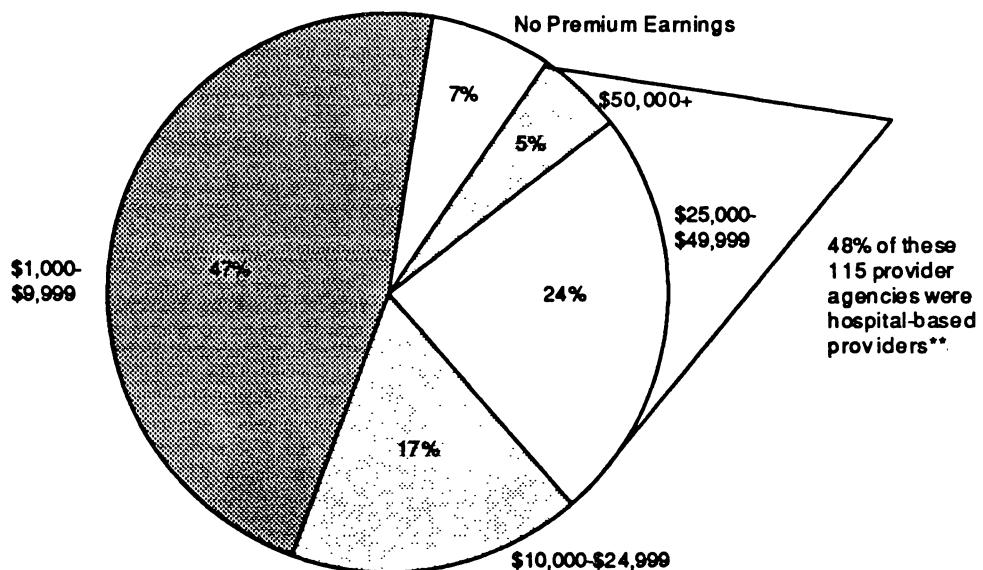
Only 4 of the 27 hospitals (15%) participating in Phase I earned more than \$750,000 over the first 18 months of the methodology's implementation, and only one (Erie County Medical Center) earned more than \$1 million. In contrast, 6 of the 27 hospitals (22%) earned nothing, and an additional 12 hospitals (44%) earned less than \$150,000 in this 18-month period. Overall, two-thirds of the hospitals participating in Phase I had minimal or no earnings from the methodology (Figure 29).

Further analysis indicated that less than 34% of the average inpatient rate increase earned by the hospitals in both the January 1991 or January 1992 rate periods, as a result of the new methodology, could be attributed to performance improvements. For many hospitals earned premiums came instead from hospitals continuing to maintain "good" performance. Perhaps more critically, even with these modest performance gains, waivers of the Department of Health's case mix and volume adjustments would have resulted in a substantial number of the 27 hospitals losing reimbursement in both rate periods if it had not been for the "hold harmless" provision of the inpatient rate methodology.

**Figure 29: Total Rate Premiums
Earned by Phase 1 Hospitals
(January 1991, July 1991, January 1992)
(N = 27)**



**Figure 30: 1992 Rate Premiums Earned by
Outpatient Provider Agencies* (N = 396)**



*These 396 provider agencies include two overlapping subgroups of nonstate operated agency providers: 259 clinic provider agencies and 137 continuing day treatment agencies. OMH officials reported that data for its state-operated outpatient programs are not available.

**Hospital affiliated providers represent approximately 25% of the clinic and continuing day treatment provider agencies statewide.

Most outpatient providers also earned small premiums from the new outpatient methodology, although hospital-based providers tended to stand out as earning higher rewards (Figure 30). According to Office of Mental Health projections, only 115 of the approximately 396 nonstate-operated outpatient clinic and continuing day treatment provider agencies,¹⁹ or 29%, will earn premiums of over \$25,000 in 1992. Notably, although hospital-based providers represent only about 25% of the provider agencies statewide, they represented 48% of these 115 high-earner outpatient providers.

These 396 providers sponsor about 800 certified outpatient programs. From a "certified program" perspective, average annual outpatient premiums are even lower. The average total earned premium ranged from approximately \$1,680 per program in 1991 to \$5,000 per program in 1992. For most programs, these minimal premiums represented only 2%-3% of their Medicaid revenue.

Discharge Planning Improvements

From a performance rather than a fiscal perspective, many of the objectives of the new Medicaid rate methodologies, related to discharge planning, were achieved. As discussed here, however, it was not always possible to link these positive achievements to the effects of methodologies.

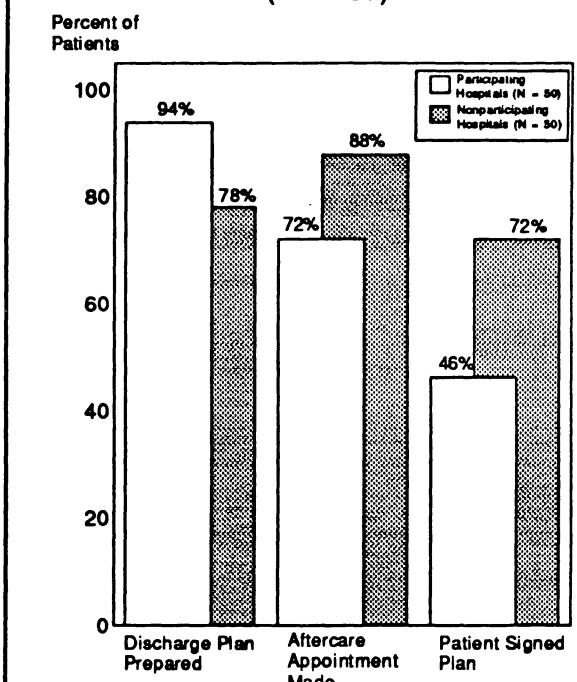
As compared to the findings in the Commission's 1988 discharge study, hospitals improved in ensuring psychiatric patients a comprehensive discharge plan (86% in the CQC 1992 study versus 54% in the CQC 1988 study) and a specific aftercare appointment upon discharge (80% versus 40%). Many more individuals in the Commission's 1992 study had

also signed their discharge plans than in the Commission's 1988 study (59% versus 20%).

Notably, however, hospitals not participating in the new rate methodology performed better than participating hospitals on two of these three measures. Although hospitals participating in the new rate methodology also made substantial improvements on these indicators compared to the benchmark of the Commission's 1988 study findings, hospitals not participating showed more substantial gains (Figure 31).

Overall, it did not appear that the new inpatient rate methodology was a significant factor influencing the improvements in discharge planning practices. Hospital staff, especially in down-state hospitals, stated that changes in their discharge practices should not be attributed to the

Figure 31: Improvements in Discharge Planning (N = 100)



¹⁹ These 396 provider agencies include two overlapping subgroups of 259 nonstate-operated clinic providers and 137 nonstate-operated continuing day treatment providers. Many of these providers operate more than one clinic or continuing day treatment program. Together, these providers operate approximately 800 certified clinics and continuing day treatment programs.

rate methodologies. Most reported that these improved practices were driven by the "professional" expectations of the psychiatric unit's administrators and senior clinicians, as well as the new legal requirements emanating from the *Heard v. Cuomo*, 150 Misc. 2d 257, 567 N.Y.S. 2d 594 [N.Y. Sup. Ct. New York County, February 1991] decision.

Shorter Lengths of Stay

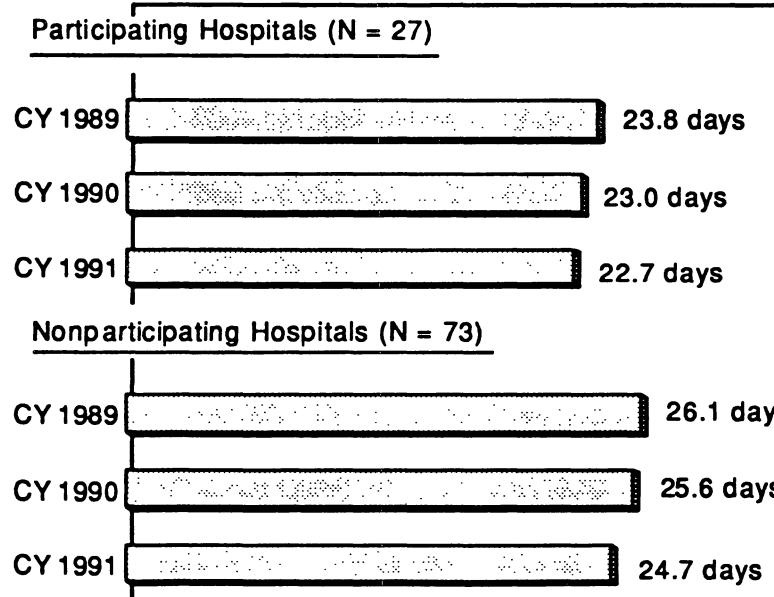
In concert with the new inpatient rate methodology's fiscal incentives encouraging hospitals to shorten the lengths of their longer psychiatric stays (over 23–31 days), Medicaid files verified that, since the start of the methodology, the average length of stay at participating hospitals decreased approximately 4.6%. Over the same period, however, hospitals not participating in the methodology showed a slightly greater 5.4% decrease in their average length of stay (Figure 32).

Further analysis indicated that hospitals participating in the new rate methodology had been slightly more successful than other hospitals in reducing their very long lengths of stay. Participating hospitals achieved an 18% decrease in discharges with lengths of stay over 90 days, compared to a 15% decrease in these extra-long stays by nonparticipating hospitals.

Outpatient Utilization

Since October 1989, when the new outpatient rate methodology was instituted, Office of Mental Health data have also shown that outpatient rate premiums, as a percent of total Medicaid revenue, have continually increased from about .5% for the first rate adjustment period (10/89-3/90) to about 1.5% in the second and third periods (4/90-9/90 and 10/90-3/91, respectively) and to about 2.0% in the fourth rate period (4/91-9/91).

Figure 32: Lengths of Psychiatric Inpatient Stays



Data provided by OMH.

Other analyses established that the statewide increases in outpatient premiums were largely attributable to the relatively small subgroup of hospital-based outpatient programs in the state. Compared with 1990 service provision, hospital-based clinics and hospital-based continuing day treatment programs enjoyed an 11.0% and 7.5% increase in services, respectively. From another perspective, hospital-based mental health outpatient programs, which represent less than 20% of all certified outpatient programs in the state, accounted for just over half (51%) of the total increase in outpatient service provision from 1990 to 1991.

Commission interviews with inpatient and outpatient staff at most of the ten hospitals visited also confirmed that hospitals were relying more on their own outpatient programs. At many hospitals, staff commented that arrangements for making aftercare appointments at their own outpatient programs had been reformed in the past few years, allowing them to make appointments within a few days to a week of discharge and reducing their reliance on free-standing mental health programs.

Utilization Down at Participating Hospitals

Whereas hospital and outpatient provider performance and practice moved in the direction of the new reimbursement methodologies' objectives in the above areas (regardless of cause), in other areas, including overall psychiatric inpatient utilization, services to persons classified as persistently mentally ill, and rehospitalization rates, changes in performance and practices were not consistent with the goals of the new methodologies.

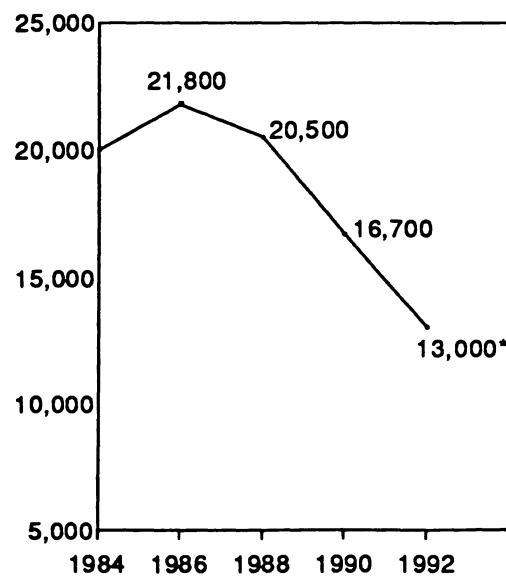
An important initial objective of the inpatient rate methodology was to increase the capacity and utilization of the state's general hospitals' inpatient psychiatric units and especially to increase access to these units by individuals

classified as persistently mentally ill. The NYS Office of Mental Health hoped to achieve this increase in service capacity and utilization primarily by increasing existing bed availability, by reducing excessively long psychiatric hospital stays, and, only secondarily, by adding new certified psychiatric beds to the general hospital system.

The Office of Mental Health's goal to increase inpatient psychiatric service access seemed readily justifiable in 1987-1988, as it was planning the new rate methodology. At that time, occupancy rates at most psychiatric units of general hospitals, especially in urban areas of the state, exceeded 95%, and many were regularly over their certified bed capacity.

Additionally, the Office of Mental Health had announced its plans to reduce the capacity in its public state psychiatric centers by approximately 8,500 beds over the period 1986-1992. As shown in (Figure 33) these targeted census reductions have been achieved.

Figure 33: Census Change in NYS Psychiatric Centers (1984 - 1992)



*Projected estimate.
Data provided by OMH.

The evaluation found that inpatient psychiatric *bed capacity* in general hospitals did indeed increase approximately 7.2% over the period 1989–1991, with the addition of 372 new certified beds. The statewide reduction in the average length of psychiatric inpatient stays from 25.1 days in 1989 to 23.8 days in 1991, also increased *bed availability* by an additional 5%.

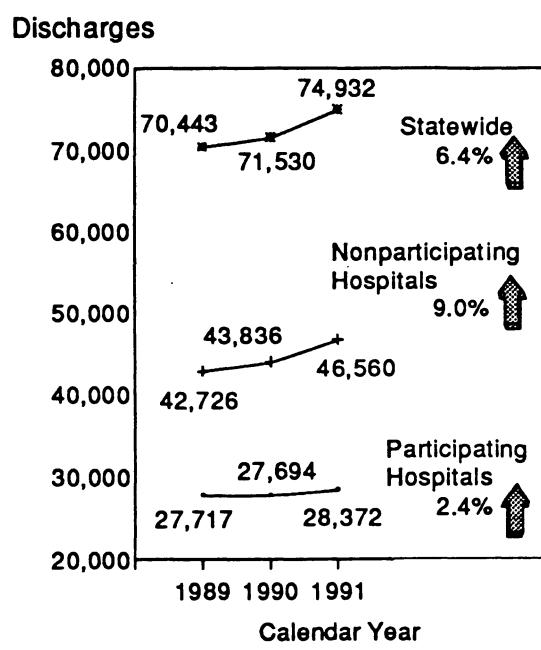
Despite this 12.2% increase in bed capacity and availability (7.2% for new beds and 5% for reduced lengths of stay), psychiatric *bed day utilization* in general hospitals for this same period increased by only 1%.

Hospitals participating in the new rate methodology—despite the fiscal incentive to *increase* their psychiatric bed days through the waiver of the Department of Health volume adjustment—actually reduced their utilization of psychiatric bed days by 2% from 1989 to 1991. Psychiatric bed day utilization at nonparticipating hospitals, on the other hand, actually increased from 1989 to 1991 (3% increase). This was an unexpected finding, as nonparticipating hospitals were still subject to the Department of Health volume adjustment, which provided fiscal incentives for *decreasing* their psychiatric bed days.

Another, perhaps more useful, index of psychiatric unit utilization is the change in the number of psychiatric patient discharges for the period 1989–1991. This index compensates for changes in bed day utilization which may be solely attributable to the hospitals' positive performance in reducing the length of the average psychiatric stay. Hospitals participating in the new rate methodology had a modest increase (2.4%) in psychiatric discharges from 1989 to 1991, while hospitals not participating in the new rate methodology showed a much greater 9% increase in psychiatric discharges over the same period (Figure 34).

Thus, despite their small decline in psychiatric bed days participating hospitals served 2.4% more patients, albeit for shorter lengths of time. On the other hand, it appeared that

Figure 34: Psychiatric Discharges from General Hospitals (1989 - 1991)



Data provided by OMH.

nonparticipating hospitals were able to “hold their own” in bed day utilization, despite a 5.8% decrease in average lengths of stays, because these hospitals actually served 9% more patients in 1991 than they had in 1989.

Increased psychiatric service provision by nonparticipating hospitals was also partially attributable to new psychiatric beds which they had put on-line since 1989. In total, 305 of the 372 new psychiatric beds established since 1989 (82%) were in nonparticipating hospitals.

Participating Hospitals Served Fewer Persistently Mentally Ill Individuals

Consistent with the small statewide increase in overall psychiatric bed day utilization (1%), inpatient psychiatric bed day utilization by persons meeting the state's criteria for “persistently mentally ill” decreased by 2% from 1989 to 1991. For the same period, however, statewide

discharges from general hospitals of persons meeting the state's criteria for persistently mentally ill actually increased 5%.

These paradoxical findings are explained partly by the 5% reduction in average length of stay for persistent patients statewide, which was comparable to the reduction in the average length of stay for all psychiatric patients statewide. These findings also reflect the unanticipated decreased service provision to persons classified as persistently mentally ill by hospitals participating in the new rate methodology, as well as the paradoxical increase in service provision to this target population by hospitals not participating in the new rate methodology.

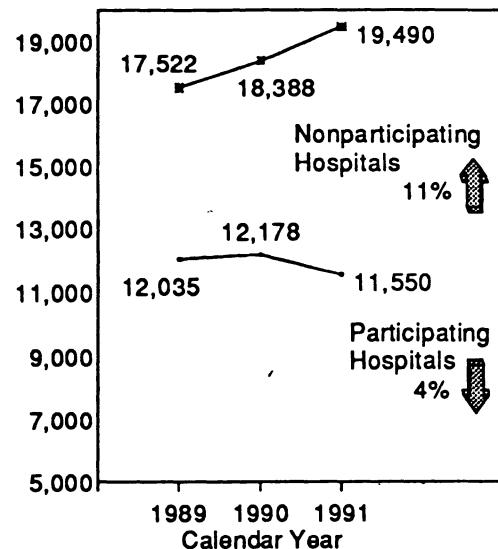
For the period 1989-1991, there was a 4% decrease in discharges of persons classified as persistently mentally ill for participating hospitals, while there was a 11% increase in such discharges for nonparticipating hospitals (Figure 35).

Contrary to expectations, since the start of the methodology, persons classified as persistently mentally ill also came to represent a somewhat *smaller* percentage of the total psychiatric inpatient population served at participating hospitals. In 1989, these patients represented 43.4% of the total psychiatric inpatient population at these hospitals, compared to 40.7% in 1991. In contrast, at nonparticipating hospitals the percentage of persons classified as persistently mentally ill stayed relatively constant over the period (41.0% in 1989, 41.9% in 1990, and 41.9% in 1991).

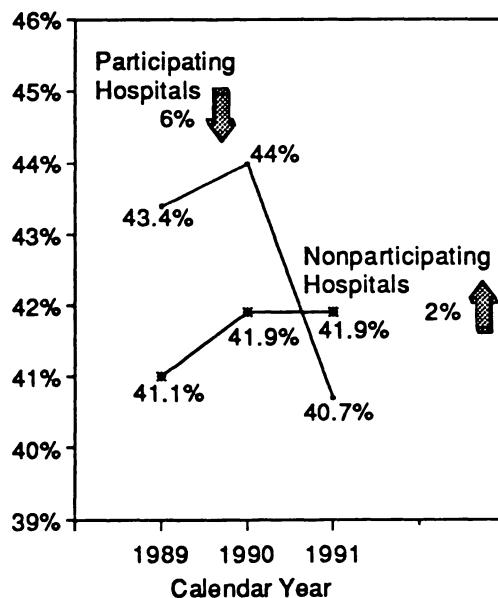
These data indicated that the new rate methodology did not encourage participating hospitals to increase psychiatric admissions significantly for any population and that it was even less successful in encouraging these hospitals to increase psychiatric admissions of persons classified as persistently mentally ill. For reasons that are not clear, hospitals not participating in the new rate methodology were actually more

**Figure 35: Number and Percent
Of Persistently Mentally Ill
Discharges from General Hospitals
(1989 - 1991)**

Discharges



Percent of Discharges



Data provided by OMH.

successful in increasing psychiatric bed days and discharges comparably for both the general psychiatric population and for persons classified as persistently mentally ill.

Few Changes in Aftercare Services

Consistent with the very modest outpatient premiums awarded to most programs, the Commission found few differences in the provision of aftercare services or in the aftercare outcomes for individuals in its 1992 and 1988 study samples. There was also little evidence in the statewide Medicaid data to suggest that either the new inpatient or outpatient rate methodology had any outpatient service linkage benefits for patients being discharged from psychiatric units of general hospitals.

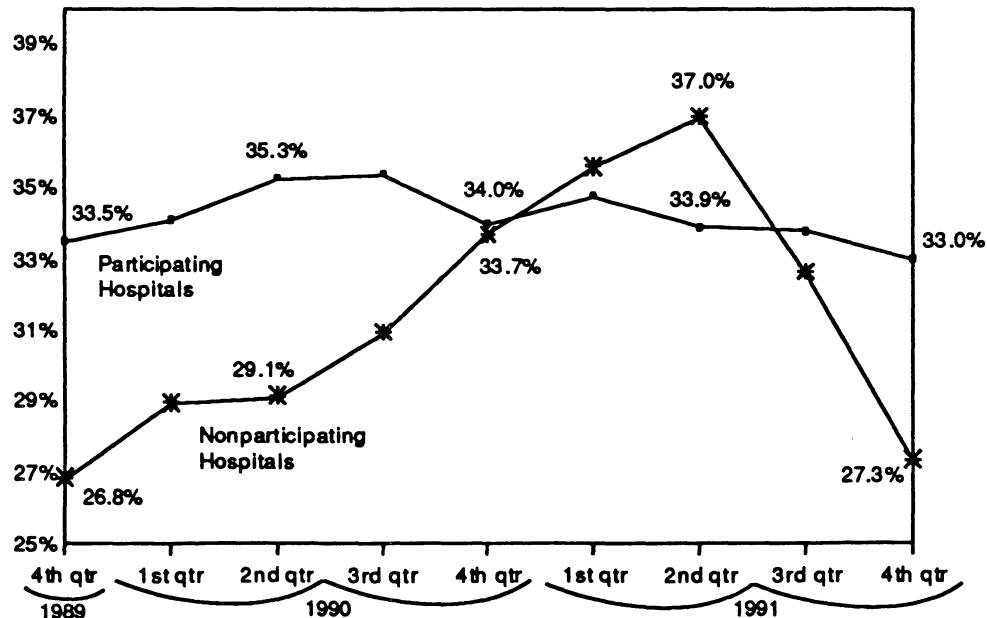
Statewide data indicated that, at the start of the methodology (October 1989), participating hospitals reportedly linked 33.5% of their psy-

chiatric patients with an outpatient provider within ten days of discharge (Figure 36). For the most recent quarter for which these data are available (October-December 1991), this percentage stood at 33.0%, reflecting almost no change. Similarly, the percentage of patients linked with services by nonparticipating hospitals stood at 26.8% prior to the start of the methodology and at 27.3% for the most recent period for which data are available.

Commission data on the two subsamples of individuals served in hospitals participating and not participating in the new rate methodology also showed little difference in outcome measures. Thirty-eight (38) percent of both subgroups of individuals were rehospitalized, and there was also virtually no difference between the two groups of individuals in terms of their likelihood to be in service contact at 30-days or 6-months postdischarge.

Finally, there was no evidence that individuals served by participating hospitals were more

**Figure 36: Percent of Discharged
Psychiatric Patients Making
Outpatient Contact Within 10 Days**



Data provided by OMH.

intensively served by outpatient providers. In the six months after their discharge, the average individual in the Commission's sample served by participating hospitals received 29 units of aftercare services, compared to 31 units received by the average individual served by nonparticipating hospitals.

There were also no significant differences in the types of outpatient services received by individuals served in participating versus non-participating hospitals. The Commission also found that there had been no significant changes in the profile of services received by the individuals followed in its 1992 study and its 1988 study.

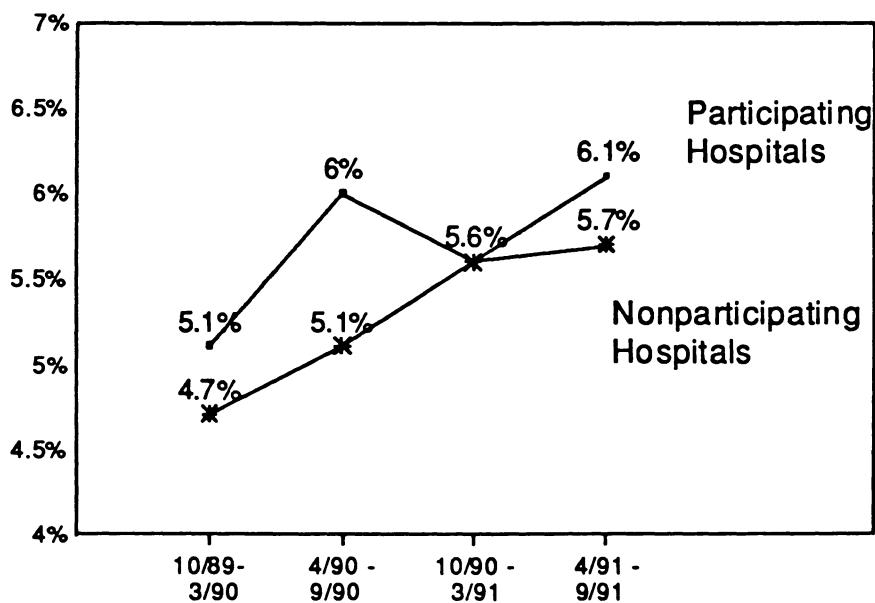
Rehospitalization Rates Up

The Office of Mental Health's hope that the new rate methodology would reduce, or at least

hold constant, rehospitalizations of patients within 30 days of their discharge was also not realized. Since the start of the methodology, rehospitalization and transfer rates for individuals within 30 days of their discharge have actually increased. For the rate period October 1989 through March 1990, the statewide rehospitalization and transfer rate stood at 5%; for the rate period April 1991 through September 1991, the rate had increased to 6%, reflecting a 20% increase (Figure 37). Of note, hospitals participating and not participating in the new rate methodology had almost matching rehospitalization and transfer rates (6.1% and 5.7%, respectively), suggesting that participation in the rate methodology was not a significant factor influencing the increase in rehospitalizations.²⁰

Further analysis of the data also clarified that the increase in the rehospitalization and transfer

Figure 37: Rehospitalizations Within 30 Days as a Percentage of Total Discharges



Data provided by OMH.

²⁰ Contrary to expectation, New York City hospitals were not influencing the statewide figure. Rehospitalization and transfer rates in New York City were generally lower than the statewide rate (5.2% versus 6.0% in 1991), and New York City rates also increased at a slower pace from 1989 to 1991 than the statewide rate (16% versus 20%).

rate was determined by increases in rehospitalizations in Article 28 hospitals. Over the period, Department of Health SPARC's data showed virtually no change in the number of patient transfers from Article 28 general hospitals to state psychiatric centers for longer-term care.

Discussion

Overall, the Commission's evaluation provided little empirical evidence to suggest that either the new inpatient or outpatient rate methodology has played a significant role in influencing psychiatric service provision. Even where changes in practice have been noted, as in the improvements in some aspects of discharge planning and in the briefer average lengths of hospital stays, these changes could not be attributed to the incentives or disincentives in the new methodologies.

The adverse findings, including the increase in rehospitalization rates by both participating and nonparticipating hospitals and the reduced service provision to patients classified as persistently mentally ill by participating hospitals, while troubling, also do not appear to be directly linked to the new rate methodologies. There were also no other significant adverse changes in practices which could be clearly linked to the new rate methodologies.

It seemed that the new rate methodologies suffered from being relatively minor events in a host of significant policy and fiscal changes which have influenced mental health inpatient and outpatient services in New York over the past several years. As delineated in Figure 38, the years following the introduction of the new rate methodologies were also marked by other significant judicial, regulatory, and fiscal reforms in mental health service delivery in New York State. These policy initiatives had major implications affecting psychiatric inpatient capacity in general hospitals and in specifying legal mandates for discharge planning for psy-

chiatric patients. Other rate reimbursement changes for hospitals instituted by the Department of Health, and many regulatory changes instituted by the Office of Mental Health—distinct from changes in the new Medicaid rate reimbursement provisions—had a dramatic impact for many providers. To most of the hospital and outpatient provider administrators interviewed by the Commission, these reforms were more important influences upon their operational practices than the new Office of Mental Health Medicaid rate methodologies.

The methodologies were also probably too complicated to be readily understood by clinical staff whose behavior and practices they were intended to influence. The inpatient rate methodology had so many overlapping provisions related to case mix, volume, length of stay, and rehospitalizations, that it took an expert mathematician on the hospital level to translate changes in inpatient unit practice to fiscal rewards. Additionally, neither rate methodology offered sufficient fiscal incentives *or any fiscal disincentives* to convincingly encourage providers to change practice. The method of payment—as a small addition to the hospital rate, rather than a separate payment—also tended to make the incentive payments virtually invisible. Also, this method of payment, coupled with delays in payment, made it difficult for clinical staff, whose behavior and practices the payments were intended to influence, to discern whether they were successful. Hospitals' quality assurance systems were also not sufficiently sophisticated to assess and monitor changes in practices consistent with the new methodologies. Therefore, clinical staff also could not rely on this resource to evaluate their performance.

The outpatient rate methodology was simpler, but the limited Office of Mental Health training sessions left almost all providers with an incomplete and inaccurate understanding of its provisions. The definition of persistently mentally ill patients—important to both meth-

Figure 38: Other Reforms

Certifying Hospitals to Accept Involuntary Admissions

In 1988, only 67% of the general hospitals in New York were certified to accept involuntary psychiatric admissions. In recent years, the Office of Mental Health has taken steps to ensure that almost all general hospitals in the state became certified to accept these involuntary admissions (9.39 certified), opening up many existing inpatient psychiatric beds for the first time to individuals who are seriously and persistently mentally ill. By late 1992, 88% of 107 general hospitals had become certified to accept involuntary admissions.

The New York/New York Agreement

In 1990, the Office of Mental Health entered into negotiations with the City of New York. The resulting formal agreement (*The New York/New York Agreement*, August 1990) clarified that general hospitals in the city would provide almost all acute inpatient psychiatric treatment, while the five state psychiatric centers in the city would provide timely access to intermediate and long-term inpatient care for individuals who, after an acute stay in a general hospital, still required psychiatric hospitalization. This agreement helped clear up the gridlock in many psychiatric units of general hospitals by facilitating timely transfers of patients needing longer-term care.

Heard v. Cuomo

In 1991, the ruling in a class action suit involving persons who were homeless in New York City (*Heard v. Cuomo*, 150 Misc. 2d 257, 567 N.Y.S. 2d 594 [N.Y. Sup. Ct. New York County, February 1991]) set clearer discharge planning standards for general hospitals, clarifying that only in very specific and limited circumstances could individuals leaving an inpatient psychiatric setting be discharged to a homeless shelter. Staff at many of the hospitals visited spoke of the influence of this decision in bringing more accountability to aftercare housing and service arrangements for individuals being discharged.

Prospective Rate Setting for Hospitals

In 1989, the NYS Department of Health shifted to prospective rate setting for all general hospitals. This shift has resulted in unpredicted and dramatic fluctuations in hospital rates in successive rate periods, which have far overshadowed any changes due to the new Medicaid inpatient psychiatric rate methodology. For individual hospitals Department of Health per diem rates often changed by more than \$100 in each subsequent annual rate period. These basic Department of Health rate changes so buffeted hospital rates that the much smaller changes attributable to the new Medicaid inpatient psychiatric rate methodology became inconsequential.

Reform of Outpatient Program Regulations and Funding

In 1991, the Office of Mental Health issued revised and stricter regulations for its clinical outpatient programs designed, in part, to increase service access to persons who are seriously mentally ill. Almost concurrently, a new funding program for selective outpatient programs (COP or Comprehensive Outpatient Program) discontinued deficit funding. In its place, COPs provided higher Medicaid rates and also imposed stricter provisions for crisis intervention services and consumer evaluation of services. Although the COP's rate increases varied across programs, it was not unusual for individual programs to achieve a 20% rate increase as a result of joining the program. For the vast majority of programs, this rate increase far surpassed, by multiples of 10 to 20, any rate premiums resulting from the new Medicaid outpatient rate methodology.

odologies—was also a new classification system, easily confused with the similarly labelled, but distinctly different, earlier Office of Mental Health target group, the seriously and persistently mentally ill (SPMI).

Finally, perhaps the most important factor impeding the impact of the new rate methodologies, was the limited quality assurance oversight during the Office of Mental Health's certification reviews in reinforcing the performance expectations of the methodologies. Failing to capitalize on this contact to reinforce the principles and expectations of the methodologies was a serious loss.

The new Office of Mental Health rate methodologies ultimately failed because hospitals and outpatient providers did not aggressively respond to them. Perhaps if the timing had been better, or the fiscal incentives and disincentives clearer and more readily understood, or if there had been more training, more hospitals and outpatient providers would have made more changes. Even in their absence, however, vigorous quality assurance monitoring by the Office of Mental Health reinforcing the desired expectations of the methodologies may have been the most potent change agent.

Chapter VI

Conclusions and Recommendations

This study offered insights about the experiences of 100 men and women with serious mental illness in New York as they made the transition back to their communities and families after a psychiatric hospitalization. It also provided an opportunity to evaluate objectively the degree to which changes in rate methodologies to provide small monetary rewards can change the way hospitals and mental health aftercare providers serve persons with serious mental illness. Perhaps most usefully, the study offered the Commission an opportunity to assess the degree to which discharge planning practices of inpatient facilities and New York's mental health aftercare system have improved since its earlier 1988 and 1989 reviews of discharge planning practices²¹ and the state's mental health outpatient service system.²²

From all of these perspectives, the study findings are sobering. Despite improvements in some basic elements of effective discharge planning, including the preparation of discharge plans and the arrangement of an initial aftercare appointment prior to discharge, the findings portray a publicly funded mental health service system that is still heavily reliant on costly hospital care and traditional clinically oriented outpatient programs. The mental health system, as it is currently designed, relies upon acute inpatient psychiatric care to provide crisis intervention and stabilization of the most overt symptoms of mental illness. Thereafter, these facilities are expected to discharge a small minority of

the patients requiring intermediate and long-term care to state hospitals and to discharge the vast majority to receive further care, treatment, and psychiatric rehabilitation services from outpatient programs in the community.

While the crisis intervention and symptom stabilization role of acute inpatient care appears to work reasonably well in achieving these objectives for those who gain access, this study also confirmed that these inpatient stays are generally not used as opportunities to engage the patient and involved family members in developing realistic plans for life in the community following discharge. Hospitals, thus, typically fail to assess the patient's strengths, desires, and choices for postdischarge services and to identify options available to meet identified needs, including needs for assistance with social, rehabilitative, vocational, financial, and other supports in the community.

Indeed, since patient and family voices have historically not been important determinants of the services provided, much of what patients want and need from the community mental health system simply does not exist.

The study findings also reaffirm the reality that although New York's mental health service system is among the best funded in the nation, for persons who are seriously and persistently mentally ill its outpatient system is still heavily dominated by clinically oriented programs. Despite this, only a minority of the men and

²¹ *Admission and Discharge Practices of Psychiatric Hospitals*, April 1988; *Discharge Practices of Inpatient Psychiatric Facilities*, August 1988.

²² *Outpatient Mental Health Services*, July 1989

women in the Commission's sample received more than an hour or so of clinical services each month. Only the very lucky few received any psychiatric rehabilitative services targeted toward assisting them with the dilemmas of daily living and survival in the community. Most of the individuals in our study had to rely primarily on their own skills and resources to negotiate life in the community, sometimes with the help of family and friends, but often alone. Only six of the 100 patients received either intensive case management or regular case management services.

Discharged patients in the Commission's 1992 study were no more likely than the few in its 1988 study to receive services to assist them with basic living needs, getting a job, returning to school, or simply making friends—the very things that consumers and families repeatedly identify as high priority needs. For those with substance and alcohol abuse problems, fewer than one in ten received services to address these problems.

Many Rehospitalizations

The study's quantitative findings, as well as the personal vignettes of the individuals studied, also document the grave difficulties many individuals with serious mental illness still encounter as they are discharged from psychiatric units of general hospitals in New York. In the study sample, nearly 40% of patients were rehospitalized within six months of their discharge, and 13% were rehospitalized two or more times in that period.

For these individuals, as well as many others who were not rehospitalized, return to their communities and families was often fraught with daily living problems, and the recurrence of acute psychiatric symptoms. Few activities and services were available to assist them in gaining specific community living skills. Although 60% were in contact with an aftercare provider at the 6-month follow-up point, they experienced many diffi-

ties. In the study sample of 100 individuals, 34% had encountered serious financial difficulties, 25% had moved residences at least once in the 6-month follow-up period; 9% were homeless for some part of the period; and 7% had trouble with the law. Two (2) of the 100 individuals had died during the 6-month follow-up period.

Psychiatric Units Are Costly Alternatives

With an average Medicaid rate of approximately \$500/day, or \$12,000 for a typical 24-day admission, rehospitalizations of individuals with serious mental illness also carry a high price tag for State taxpayers. Applying established Medicaid per diems to the approximately 2,500 days that the 38 rehospitalized individuals in the sample spent in general hospitals or state psychiatric centers in the 6-month follow-up period results in an approximate total bill of \$1.4 million, or approximately \$36,750 per individual rehospitalized.

By comparison, the Commission found that the aftercare nonresidential service cost for the 100 individuals in the 6-month follow-up period was only approximately \$190,000. Even when estimated SSI entitlements and the residential costs for the few individuals receiving these services are added in, the total residential, non-residential, and entitlement cost for the 100 individuals for the full 6-month follow-up period was only approximately \$670,000, or less than half of the estimated rehospitalization costs for the 38 individuals.

Using these figures, it is apparent that even small reductions in rehospitalization rates would allow for substantial reinvestment potential, especially for the expansion of the generally lower-cost psychiatric rehabilitation programs, including vocational programs, psychosocial clubs, family support programs, and Compeer programs. Conversely, in the absence of making these psychiatric rehabilitation and other ser-

vices more available, it appears that rehospitalization rates may continue to increase, potentially further eroding existing available funding for aftercare services.

Hospitalizations Offer No Miracle Cure

Despite their high price tags, psychiatric hospitalizations are also not miracle cures. With a few notable exceptions, the most prevalent sight on most of the psychiatric units visited by the Commission seemed to be "down time," with patients rarely engaged in activities more than three or four hours a day. Rest and recuperation, which many of the individuals in the Commission's study clearly appreciated, and a supervised medication regimen, were the predominant fare.

For almost all 100 individuals studied, inpatient treatment plans focused exclusively on the individual's reasons for admission and eliminating overt psychiatric symptoms, including hallucinations, delusions, paranoid thinking, and suicidal ideation, usually with the assistance of psychotropic medications. Once these overt symptoms cleared, often within a week or two of admission, the individual was readied for discharge. In the meantime, the hospital would offer the patient safe shelter, three meals a day, an opportunity to rest and recuperate, and routine medical attention.

What is missing is any reliable assurance that this period of rest and recuperation will be followed with a reasonably comprehensive and individualized program of treatment, psychiatric rehabilitation, and other necessary supports in the community, including access to alcohol and substance abuse treatment programs. Indeed, even the assessments done for most of the patients in our sample, while they were in the hospital, usually overlooked any meaningful evaluation of practical daily living difficulties that the individual was likely to encounter upon

discharge. In many cases, it was as if the hospital staff, including the discharge planning staff, simply did not want to open this Pandora's box.

Consumers and Families Still Outside Looking In

Perhaps one of the most discouraging study findings was that, with rare exceptions, the hospitals and outpatient providers visited still did not have clear expectations that patients would have a meaningful role in developing their treatment plans, nor that patients' voices and choices would shape the services offered and operating practices of provider agencies. Although the Commission generally found that providers were more aware that they *should* be making changes in these areas, the records reviewed tended to suggest that clinical staff behaviors toward patient inclusion and substantive involvement had not significantly changed.

The Commission also found little meaningful attention to treatment challenge issues raised by patients while they were in the hospital. These issues, even when they were not accompanied by assaultive or other dangerous behaviors, were almost uniformly addressed as non-compliance or discipline problems, with the predominant goal of achieving patient acquiescence and renewed compliance, rather than attempting to identify alternative methods of treatment that patients might find more acceptable.

Similarly, despite verbal expressions to the contrary at several hospitals and outpatient programs visited, record documentation often suggested an absence of attention to the substantial support role that families played for the majority of the individuals in the sample. Particularly striking was the finding that for one-third of the individuals returning home to live with family, clinical records provided no documentation that the family member had been consulted or even informed 48 hours prior to the individual's discharge.

These findings take on special meaning in the context of the other study findings that the presence of informal supports of family or friends in an individual's life was significantly associated with their successful transition from the hospital to the community, and particularly in avoiding a rehospitalization within six months of discharge. Similarly, the study found that a patient's index of treatment challenge while in the hospital was significantly correlated to his/her likelihood to be rehospitalized, strongly suggesting that more constructive attention to these issues, particularly where conflicts are over the types of treatment and programs being prescribed, may yield more positive outcomes for individuals.

Inattention to informal supports for persons with serious mental illness was also seen in the referral patterns for aftercare services. None of the discharge plans for individuals in the sample referenced the referral of family members to support programs, and fewer than 5% of the individuals in the sample participated in psychosocial clubs, consumer-directed support groups, or Compeer programs at any point in the full 6-month follow-up period. Failure to provide referrals for these services was linked both to the inattentiveness of clinical staff to referring patients and families to available informal support programs, like psychosocial clubs, Compeer programs, and consumer-run programs, and the absolute limited supply of these services in many communities. Limited to small budgets, often of less than \$25,000, most of which have not substantially increased in the past five years, few of these programs have been able to expand or to devote substantial resources to making their services better known in their communities. In fact, some of these consumer-directed options have been cut (e.g., the Alliance in Syracuse) during a period of shrinking resources.

The New Rate Methodologies Foster Little Reform

Despite the best of intentions, the new Medicaid inpatient and outpatient reimbursement schemes implemented by the Office of Mental Health in 1989 have also been largely ineffective in shaking this service system loose from its usual patterns and practices. Many factors, including several that were clearly beyond the control of the Office of Mental Health, contributed to the disappointing outcomes of the new Medicaid rate methodologies, despite the investment of approximately \$20 million annually to implement them.

In hindsight, it is apparent that the methodologies were simply too complex to be readily understood and that they provided too little money to individual providers to influence significant changes in practice. Most providers also had a poor understanding of the rate methodologies' explicit provisions or how these provisions affected their earned premiums, which were camouflaged in small overall rate adjustments, and which were often delayed. Perhaps most critically, most people in the mental health system were so tied up in responding to other concurrent systemic reforms in regulation and rate structures that they had little time or inclination to concentrate on understanding either the new inpatient or the new outpatient rate methodologies.

The Commission also found that in the few instances where practices had improved (e.g., provision of discharge plans and aftercare appointments and shortened length of stays), these changes usually could not be linked exclusively or even primarily to hospitals participating in the new rate methodologies. In fact, in many instances the performance of nonparticipating hospitals exceeded that of participating hospitals.

And, without exception, the senior staff of the hospitals making performance improvements strongly objected to any suggestion that they had changed their ways for the small monetary rewards that were offered. Especially in New York City, hospital providers reported being strongly influenced by the *Heard v. Cuomo* decision, which essentially mandated discharge plans and precluded hospitals from discharging psychiatric patients without referrals to after-care housing and services. Many hospital staff also stated that their improved performance sprang from their efforts to reduce backlogs in their psychiatric emergency rooms and to ensure more timely discharges to free up needed beds. Finally, across the state, psychiatric unit administrators spoke favorably of the more streamlined access they now had to intermediate and long-term psychiatric care in state psychiatric centers as a result of the NY/NY Agreement and other local agreements orchestrated by the Office of Mental Health since 1988.

Other Important Systemic Reforms Not Achieved

More importantly, in most areas neither the new Medicaid methodologies nor other government-sponsored reforms nor the personal motivations of providers spurred needed changes. Statewide data provided by the Office of Mental Health indicated that the methodologies' objectives encouraging hospitals and outpatient providers to ensure greater service access to the persistently mentally ill were largely unachieved (see Figure 35, p. 57). And, despite the fiscal disincentives of the inpatient rate methodology discouraging rehospitalizations within 30 days of discharge, since 1989, statewide rehospitalization rates have actually increased about 20%, with little discernible difference between hospitals participating and not participating in the new rate scheme (see Figure 37, p. 59).

Office of Mental Health statewide data also indicate that the percentage of discharged individuals who make contact with a mental health aftercare provider within 10 days of their discharge did not change substantially since the onset of the new inpatient rate methodology, despite the \$65 bridging fee it offered to hospitals that ensured such contact (see Figure 36, p. 58). The Commission also found no measurable improvement in the percentage of the sample individuals in its 1992 study versus its 1988 study who were in contact with aftercare services at the 6-month follow-up period.

Where to Go From Here

The Commission believes that the findings of this study provide clear direction for reform. Most directly, the findings provide a strong imperative to involve persons with serious mental illness and their families in treatment planning, in shaping the types of services needed upon discharge, and in providing supports to assist persons with mental illness reintegrate into their communities. Listening to persons with serious mental illness and their families will mean a much greater emphasis in making psychiatric rehabilitative services available, rather than continuing the state's heavy reliance on clinical programs alone which do not assist individuals and families substantially in coping with the problems of daily living.

The time has also come for the Office of Mental Health to develop a meaningful and stably funded program for informal support services for persons with serious mental illness and their families, with the active involvement of consumer and family groups. We note that the state currently funds a substantial family support services program which the Office of Mental Retardation and Developmental Disabilities has developed over the past decade.

The current fiscal environment also substantially forecloses the possibility that new funds will be available to add to what is already the most richly financed outpatient mental health system in the country. Instead, we must think about reinvesting existing funds to create a community mental health system that is more responsive to the needs of consumers and families. Most psychiatric rehabilitation program models and informal support programs have price tags of 50-75% lower than traditional clinical services. Promoting the reinvestment of only a small portion of existing clinical funding would yield a great increase in the availability of these alternative services.

Simultaneously, as we reinvest to reshape the nature of the mental health outpatient service system, we must also restructure our quality assurance oversight of publicly funded programs. Reform in this area should bring a greater emphasis on the outcomes of service provision and less emphasis on process and paperwork, as well as a greater focus on including persons with serious mental illness and their families as vital players in the quality assurance oversight of all programs.

Restructuring the Service System

The Commission recommends four approaches in financing the restructuring of the service system. First, the Office of Mental Health, with the support of the Legislature, should consider the reallocation of a proportion of existing funding for traditional clinical services (e.g., clinics and continuing treatment programs) for psychiatric rehabilitative services in each county of the state and New York City. In this effort, counties and New York City should be allowed considerable discretion as they make individual community-based decisions to downsize or convert clinical programs to provide more funding for psychosocial clubs, vocational programs, consumer-directed services, family support pro-

grams, Compeer programs and the like. A good first step might be to ask counties and the City of New York to make a 5% initial annual reallocation, with an additional 1% reallocation annually for ten years.

The second approach should center on the intensive reevaluation and monitoring of OMH-contracted Community Support Services (CSS) programs. Presently, the state invests approximately \$86 million in these programs annually. These 100% state-funded programs, initially targeted primarily to rehabilitative and case management services for persons who are seriously mentally ill, are today largely unmonitored by the Office of Mental Health for either the nature or quality of their services.

In some communities of the state, these programs are seen as vital and valuable providers of psychiatric rehabilitative services. Unfortunately, in many other communities, there has been longstanding criticism of the services provided with this funding. Recently, the Commission has had its own opportunity to observe the operation of many CSS programs serving residents of adult homes, and this experience has verified that there is little external quality control for these programs and that many suffer from a lack of clarity in their mission.

The Commission believes that a reevaluation of the CSS program may also point to other opportunities for reinvesting existing funds in services that are more directly tailored toward supporting and assisting seriously mentally ill persons in the community.

The Commission would also support the increased reliance on localities in making their own choices for CSS funding, with the dual contingencies that they ensure the active involvement of local consumer, family and provider groups and that they maintain outcome data on funded programs to provide an evaluative basis for assessing the impact of CSS services.

Notwithstanding the findings of this study, the Commission also believes that using fiscal incentives in the mental health system to change provider behavior and practices in ways that are desired should continue to be explored. However, it is clear that for such incentives to work, they must: (1) be clear, (2) be visible to the persons whose behavior is to be changed, (3) substantial enough to induce the desired change, and (4) produce readily measurable beneficial results for patients that are closely monitored through quality assurance oversight.

The Commission believes that the implementation of a system of fiscal incentives that meets these criteria will necessarily require that hospitals and outpatient programs develop patient-centered quality assurance programs that evaluate the achievement of desirable outcomes. At the same time, the State Office of Mental Health, itself, will need to develop a reliable method of verifying such outcomes as a condition of payment.

Thus, the Commission recommends that the Office of Mental Health consider two additional avenues to system restructuring which rely on fiscal incentives. One approach would focus directly on rehospitalizations and offer fiscal incentives to localities for reducing psychiatric rehospitalization rates within six months of discharge. Reducing hospital bed days is the clearest source of substantial new revenues for localities to develop alternative aftercare supports. By allowing localities to reinvest 50% of the savings in the state's Medicaid share of any reduction in psychiatric hospital bed days in alternatives to hospitalization, including in-home crisis services, consumer-directed safe houses, and crisis residences, as well as psychiatric rehabilitative services, alcohol and substance abuse programs, the state would both provide localities with a clear directive for reform and assist them with the means of achieving it. Additionally, as reducing psychiatric hospital bed days will also lessen the local county's Medicaid

share, a portion of these local savings, at the localities' discretion, could also be used to finance alternative services.

Finally, the Commission would support the preservation of the current \$4.2 million state share now spent annually for the new Medicaid inpatient and outpatient rate methodologies for an alternative incentive plan which measurably improves the level of care and services provided to persons who are seriously mentally ill by psychiatric units of general hospitals and outpatient programs reimbursed by Medicaid. This plan must, however, much more explicitly link any fiscal rewards to achieving specific and measurable outcomes, and these rewards must be clearly understood and visible to the men and women charged with providing the services. For example, fiscal incentive payments could be offered to hospitals for developing discharge plans that explicitly engage the patient and involved family members in decision-making for all the services needed for the first three months subsequent to a psychiatric hospitalization and for providing follow-up by hospital staff to ensure the implementation of discharge plans. Fiscal incentive payments could also be offered to outpatient providers for visiting their patients in the hospital, prior to discharge, to ease the linkage with aftercare services.

The Commission is aware that some hospitals and outpatient providers would prefer continuing the existing new Medicaid rate formulas. Yet, the empirical data provide little evidence that either methodology in its present form has substantial potential for redirecting the service system to better meet the needs of persons with serious mental illness. While recognizing the intention of the Office of Mental Health to improve performance of inpatient and outpatient providers, the Commission believes that after a three-year trial, it is time to consider alternate ways to invest resources to promote change.

Better Oversight of Funded Programs

The Commission also believes that more focused monitoring of hospitals and OMH-funded or -operated outpatient services for persons who are seriously mentally ill to assess actual compliance with important policies is critical to any marked reform in the service system. Stating expectations and guidelines for services, which the Office of Mental Health has increasingly done in the past several years, is an important first step, but without effective monitoring against expected performance outcomes and, where warranted, appropriate sanctions to reinforce them, the new expectations and guidelines cannot be expected to take hold. In particular, the Commission believes that the new OMH guidelines for Comprehensive Outpatient Programs must be vigorously assessed, as must OMH's expectations for real consumer and family involvement in treatment planning and program evaluation and reform.

Recommendations

1. The Office of Mental Health should not continue the new inpatient or outpatient Medicaid rate reimbursement methodologies in their present forms. The Office should, however, consider other less complex and more explicit fiscal incentive and payment plans which will encourage the delivery of services to achieve specific and measurable outcomes, including services to enhance patient and family involvement in discharge planning, follow-up of patients after hospital stays to ensure the implementation of discharge plans and to prevent rehospitalizations, and closer coordination among hospitals and outpatient programs in meeting the needs of patients.

The Office of Mental Health should also explore the advisability of providing fiscal

incentives to localities which show a demonstrable reduction in psychiatric rehospitalization rates for patients within six months of a previous discharge. At the localities' discretion, savings from reduced rehospitalization rates could be used to develop or expand psychiatric rehabilitative programs, informal support services, and/or program alternatives to acute hospitals, including home-based crisis services, alcohol and substance abuse services, safe houses, and crisis residences.

2. Within the 1993-94 fiscal year, the Office of Mental Health, in concert with the Department of Social Services and the Division of the Budget, should develop a fiscal plan which will encourage the reinvestment of outpatient mental health Medicaid and Community Support Services funds toward the restructuring of the mental health outpatient service system to provide more direct daily living supports for persons with serious mental illness and their families. This plan, which should form the basis for the Office's fiscal year 1994-95 budget request, should include target amounts for reinvested resources statewide and for each county and New York City, as well as a timetable for reinvestment. Within their targeted amounts, localities should be given considerable discretion in making local reinvestment decisions, with the explicit provision that consumers, families, advocates, and providers are actively involved in this local decision-making process.
3. As it moves toward restructuring available community services for persons with serious mental illness, the Office of Mental Health should set as a priority development and funding of a statewide program for informal support services for persons with serious mental illness and their families, comparable to the Office of Mental Retardation and Developmental Disabilities' family support

- program. In developing this program, the Office of Mental Health should work closely with consumer and family groups, as well as established providers of informal support programs, including members of the New York State Association of Psychiatric Rehabilitation Services, the Alliance for the Mental Ill, and Compeer.
4. The Office of Mental Health should undertake a major effort to evaluate and restructure its programmatic and fiscal oversight of mental health outpatient programs with an aim toward establishing a quality assurance system which will incorporate individuals with mental illness and their families in assessing the quality and effectiveness of services. The *revitalized* quality assurance system should also be capable of providing empirical data on a variety of specific programmatic and fiscal indicators, which will help consumers and the public assess the effectiveness of programs in meeting the needs of persons with mental illness.

Appendix A



NEW YORK STATE
OFFICE OF MENTAL HEALTH

44 Holland Avenue, Albany, New York 12229

RICHARD C. SURLES, Ph.D., Commissioner

March 8, 1993

Clarence Sundram, Chairman
Commission on Quality of Care for the
Mentally Disabled
99 Washington Avenue, Suite 1002
Albany, NY 12224

Dear Mr. Sundram:

Thank you for the opportunity to review the Commission's draft report: Discharge Planning Practices in Psychiatric Units of General Hospitals. OMH commends the Commission on the quality and comprehensiveness of the study and is in general agreement with the report's findings and recommendations.

Of particular interest in the study was the scale developed to assess patients' level of "challenge" to inpatient treatment. It appears that this may be a useful tool both during the inpatient stay and upon discharge to identify risk areas for rehospitalization. The Commission is invited to share this information with the field through an upcoming edition of our Quality Assurance newsletter.

It was positive to note the improvements in several areas of discharge planning practices including more comprehensive discharge plans and better linkage with mental health aftercare services. The Commission's finding that in almost all communities clinic aftercare appointments can usually be arranged within a few days of inpatient discharge was encouraging.

At the same time, improvements are clearly needed in those areas in which the study found little change in performance since the 1988 report. These include the need for greater patient and family involvement in discharge planning and the need to broaden referrals for aftercare services to include not only mental health clinic services but also a wider range of residential, substance abuse and rehabilitation services.

As detailed in the accompanying response, many of the Commission's recommendations are in line with actions taken by OMH and initiatives presently underway. Once again, thank you for the opportunity to comment on this report. If you have any questions regarding the attached response, please contact Dr. Sandra Forquer, Deputy Commissioner for Quality Assurance at 473-6383.

Sincerely,

Richard C. Surles, Ph.D.
Commissioner

cc: Sandra Forquer, Ph.D.

Recommendation #1

The Office of Mental Health should not continue the new inpatient or outpatient Medicaid rate reimbursement methodologies in their present forms. The Office should, however, consider other less complex and more explicit fiscal incentive and payment plans which will encourage the delivery of services to achieve specific and measurable outcomes, including services to enhance patient and family involvement in discharge planning, follow-up of patients after hospital stays to ensure the implementation of discharge plans and to prevent rehospitalizations, and closer coordination among hospitals and outpatient programs in meeting the needs of patients.

The Office of Mental Health should also explore the advisability of providing fiscal incentives to localities which show a demonstrable reduction in psychiatric rehospitalization rates for patients within six months of a previous discharge. At the localities' discretion, savings from reduced rehospitalization rates could be used to develop or expand psychiatric rehabilitative programs, informal support services, and/or program alternatives to acute hospitals, including home-based crisis services, alcohol and substance abuse services, safe houses, and crisis residences.

Response

OMH concurs that the inpatient/outpatient Medicaid rate reimbursement methodologies need to be simplified. We are in agreement that incentive payments appear to be more effective if they are made separately for distinct services rather than being subsumed within the general rate. The effectiveness of incentive payments also appears to be enhanced when they are focused toward rewarding improvements in performance and outcomes.

The Commission's report provides a useful insight into the performance of the rate methodology. It accurately depicts some of the reasons why the methodology has not had a greater impact on the discharge planning practices of psychiatric units in general hospitals.

OMH is preparing detailed successor proposals to the ARMS methodology. These proposals aim to target payments toward services to improve discharge linkages and reduce rehospitalization rates. As these proposals are further refined, OMH will incorporate many of the recommendations in the Commission's report.

Recommendation #2

Within the current fiscal year, the Office of Mental Health, in concert with the Department of Social Services and the Division of the Budget, should develop a fiscal plan which will encourage the reinvestment of outpatient mental health Medicaid and Community Support Services funds toward the restructuring of the mental health outpatient service system to provide more direct daily living supports for persons with serious mental illness and their families. This plan which should form the basis for the Office's fiscal year 1994 budget request, should include target amounts for the reinvested resources statewide and for each county and New York City, as well as a timetable for reinvestment. Within their targeted amounts, localities should be given considerable discretion in making local reinvestment decisions, with the explicit provision that consumers, families, advocates, and providers are actively involved in this local decision-making process.

Response

OMH agrees with the Commission regarding the importance of daily living supports for persons with serious mental illness and their families. The restructuring of the mental health outpatient service system to provide more of these supports is a goal supported by OMH through the design of the new outpatient regulations as well as a number of other initiatives.

The recommendation to develop a fiscal plan to encourage the reinvestment of outpatient funds to provide more direct daily living supports merits consideration. It is unlikely, however, that this could be accomplished as part of the fiscal year 94 budget request without considerable support from advocates and provider groups. Moving forward with any plan for reinvestment means that some providers may be adversely impacted by the removal of current funding streams and that services to patients participating in those programs may be disrupted. Therefore, adequate planning time is needed for such an initiative to ensure the full participation of consumers, families, advocates and providers in, not only the local decision process, but also the development of a statewide policy supporting the proposed fiscal changes.

Toward this goal, the OMH 507 Statewide Comprehensive Plan for Mental Health Services 1993-1997 focuses on ensuring substantial participation of consumers and families in the planning, delivering and monitoring of community support services including clarification of basic program expectations and outcomes. Activities such as those outlined in the statewide plan would begin the process of engaging localities in a dialogue regarding how funds can be reinvested in community support programs. Regional planning advisory committees with representation from consumers, families, advocates and providers would then be well positioned to support localities in identifying the priority programs to which these funds should be reinvested.

Recommendation #3

As it moves toward restructuring available community services for persons with serious mental illness, the Office of Mental Health should set as a priority development and funding of a statewide program for informal support services for persons with serious mental illness and their families, comparable to the Office of Mental Retardation and Developmental Disabilities' family support program. In developing this program, the Office of Mental Health should work closely with consumer and family groups, as well as established providers of informal support programs, including members of the New York State Association of Psychiatric Rehabilitation Services, the Alliance for the Mentally Ill, and Compeer.

Response

Development and funding of informal support services for persons with serious mental illness and their families continues to be a priority for OMH. A number of ongoing initiatives provide support, referral and technical assistance to mental health self-help groups and other informal support systems.

In both the 92-93 and 93-94 budgets, a percentage of the Community Support Services base allocation was earmarked specifically to support self-help initiatives and other informal support services. As a result of these efforts, 48 of New York State's 62 counties have at least one self-help program for persons diagnosed with serious and persistent mental illness. Prior to 1990, there were only a handful of such programs across the state.

On a related front, OMH is developing an educational/advocacy program for family and recipient organizations which will address some of the discharge planning issues of psychiatric units in general hospitals as identified in the Commission's report. This program will include information regarding the existence and importance of informal support systems, including recipient and family supports. Advocacy organizations in some localities have had success in working with their local general hospitals via staff training and individual advocacy and this program will build on those efforts.

Recommendation #4

The Office of Mental Health should undertake a major effort to evaluate and restructure its programmatic and fiscal oversight of mental health outpatient programs with an aim toward establishing a quality assurance system which will incorporate individuals with mental illness and their families in assessing the quality and effectiveness of services. The revitalized quality assurance system should also be capable of providing empirical data on a variety of specific programmatic and fiscal indicators, which will help consumers and the public assess the effectiveness of programs in meeting the needs of persons with mental illness.

Response

On January 1, 1993 OMH implemented Tiered Certification, a restructured system for conducting outpatient certification. Tiered Certification is uniformly applied throughout all regions of NYS and focuses on reviewing the most important elements of the outpatient regulations. It includes outcome measures and utilizes an objective scoring system which determines length of operating certificate and nature of follow-up activities/sanctions. This new method of programmatic monitoring is a major step forward for OMH as it focuses efforts on remediating substandard programs, maximizing limited compliance staff resources and identifying "best" practices for technology transfer.

The merit of including recipients of mental health services and their families in the process of monitoring programs is fully consistent with OMH's current plans. In 1992, OMH initiated a request for proposals to develop a recipient satisfaction survey process. There were no satisfactory bids received and so a revised RFP was issued in March 1993. The goal is to produce program-specific reports summarizing recipient perspectives on individual programs. These reports would then be available to both OMH and the program as part of the Tiered Certification review. This effort is consistent with OMH's recipient empowerment initiatives and is intended to help sensitize surveyors and programs to the consumer perspective.

OMH is also incorporating a family member/advocate monitoring component into its Tiered Certification for licensed housing settings. This effort is planned to begin in July, 1993 and be expanded in FY 94/95.

In regard to fiscal oversight of outpatient programs, OMH now has on file data collected from the Consolidated Fiscal Report. The data is for calendar year 91 for upstate programs and FY 90/91 for NYC and includes cost, staffing and salary information. Analysis of this data is preliminary at this point but there is significant potential for cost effectiveness comparisons among programs. These comparisons may help identify fiscal indicators of effectiveness and/or better methods for establishing Medicaid fees for the outpatient system.

OMH has also initiated a linkage between Medicaid billing practices and programmatic monitoring by conducting utilization review audits of outpatient programs. These audits review programs who are "outliers" in terms of their Medicaid billing practices. During FY 92-93, 31 utilization review audits were conducted. Another series of these audits will be conducted during FY 93-94.

OMH has also developed new incident management software for use by licensed and funded mental health programs. The software will allow programs to register, classify, report and monitor the investigation of incidents which involve their clients or staff. This new tool will allow programs to compile and use data about incidents to continuously improve the quality of the services they provide. The software will be provided free of charge in the 1993-94 fiscal year. A concurrent revision of incident reporting regulations (Part 524) is also underway.



ST. VINCENT'S HOSPITAL

and Medical Center of New York

203 West 12th Street
New York, NY 10011
(212) 790-8252 FAX. (212) 790-8794

JOSEPH T. ENGLISH, M.D.
CHAIRMAN, DEPARTMENT OF PSYCHIATRY

NEW YORK MEDICAL COLLEGE

Valhalla, New York 10595

PROFESSOR OF PSYCHIATRY
ASSOCIATE DEAN

March 1, 1993

Clarence Sundram
Chairman
State of New York
Commission on Quality of Care for the
Mentally Disabled
99 Washington Avenue, Suite 1002
Albany, NY 12210-2895

Dear Mr. Sundram:

I appreciate the opportunity to respond to the Commission's draft report entitled, Discharge Planning Practices on Psychiatric Units of General Hospitals, and specifically, the recommendations with respect to the State's Alternative Reimbursement Methodology (ARMS) for inpatient and outpatient payments to hospitals. On behalf of Greater New York Hospital Association's (GNYHA) Mental Health and Substance Abuse Services Committee as its Chairman, I would like to commend the fine work of the Commission in its thoughtful and comprehensive examination of the changes in hospital utilization, length of stay, patient mix, discharge planning activities, post-hospital discharge services and other attributes of health care service delivery to the mentally ill. Notwithstanding the report's conclusions with respect to the effects of ARMS on the delivery system, the report clearly identifies important issues for the improvement of discharge planning and the expansion of out-of-hospital placement options.

GNYHA has worked closely with the New York State Office of Mental Health (OMH) over time on the development and implementation of ARMS. Although GNYHA and OMH have not always agreed on how best to construct a reimbursement system for psychiatric care or our reasonable expectations for system changes to be produced by a payment system, there has been agreement that there is much value in efforts to improve the method of reimbursement because of the current complexities of meeting the resource

requirements of the patients in need of psychiatric care. GNYHA still believes in the value of the ARMS effort and therefore, disagrees with the Commission's recommendation to discontinue ARMS.

I would like to provide the following reasons in support of the continuation of ARMS:

- 1. A Longer Demonstration Period is Needed:** ARMS has not been in effect long enough for a large enough group of hospitals to really understand its usefulness either as a reimbursement system or as a change agent in the health care delivery system for inpatient or outpatient care. ARMS was not intended to address certain deficiencies in the current system including expansion of alternative placement options, i.e., residential treatment centers; enhancement of private physician fees; and the planned reduction of State long term care capacity. From a regulatory standpoint, ARMS took effect in October 1989, however, the first round of rate changes using the ARMS methodology did not take place until July 1990. Because of the delayed reaction of the rates in response to perhaps changing patterns of practice, it likely takes a longer period of time for any reimbursement-related incentives to be realized. The Commission's analysis uses 1991 data as the benchmark for measuring post-implementation changes. However, these data only represent the first full year of implementation. A longer period of demonstration is needed to better understand the impact of new reimbursement system. There has been too much investment of State and hospital time and effort in the ARMS project just to abandon it at this early date. It would be inappropriate public policy to lose the important building blocks created from this project.
- 2. There is Value in Testing New Payment Options:** Typically, reimbursement methods for psychiatric services have been separated from the methods of payment for other general hospital services on both the Federal and State levels. That is because of the complexities of psychiatric illnesses and the inability to adequately predict resource utilization of patients according to a predetermined categorization of patients. Given the current pressures for health reform on the Federal and State levels, there will be great interest in changing the way hospitals are reimbursed for services. The blanket elimination of ARMS will set the State back in terms of seeking improvements in the reimbursement for psychiatric services. It is agreed that there are certain deficiencies in the ARMS methodology, however, these can be addressed and appropriate modifications can be developed. The data already collected through ARMS can be used to better understand how to rebuild ARMS.
- 3. The Reimbursement Implications of Eliminating ARMS Need to Be Carefully Considered:** Notwithstanding the general policy considerations arguing against the elimination of ARMS, there are certain significant technical reimbursement issues which need to be addressed prior to reverting back to the previous system. There needs to be assurances that no hospital will be penalized financially from participation

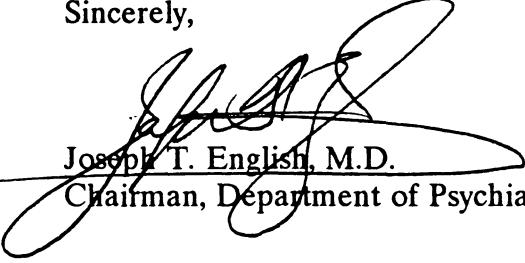
3/1/93 - Letter to Clarence Sundram
Page 3

in ARMS.

4. **ARMS Funding Needs to Remain in the Inpatient System:** The total annual ARMS payments to hospitals by all non-Medicare payers was estimated at \$11.7 million by the State. Hospitals cannot afford to lose this additional funding mechanism to meet their current financial requirements. It is inappropriate policy to claim that this funding should be directed to other sources for the improvement of health care delivery to the mentally ill. Alternative funding sources should be considered to improve incentives for the expansion of out-of-hospital placement options and other programs. The ARMS funding is considered to be an investment in the hospital system to provide needed services and coordinate the care needs of psychiatric patients.

Thank you again for the opportunity to comment on the Commission's recommendations. Please let me know if you would like to discuss any of these issues further.

Sincerely,



Joseph T. English, M.D.
Chairman, Department of Psychiatry

JTE/kl

The Commission on Quality of Care for the Mentally Disabled is an independent agency responsible for oversight in New York State's mental hygiene system. The Commission also investigates complaints and responds to requests concerning patient/resident care and treatment which cannot be resolved with mental hygiene facilities.

The Commission's statewide toll-free number is for calls from patients/residents of mental hygiene facilities and programs, their families, and other concerned advocates.

Toll-free Number:

1-800-624-4143 (Voice/TDD)

