County of Los Angeles Department of Health Services
Mental Health Services

E&R PAPERS

Date: Feb. 7, 1977 Vol. V No. 1

A SURVEY ON NEEDS FOR ALTERNATIVES TO HOSPITALIZATION

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ACKNOWLEDGEMENTS

This study was completed with the aid of the staff at each of the inpatient facilities. Survey coordinators at the participating hospitals were: Betty Bacon (Gateways), Loretta Hansen and Connie Arokiasamy (Antelope Valley Hospital), Lee Weinstein and Jack Eubanks (Metropolitan), Johanna Lery and L. Ciaramelli (Olive View), John McClure (Ingleside), Kay Angeloni (Long Beach NPI), Jean Dickerson (Alhambra Psychiatric Hospital), Dorothy Burndt (St. Johns), Juliette Lee (Camarillo), Evelyn Ford (Harbor General), Diann Worell (Central City), Shelley Osmond and George Wolkon (LAC-USCMC).

Sol Roshal, Mike Mochizuki, Pat VanDoren, Leo Grim, Clyde Kobayashi, and Lou Ann McAdams, all of the Evaluation and Research Division, participated in the preparation of this report.

ABSTRACT

In May 1976, surveys of Short-Doyle inpatient facilities were conducted to obtain estimates of the number of hospital days which might be saved were appropriate alternatives to hospitalization available. In the one-day caseload and the three-day admissions survey, primary therapists made judgments with respect to each inpatient as to whether he or she could be served in an alternative program and, if so, what services would be necessary in a viable alternative. Ten out of 13 local Short-Doyle inpatient facilities participated in the surveys. Both of the State Hospitals serving Los Angeles County residents participated in the admissions survey; one provided caseload survey data in the May survey. The other hospital conducted the caseload survey in October, and their data have been combined with the other in this report. In all, 2208 clients were represented in the surveys.

According to the therapists surveyed, 42.6% of the caseload sample and 20.1% of the admissions sample could, on the day of the survey, be served in alternative programs. If the caseload percentage is applied to the estimated total Los Angeles County inpatient caseload, an estimated 322,660 inpatient days might be saved if alternatives were available.

Clients who could be served in alternatives were likely to be the longer-term clients, conservatorship cases, and persons who meet no LPS criteria (although many who met LPS criteria could also be served in alternatives).

Responses to questions on the characteristics necessary in alternatives for particular clients showed a high need for residential care with close supervision and/or locked capabilities. It was concluded that while a significant number of inpatient days could be saved through a program of minimal-supervision alternatives, a large decrease in days could be expected only if more intensive programs were implemented.

It was recommended:

1. that expansion of the admissions screening and diversion functions take second place to enrichment of the discharge planning and utilization review mechanisms in planning aimed at reducing hospital use. This recommendation was based upon the finding that 80% of the admissions surveyed were judged unable to be served in alternatives.

2. that the County develop a coordinated plan for a program of minimal-supervision residential alternatives, which might be expected to save approximately 55,000 inpatient days.

3. that the County determine the cost of residential programs providing close supervision and/or locked capabilities, various levels of medical support, and programs of residence-based therapy judged necessary for a large number of the clients surveyed. If such intensive programs are shown to be feasible, small pilot programs might be designed and evaluated. If costs estimates are very high, however, funds would have to be diverted from other programs if inpatient use is to be replaced with alternative treatment.

A SURVEY ON NEEDS FOR ALTERNATIVES TO HOSPITALIZATION

It is the policy of the County of Los Angeles Mental Health Services to provide inpatient services when hospitalization is the most appropriate treatment for the client concerned. Many professionals assume that some large but unknown number of inpatients are hospitalized because alternative non-hospital treatments, while more appropriate, are not available. If this is so, plans for alternative programs must be based upon some knowledge of the numbers of patients who could be served in particular programs. The survey described here is a preliminary attempt to provide this information for planning alternatives.

The survey was designed specifically to obtain estimates of the number of hospital days which could be saved if appropriate alternative programs were available. To determine what kinds of alternative facilities and programs would be appropriate, we asked for judgments on the characteristics of programs which would be necessary to meet patients' treatment needs as well as or better than their current hospital treatment.

Survey Method

All local Short-Doyle hospitals and the two primary State Hospitals used by Los Angeles County residents were asked to participate in two sample surveys, a one-day caseload survey and a three-day survey of admissions. The surveys were conducted on four successive days in May 1976, except that one State Hospital did not conduct the caseload survey until the following October.

The survey form was the same for both the admissions and the caseload surveys. It was to be completed by the primary therapist(s) of the clients in the sample. For the caseload sample, the hospitals were instructed to complete

the survey form on the billable mentally ill Short-Doyle clients on the caseload on Tuesday, May 4 (October 12 for one State Hospital).* The admissions sample was to include all billable mentally ill Short-Doyle admissions for the next three days, May 5-7.** Only Los Angeles County residents were to be surveyed. Clients in the State Hospital substance abuse programs were excluded. Developmentally disabled clients were included only when they were being treated for mental health problems.

The survey form (see attachment) included basic demographic items, legal status and judgments as to whether the client met LPS criteria, judgments as to whether the client could be served outside the hospital if good alternative programs were available, and questions on components necessary in an alternative program for the client concerned. All questions were to be answered in terms of the client's condition on the day of the survey.

Sample size. All local Short-Doyle inpatient hospitals were asked to participate in the survey, as were the two State Hospitals serving the greatest numbers of Los Angeles County inpatients. Of the total of 13 local inpatient units asked to participate, three contract hospitals did not provide data. Both State Hospitals participated in the admissions survey in May, but the caseload survey was not completed by one of these hospitals until October. The October and May data have been combined in the analyses presented in this report, as the two sets of results did not appear significantly different from one another.

Table 1 shows, for participating hospitals, the number of clients represented in each survey compared with the number expected from estimates based upon monthly caseload and admissions reports. The expected and obtained numbers are quite

*Persons discharged to the community on the day of the caseload survey were excluded.

**A transfer from another inpatient unit was considered an admission only if the admission to the first hospital occurred on the same day as the transfer.

Table 1

Number of clients represented in survey compared with number predicted from participating hospitals

	Administrative Category			
One-day caseload	Total	State Hospitals	County Hospitals	Contract Hospitals
Sample n	2074	1740	207	82
Estimated actual n*	1979	1632	269	78
% sample of estimate	104.8	106.6	77.0	105.1
Admissions - 3 days				
Sample n	134	65	55	14
Estimated actual n**	162	97	50	15
% sample of estimate	82.7	67.0	110.0	93.3

*For County and contract hospitals, based upon May 1976 beginning caseloads reported on CL-102. For State hospitals, based upon State Hospital Fact Sheet, in-hospital population at end of September 1976 (for the hospital surveyed October 12) or April 1976 (for the hospital surveyed on May 4).

**For County and contract hospitals, based upon one-tenth of May 1976 admissions reported on CL-102. For State Hospitals, based unpon one-tenth of May admissions (children, adolescents, geriatric, and mentally ill), State Hospital Fact Sheet.

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close except for a less than expected number of forms completed in the County hospital caseload survey and the State Hospital admissions survey. Had all hospitals participated, we would have expected 2004 clients represented in the caseload survey and 170 in the admissions survey. The obtained number surveyed therefore represents 103% of the total estimated Los Angeles County one-day inpatient caseload and 79% of the total estimated Los Angeles County inpatient admissions for three days.

Professions of persons completing forms. For the purpose of the survey, the primary therapist was defined as the professional most qualified, because of familiarity with the patient's treatment needs, to determine alternative services which could meet those needs. Table 2 shows that the largest category of respondents for State and contract hospitals was "social worker" and for County hospitals, "psychiatrist." In the State Hospital sample, 33.8% of the forms were designated as prepared by two or more professionals.

Results

"Can you conceive of an alternative?"

We asked a general question in order to estimate the number of persons who require hospitalization as the only possible treatment: "Can you conceive of an alternative program (other than hospitalization) which could serve the patient's current treatment needs as well as or better than his or her current hospitalization? (This ideal alternative should be a possibility in today's culture but need not currently exist in the community.)"

Table 3 shows, for the caseload and admissions surveys, the distribution of responses to this question by type of hospital administration. The caseload sample, as might be expected, produced a higher percentage of "yes" responses (the therapist could conceive of an alternative) than the admissions survey. The relatively high percentage of "yes" responses in the State Hospital caseload sample, the sample representing by far the largest number of clients, implies a significant impact on the level of hospital use were alternative programs available.

Estimate of days saved. On the basis of the number of "yes" responses to this question for the caseload sample, an estimate can be made of the number of hospital days which might be eliminated each year were adequate alternative programs provided in the community. These estimates, of course, show nothing about the relative cost of providing alternative programs as opposed to hospital programs.

Assume that on the day of the survey all inpatients on the caseload of participating hospitals were in fact surveyed. Data are not available for a comparison of the exact survey day caseload figures with the number of questionnaires received. But the caseload estimates based upon monthly figures, as presented in Table 1, are close enough to the actual number of clients surveyed to justify the assumption that all clients were included. Given this assumption, the number of clients reported as capable of being served in alternatives on the day of the survey can be taken as an estimate of the number which would be reported on any one day.*

*A county-wide estimate would include days saved potentially in the three hospitals which did not participate in the survey. The estimated total one-day caseload for these hospitals, however, is only 25 patients; the increase the estimate of days saved would be minimal were we to include an estimate or nonparticipating hospitals.

Table 2

Profession of person completing the survey form
(Admissions and caseload surveys combined)

Profession	Administrative category							
	State Hosp.		County Hosp.		Contract Hosp.		All Hospitals	
	N	% of this sample	N	%	N	%	N	%
Psychologist	57	3.1	7	2.7	6	6.3	70	3.2
Psychiatrist	20	1.1	188	71.8	11	11.5	219	9.9
Other M.D.	24	1.3	33	12.6	0	-	57	2.6
Social Worker	858	46.4	9	3.4	51	53.1	918	41.6
Registered Psychiatric Nurse	75	4.1	5	1.9	28	29.2	108	4.9
Other	146	7.9	18	6.9	0	-	164	7.4
Multiple professions	625	33.8	0	-	0	-	625	28.3
No answer	45	2.4	2	0.8	0	-	47	2.1
Total	1850	100.1	262	100.1	96	100.1	2208	100.0

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Table 3

"Can you conceive of an alternative program ... which could serve the patient's current treatment needs as well as or better than his or her current hospitalization?"

- Caseload Survey -

Answer	State Hosp.		County Hosp.		Contract Hosp.		All Hospitals	
	N	% of this sample	N	%	N	%	N	%
Yes	791	44.3	61	29.5	32	39.0	884	42.6
No	978	54.8	146	70.5	48	58.5	1172	56.5
No answer	16	.9	0	0	2	2.4	18	.9

- Admissions Survey -

Yes	15	23.1	6	10.9	6	42.9	27	20.1
No	50	76.9	49	89.1	8	57.1	107	79.9
No answer	0	0	0	0	0	0	0	0

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On the day of the caseload survey, the primary therapists of 884 inpatients could conceive of an alternative program which could serve those patients' current treatment needs as well as or better than their current hospitalizations. (This is the number of "yes" responses in Table 3.) If we infer from these responses that those 884 inpatients would not need to be hospitalized on that day were alternatives available, than 884 inpatient days could be saved in one day if we had adequate alternatives to hospitalization.

Because there is no reason to believe that the day of the survey was different from any other day of the year, we assume that on any one day we would obtain roughly the same number of estimated days saved as on the day of the survey. Therefore the yearly estimate of potential days saved, given adequate alternatives, is 834 (the number on the day of the survey) times 365, or 322,660. Most of this estimate is attributable to the State Hospitals, where the yearly estimate of days saved using the same method is 288,715.

There is some indication that these estimates may be low. In a later part of this survey, the primary therapists were asked to assume that high-quality non-hospital programs were available and to identify the type of living arrangements which would be recommended in a program which would meet the client's current treatment needs as well as or better than his or her current hospitalization. Of those designating alternative living arrangements in these later questions, 27.7% in the caseload survey had answered "no" when asked on the previous question if they could conceive of an alternative program ("ideal") which could serve the client's needs as well as hospitalization.

It may be that the use of the term "ideal" in the phrasing of the more general question produced a negative response just because it might be difficult to think in terms of "ideal" programs for severely disturbed patients. Some support for this interpretation comes from the fact that of those who answered that they could not conceive of an (ideal) alternative program but later designated a residential alternative, 53.4% on the caseload survey and 43% on the admissions survey said that a locked residential facility would be the appropriate alternative. It may be that on the earlier more general question some respondents had not considered a locked facility in the range of ideal alternatives.

Another interpretation was suggested by the person who coordinated the survey at one hospital. The instructions for answering the general question on ideal alternatives stated, "Answers to this question will give a 'bottom line' for estimating the number of persons who require hospitalization as the only possible treatment." (No such instructions were given for other questions.) For persons employed by the inpatient system, there may have been some tendency to inflate the estimate of the number who require hospitalization. Fewer inpatients mean fewer hospital jobs.

At any rate, because of the uncertainty in interpreting these apparently inconsistent answers of some respondents, it is probably wiser to use the percentage "yes" responses on the more general question to estimate the potential number of days saved. It should be kept in mind, however, that this estimate may be conservative.

Client variables associated with a "yes" response: Length of current episode. In Table 4 are shown the distributions of responses to the question "Can you conceive of an alternative program...?" by the length of the client's current hospital episode (caseload sample). Note that the proportion of "yes" responses generally increases with the number of days the client has been hospitalized. Most likely, many long-term inpatients had, after a month or so, received whatever benefit hospitalization might provide.

Legal status. Tables 5 (caseload) and 6 (admissions) show the percentage "yes" response as a function of the client's legal status. In the caseload sample, the percent of "yes" responses is lowest for clients under a 72-hour hold and 14-day certification for intensive treatment and highest for conservatorship cases.. There was a low percentage of "yes" responses in the admissions survey

Table 4

"Can you conceive of an alternative ...?"
by length of time hospitalized, this episode
(Caseload survey only)

Conceive of an alternative?

Length of current episode	Yes N	Yes Row %	No N	No Row %	No answer N	No answer Row %	Total N	Total % of column
1 - 7 days	53	19.9	207	77.8	6	2.3	266	12.8
8 - 14 days	69	31.1	152	68.5	1	.4	222	10.7
15 - 30 days	113	41.8	156	57.8	1	.4	270	13.0
One-three months	218	48.9	224	50.2	4	.9	446	21.5
Three-six months	117	47.6	129	52.4	0	-	246	11.9
Six months-one year	119	48.4	125	50.8	2	.8	246	11.9
One-five years	119	50.4	116	49.2	1	.4	236	11.4
Over five years	71	56.8	52	41.6	2	1.6	125	6.0
No answer	5	29.4	11	64.7	1	5.9	17	.8
Total	884	42.6	1172	56.5	18	.9	2074	100.0

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Table 5

"Can you conceive of an alternative ...?"
By legal status

Caseload survey

Conceive of an alternative? –

Legal status	Yes N	Yes Row %	No N	No Row %	No answer N	No answer Row %	Total N	Total % of column
Voluntary (W&I 6000)	365	39.4	553	59.7	9	1.0	927	44.7
72-hr. hold (W&I 5150)	39	22.5	131	75.7	3	1.7	173	8.3
14-day cert. (W&I 5250)	53	29.6	125	69.8	1	.6	179	8.6
Conservatorship (W&I 5350, 5353, 5358)	385	53.8	327	45.7	3	.4	715	34.5
Other	28	49.1	29	50.9	0	-	57	2.7
No answer	14	60.9	7	30.4	2	8.7	23	1.1
Total	884		1172		18		2074	

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Table 6

"Can you conceive of an alternative ...?".
By legal status

Admissions survey -

Conceive of an alternative?

Legal status	Yes N	Yes Row %	No N	No Row %	Total N	Total % of column
Voluntary (W&I 6000)	8	23.5	26	76.5	34	25.4
72-hr. hold (W&I 5150)	18	18.6	79	81.4	97	72.4
14-day cert. (W&I 5250)	0	-	1	100.0	1	0.7
Conservatorship (W&I 5350, 5353, 5358)	1	100.0	0	-	1	0.7
Other	0	-	0	-	0	-
No answer	0	-	1	100.0	1	0.7
Total	27		107		134	

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generally, but the percentage was slightly higher for voluntary patients than for 72-hour holds (Table 6). Of course a "voluntary" legal status does not necessarily imply that the client does not meet LPS criteria for involuntary treatment.

LPS criteria. The respondent was asked to judge, regardless of the formal legal class of the client, whether the client on the day of the survey met one or more LPS criteria: dangerous to self, dangerous to others, gravely disabled. Tables 7 (caseload) and 8 (admissions) show the distribution of "yes" responses according to LPS criteria met. In the caseload sample, as could be expected, the greatest "yes" response, 56.5% is associated with clients who meet no LPS criteria. The next highest percentage, 48.8%, was for the "gravely disabled only" caregory, composed of 42.6% of all clients in the caseload sample. For all categories, the "yes" responses in the admissions sample is lower than for the caseload sample, even for the group of clients meeting no LPS criteria (Table 8).

Summary. The data suggest that primary target groups for programs to serve as alternatives to hospitalization are longer-term clients, gravely disabled clients and the group under conservatorship. Of course there would be expected to be great overlap among these groups. It is interesting that the fact that a client was under an involuntary legal classification and/or met one or more LPS criteria does not necessarily imply that alternative programs would be considered inappropriate, except, perhaps, for new admissions, 80% of whom are judged at admission to "need" hospitalization in lieu of alternative programs.

Services/facilities needed

Most of the remaining survey questions focused on the living arrangements and services necessary in alternative programs which could meet the client's

current treatment needs as well as or better than his or her current hospitalization. The respondents were first asked to designate the appropriate alternative living arrangement, whether independent living, client's own family, or residential care (any facility in which room and board are provided). If they checked residential care they were asked whether locked facilities, minimal or close supervision, or evening care only were appropriate for the client concerned. Then necessary services were designated: evaluation/diagnostic services, medical services, and various modes of psychotherapy. (See attached questionnaire for the precise wording of the options listed.)

Tables 9 (caseload) and 10 (admissions) show the distributions of responses to this set of questions on components necessary in an alternative program for the client concerned. Distributions are shown separately for State Hospitals, County hospitals, and contract hospitals.

The percentages in Tables 9 and 10 are of the respective samples in each type of hospital. That 50.1% of the State Hospital caseload sample (Table 9) were categorized as needing residential care means that residential care was judged adequate to meet the <u>current</u> treatment needs of 50.1% of the clients surveyed as well as or better than their current hospitalization. Clients <u>not</u> represented in the table might need (now or in the future) some of the component services listed, but not as a <u>current alternative</u> to hospitalization.

As would be expected for a hospitalized group, residential care was by far the most often designated alternative living arrangement (49.1% of the caseload sample and 31.3% of the admissions sample). In both surveys the level of supervision required in a residential alternative was high; locked facilities and close supervision were checked more often than evening care or minimal supervision. These data suggest that residential alternatives for many patients could be costly.

Table 7

"Can you conceive of an alternative ...?"
by whether patient meets one or more
LPS criteria

Caseload survey

Can you conceive of an alternative?

	Yes		No		No answer		Total	
LPS criteria met	N	Row %	N	Row %	N	Row %	N	% of column
None/no answer	187	56.5	133	40.2	11	3.3	331	16.0
Gravely disabled (g.d.) only	431	48.8	452	51.1	1	.1	884	42.6
Dangerous others (d.o.) only	27	35.1	48	62.3	2	2.6	77	3.7
G.d and d.o.	53	32.3	109	66.5	2	1.2	164	7.9
Dangerous to self (d.s.) only	51	41.5	72	58.5	0	-	123	5.9
d.S. and g.d.	71	26.1	201	73.9	0	-	272	13.1
d.S. and d.o.	19	36.5	33	63.5	0	-	52	2.5
d.S., d.o., and g.d.	45	26.3	124	72.5	2	1.2	171	8.2
Total	884	42.6	1172	56.5	18	.9	2074	99.9

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Table 8

"Can you conceive of an alternative ...?"
by whether patient meets one or
more LPS criteria

Admissions survey

Can you conceive of an alternative?

	Yes		No		Total	
LPS criteria met	N	Row %	N	Row %	N	% of column
None/no answer	4	25.0	12	75.0	16	11.9
Gravely disabled (g.d.) only	8	22.2	28	77.8	36	26.9
Dangerous others (d.o.) only	1	8.3	11	91.7	12	9.0
G.d. and d.o.	1	25.0	3	75.0	4	3.0
Dangerous to self (d.s.) only	7	25.9	20	74.1	27	20.1
d.S. and g.d.	3	21.4	11	78.6	14	10.4
d.S. and d.o.	2	14.3	12	85.7	14	10.4
d.S., d.o., and g.d.	1	9.1	10	90.9	11	8.2
Total	27		107		134	

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Table 9

Components Necessary In Alternative Programs:
Caseload Survey

Components	ADMINISTRATIVE CATEGORY							
	State Hosp.		County Hosp.		Contract Hosp.		All Hospitals	
Living arrangements:	N	% of this sample	N	% of this sample	N	% of this sample	N	% of caseload sample
Residential care	894	50.1	84	40.6	40	48.8	1018	49.1
Independent living	58	3.2	13	6.3	7	8.5	78	3.8
Own family	71	4.0	12	5.8	8	10.0	91	4.4
Locked facilities	376	21.1	35	16.9	13	15.8	424	20.4
Close supervision	630	35.3	56	27.1	31	37.8	717	34.6
Minimal supervision	233	13.1	26	12.6	7	8.5	266	12.8
Evening care only	9	.5	5	2.4	1	1.2	15	.7
Evaluation/diagnostic Services:								
Physiological tests	316	17.7	24	11.6	10	12.2	350	16.9
Observation/psychological testing only	451	25.3	45	21.7	23	28.0	519	25.0
Medical services:								
Supervision/monitoring of psychotropic Meds:								
Intensive observation	604	33.8	31	15.0	30	36.6	665	32.1
Minimal observation	256	14.3	37	17.9	7	8.5	300	14.5
Intermittent checks	219	12.3	26	12.6	8	10.0	253	12.2
Care/treatment for non-acute physical conditions	170	9.5	23	11.1	5	6.1	198	9.5
Other services:								
Outpatient therapy	278	15.6	37	17.9	12	14.6	327	15.8
Day treatment	496	27.8	45	21.7	27	32.9	568	27.4
Milieu therapy-residential setting	769	43.1	53	25.6	32	39.0	854	41.2
Individual/group therapy-residential setting	742	41.6	45	21.7	25	30.5	812	39.2
Substance abuse treatment	81	4.5	16	7.7	1	1.2	98	4.7
Social skill retraining	826	46.3	48	23.2	28	34.1	902	43.5
Primarily custodial care	189	10.6	10	4.8	0	—	199	9.6
Other services not listed	188	10.5	2	1.0	12	14.6	202	9.7
SAMPLE N	1785		207		82		2074	

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Components Necessary in Alternative Programs: Admissions Survey

Administrative Category

Components	State Hosp. N	State Hosp. % of this sample	County Hosp. N	County Hosp. % of this sample	Contract Hosp. N	Contract Hosp. % of this sample	All Hospitals N	All Hospitals % of admissions sample
Living arrangements:								
Residential living	33	50.8	3	5.5	6	42.8	42	31.3
Independent living	2	3.1	2	3.6	1	7.1	5	3.7
Own family	3	4.6	1	1.8	1	7.1	5	3.7
Locked facilities	19	29.2	1	1.8	1	7.1	21	15.7
Close supervision	27	41.5	1	1.8	4	28.6	32	23.9
Minimal supervision	7	10.8	1	1.8	2	14.3	10	7.5
Evening care only	1	1.5	0	-	0	-	1	0.7
Evaluation/diagnostic services:								
Physiological tests	9	13.8	0	-	2	14.3	11	8.2
Observation/psychological testing only	21	32.3	5	9.1	4	28.6	30	22.4
Medical services:								
Supervision/monitoring of psychotropic meds:								
Intensive observation	11	16.9	1	1.8	5	35.7	17	12.7
Minimal observation	8	12.3	0	-	2	14.3	10	7.5
Intermittent checks	14	21.5	5	9.1	1	7.1	20	14.9
Care/treatment for nonacute physical conditions	4	6.2	0	-	1	7.1	5	3.7
Other services:								
Outpatient therapy	9	13.8	3	5.5	4	28.6	16	11.9
Day treatment	12	18.5	3	5.5	2	14.3	17	12.7
Milieu therapy-residential setting	7	10.8	1	1.8	4	28.6	12	9.0
Individual/group therapy-residential setting	7	10.8	0	-	2	14.3	9	6.7
Substance abuse treatment	2	3.1	0	-	3	21.4	5	3.7
Social skill retraining	12	18.5	0	-	2	14.3	14	10.4
Primarily custodial care	8	12.3	0	-	0	-	8	6.0
Other services not listed	8	12.3	0	-	2	14.3	10	7.5
SAMPLE SIZE	65		55		14		134	

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With respect to medical services, the responses indicate relatively little need for other than supervision and monitoring of psychotropic medication (58.8% in the caseload sample). Only 16.9% in the caseload sample and 8.2% in the admissions sample were thought to need diagnostic physiological tests which may be feasible only in a hospital setting (e.g. using highly specialized medical equpiment). Care or treatment for nonacute physical conditions was considered appropriate in an alternative program for only 9.5% of the caseload sample and 3.7% of the admissions sample.

Of the psychotherapeutic services listed, those which might be possible within a residential setting were most often designated in the caseload sample: milieu therapy within a residential setting, 41.2% individual or group therapy within a residential setting, 392% and social skill retraining (training in the practical problems of everyday living), 43.5% This relative emphasis on residence-based therapies is not evident in the admissions sample. Clients judged to need "primarily custodial care" in an alternative program constituted 9.6% of the caseload sample and 6% of the admissions sample. "Other" services necessary included educational and vocational rehabilitation programs and many designations of particular therapeutic approaches, like behavior modification.

Estimates of needs for particular types of facilities. To plan residential facilities as alternatives to hospitalization, it is necessary to consider together such variables as the level of supervision necessary (high or low staff-to-patient ratio?) and the extent to which medical personnel and equipment must be available. An attempt was made therefore to create composite categories of requirements for alternative living arrangements and levels of medical care needed. Clients surveyed were then grouped into the various composite categories of requirements.

With respect to living arrangements, each client was categorized as needing one of the following types, which are also listed in the far left column in Tables 11 and 12.

a) None designated - This category represents clients for whom no alternative living arrangement was designated as an adequate alternative to hospitalization and represents 41.6% of the caseload sample and 57.5% of the admissions sample. On a small number of survey forms, the therapist did not check an alternative living arrangement but did check certain diagnostic or medical services as necessary. It is not know whether this pattern of response represents indecision, error, or misinterpretation of the questions by the therapists.

b) Independent living or living with own family. This category includes a small proportion of both the caseload sample, 8.0%, and the admissions sample, 7.5%.

c) Residential care with minimal supervision (low staff to patient ratio), not in a locked facility. These clients need a facility with room and board provided but do not need intensive supervision. Included are 10.2% of the caseload sample and 5.2% of the admissions sample.

d) Residential care with close supervision (high staff to patient ratio), but not in a locked facility. This is a relatively large group of patients - 17.8% of the caseload sample and 11.9% of the admissions sample.

e) Residential care in a locked facility. This category represents all clients thought to need a locked facility, regardless of the level of supervision indicated. Clients in this category are another relatively large group - 19.9% of the caseload sample, 13.4% of the admissions sample.

f) Other residential. In this category are clients judged to need residential care but with unspecified supervision levels, or evening care only.

g) Other. Represents sets of responses not classifiable into the other categories.

Medical and diagnostic services were classified roughly according to the level of medical personnel or equipment implied in the survey questionnaire; these categories are column headings in Tables 11 and 12:

a) None designated. This category includes those for whom no evaluative/diagnostic or medical services were designated as services necessary in viable alternatives. Included are 37.8% of the caseload sample and 59% of the admissions sample.

b) Observation/psychological testing only. For clients in this group (1.3% of the caseload sample, 5.2% of the admissions sample) observation or psychological testing but no medical services would be required in an adequate alternative. Some clients in other categories were judged to need observation/psychological testing for evaluation, but these clients were grouped in categories which indicated a more

intensive level of medical services; if the latter were available, it is assumed that the capacity for observation/psychological testing would be present or added at minimal cost.

c) Minimal or intermittent observation for supervision/monitoring of psychotropic medication. These are clients for whom an appropriate alternative would include this level of medication supervision but not physiological tests for diagnostic purposes or treatment for nonacute physical conditions. This category includes 21.6% of the caseload sample, 17.2% of the admissions sample.

d) Physiological tests, for diagnostic purposes, which may be feasible only in a hospital setting, e.g., requiring specialized medical equipment. This category excludes clients who also need intensive medication supervision and/or treatment for nonacute physical conditions and comprises only a small percentage of each sample (2-3%). Additional clients who need physiological tests are grouped in categories f. and h.

e) Intensive medication supervision. This group includes clients needing intensive observation related to psychotropic medication but not needing physiological tests or treatment for nonacute physical conditions. The group constitutes 15.4% of the caseload sample and 7.5% of the admissions sample.

f) Physiological tests as well as intensive medication supervision. This category represents 11.8% of the caseload sample, 4.5% of the admissions sample, and does not include clients needing care for nonacute physical conditions as well.

g) Care for nonacute physical conditions. Clients in this group may also need supervision for psychotropic medication, but such supervision would be assumed to be available in a facility equipped to care for nonacute physical conditions. This group is composed of 7% of the caseload sample and 3% of the admission sample.

h) Care for nonacute physical conditions as well as physiological tests for diagnostic purposes. This group presumably has the highest requirements for medical services but comprises only 2.6% of the caseload sample and .7% of the admissions sample. These clients may need supervision for psychotropic medication as well.

In Tables 11 and 12 are presented the number and percentage of each sample in each combination of living arrangement and diagnostic medical/services categories. Although no cell represents a large percentage of the sample, different combinations of the cells can yield need estimates for planning alternative facilities. For example, the caseload survey shows an estimated 148 persons on the day of the survey needed residential care in a facility which need not be equipped to care for nonacute physical conditions but for which specialized physiological testing must be accessible. Using the estimation rationale described on page 4 ff, it can be assumed that approximately the same number of persons could use this type of care on any other day of the year. Multiplying 148 by 365, we can estimate that approximately 54,020 hospital days could be avoided were such a facility available to all inpatients for whom it could provide an alternative to hospital treatment.

To show the relative impact of providing each of the identified combinations of services and types of residential care in Table 11, Table 13 gives the estimated inpatient days which could be saved were the combinations of alternatives available. Each estimate was derived by multiplying the number of clients in the caseload sample deemed to need each combination (Table 11) by 365 to give the estimate of yearly days potentially saved. These estimates are less conservative than those based upon the more general question asking whether the therapist could conceive of an "ideal" alternative.

Providing these alternative facilities may be as costly as or more costly than providing inpatient treatment. Of the total of 370,840 potential days saved (Table 13), 285,795 are attributable to residential facilities providing close supervision or locked capabilities. Of these 285,795 days, 129,940 are in categories calling for intensive medication supervision. Facilities meeting these requirements are not likely to be inexpensive, especially if psychotherapy is also provided (see Table 9 and 10). In addition, if the funding of an alternative is justified on the basis of inpatient costs to be saved, mechanisms would have to be set up to control access to and length of stay in the alternative program. All other things being equal, an alternative will save no money if it costs one-half the per diem cost of a hospital but keeps a client twice as long. And obviously a facility housing only persons who would not have been hospitalized anyway cannot cut inpatient days.

The cost of alternative programs was not in the scope of this study. But some relative judgments can be made on the basis of the data. For example, residential care with minimal supervision is certain to involve smaller personnel costs than would be required for close supervision or for a locked facility. If

CASELOAD SURVEY: COMBINATIONS OF NECESSARY DIAGNOSTIC AND MEDICAL SERVICES AND LIVING ARRANGEMENTS

Diagnostic and Medical Services

g Arrangements	None designated		Observation/ Psychological Tests Only[1]		Minimal/ Intermittent Medication Supervision[2]		Physio. Tests[3]		Intensive Medication Supervision[2]		Physio. Tests and Intensive Medication Supervision[4]		Care for Non-acute Physical Conditions[5]		Care for Non-acute Physical Conditions & Physio. Tests[6]		Total	
	N	%*	N	%*	N	%*	N	%*	N	%*	N	%*	N	%*	N	%*	N	%*
designated	672	32.4	0	-	21	1.0	13	.6	29	1.4	118	5.7	7	.3	3	.1	863	41.6
endent living or Family	43	2.1	10	.5	79	3.8	3	.1	16	.8	9	.4	5	.2	0	-	165	8.0
ential Care:																		
th minimal pervision (not cked)	15	.7	6	.3	144	6.9	8	.4	21	1.0	1	.0	14	.7	3	.1	212	10.2
th close supervision ot locked)	29	1.4	6	.3	113	5.4	14	.7	97	4.7	41	2.0	54	2.6	16	.8	370	17.8
locked facility	18	.9	4	.2	69	3.3	11	.5	147	7.1	71	3.4	62	3.0	31	1.5	413	19.9
her residential	3	.1	0	-	14	.7	1	.0	2	.1	1	.0	0	-	0	-	21	1.0
	4	.2	1	.0	8	.4	2	.1	8	.4	4	.2	3	.1	0	-	30	1.4
otal	784	37.8	27	1.3	448	21.6	52	2.5	320	15.4	245	11.8	145	7.0	53	2.6	2074	99.9

*Percentage of total caseload sample (Table Total, 2074).

[1]Patients in other categories may need these services in combination with the services labeled.

[2]Excludes patients also needing physiological tests and/or treatment for nonacute physical conditions.

[3]Excludes patients also needing intensive medication supervision and/or treatment for nonacute physical conditions.

[4]Excludes patients also needing treatment for nonacute physical conditions.

[5]Excludes patients also needing physiological tests; includes those needing medication supervision also.

[6]Includes those needing medication supervision also.

Table 12

Admissions Survey: ...ations of necessary diagnostic and medical ...es and living arrangements

Living arrangements	None designated		Observation/ psychological tests only[1]		Minimal/ intermittent medication supervision[2]		Physiological tests[3]		Intensive medication supervision[2]		Physiological tests and intensive med. supervision[4]		Care for non-acute physical conditions[5]		Care for non-acute physical conditions and physiological tests[6]		Total	
	N	%*	N	%*	N	%*	N	%*	N	%*	N	%*	N	%*	N	%*	N	%*
None designated	73	54.5	0	—	0	—	1	0.7	0	—	3	2.2	0	—	0	—	77	57.5
Independent living or with family	2	1.5	1	0.7	6	4.5	0	—	0	—	1	0.7	0	—	0	—	10	7.5
Residential Care:																		
With minimal supervision (not locked)	0	—	1	0.7	4	3.0	0	—	1	0.7	0	—	1	0.7	0	—	7	5.2
With close supervision (not locked)	2	1.5	1	0.7	5	3.7	1	0.7	2	1.5	2	1.5	2	1.5	1	0.7	16	11.9
In locked facility	1	0.7	3	2.2	5	3.7	2	1.5	6	4.5	0	—	1	0.7	0	—	18	13.4
Other residential	0	—	0	—	1	0.7	0	—	0	—	0	—	0	—	0	—	1	0.7
Other	1	0.7	1	0.7	2	1.5	0	—	1	0.7	0	—	0	—	0	—	5	3.7
Total	79	59.0	7	5.2	23	17.2	4	3.0	10	7.5	6	4.5	4	3.0	1	0.7	134	100.0

Diagnostic and Medical Services

* Percentage of total admissions sample (Table Total 134).
1 Patients in other categories may need these services in combination with the services labeled.
2 Excludes patients also needing physiological tests and/or treatment for nonacute physical conditions.
3 Excludes patients also needing intensive medication supervision and/or treatment for nonacute physical conditions.
4 Excludes patients also needing treatment for nonacute physical conditions.
5 Excludes patients also needing physiological tests; include those needing medication supervision also.
6 Includes those needing medication supervision also.

Table 13

Potential yearly inpatient days saved if combinations of necessary diagnostic and medical services and living arrangements were provided

	Diagnostic and Medical Services								
	None designated	Observation/ Psychological Tests Only[1]	Minimal/ Intermittent Medication Supervision[2]	Physio. Tests[3]	Intensive Medication Supervision[2]	Physio. Tests and Intensive Medication Supervision[4]	Care for Non-acute Physical Conditions[5]	Care for Non-acute Physical Conditions & Physio. Tests[6]	Total
ving Arrangements									
sidential Care:									
With minimal supervision (not locked)	5,475	2,190	52,560	2,920	7,665	365	5,110	1,095	77,380
With close supervision (not locked)	10,585	2,190	41,245	5,110	35,405	14,965	19,710	5,840	135,050
In locked facility	6,570	1,460	25,185	4,015	53,655	25,915	22,630	11,315	150,745
Other residential	1,095	—	5,110	365	730	365	—	—	7,665
Total	23,725	5,840	124,100	12,410	97,455	41,610	47,450	18,250	370,840

[1]Patients in other categories may need these services in combination with services labeled.

[2]Excludes patients also needing physiological tests and/or treatment for nonacute physical conditions.

[3]Excludes patients also needing intensive medication supervision and/or treatment for nonacute physical conditions.

[4]Excludes patients also needing treatment for nonacute physical conditions.

[5]Excludes patients also needing physiological tests; includes those needing medication supervision also.

[6]Includes those needing medication supervision also.

?:jh

54,750 inpatient days could be saved with a combination of residential care with a low staff to patient ratio and no more than minimal or intermittent medication supervision, then efforts should be concentrated on providing this relatively inexpensive alternative.* At the same time it should be recognized that the availability of sufficient minimal-supervision facilities will not reduce hospital days by more than approximately 55,000 a year.

Other impediments to discharge

In the final section of the survey the therapist was asked to indicate non-treatment related conditions which have impeded the client's discharge: ineligibility for public assistance, delay in SSI certification, conservator's not agreeing to an alternate placement, or other problems. Table 14 shows the distribution of responses on this question for the caseload sample. The numbers and percentages are not high, especially as any one client may be represented in several categories. The relatively high percentage of "other" responses is attributable mainly to the State Hospital sample. As the therapist was asked to describe any "other" conditions which had impeded discharge, these written statements were analyzed from a 25% sample of the State Hospital caseload survey forms. Of the sample forms which included a description of an "other" condition, 60% were classifed in one of the following categories: a) client had rejected either alternative placement or therapy in general; b) legal problems prevented discharge; c) appropriate alternatives could not be found (a condition implicit in the survey rationale).

*Estimate includes days saved given "observation/psychological tests only".

Summary and Recommendations

According to the results of the survey, a large number of persons currently in inpatient facilities do not need a "hospital" per se. A conservative estimate is that 322,660 hospital days could be saved were adequate non-hospital alternatives accessible to these persons. Most of this reduction would be assumed to come from State Hospital use.

Adequate alternatives would have a much greater impact on length of inpatient stay than on the number of admissions. While 50% of patients hospitalized for greater than 30 days were judged able to be served in alternatives to hospitalization, only 20.1% of the sample of admissions were so rated. These data imply that efforts to reduce inpatient days should focus on the discharge rather than the admission process. It is recommended therefore that expansion of the admissions screening and diversion functions take second place to enrichment of the discharge planning and utilization review mechanisms in planning aimed at reducing hospital use.

The survey indicates that the primary target groups to consider in planning alternatives are conservatorship cases, persons who have been hospitalized for greater than one month, and persons who meet no LPS criteria. These characteristics suggest that plans should focus on the "chronic" rather than the "acute" patient. Cost estimates for alternative programs should take into account the likelihood that long-term care must be provided for these patients.

Table 14

Other conditions which have impeded discharge
(Caseload sample only)

	Administrative Category							
	State Hosp.		County hosp.		Contract hosp.		All Hospitals	
Condition	N	% of this sample	N	% of this sample	N	% of this sample	N	% of caseload sample
Ineligible for public assistance	60	3.4	7	3.4	4	4.9	71	3.4
SSI certification delayed	103	5.8	1	0.5	1	1.2	105	5.1
Conservator will not agree	95	5.3	4	1.9	1	1.2	100	4.8
Other	289	16.2	11	5.3	12	14.6	312	15.0
Sample size	1,785		207		82		2,074	

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Most of those who could be served in alternatives to hospitalization need a considerable amount of care and treatment, according to the therapists making the judgments. Most need residential care, and even the 8.2% of the caseload sample who could live independently or with their families in most cases were judged to need additional medical or diagnostic services as an alternative to hospitalization. Most of those for whom residential care was an alternative were thought to need close supervision, locked facilities, and/or intensive supervision of psychotropic medication use. The need for residence-based and other outpatient psychotherapy was also high.

Alternative programs with the characteristics judged necessary by the therapists surveyed may be expensive. Residential facilities providing minimal supervision will be the least costly to provide and exist already to a certain degree in the form of board and care homes. Alternative methods of enhancing the use of existing facilities are already being explored. Difficulties have been encountered in setting up a way to fund placements in such facilities. There are also problems in maintaining standards of care in facilities over which the Department of Health Services has no direct control. Because of selectivity on the part of the facilities, some more "difficult" clients cannot be placed at all. Linkages for outpatient therapy are often not completed, and in many cases the client requires a residence-based therapy program. Finally, it is likely that hospital staff continue to resist discharge of clients who no longer need hospitalization.

These are all difficult problems, and no specific solutions will be recommended here. It is, however, recommended that the County develop a coordinated plan for a program of minimum-supervision residential alternatives. The plan should include an estimate of the potential number of current inpatients who could be

cared for in existing facilities which meet minimum standards of care. The estimate would involve determination of the current available slots (per year), as many of these facilities are now housing persons who would not be hospitalized anyway. Methods for controlling access to and length of stay in these facilities must be specified and costed. If it is determined that the number of available residential beds is inadequate to provide for a significant reduction in hospital days, then plans for additional facilities must be developed and implemented if hospitalization is to be reduced. The question of providing therapy for this group of clients must also be addressed. Can the County afford to sponsor a program of residence-based therapy? If not, are responsibilities for these former inpatients clear enough to ensure that linkage to outpatient and day treatment programs are completed when appropriate?

Considering the problems involved in providing adequate minimum-supervision alternatives, it may be that most planning resources must go to solving these problems in the foreseeable future. But some attention should be given to plans for the more intensive residential treatment needed by most of the clients. It is recommended that the County determine the cost of residential programs providing close supervision and/or locked capabilities, various levels of medical support, and programs of residence-based therapy, probably geared toward social skill retraining. Cost estimates should take into account the costs of controlling access to and length of stay in these facilities. If cost estimates show such programs to be feasible at least on a limited basis, small pilot programs could be implemented.

It is clear that a significant reduction in hospital days would require relatively rich alternatives if the care seen as necessary is to be provided. It may be that per diem cost estimates for such programs will be much higher

than, for example, State Hospital costs. This survey has not assessed services currently provided in inpatient programs. Instead the data show the characteristics which inpatient therapists say are necessary in alternative programs. Given a high cost for these alternative programs, a difficult decision would have to be made. For those inpatients who could be served outside the hospital, decision-makers would have three possible courses of action -- to allow these patients to remain in hospitals, to develop costly alternative programs, possibly by diverting funds from outpatient programs, or to continue to promote hospital discharge without providing alternative care.

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3-6) Reporting unit number: __ __ __ __

7) Survey phase: (Check one.)

1. Caseload sample___
2. Admissions sample___

8) Profession of the person completing this form:

1. Psychologist___
2. Psychiatrist___
3. Other M.D.___
4. Social Worker___
5. Registered Psychiatric Nurse___
6. Other___

9-10) Patient ID: Last initial___ First initial___

11) Sex: 1. Male___ 2. Female___

12-17) Birth date: Year (last 2 digits):__ __ Month: __ __ Day:__ __

Days hospitalized this episode: Total successive days hospitalized in this or other hospitals to date. (RIGHT JUSTIFY.) Count both the admission day and the day of the survey as one day each. If the person is admitted on the day of the survey, count one day (000 1).

18-21) __ __ __ __ days

What is this patient's current legal classification? Enter government code section number:

22-25) __ __ __ __

Regardless of the formal legal classification of the patient, does he or she today meet one or more LPS criteria? (Check as many as apply.)

26-28) Dangerous to self___ Dangerous to others___ Gravely disabled___

Can you conceive of an alternative program (other than hospitalization) which could serve the patient's current treatment needs as well as or better than his or her current hospitalization? (This ideal alternative should be a possibility in today's culture but need not currently exist in the community.)

29) 1. Yes___ 2. No___

Assume that high-quality non-hospital programs were available in the community for this patient at the present time. We would like your assessment of the services necessary in such programs in order for them to meet this patient's current treatment needs as well as or better than his or her current hospitalization. Please answer items A through C in terms of the patient's condition today.

A. First, considering the patient's condition today, what type of living arrangement would you recommend as an alternative to hospitalization? (Check no more than one.)

30)

1. Residential care (room and board, with conditions checked under B. below) _____
2. Independent living____
3. Own family (as you see the patient's family now) ____

(Continued on next page.)

B. If you checked residential care above, does the patient need: (Check as many as apply.)

Locked facilities?___

(32) Close supervision (high staff to patient ratio)?___

(33) Minimal supervision (low staff to patient ratio)?___

(34) Evening care only?___

C. Considering the patient's condition <u>today</u>, which of the following services would be necessary in a program which would serve as an alternative to his or her current hospital treatment? (Check as many as apply.)

1) EVALUATION/DIAGNOSTIC SERVICES:

(35) 1. Requiring physiological tests which may be feasible only in a hospital setting (e.g., using highly specialized medical equipment)____

2. Observation, psychological testing only____

2) MEDICAL SERVICES:

a) Supervision/monitoring of psychotropic medication, requiring:

1. Intensive observation____

(36) 2. Minimal observation____

3. Intermittent checks____

b) Care and treatment for non-acute physical conditions (i.e., care which might be provided in a nursing home or convalescent

(37) hospital)____

3) OTHER SERVICES:

(38) a) Outpatient psychotherapy___

(39) b) Day treatment, including psychotherapy, activity center, etc.___

(40) c) Milieu therapy within a residential setting___

(41) d) Individual or group therapy within a residential setting___

(42) e) Substance abuse treatment/detox___

(43) f) Social skill retraining (training in the practical problems of everyday living)___

(44) g) Primarily custodial care___

(45) 4) OTHER:___ Please describe on back of page.

Have any of the following conditions impeded this patient's discharge? (Check as many as apply.)

(46) Patient is ineligible for public assistance___

(47) Patient's SSI certification has been delayed___

(48) Patient's conservator will not agree to an alternate placement____

(49) Other non-treatment-related problems have impeded discharge_____. Please describe on back of page.

(50-56) _ _ _ _ _ _ _

(Please leave these spaces blank.