COUNTY OF LOS ANGELES

DEPARTMENT OF MENTAL HEALTH

EVALUATION REPORT

CONTINUITY OF CARE OF ~~CENTRAL~~ SOUTHEAST REGION PATIENTS DISCHARGED FROM LOCAL AND STATE HOSPITALS

Southeast Mental Health Region

QUALITY SUPPORT BUREAU

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Continuity of Care of Southeast Region Patients Discharged from Local and State Hospitals

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This is the second of five papers (One for each Mental Health Region) dealing with the continuity of care of patients who have been discharged from State and Local Short-Doyle Hospitals. The Central Region report/1 demonstrated that there is a need to strengthen the referral process and that giving structured referrals to a patient enhances the chance that the patient will be sucessfully connected to an outpatient or day-treatment service.

The purpose of these papers is to analyze the continuty care process in each Region to determine to what extent the continuity care policy of the Department of Mental Health is being achieved. This policy reads:

> "Establish a comprehensive and coordinated single system of care with a full range of services...primarily focusing on the severly and chronically mentally disordered population."
>
> "The matter of continuity of care is central in determining the quality of services delivered."
>
> "Procedures including Case Management must be clearly articulated to assure that this priority to continuity is implemented."

The success of this policy in regards to the chronic patients depends on establishing a method that will increase the proportion of discharged hospital patients that are successfully connected to an aftercare facility. As stated in the Departments' policy,

> "...there is a wide array of daytreatment, rehabilitation and socialization programs throughout the county provided both by the Department of Mental Health and by (its) contractors." ...these programs take on a renewed importance as components of the system's spectrum of care."
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> "It (is) essential that these daytreatment and rehabilitation programs be closely linked, not only with the acute care aspects the systems for referral process, but also with the community care facilities where a large part of their clientele will be in residence."

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[1] Rice, Roger E. Continuity of Care of Central Region Patients Discharged from Local and State Hospitals. Evaluation Report, January 21, 1981.

There are two vital elements to the above policy, one is the attainment of a successful referral mechanism and the other is the availability of an effective after care program. The Central Region report indicated that it is the former that needs the most strenghtening in the Department system, especially in light of the fact that some of the after care facilities had been underutilized in the past (Fowler and Honnard, 1980). However, as the referral system becomes more effective, more after care facilities will probably be needed.

The question of where after care programs are effective in reducing rehospitalization has been answered in the affirmative in most the literature published to date. There is of course some contrary findings. The literature reviewed below makes up a substantial segment of studies reported on this subject, and it is fairly representative of the available literature.

Brief Literature Review

First it should be noted that the type of patient targeted by the Department's policy, the severely and chronically ill, are those that tend to have multiple previous hospitalization (one measure of chronicity) and can be predicted to have hospitalizations in the future (Glick, Hargreaves and Drues, 1976; Summers, 1979; Rosenblatt and Mayer, 1974; Buell and Anthony, 1973; Kirk, 1976).

McCranie and Mizell (1978) found that attendance of an aftercare program was inversely related to rehospitalization. They followed their subjects (N = 421) from 1 to 4 1/2 years depending on the discharge date. The number of aftercare units varied from 1 - 65 ($\bar{X}$ = 11.1 visits). Forty percent were rehospitalized at least once. Those patients who attended less than 10 sessions (242) had a recidivism rate of 47%; those attending 10-17 sessions had a recidivism rate of 36%; and those who attended more than 18 times had a rehospitalization rate of 24%. Diagnosis was not related to recidivism. Among psychotics who came over 9 times, rehospitalization was greatly reduced for females, blacks and older people. These groups were also the most likely to attend 10 times or more.

A study that had findings between McCranie's and Mayers is that of Kirk (1976). He reviewed several studies (not including McCranies) that had different outcomes and concluded that the ambiguous results come about because of the different methodologies used (length of follow-up, type and size of patient sample and treatment settings). In his own study of 319 aftercare attenders and 260 non attenders he found the recidivism rate higher among the non-attenders. He also found that among the attenders the rate of recidivism was inversely related to the number of sessions attended. Those with 1-10 after care visits were most likely to be rehospitalized and as the number of visits increased from 11, the likelihood of recidivism steadily decreased. An important finding was: 1) chronic patients had the highest rate of rehospitalization (see above); and 2) chronic patients were most likely to be found in the aftercare attender group. Overall the chronics were also the most effected by the sessions. Their readmission rate dropped steadily as the number of visits increased

from 6. His two conclusions have important meaning to this Department's policy. They are: 1) Long term after care attendance may be more effective in preventing rehospitalization among the more chronic patients; and 2) Individuals (chronic) who seek out after care may more easily accept referrals because they may be more socialized into the patient role.

Other studies that have been reviewed to date also indicate that aftercare programs effective. Hornstra and McPartland (1963) found that those patients who were referred to an aftercare clinic were less likely than those not referred to be rehospitalized within a one year follow-up period. In a six month follow-up program Buell and Anthony (1973) found a significant relationship between receipt of aftercare and reduced rehospitalization. They found no difference in the demographics between the attenders and non attenders. In a later review of studies, Anthony, Cohen and Vitalo (1978) found that aftercare programs with schizophrenics are effective in reducing hospitalizations. In a study of "Brief vs Standard Hospitalization", Endicott, Cohen, et al (1979) found that aftercare was a significant factor in preventing rehospitalization. Only one study (Mayer, et al 1973) reported negative results of an aftercare program.

Thus if clients can be connected with an agency in the community it appears that the chance of recidivism is reduced. The two aftercare programs in the cited studies range from individual treatment in an outpatient clinic, to intensive day treatment to socialization programs. Comparison between types of programs have yielded no consistent results except that medication seems necessary as does frequent contacts.

Procedure and Findings

During the time period of this study there was no established referral system. Given the necessity for follow-up time and the limitations of the current data system, the data presented below describe the outcome of the continuity of care efforts 2 years ago. The information presented, however, may give direction to our current efforts and can act as a base for future studies. Southeast implemented a Case Management Program and structured referral system in September 1980. Through this program a referral network is being established to enhance the probability that the chronically mentally ill patient will be connected to a community service.

All patients who resided in the Southeast Mental Health Sectors and who were discharged from Short-Doyle and State Hospitals during January through March 1980 were studied. This resulted in a total sample of 512 discharged patients. Metropolitan State Hospital had discharged 369, Central City CMHC had discharged 60 patients, other contract hospitals had discharged 17 and other County and State Hospitals had discharged 66. These patients were tracked within the patient file through September 1981. However, State hospital patient transactions were not available after June 1980. Thus the data pertaining to State rehospitalization are deficient because they were not available for the full 6 months after the patients' discharge. The rate of rehospitalization is, therefore, conservative.

Each patient's record was individually studied and his/her treatment record was summarized for six months after discharge. Also available was the previous five year history on each patient so their overall utilization of services over this time period could be analyzed.

After care services were defined as those delivered at outpatient clinics and day treatment facilities. Several reporting units (4299, 6207, 6209, 6211, 6258, 6260, 6262, 6951, and 6954) were not counted as outpatient or day treatment services because they are emergency or consultation liaison units where patients usually come in expectation of being admitted to the hospital or were in the hospital with a physical condition.

A missing link in this follow-up study is the Office of Mental Health Social Service. Their services were not part of the Short-Doyle computer file and, therefore, the services offered by OMHSS were not available for this study.

From Table 1 it can be seen that only 21% of the 512 patients made a contact with a community treatment service within 30 days and 31.1% were connected after six months. As in the Central Region, these percentages varied according to the hospitals from which the patient came. Central City's successful referral rate was 31.3% within 30 days while "other" contract hospitals only had a 17.7% rate. For the six month period, the connection rate ranged from a low of 29.4% at "other contract hospitals" to a high of 48.3% for Central City. The Metropolitan State Hospital rate was 35.5%.

It should be noted that some of the discharges from the State Hospitals were undoubtedly connected with OMHSS. However, since OMHSS is primarily a case manager social service, OMHSS should refer patients for mental health services other than case management and, therefore, many of the referrals to OMHSS should in turn be referred to Short-Doyle facilities and be in the computer system.

It should be emphasized that patients leaving inpatient facilities are in crisis (Wolkon, 1968). Among their other fears and conflicts, they are also frightened about returning to the setting where their breakdown occurred. It has been reported that the vast majority of the patients leaving psychiatric hospitals need on the average 2.5 separate services, not counting financial help (Wolkon and Tanaka, 1965).

Table 2 displays the rate of rehospitalizations. During these same time periods, 19.2% of the individuals were readmitted to a hospital during the first 30 days. After 6 months, the recidivism rate was 32.8%. The rate of recidivism also varied according to the hospital from which the patients were discharged. The patients with the highest recidivism rate were from "other contract hospitals". The recidivism rates were 35.3% and 47.1% for the two time periods. The lowest recidivism rate was for patients discharged from Central City CMHC (15.0% and 23.3%). Central City had the highest successful referral rate and the lowest rate of recidivism while other contract hospitals had the lowest rate of successful connections and the highest rate of recidivism (Table 3). This is similar to the findings in the Central Region where an inverse relationship was found between successful referrals and the rate of recidivism.

A peripheral finding was that over a 5 year period, 6% of these 512 patients utilized 46% of the inpatient services. Thus the remaining 94% only used 54% of the total patient days. This is similar to findings reported for the Central Region patients.

Discussion and Recommendations

It should again be mentioned that the case management and structured referral system of the Southeast Mental Health Region had not been implemented during the time of this study period. The 1981-82 plan for this Region's case management plan has a goal of less than 18% recidivism in fiscal year 1982. Given the empirical findings cited above, 18% seems an optimistic goal. It would seem reasonable that a subgoal of percent of discharges connected to after care be established, also.

As of March 1980, it can be said that there was at best a minimal continuity of care program in the Southeast Mental Health Region. The percentage of patients who received after care are not even in the lower range of those who received after care services as reported in several other studies. Kirk's (1976) review of the literature indicated that from 36-66% of the patients discharged from hospitals received such care. Levenstein, et al (1966) reported that 52% of the discharged patients he was following were in continuous outpatient treatment and another 24% received 10-39 outpatient sessions during the first year out. In discussing referral outcome, Wolkon, (1977) noted that, "The empirical studies of referral outcomes have success rates ranging from 30-70".

Patients discharged from the State Hospital may be being referred to the State Office of Mental Health Services (OMHSS) for case management, but few are getting referred to other Short-Doyle treatment facilities. In most instances, the only record there is of exhospital patients receiving services in the community is a peremptory contact with a Short-Doyle clinic where they receive one or two sessions. Thus the few instances when these patients do connect with services, they are either in a crisis that leads to immediate rehospitalization or they are not being successfully induced to stay for aftercare services.

The first problem, lack of successful referrals, should be corrected with the implementation of structured continuity of care system; i.e., linking patients being discharged from hospitals to community resources. The Region should develop policies and procedures that facilitate discharge from Hawkins inpatient and State hospitals and linkage to community facilities; and policies and procedures for the same purposes in contract hospitals.

Linkage is part of the Regions case management process, but it should be developed more.

In a Southeast Mental Health Region statement dated September 2, 1980, the case management process is described as involving: "1) Identification, 2) assessment, 3) planning, 4) coordination, 5) linkage, 6) follow-up, 7) monitoring, 8) tracking, 9) advocacy and 10) documentation. "...Ser-

vices include assisting clients through supportive interventions, in their efforts to utilize the complex human service systems." To complement this, both the State hospital and OMHSS may need to develop a more aggressive system of making referrals. The need for a specific defined and structured referral procedure has been adequately demonstrated in the literature (Wolkon, Peterson and Rogowski, 1978).

Day treatment programs are not the only mode available for maintaining exhospital patients in the community. In fact most of the successful programs referred to in the introduction consist of different types of "therapy groups" as well as to a few individual therapy programs. Any outpatient service is in a position to offer group services for the chronically mentally patient as well as medication It should be reemphasized that Kirk (1976) found that it was the chronic patient who tended to have the most successful referral history and once successfully referred they stay in treatment the longest. He also found that the aftercare programs had the most effect on the chronic patient.

Therapists in clinics can also offer indirect services to the chronic patient. In San Mateo County, a group for relatives of schizophrenics was formed by treatment staff (Schiz-Anon) to help them help the patients. This group proved effective in contributing to the decrease in rehospitalization over a two year period (Schenoy, Shires, and White, 1981). Locally the Project Return Program which utilizes volunteers should also help the expatient in making a community adjustment.

When Summers (1979) questions whether some patients are being discharged too soon, as so many became recidivists, he also noted that 75% had not invested themselves in out patient therapy of any kind. In the present study only 36% had become involved in out patient service within 6 months.

RR:mw
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Table 1

Days Between Discharge From an Inpatient Facility and Date of First Admission to a Short-Doyle Outpatient or Day Treatment Facility

Hospital of Discharge	Days 1-7		8-15		16-30		31-60		60-180		None		Total
	N	%	N	%	N	%	N	%	N	%	N	%	N
Metro SH	18	4.9	25	6.8	28	7.6	27	7.3	33	8.9	238	64.5	369
Central City CMHC	11	18.3	4	6.7	4	6.7	5	8.3	5	8.3	31	51.7	60
Other Contract Hospitals	1	5.9	1	5.9	1	5.9	0	0.0	2	11.8	12	70.6	17
Other County & State Hospitals	5	7.6	5	7.6	5	7.6	2	3.0	8	12.1	41	62.1	66
Total	35	6.8	35	6.8	38	7.4	34	6.6	48	9.4	322	62.9	512

Table 2

Days Between Discharge From an Inpatient Facility and Date of First Readmission to A Short-Doyle Hospital

Hospital of Discharge	Days 1-7		8-15		16-30		31-60		61-180		None		Total
	N	%	N	%	N	%	N	%	N	%	N	%	
Metro SH	22	6.0	23	6.2	23	6.2	27	7.3	25	6.8	249	67.5	369
Central City CMHC	3	5.0	4	6.7	2	3.3	2	3.3	3	5.0	46	76.7	60
Other Contract Hospitals	2	11.8	3	17.6	1	5.9	2	11.8	0	0.0	9	52.9	17
Other County & State Hospitals	8	12.1	2	3.0	6	9.1	3	4.5	7	10.6	40	60.6	66
Total	35	6.8	32	6.2	32	6.2	34	6.6	35	6.8	344	67.2	512

Table 3

Percents of Successful Referrals and Recidivism within 30 Days of Discharge from Hospitals

Hospital	Percent Readmission	Percent Connected
Other Contract Hospital	353	17.7
Metropolitan State Hospital	18.4	19.3
Other County & State Hospitals	24.2	22.8
Central City CMHC	15.0	31.7

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