The New York State Office of Mental Health is in the process of preparing local area planning guidelines for the 1990-91 planning year. It is anticipated that the local plan guidelines will be disseminated during December, with a response from localities due on April 1, 1990. As part of the process in developing both the State plan and the local plan guidelines, OMH has developed a Mental Health Planning Advisory Committee. The Committee established a number of special task forces with the purpose of developing policy and planning recommendations on specific issues or populations related to improving the Mental Health Service Delivery System. A Geriatrics Task Force was created as one of the special population-focused planning bodies. The designation of this task force is a step toward a clearer identification of the needs of the elderly mentally ill and the scope of responsibility of the public mental health system in meeting those needs. The Task Force's mission is to examine the full continuum of care and treatment for this population, including inpatient services, and to make program and budgetary recommendations to OMH.

Dr. Barbara Morrison, OMH, Associate Commissioner for Long Term Care, is the staff coordinator for the Geriatrics Task Force. In addition to OMH staff, the Task Force includes representatives from other State agencies, local associations, providers and consumers. The Aging Network is represented by Belle Moser from the New York City Department for the Aging, and Robert O'Connell from the State Office for the Aging.

The Task Force is in the process of examining a number of issues and will be developing recommendations. Discussions of the Task Force will play out in the context of the attached background paper on Geriatric Populations. The paper provides an overview on available data and research as well as a conceptual description of the Mental Health Services for the Elderly Delivery System. An example of the Task Force input is reflected in the discussion of identifying the target populations. The background paper proposes that the target be those elderly who are seriously and persistently mentally ill (page 3). The Task Force has found that definition to be extraordinarily restrictive, and is pursuing avenues to broaden those older persons who could legitimately receive services through the Mental Health System.

(over)
As the Task Force functions at the State level the local planning system will be commencing. The guidelines to be provided by OMH will require that geriatric populations be prioritized for programs in the upcoming planning cycle. The guidelines will separate the needs of children and youth, adults, and the elderly, requiring that there be distinct responses to each. The guidelines will also require broad participation in the local planning process. This provides Area Agencies with an opportunity to ensure that its staff, Advisory Committee members and other advocates for the elderly are included. It is recommended that those Area Agencies who have not already done so, and who are seeking opportunities to shape Mental Health Service Delivery to older persons commence discussions with local mental health officials on the upcoming plan. The greatest impact on overall service delivery to the elderly can be made at the local level. In addition the representatives of the Aging Network who are serving on the Geriatric Task Force would welcome your comments and recommendations in general and as you review the background paper.

Two additional information materials are provided for your information; a) Mission of the Office of Mental Health; and b) Intensive Case Management Report.

Attachments
GERIATRIC POPULATIONS

Introduction

The public mental health system is under pressure to serve the needs of multiple populations. The needs of the elderly mentally ill must be balanced against those of younger adults with serious and persistent mental illness, children and youth, and the homeless. A critical question is which subset of the elderly population should be the target of public mental health dollars? As with other populations, SOMH has made a policy decision to target its resources to the seriously and persistently mentally ill. What implications does this policy have for the future design and delivery of public mental health services to the elderly?

The purpose of this background paper is to provide an overview of available data and research reported in the literature regarding patterns of mental illness in the elderly, as well as their needs for a variety of support and treatment services. Most of the elderly with mental impairments are served in a variety of health and social service settings. A question for future planning is what relationship the public mental health system should have to these other settings in meeting the needs of the mentally ill elderly.

A conceptual framework of a continuum of mental health services for elderly in the community is provided for use by the Geriatric Task Force in making recommendations as to which components of the continuum should be the responsibility of the public mental health system. Where available, data on current OMH activities and initiatives are provided for different components of the continuum.

Throughout the paper, emphasis is placed on the role of reimbursement, particularly Medicaid policy, in shaping the current pattern of mental health services for the elderly. As OMH seeks to clarify its role in serving this population, patterns of public funding will be a key consideration.

The designation of a Geriatric Task Force as part of the State Office of Mental Health's 507 Plan Process is a step toward articulating the scope of responsibility public mental health system in meeting the needs of the mentally ill elderly. The purpose of the Task Force is to examine the full range of services needed by this population and to make planning recommendations for OMH, with special attention to the relative roles of various sectors of public and private human services.
The fastest growing segment of the elderly population is among those age 85 years and older. In addition, the percentage of women, racial/ethnic minorities and individuals living alone are increasing among the elderly. These trends will have implications for the design and delivery of health, mental health, and social services in the future.

Available research indicates that the mentally ill elderly underutilize both private and public formal mental health services. This has been explained by a number of factors including reluctance of this age group to use psychiatric services which they feel are stigmatizing; lack of skilled staff and relevant programming for the elderly mentally ill; and selection bias against the elderly mentally ill by providers, some of which is shaped by reimbursement patterns.

Further, there are more mentally ill elderly who reside in their own homes or with family than are being cared for in either nursing homes or state hospitals. This emphasizes the need for a range of community-based social, health, and mental health services for this population, including support services and respite to caregivers.

As the mental health system in New York State moves toward expansion of community-based options, decisions must be made as which subset of the elderly mentally ill are to be targeted for these services. This requires specification of the target population, an accurate identification of their needs, responsive planning, and development of age-appropriate programs of treatment and support.
NEED TO IDENTIFY TARGET POPULATIONS

Defining Serious and Persistent Mental Illness

The Office of Mental Health has made a policy decision to make services to the seriously and persistently mentally ill a priority. What implications does this have for services to the elderly mentally ill? Which subsets of the this population should be the primary responsibility of the public mental health system?

Present efforts to operationalize the definition of "seriously and persistently mentally ill" focuses on 3 areas: diagnosis, degree of functional disability caused by mental illness, and duration of the mental illness as related to previous and/or long term use of mental health services:

A. The individual must be 18 years of age and older and have a primary DSM-III-R psychiatric diagnosis other than alcohol or drug disorders, organic brain syndromes, or developmental disabilities.

B. The individual must be seriously functionally disabled due to mental illness _for at least the past 12 months_ in at least 3 of the following areas:

- self-care
- social functioning
- activities of daily living
- economic self-sufficiency
- self-direction
- ability to concentrate

C. The individual must have _at least one_ of the following characteristics:

- Client is currently enrolled in the NYS CSS program and has been served in an OMH-certified or funded program during the last 2 years.

- Repeated admissions to OMH-certified programs (3 or more admissions in the last 18 months)

- Two or more psychiatric hospitalizations in the last two years.

- One consecutive stay of 6 months or more in a psychiatric hospital, an OMH-certified residence, or an OMH-designated adult home or single room occupancy hotel.

- Receive SSI or SSDI due to mental illness.
Using this definition of serious and persistent mental illness, the Planning Division of OMH estimates that in 1990-91, there will be 20,301 individuals age 65 and over who meet this definition. In addition there will be 60,251 older individuals with a mental illness diagnosis and significant dysfunction. This would suggest that there are at least 3 groups for whom analyses and planning must be addressed:

Group 1: Elderly individuals with serious and persistent mental illness residing in the community

Group 2: Elderly individuals with serious and persistent mental illness residing in institutional settings

Group 3: Non-SPMI elderly with mental illness and significant dysfunction

Population-Related Questions for the Task Force

For each group, the following questions will be addressed by the Geriatric Task Force:

1. What values and assumptions should guide the approach to service planning and delivery?

2. What are the major service needs for each group?

3. What services currently exist to meet these needs?

4. Where do gaps need to be filled or services enhanced?

5. What are the relative areas of service responsibility between private and public sectors and between local and state providers?

6. What are the relative roles and responsibilities of local, state, and federal governments in regulating and funding need services?

7. What should be the priorities of the NYS Office of Mental Health with regard to each group?
CURRENT PATTERNS AND ISSUES IN SERVICE PROVISION

Reimbursement As A Factor in Shaping Mental Health Services for the Elderly

Mental health programs for the elderly have been shaped by the nature of reimbursement for such services. As particular service needs are highlighted, reimbursement issues will be identified. However, there are noteworthy reimbursement trends:

Swan and Gerard (1987) state that, "In the United States, funding policies have often had unfortunate effects on the mental health system—generally favoring inpatient over outpatient care; direct over indirect services; medically oriented over psychologically oriented care; acute over chronic care; and more-restrictive over less-restrictive alternatives. The resulting system is fragmented, uncoordinated, inequitable, and incapable of implementing needed programs and services."

Government funding programs have been particularly important in shaping the mental health system, with Medicaid being the principal funding source for public mental health programs. State support has traditionally focused on the operation of state hospitals, but in recent years more state funds have been devoted to community-based and outpatient programs. State funding for Community Mental Health Centers has increased, especially as federal support has been withdrawn. In total, state and local governments account for about 83% of public mental health expenditures, compared to about 13% by the federal government (NIMH, 1985).

Medicare

Of special importance to the elderly, is the role of Medicare in funding mental health services. In 1981, only about 13% of federal funding for mental health services came from the Medicare program (NIMH, 1985). From the start, Medicare severely restricted its mental health coverage, setting narrow life-time limits in inpatient psychiatric care. Agencies for the care and treatment of mental diseases are excluded from Medicare reimbursement for the delivery of posthospital skilled nursing facility care (Scheffler, 1985).

Medicare restricts outpatient mental health services to $250 per patient per year, with a 50% co-insurance, thereby making mental health services costly to elderly patients, while discouraging participation by psychiatrists in the treatment of patients in clinics and nursing homes (Stotsky and Stotsky, 1983). These restrictions reinforce the tendency of the aged to receive care for mental disorders from medical providers, often under medical diagnosis. Thus most care for the mentally impaired elderly is delivered by general hospitals and nursing homes.
Medicaid

As the major funder of public mental health, Medicaid has shaped the system through its emphasis on medical supervision and inpatient services. Medicaid has funded the development of the nursing home industry as a substitute for state mental hospitals, especially for the aged (Gruenberg and Archer, 1979; Koran, 1981). Medicaid coverage was cut in the early 1980's, especially by new length of stay limits and reimbursement rate limits for inpatient psychiatric care (Sharfstein, Frank and Kessler, 1984). These cuts placed a greater burden on state and local governments for care of the indigent mentally ill. Medicaid does not reimburse inpatient psychiatric care for persons between the ages of 22 and 64 in institutions for mental disease (IMDs). The availability of Medicaid coverage for inpatient care of persons over the age of 65, promotes the use of inpatient alternatives for this population.

Private Insurance

For the retired population 65 years of age and older, private insurance is even less likely to pay for psychiatric care. Due to superannuation policies and retirement decisions, most aged do not have the option of obtaining coverage for psychiatric care through employment-related insurance programs. Further, for the individual diagnosed as chronically mentally ill, it is unlikely that a private insurance carrier would give them a policy. (Swan and Gerard, 1987)

Community-Based Services

Most of the mentally ill elderly and those elderly who are at risk for serious mental problems reside in the community. Yet, community-based services are significantly under developed for this population. Services needed by this rather heterogeneous group encompass those provided by a variety of health and human services agencies. Formal mental health services represent but one component in the continuum of care.

In 1982 the General Accounting Office issued a report in which it defined the "essential elements of a basic program of community mental health services for the elderly". Note that both short term and longer term inpatient services are included in the continuum of care for the elderly mentally ill in the community. As such they are seen as adjuncts to community-based services with an expectation that mentally ill individuals will flow in and out of inpatient services as the need arises.
The GOAs components are as follows:

(1) Psychogeriatric Assessment  
(2) Outreach  
(3) Crisis/Emergency/Short-Term Inpatient Care  
(4) Day Treatment Services  
(5) Specialized Outpatient Treatment  
(6) Case Management  
(7) Sheltered Living and Social Support Services  
(8) Family Counseling, Consultation and Education  
(9) Long Term Inpatient Care/Treatment  

In its planning activities, the NYS Office of Mental Health has collapsed these 8 categories in to 4 broad service areas:

(1) Acute Services  
(2) Outpatient Services  
(3) Inpatient Services  
(4) Community Support Services/Program  

Each of these will be briefly examined in this background paper to highlight current patterns and issues related to delivery of these services to the elderly.

ACUTE SERVICES

Psychogeriatric Screening and Assessment

Elderly persons experiencing emotional or psychiatric disturbance are most likely to present to medical settings. They may also be identified by families and providers of other services such as senior centers, adult day care, and home care. Mental health professionals are the least likely to see such individuals as a first point of contact.

This suggests that generic health and social service providers must be trained to do preliminary mental health screening and to make appropriate referrals to the mental health system. The mental health system, in turn, must have the capacity to reach out to settings where the mentally ill elderly are to be found for assessment and treatment. Other provider systems are more likely to continue their care of the mentally impaired elderly, if needed back-up services from the mental health system are forthcoming.

Screening and referral services in which mental health professionals work directly with the elderly in generic health settings would reach a group at highest risk for depression and
anxiety disorders. Geriatric nurse practitioners could work with psychologists and psychiatrists to add mental health evaluation to the comprehensive medical screening offered in specialized geriatric health clinics (Bliwise, 1987).

**Acute and Emergency Outreach Services**

Such screening, assessment and outreach services require a mobile capacity. Community Mental Health Centers (CMHCs) are a natural for the provision of such services. Yet, CMHC's have historically not provided services of this nature to the elderly population. There are a few model programs of this type among CMHCs in New York State.

Several state operated programs have mobile geriatric teams which screen elderly individuals in their own homes, PPHAs, and nursing homes. These teams are vital to the assessment of the appropriateness of inpatient admission and serve an admission diversion function.

Geriatric clinics which can assess the mental, as well as physical status of presenting patients need to be expanded. Such clinics may or may not operate under the aegis of the mental health system. Hospitals and nursing homes need to have staff with mental health expertise who can function as part of a diagnostic and assessment team. Where needed, the mental health professionals can be brought it to assist with the assessment and treatment planning process.

Increasingly providers of home care services have identified the need for mental health services among their clientele. In their efforts to provide personal care assistance, they are encountering larger numbers of individuals with a range of behavioral problems which they have not been trained to manage and perhaps should not be expected to manage. Mobile teams and outreach services could provide back-up to home care providers.

Bliwise (1987) suggests that this an appropriate function for Community Mental Health Centers especially in regard to the dementia patient "... the CMHC can act as a coordinating agency to help families obtain an accurate diagnosis; educate all those involved about the disease; provide respite for families; train family members in behavioral management techniques; and assist families with information and counseling when a nursing home placement becomes necessary. The CMHC can also extend educational services and training in behavioral management techniques to nurses, nurse assistants, and others who provide direct care to the elderly patient with senile dementia". These roles could be extended to address other mental illnesses.
One of the major barriers to the adequate provision of screening, assessment and outreach services, is the limited reimbursement for such services. Private insurance policies rarely include such coverage. Medicare policy plays a role in determining the availability of these mental health services to the elderly. The Medicare requirement that mental health services be given under medical supervision excludes providers such as CMHCs, and the services that they provide (GAO, 1982). Free standing CMHCs cannot receive direct Medicare reimbursement (Flemming, 1984) and CMHCs are covered by Medicaid in some states, but not in others (GAO, 1982). The Office of Mental Health has used Federal ADM Block Grants funds to encourage CMHCs to expand their mobile geriatric and outreach services.

The New York State Department of Health has a major initiative to promote screening, assessment, and referrals services for Alzheimer's Disease. DOH has funded several Alzheimer's Disease Assistance Centers across the state. These centers also conduct research and provide a major data source for the Alzheimer's Disease registry maintained by the Department.

**Acute Emergency and Short Term Stabilization**

As with other age groups, there will be elderly individuals (with or without a psychiatric history) who will experience acute episodes of severe emotional or psychiatric disability for which crisis intervention and short-term stabilization are required.

This is one service arena which has received considerable attention by the State Office of Mental Health. Current policy views the general hospital at the local level as the preferred site for crisis, emergency and short-term inpatient stabilization. A comprehensive emergency system mental health system is viewed as one in which there is a mobile crisis outreach capacity; crisis residential capacity; availability of observation beds to sort out whether the behavior observed is a consequence of mental illness or some other cause; crisis intervention aimed at short-term stabilization and referral for ongoing treatment if needed, and linkages to other needed service systems.

The need for special skills in diagnosis and management of the psychogeriatric patient also applies to emergency services. Linkages to aging and health services are especially critical for emergency services in order to divert inappropriate geriatric admissions to longer term inpatient settings. Once admitted, geriatric patients are particularly difficult to discharge.
OUTPATIENT PROGRAMS

Outside of the Mental Health System

The elderly in the community need a variety of mental health interventions and treatment programs. These may or may not be provided in formal mental health settings. Senior Centers and Adult Day Care Programs are natural settings for provision of preventive and moderately intensive mental health services such as counseling, psychotherapy, remotivation, and group activities which reduce the risk of isolation and depression. Staff of such programs can be trained in mental health techniques and/or mental health staff professionals can be employed in these settings on a regular basis. Joint planning, joint program development and close coordination between the aging network and the mental health network are required to enhance services of this nature. Many more at risk and mentally ill elderly are likely to be reached in these programs than those operated by the mental health system.

Within the Mental Health System

The mental health system offers a variety of outpatient mental health programs including clinic programs, day treatment, continuing treatment, and partial hospitalization (for the most psychiatrically unstable individuals). There is little information on the use of such programs in the private sector by the elderly. The New York State Office of Mental Health operates 238 outpatient programs. At the end of SFY 88-89, there were 29,059 individuals served by OMH outpatient programs and 15% of these or 4,239 individuals were over the age of 65.

In a recent survey undertaken by the Bureau of Long Term Care at OMH, field staff identified several issues specific to outpatient services to the geriatric population. Among these were the need for better staff training in working with elderly patients, the need for development of treatment protocols specifically for this population, and appropriate use of pharmacotherapy.

COMMUNITY SUPPORT SERVICES/PROGRAMS

Case Management

Elderly with mental impairments receive case management services from a variety of sources. The State Department of Social Services offers case management to clients who receive medicaid and SSI—many of whom are elderly. The State Office for the Aging has case management services under its Expanded In-Home Services to the Elderly Program (EISEP). Undoubtedly, the caseloads of both programs contain elderly individuals with some
degree of mental disability. Such individuals are also found in DSS Protective Services where case management is also provided. All of these case management programs require linkages with the mental health system in order to effectively serve their clients.

The Office of Mental Health has historically offered some case management services to community-based individuals who are mentally ill. Recently a major initiative of Intensive Case Management has been undertaken to target heavy users of mental health services. Although these services are not targeted to the elderly, there are elderly individuals among clients targeted for these services. As the program progresses, one area of study might be to profile elderly clients on ICM caseloads in order to determine their special needs, as well as any training implications for intensive case managers.

Supportive Services

The ability to both divert geriatric inpatient admissions, as well as discharge geriatric inpatients depends on the availability of a range of residential options and supportive services. An increasingly articulated value is that the mentally ill (including the elderly) should, wherever possible, access and reside in generic housing. This produces increased opportunities for integration into the larger community. Fiscal and social supports may be needed to facilitate access to generic housing and to ensure successful residence.

In-Home Supports

For the mentally impaired elderly residing in their own homes, in-home services which provide assistance with housekeeping and personal care are essential for community living. As previously noted, home care providers are encountering a hidden population of mentally at-risk individuals in the caseloads. In addition, former state hospital patients require in-home supports once a suitable residence is found for them.

At the present time there is a dire shortage of home care workers in New York State. The New York State Labor-Health Industry Task Force on Health Personnel concluded in its January, 1988 Preliminary Report that the home care crisis is expected to continue as the growth in the state's elderly population increases. The turnover rate among home care aides is very high. Part of this can be explained by the demands of caring for heavy care clients with problems behaviors which are difficult to manage. Aides need additional training in working with the elderly with mental and behavioral problems, as well as back-up mental health services to which clients and their families can be referred.
Home care is one target area for manpower planning at the State in general and within specific State agencies. Some consideration should be given to the redeployment of Mental Health Therapy Aides (MHTAs) as in-home support staff to the mentally ill given their expertise in working with this population. There has also been the suggestion that OMH develop its own capacity to provide in-home services to individuals discharged from state hospitals and/or those attending outpatient programs.

**Sheltered Living Options**

The elderly with mental impairments who cannot live independently require a range of supported living environments which provide supervision and ADL assistance. New York State makes a significant financial investment in the provision of housing options for functionally impaired individuals, including the elderly mentally ill. Some of these operate within the mental health system, but the majority do not.

**Adult Care Facilities**

Adult Care Facilities in New York are regulated and licensed by the State Department of Social Services. They are residential care facilities providing personal care and supervision for five or more adults. Services provided generally include room, board, housekeeping, supervision, activities, medication management, and limited case management.

Adult Care facilities currently provide care to two primary populations: (1) the elderly with a range of physical care and ADL needs and (2) persons who are functionally impaired because of mental illness. The latter tend to be younger, and increasingly drug involved. Data compiled by SDSS in December of 1985 indicate that of the 25,026 adult home residents, 71% were over the age of 65 years. There is a significant proportion of former state hospital patients in adult homes—22% were placed in adult homes directly from state hospitals.

Adult home providers receive no special training in the management of behavioral problems. Yet, they are increasingly being asked to serve a more psychiatrically disabled group—some of whom will be psychogeriatric patients. The quality of services provided to adult home residents who are mentally ill is a growing concern.

**Supported-or Enriched Housing**

The State Department of Social Services, the State Office for the Aging, and the State Office of Mental Health all have initiatives in the area of supported or enriched housing for individuals with a range of functional limitations.
DSS/SOFA enriched housing programs provide long term residential care to five or more adults, primarily persons 65 years or older, in community-integrated settings resembling independent housing units. The program provides room, board, housekeeping, personal care, and supervision. Enriched housing programs may be operated only by public or not-for-profit sponsoring agencies. Program sites are either small, free-standing houses or clusters of apartments no more than 25% of the total units within a multi-apartment complex. This is a small program with 587 beds in November of 1987. The elderly residents of enriched housing require a range of mental health support services which must be coordinated by the aging, social service, and mental health providers at the local level.

Unlike the DSS/SOFA enriched housing initiative which targets the geriatric population, SOMH's supported housing initiative is aimed at providing residential alternatives for younger adults, especially those who are being transitioned out of community residence programs.

Community Residences

The OMH Community Residence Program was designed as a transitional living option for persons discharged from state hospitals in order to prepare them for more independent living in the community. These residences are licensed by SOMH to provide three levels of supervision: (1) 24 hour supervised living (2) intensive supportive with daily visits by a professional in an apartment setting and (3) supportive apartment programs with professional visits 1-3 times per week. There are 6,270 community residence beds licensed by SOMH and of these only 158 or 2% are targeted to the geriatric population. Many CR providers are reluctant to take older patients who they fear will require too much physical and personal care assistance and who they believe are harder to transition out of the CR program. Data do not exist to support or refute these beliefs.

However, in the aforementioned survey of OMH staff, the lack of transitional housing and placement programs designed specifically for the geriatric patient was identified as a problem. Based on experience with efforts to transition geriatric residents (especially those with long stays in the state hospital), staff indicated that the geriatric client may require a longer periods of preparatory work with several trial visits to a potential placement site.
Family Care and Family-Type Homes

SDSS had 866 family care homes with 2,380 beds as of November, 1987. Within the Office of Mental Health, the Family Care Program is the oldest residential alternative having been in existence for over 50 years. The program provides flexible 24 hour supervision in a family home in the community. Some OMH Family Care providers receive additional training in personal care assistance so that they can take mentally ill residence with higher physical care needs. Currently there are 717 homes with a bed capacity of 2,677. Of the 2,330 family care residents, 46% or 1,069 residents are over the age of 65—making Family Care the most significant residential alternative for geriatric patients in the mental health system.

The Family Care program has had a checkered history and the success of the program varies considerably across regions of the state. Key variables in program success appear to be alternative employment opportunities for potential family care providers, aggressiveness of recruitment efforts, commitment to the program by managers and staff, careful matching of provider and patient, and availability of funds to enhance family care rates.

Family Support Services

OMH staff responding to the LTC Bureau survey indicated that families of the mentally ill request programs that provide education on mental illness, training in crisis intervention techniques, and behavior management. Families also need counseling and support to cope with their reactions to the mental illness, as well as a range of personal problems. Respite services also appear to be a high priority among families.

Because caregivers of the elderly mentally ill may not be connected to the mental health system, programs for families and caregivers operated under aegis need to have relevant mental health content. One fine example is the "Practical Help" Caregiver Training Program Developed by the New York State Office for the Aging (SOFA). SOFA modified its curriculum to include a mental health component, with special attention to dementia. Mental health professionals should be involved in the development of curriculum and support program design for families and other informal caregivers of the frail elderly.

For families of those with more serious mental illness, the Office of Mental Health funds a number of family psychoeducation and family support activities. Although not targeted to the geriatric population, families of the mentally ill elderly participate in these programs. As OMH increases its understanding of the special needs of the psychogeriatric population, special family psychoeducation content might emerge.
INPATIENT SERVICES

Long Term Care: Nursing Facilities

Mental Health Services in Nursing Facilities

In a 1986 DHHS (ADAMHA) report entitled, Mental Health Services in Nursing Homes: An Agenda for Research, the following statement was made:

The number of elderly persons requiring mental health services is expected to increase substantially in the years ahead . . . the continuing growth of the number of elderly who will need nursing home care all point to an increase in the number of persons living in nursing homes who will have diagnosable mental disorders. . . .

Nursing homes have lacked the financial resources to handle the influx of mental patients; nursing homes lack staff specifically trained in the care of the mentally ill; many people believe that mental problems are a normal and irreversible facet of aging and view attempts to at intervention as a waste of time; current reimbursement systems (Medicaid and Medicare) provide limited coverage for mental health services and the lack of assured reimbursement discourages the assessment, diagnosis, and proper treatment of mental illness in nursing homes.

While we continue to seek appropriate alternatives to nursing home care, we believe that nursing homes will continue to be the focal point for the care of the elderly who are mentally ill or at highest risk of becoming so. Thus we, as a humanitarian society, need to assure that this care is the best that our knowledge and efficient use of available resources will allow us to provide."

The National Institute of Mental Health has identified the provision of mental health services in nursing facilities as a major priority. At the same time, the Health Care Financing Administration which regulates funding for nursing home services through the Medicaid program creates significant barriers to the provision of mental health services in nursing facilities.

The clearest indication of the "mixed message" from the federal government on this issue relates to the "IMD issue". The federal government has maintained a strict exclusion of Medicaid nursing home funding to facilities that primarily treat those with mental diseases (institutions of mental disease or IMDs), arguing that such care is a state responsibility. This
disallowance has been upheld in the courts, particularly the Supreme Court in Connecticut v. Heckler (1985). States have the option to provide Medicaid coverage in IMDs for those under 21 and over 65 and New York State is one which exercises this option.

Nursing homes which care for a significant number of mentally ill individuals or which advertise themselves as specializing in the care of such persons, are at risk of being labeled an IMD. There is therefore a potential loss of Medicaid revenue (especially if the facility also serves individuals aged 22 to 64) for specializing in the care and treatment of the mentally ill who also require skilled nursing care. One way to manage this in New York State would be to designate particular nursing facilities as "psychogeriatric" facilities for care and treatment of the elderly mentally ill and restrict admission to those over the age of 65 making them fully Medicaid reimbursable.

A more recent indication of concern about the placement of mentally ill individuals in nursing facilities is the Nursing Home Reform Act under OBRA'87. The statute was promulgated based on practice of some states of shifting patients from state psychiatric hospitals to nursing homes. Swan and Gerard (1987) provide a perspective on this: "... reimbursement programs, particularly those that funded alternate types of care, promoted deinstitutionalization from state mental hospitals and reinstitutionalization in nursing homes. These moves resulted in the substitution of federal for state funding. Nursing home costs were lower per diem than mental hospital care. However, longer average nursing home stays may keep such moves from being cost effective. Moreover, part of the per diem differential is based on the receipt of patients of less active treatment in nursing homes than in mental hospitals. It is clear, however, that states participated in the shift of aged patients to nursing homes in order to promote cost savings in their programs—federal match to state Medicaid was a strong incentive to switch from state-funded mental hospitals".

To stem this practice, the federal government issued new requirements for screening and assessment of all mentally ill and mentally retarded individuals applying for nursing home placement to assure that this level of care was actually required. These are part of the Nursing Home Reform Act of OBRA'87.

New York state was not one of the states engaging in this practice. At the present time there are 101,000 nursing home beds certified by the New York State Department of Health with a 97% occupancy rate. In effect, there were no excess beds willing and able to take dischargees from state psychiatric hospitals. We also have a system under the Resource Utilization Groups (RUGs) prospective reimbursement which creates a fiscal incentive for nursing homes to take patients with heavy skilled
nursing needs and creates a disincentive to take those whose needs are for supervision and behavior management. Because of these factors the capacity of state hospitals to discharge appropriate individuals to nursing facilities in this state are significantly hampered. The new screening requirements have further created stigma and barriers for the mentally ill elderly who need nursing home care in this state.

With the stated intent of assuring that mentally ill individuals were appropriately placed in nursing homes, the Nursing Home Reform Act provides reimbursement for screening and assessment activities, but does not provide additional funds for mental health services in nursing homes. This is especially problematic for individuals with dementia since they are excluded from the assessment requirements based on the federal government's position that they are "automatically" considered appropriate for care and treatment in a nursing home.

In order to meet the needs of mentally ill individuals in their care, nursing homes need additional staff development and program resources—without the risk of an IMD designation. A small technical group has been formed by DOH, DSS and OMH to examine the issues related to the needs of the mentally ill in nursing homes and to examine ways in which existing RUGS categories could be modified to provide additional funds for mental health services.

**Long Term Care: The State Psychiatric Center**

To the extent that hospitals and local providers take responsibility for acute and intermediate care, the state psychiatric center's role will be more narrowly defined and focused on the provision of long term or extended care of the most psychiatrically disabled.

The objective of extended care is to prevent further deterioration among the relatively small patient population with severe and persistent disabilities requiring long term hospitalization. This level of care focuses on patients requiring secure care, with multiple disabilities, or with health problems requiring intensive nursing care, in addition to their need for active, rehabilitative treatment. Extended care stay typically exceeds 180 days.

New York State currently has 16,987 adults in state operated psychiatric centers. Of these, 36% or 6,036 are over the age of 65 years. The geriatric inpatient population has an average length of stay of 27 years.
Target Population and Admission Criteria

There are several areas of concern related to inpatient care of the psychogeriatric patient, not the least of which is whether these services are targeted to individuals who really require this level of care. Historical admission practices would suggest that some of the long stay geriatric patients would not meet the more stringent admission criteria used today in an environment of inpatient census control. In the past, the state hospital was the first portal, rather than the last for elderly patients with psychiatric symptoms or problem behaviors.

Examination of data on geriatric patients across OMH facilities would suggest that admission criteria vary considerably by facility for this population. As previously noted greater emphasis is being placed on nursing facilities as the preferred treatment site for some categories of mental illness, particularly organic disorders and dementia. This trend has implications for geriatric admission policy to state hospitals. Although the state hospital must be prepared to treat individuals with concomitant dementia and psychiatric illness, admission criteria must be developed which discourage admission of individuals with a primary diagnosis of organic brain disease. The ability of the state hospital to resist pressures to admit such patients depends on available alternative care sites in the community and in the nursing facilities. The critical question is which geriatric patients require extended active treatment in a state hospital?

There appear to be a significant number of geriatric inpatients who no longer require active treatment and need an alternate level of care. Based on applications of the Patient Review Instrument (PRI) which the state uses to determine the need for skilled nursing care, DOH and OMH estimate that there are over 2,000 persons in state hospitals who are appropriate for skilled nursing facility care. This represents 30% of the geriatric inpatient population.

In addition to the reimbursement barriers to alternative placement previously discussed, factors such as patient and family resistance, staff resistance, and lack of placement alternatives in nursing facilities or the community all contribute to this situation. Considerable attention should be given to overcoming these barriers as part of the planning process. It should be noted that in spite of these problems, discharges from state hospitals to nursing facilities have tripled in the last four years from an average of 206 per year in 1985 to 637 per year in 1989. Some state hospitals have devoted staff full-time to discharge activities which include brokering with nursing facilities, families and patients to increase the chances for a successful placement.
Psychogeriatric Extended Care and Treatment

Once a target population or populations are clearly identified, attention will need to be focused on the content and quality of treatment services to the psychogeriatric population. Research and planning efforts must focus on a more refined definition of treatment needs, age-appropriate treatment modalities, and cost-effective strategies of service delivery.

One OMH initiative which will move the state of practice forward for this population is the creation of the Central Islip Psychogeriatric Center on Long Island. The Center will be the focal point for the development and testing of treatment modalities, staff training, research, and technology transfer within the mental health system.

Research is also being undertaken at the Nathan Kline Institute on psychopharmacology and the geriatric patient. The appropriate use of psychotropic medications in the elderly is a key concern for extended treatment settings. It is know that the long term or inappropriate use of these drugs create significant functional and cognitive deficits which increase, rather than lessen, the need for extended care.

Conclusion

There are multiple players in the provision of mental health services to the elderly. The capacity of these providers to deliver services to appropriate individuals in a cost-effective manner is significantly shaped by the nature of public funding for mental health services. The major planning challenge for the public mental health system is to determine which subset of the elderly with mental impairments will be the target for its community-based and inpatient services, as well as the direction and scope of these services.

SOMH must also identify where linkages are required with other service providers to enhance mental health components of generic health and social services programs where the elderly are most likely to be served. The Geriatric Task Force of the Office of Mental Health's 507 Plan Process will make recommendations in these areas.

Prepared by:
Dr. Barbara J. Morrison
Associate Commissioner
Long Term Care

June 19, 1989
APPENDIX A

DATA ON PREVALENCE OF MENTAL ILLNESS IN THE ELDERLY
NEW YORK STATE
POPULATION PROJECTIONS

PREVALENCE OF MENTAL ILLNESS AGES 65+

1990 ESTIMATES

NON MENTALLY ILL 97%
2418821

MENTALLY ILL 3%
80552
NEW YORK STATE
NURSING HOME POPULATION AGES 65+

PREVALENCE OF MENTAL ILLNESS

1990 ESTIMATES

NON MENTALLY ILL 95%
99886

SPMI 5%
5702
PATTERNS OF MENTAL ILLNESS AMONG THE ELDERLY

Depression

There is disagreement among mental health professionals on the prevalence of depression among the elderly. However, depression has long been recognized as a major psychiatric disorder in later life. The prevalence rates of depressive disorder from recent studies are substantially lower than previous estimates in either the community (Blazer, 1983, Kay and Bergman, 1980) or among psychiatric inpatients (Redick and Taube, 1980). Lower estimates have been attributed to better diagnostic techniques, as well as relative improvements in health and standard of living of many of today's elderly.

The median prevalence rate for depressive disorder across studies was 3.75%; the median for significant dysphoria was 14.75 percent. Although many of the elderly reported numerous symptoms of depression, only 4-5% met the criteria for major depressive illness. If these rates are applied to the 65+ population in New York State in 1990, there will be approximately 124,967 older individuals with major depressive illness and 368,000 with significant dysphoria—both of which can impair ability to undertake the basic activities of daily living.

Gender, social class, marital status, and physical illness are highly correlated with depression. Women, the poor, the unmarried, and those with physical illness are more likely to suffer from depressive illness. Given the previously noted increase among women, minorities (who are more likely to be poor), and persons living alone among the elderly, it could be hypothesized that depression may increase among future cohorts of elderly.

Depression is one disorder for which the interplay between physical and mental illness is very strong. Medical and health care providers are frequently the first to encounter the symptoms of depression among their older patients. Yet few health care providers are sufficiently trained to recognize such psychiatric disability in the elderly who are prone to somatization of psychiatric symptoms.

The prognosis for late-life depression is poor, especially for patients with recurring and chronic depression (Mann, Jenkins, and Belsey, 1981). Some of this has been explained by the greater risk of adverse reactions to psychotropic drugs among the elderly (Davidson, 1978, Salzman, 1985). Today the most common treatment for depression in the elderly is pharmacotherapy alone (Forde and Sbordone, 1980). Given the reluctance of the elderly to use psychiatric services and a similar reluctance of general practitioners to refer elderly patients to mental health
professionals, those who have drug reactions and cannot continue drug therapy may have their depression go untreated (Bliwise, McCall, and Swan, 1987).

Dementia

The incidence and prevalence of dementing illness, including Alzheimer's disease, increases dramatically with advanced age. Diagnostic problems still make a definitive diagnosis difficult. The ability to accurately distinguish non-reversible dementia from other disorders which produce reversible symptoms of dementia is critically important. Among the elderly, conditions such as drug interactions and toxicity, malnutrition, alcohol abuse, and severe grief reactions can produce symptoms of dementia. Early detection and intervention can reverse these effects. Health care professionals and primary medical care sites need training in the early detection and management of these conditions.

The care and treatment of individuals with nonreversible and progressive dementia will be a major public health challenge in the decades ahead. Dementia associated with Alzheimer's disease and vascular or multi-infarct dementias are the most commonly observed dementias in later life (Mortimer, Schuman, and French, 1981). Most dementias are progressive, irreversible, directly associated with diminished cognition and functional ability, and an increase in behavioral problems (Roth, 1971). More important that the type of dementia, is the degree of cognitive impairment which results. Impaired cognition hampers the ability of the older person to perform the basic activities of daily living and increases the risk of institutionalization.

Based on several studies of community-based elderly, the prevalence rates for mild to moderate cognitive impairment were quite variable with a range of 2.6% to 23.3%, with a median of 11.15%. Difficulty in recognizing the early stages of dementia probably accounts for this variation. Prevalence of severe cognitive impairment ranged from 1.3% to 6.5%, with a median of 5.7% (Akesson, 1969, Broe, et al., 1976, Cooper, 1984, Gurland, et al., 1980)

If these rates are applied to the elderly in New York State, there will be approximately 424,887 individuals with some degree of cognitive impairment related to dementing illness. It should be noted that prevalence rates of dementia for individuals age 80 and over (i.e. the fastest growing segment of the elderly population) exceed 20% (Cooper, 1984, Kay, et al., 1964).
Anxiety Disorders

Anxiety disorders have not received much attention in the studies on late life mental illness. However, recent studies suggest that the elderly are more likely, compared to other age groups, to take anxiolytic medication. One of the best designed studies (Uhlenhuth, et. al., 1983) reported prevalence rates for generalized anxiety of 7.1% for persons aged 65-79. In the same study, rates for agoraphobia and panic disorders were 1.7% and 1.4%, respectively.

The literature clearly indicates the difficulty in diagnosing anxiety in the elderly. Factors such as adverse social conditions, loneliness, widowhood, family problems, and previous psychiatric problems can all contribute to the disguise or exacerbation of symptoms of anxiety in the elderly. The coexistence of physical illness and anxiety often goes unrecognized (Bliwise, et. al. 1987)

Schizophrenia and Paranoid Disorder

Schizophrenia and paranoia in late life are characterized by serious disturbances in thinking and behavior. Most studies of these disorders in late life have been conducted in Europe where the term "paraphrenia" is used to describe elderly patients with schizophrenic-like syndrome that includes paranoid delusions and that arises in late life (Bridge and Wyatt, 1980; Gurland and Cross, 1982). The prevalence rate across several studies in Europe and the U.S. is very low, less than 1% in the elderly population.

Significantly high rates of sensory deficits (especially hearing impairment) were found among elderly with paranoid disorders. This suggests that routine examinations of elderly presenting with psychiatric symptoms should include a comprehensive assessment of sensory acuity.

A frequently observed phenomenon among schizophrenic geriatric patients in state hospitals is that as they age their behavior symptoms decline. Studies that followed schizophrenic patients into old age revealed declines in affective expression, diminished severity of psychotic symptoms, and increased sociability (Bleuler, 1974; Ciompi, 1985; Wenger, 1958). Cognitive impairment was frequently observed among older schizophrenics with rates similar to those of elderly in the community.

Within the state hospital system this is one group which has many candidates for alternate levels of care, especially in residential health care facilities. In spite of declines in problem behaviors, they are stigmatized by their schizophrenic histories, making discharge and alternative placement difficult.
Substance Abuse

Much recent attention has been focused on the mentally ill chemical abuser or "MICA" patient. The image one conjures of a MICA patient is young, male, and drug involved. Yet, there are geriatric MICAs who frequently have been overlooked in the research, planning, and program development for this subgroup. As with the younger population, there is controversy over ways to assess the relative primacy of mental illness vs. substance abuse. That the two coexist in some elderly patients is undeniable.

Bliwise, et. al. (1987) report on six large studies of community-based elderly populations. Prevalence rates of alcohol abuse were fairly consistent across all six studies. The prevalence rates of heavy alcohol use among the elderly ranged from 3% to 9% with a median of 6 percent. Prevalence rates of alcohol abuse ranged from 1% to 5% with a median of 1.4%. Diagnostic criteria developed to assess levels of alcohol intake as an index of abuse were normed on younger populations. Use of these criteria may lead to underreporting of alcohol abuse among the elderly. The elderly experience more impairment at lower doses of alcohol compared to the young.

Although these rates for community-based residents are relatively low, elderly alcoholics are at high risk for institutionalization in either nursing homes or state hospitals (NIMH, 1970). Blose (1978) reported that 40 to 60 percent of white males residing in nursing homes had alcohol-related problems.

Two distinct groups of older alcoholics have been identified: those with long standing alcohol problems (67%) and those who began heavy drinking in late life (33%). Either of these groups may present to medical, social, or mental health services because of the physical, behavioral, and/or social consequences of their drinking behavior. This is a subset of the elderly population for whom early detection, intervention and ongoing supportive services will be needed if they are to remain in the community.
REFERENCES


Blueler, M. (1974). The Long Term Course of Schizophrenic Psychoses. Psychological Medicine, 4, 244-254


Davison, W. (1978). Neurological and Mental Disturbances Due to Drugs. Age and Ageing, 7 (Suppl.), 119-126


General Acouting Office. (1982). The Elderly Remain in Need of Mental Health Services. (Publication # GAO/HRD0 82-112) Gaithersberg, MD: Author
Gurland, B.J., et.al. (1980). The Epidemiology of Depression and Dementia in the Elderly: The Use of Multiple Indicators of These Conditions. In J.O. Cole and J.E. Barrett (Eds), Psychopathology in the Aged, (pp. 37-60), New York: Raven


MISSION OF THE OFFICE OF MENTAL HEALTH

The New York State Office of Mental Health is undertaking a major change in its mission, methods and priorities. In the past, OMH was frequently criticized for providing insufficient resources and support for people with serious mental illness. OMH administers a system which provides more State operated services and community services than any state in the U.S.; its per capita expenditures are the highest among states in the nation. However, the system is largely institutionally based, and its State hospital census is also the nation's highest.

In recent years, OMH has significantly expanded support for persons with the most serious mental illness. Patients discharged to home and community now have an opportunity for continuing treatment and support. However, while most seriously mentally ill people now reside in communities (usually with their families), the vast proportion of State and federal resources continue to support inpatient treatment.

The overall responsibility of the Office of Mental Health is to ensure that all citizens of New York State have access to needed mental health services. Over the next several years, the Office of Mental Health will functionally establish that the priority of the public mental health system is to provide emergency access, treatment and rehabilitation within a comprehensive, coordinated system to those persons of all ages who are experiencing serious mental illness. This mission must be accomplished in an environment which respects the human dignity of each person and offers the person and the family hope. The principles listed below highlight some of the most critical aspects of this responsibility.

Philosophy and Principles

- Community service and support systems must be responsive to individuals' unique and multiple needs.

- Individuals with serious and persistent mental illness and their families should have options, within a flexible system, as to service and provider type.

- Members of minority and ethnic groups, the elderly, and those with multiple disabilities must have access to community service and support systems responsive to their individual needs.

- The public mental health system must assure the accessibility and availability of effective services for all individuals, especially those with serious and persistent mental illness, who are unable to acquire needed services without the assistance of government.
The mental health services system should have the capacity to treat the vast majority of persons who are seriously, acutely mentally ill and can be effectively treated in their home communities if the range and mix of services are consistent with their needs.

Local governments and local providers must be supported and assisted in their development of responsive and needs-based community systems for seriously and persistently mentally ill persons.

For individuals who are seriously and persistently mentally ill, mental health services must be effectively integrated with health, social services, and other common community services, at the local level.

The vast majority of persons with long term mental illness can live meaningful and productive lives in community settings when given flexible support.

Consumers must have access to services and opportunities for growth within a structure that promotes participation and protects their personal and civil rights.

Families of consumers must have access to services and opportunities for education within a system that promotes their participation.

Research, staff development, training and new technologies which promote improvements in services and treatment of those who experience long-term serious mental illness must be supported.

**MAJOR PROGRAM STRATEGIES AND DIRECTION**

Often a person with a serious mental illness confronts a fragmented service system which is difficult to negotiate and which may frequently exclude those most in need. It is a priority task of OMH to develop a unified and coordinated system designed to meet the needs of the most seriously ill, as well as ensuring access for all citizens who need mental health services.

The resulting system must provide for adequate evaluation of the needs of those entering the system. It must provide a variety of community options to those not needing hospitalization. Acute care services for those in need of short term hospitalization must be made available in the community. A clearly delineated role must be established for the State psychiatric hospitals, which will be maintained and staffed at levels adequate to meet the needs of those needing longer term hospitalization.
During the past year, OMH has focused on developing the missions and objectives for the public mental health system, on assuring system access for the seriously mentally ill, and on establishing a more accurate data base to assess program performance. As part of this focused effort, the Office has organized its programs into four major categories: Emergency, Inpatient, Outpatient, and Community Support.

**Emergency Programs**

Currently, emergency services are provided primarily in emergency rooms of general hospitals and in some State psychiatric centers. The psychiatric component of these services is unregulated by OMH and is inadequately funded, resulting in a limited capacity to provide triage. The lack of a comprehensive emergency system has resulted in emergency room overcrowding, and overutilization of costly acute inpatient hospitalization.

During 1988 and 1989, the Emergency Services Task Force of the Planning Advisory Committee considered this situation and issued its report and recommendations (see Appendix __). During 1989 - 90 and 1990 - 91, the Office will move forward in developing a comprehensive emergency system as detailed in Chapter 3, Office of Mental Health Strategic Plan 1991 and Beyond.

**Inpatient Programs**

During the past year, OMH established short and long term goals for State operated inpatient services. In the short term, the State psychiatric centers have a primary mission in symptom reduction, psychiatric rehabilitation, and maintenance care. In the long term, State psychiatric centers are more appropriately used for intermediate and long term care with general hospitals providing acute hospitalization.

Short-term acute hospitalization is best provided in general hospital settings, close to the individual's home community. General hospitals have the medical services and intensive staffing levels needed for treatment of acute episodes of mental illness, factors which are not available in State psychiatric centers.

OMH has undertaken several initiatives which are intended to stimulate the increased participation of the general hospitals.

- Legislation was passed to require Article 28 (general hospitals) hospitals with psychiatric units to accept emergency psychiatric patients pursuant to Article 9.39 of the Mental Hygiene Law.
OMH and DOH are jointly developing a rate methodology which creates incentives for general hospitals to treat individuals in their acute phase of illness.

In future years OMH proposes to develop joint State and local placement teams available to general hospitals to facilitate placement of hard to place patients.

In addition, the Planning Advisory Committee has established a task force to deal with acute inpatient care. It will deal with current volume and geographic distribution of resources and with the notion of developing a method to plan for adequate future resource development and distribution. It will address issues of access to these beds for priority populations. Current standards for program design and staffing will be assessed and recommendations will be made concerning regulatory or other program guideline development. Also, the task force will review and comment on current proposals regarding the structural aspects of reimbursement methods to hospitals for providing acute care.

The Office's planned activities for inpatient care are detailed in Chapter 3, Office of Mental Health Strategic Plan 1991 and Beyond.

Outpatient Programs

The Office of Mental Health operates or licenses more than 900 outpatient programs including clinic services, day treatment, continuing treatment and intensive day treatment. However, outpatient services have not effectively reached the most seriously mentally ill; service duplication and service gaps have existed, and outpatient services have generally not been coordinated effectively with inpatient care, especially in urban areas.

A review of regulations has focused on barriers to the development of flexible, consumer-oriented services. State psychiatric centers, with the leadership of the OMH Regional Offices, are participating with communities in establishing service priorities, including outpatient service needs.

OMH intends to refocus and redesign existing outpatient programs. Ideally, outpatient treatment services should be designed to continue the stabilization and support of individuals after acute inpatient care is no longer necessary, and to prevent unnecessary hospitalization. To this end, OMH plans to encourage existing outpatient services to better serve as discharge or diversion options from acute inpatient units.

During 1988 and early 1989, the Planning Advisory Committee's Outpatient Task Force met. This group did its work in terms of principles and values in relation to target
populations to be served, access to services, and design of a service system (see Appendix __). They dealt with these issues generally and did not address the four major outpatient programs in the OMH Dictionary. This task force will continue its work addressing the major outpatient programs and focus its attention on funding issues and Medicaid reform for the outpatient system. The Office of Mental Health's planning activities in this area are detailed in Chapter 3, Strategic Plan for 1991 and Beyond.

Community Support Programs

Community support non-residential programs in New York have been characterized by capacity building and growth. Funding for CSS programs has increased from $9.3 million in 1978 to more than $100 million today.

Growth in community residential programs (including community residences, residential care centers for adults and family care) has grown over the last four years, increasing from 5,429 beds in 1984 to 9,039 in 1988.

The challenge facing the OMH community support program is to create an accessible service delivery system which uses existing medical, social services, income support and entitlement programs whenever possible and ensures that the seriously mentally ill are connected to those services. Further, the system must have the capability to help clients develop living skills, ongoing supports, and a strong natural support network.

Community support services will focus on serving the seriously mentally ill as a priority. OMH has begun to redirect the focus of its community support programs by targeting services to individuals, rather than to funding categories.

In residential services, more housing will be developed to supplement the current community residence program (see Supported Housing Task Force Report, Appendix __ and Chapter 3, OMH Strategic Plan 1991 and Beyond). Improvements in staffing will support mentally ill individuals with multiple service needs in these alternative housing programs.

Regional level training and technical assistance will be provided to support psychiatric rehabilitation efforts. More emphasis will be placed on the continuing development and expansion of work initiatives to prepare mentally ill people for competitive work settings (see Chapter 3, Rehabilitation and Chapter 5, Rehabilitation Task Force Background Paper). In the area of consumer advocacy, training and consumer-oriented or operated services will be developed. Consumer participation in all spheres of service delivery will be encouraged.

During 1988 and early 1989, the Planning Advisory Committee's Community Support Task Force met and issued its
report and recommendations (see Appendix __). This Planning cycle the Advisory Committee will have a Task Force on Discrimination and Stigma (see Chapter 5, MHPAC Task Forces for 1989 - 90). The Office's planned activities for community support, including case management, intensive case management, rehabilitation, residential and supported housing, are detailed in Chapter 3, OMH STrategic Plan 1991 and Beyond.

Policy Reform

Like all State agencies, OMH derives its authority from statute and regulation. However, OMH's basic regulatory structure has gone largely unrevised for 25 years. Moreover, in recent years, OMH has attempted to design and implement new programs primarily through prescriptive regulations.

In the fall of 1987, OMH ceased this practice. Instead, the Office is developing a new approach which begins with a clear articulation of policy and the expected impact of policy on patient care. Specific strategy for implementing policy depends upon planning and negotiation involving local government and mental health officials at the regional and local level.

In addition, the Office is re-examining existing policies and regulations to determine their usefulness and consistency with the mission of the agency. One aspect of this regulatory study has been a series of Statewide hearings at which local government, providers, patients, families and advocates can discuss which policies and regulations are inhibiting good patient care. These hearings have been well attended and consumer participation has been high.

State Planning

Historically, OMH has utilized the budget process and the State Mental Health Services Council as the primary vehicles for developing formal statements of plans and policies. Generally, the OMH budget was developed from a decentralized process of requests from the field, with OMH Central Office staff sorting these requests and establishing priorities. While the State Plan was largely the work of Central Office staff, many constituent groups were provided an opportunity to influence the content of the plan.

Beginning in 1988, the budget process was revised to enable OMH to establish a policy and priority direction, and to assure that budgeting mirrors that direction. Except in the area of local aid, the Commissioner established the major areas in which changes, both reductions and enhancements, were to be concentrated. In the area of local aid, priorities were developed through a new set of guidelines which give local government a greater voice in establishing priorities for consideration by OMH.
During 1988 and 1989 the Planning Advisory Committee's Task Force on State and Local Planning met and issued its report and recommendations (see Appendix ). This task force had significant impact upon the state and local planning process. The group assisted the Office in developing the 1990 Local Area Planning Guidelines issued to local governmental units early in 1989.

The Local Planning Guidelines for Local Governmental Mental Health Plans were a major step in achieving the goal of replacing centralized inflexible planning with geographic based local planning with open and expanded participation. Another goal of this process is one of local areas developing comprehensive service system plans which reflect both state and local policies and priorities. These guidelines support an open process designed to encourage the development and implementation of local priorities, and flexible enough to allow local areas considerable discretion in how best to implement state priorities.

The local guidelines focused on target population based planning for children, adults and the elderly and further distinguished between adults with serious and persistent mental illness (SPMI) and those with less serious disabilities. Planning for access to generic services and supports was emphasized. Area planning was encouraged, along with broad participation from consumers, family members, providers and others. These guidelines call for plans with one and five year goals. Data was provided to each Local Governmental Unit (LGU) on its current prevalence rates and levels of expenditures and services for both state and local providers.

The data provided by the local plans form the basis, aggregated up by region and statewide, for the projections in Chapter 3, Office of Mental Health Strategic Plan 1991 and Beyond.

Also beginning in 1988, OMH modified its State planning effort to assure that a much larger constituency can influence planning and policy consideration. Consistent with new federal law, OMH is dramatically increasing consumer involvement in planning and assuring that the needs of the most seriously mentally ill are given special consideration. Consumers and families are represented on the MHPAC and the five Regional Planning Advisory Committees (RPACs).

**Consumer and Family Empowerment**

The growth and development of the public mental health system has largely been the result of professional and provider leadership. Mental health services (especially voluntary agency
service), have emerged from provider rather than constituent advocacy. Only in the past five years have family members of mentally ill people emerged as an active force in the public mental health system. Patients and ex-patients have also only recently begun to participate in the planning and implementation of public mental health services.

OMH is supporting and stimulating the growth of both the family and consumer movements. It does so for several reasons. First, patients who develop a support network of family and friends are less likely to experience serious relapse from their illness, and are more likely to experience successful outcomes from treatment and rehabilitation. Second, programs which provide service choices that take the desires, motivations and concerns of consumers and families into consideration are more likely to succeed.

During 1988-89 and continuing in 1989-90, the Office has funded a wide range of advocacy, self-help, family support, consumer outreach, and support services for consumers. Two examples of family and consumer programs are the Family Networking and Education Project and the Friends of the Homeless Mentally Ill. The Family Networking and Education Project is developing educational materials and a family hotline to assist family members of the mentally ill throughout the State. The Friends of the Homeless Mentally Ill is a consumer run outreach program in the Bronx which advocates for donations of food supplies for the homeless and prepares and brings food to the homeless mentally ill.

Accountability

The Office of Mental Health is both large and diverse. OMH provides direct service through 33 State psychiatric centers (22 adult, 6 children, 3 forensic and 2 research), and employs a workforce of almost 38,000. Through local government, it funds a variety of services with a combination of local aid, 100 percent State grants, and Medicaid. OMH also directly contracts with voluntary agencies for residential services. In addition, the Office licenses and regulates over 2,000 programs, ranging from large private psychiatric hospitals to small outpatient clinics.

OMH has primarily relied upon a strong management structure to oversee this network, with five regional offices to monitor and license programs. The Central Office aggressively supports the regions when difficult problems emerge.

With the growth in OMH programs, and especially with increased decentralization of service sites, OMH must develop a different management approach to assure performance and accountability. Over the years, OMH has added new responsibilities without a well developed framework of priorities and mission. Frequently, these new responsibilities have come
through legislative direction or through the addition of new services to respond to a perceived problem. The outcome of these actions can best be viewed through examining the OMH budget, which contains multiple funding streams for the same program category, resulting in complex monitoring systems and often duplicate spending plan.

Additionally, discrepancies in local interpretation of program intent makes it difficult for OMH to consistently describe its services and programs. As a result, it is almost impossible to hold local government and voluntary providers programmatically accountable. While OMH does hold tight control over those programs which it operates, such control extends primarily to personnel and operating costs, not to service and program accountability. To address this situation, OMH is embarking on an ambitious and long-range plan which will permit the budgeting of similar funding streams for related programs and which will link the availability of State resources to performance. The major strategies are conceptually straightforward, but implementation will be time consuming and complex. These major strategies are:

1. Reduce the number of OMH budget categories, each of which will be classified as a program within one of four categories: Emergency; Inpatient; Outpatient; and Community Support. The budget classifications will be utilized for both local programs and State operated programs (this format was used for the 1989-1990 budget);

2. Develop program definitions for each of the budget classifications that logically relate the budget categories to service programs. For example, the major budget category "Outpatient" would have four sub-sets, "Clinic," "Partial Hospital," "Rehabilitative Treatment" and "Continuing Treatment." Each of these four sub-sets will have a specific program definition, thus permitting OMH to describe both the purpose and distribution of all public funds for the outpatient component at a level of clarity not now available. This is a priority activity for 1989-1990;

3. Develop "program guidelines" indicating the intent of each of the major programs that OMH provides. "Program Guidelines" will generally describe the intent of a program (i.e., "Partial Hospital"), persons eligible for the program, the range of clinical and administrative activities associated with the program, and the method of payment for the program. The "program guidelines" will offer local and State programs latitude in developing strategies for service delivery, while giving OMH a base-line to assess whether public funds are being utilized for the
intended purpose. The guidelines also will permit OMH to decrease the extensive and detailed development of prescriptive regulations. As with number 2 above, this is a priority activity for 1989-1990;

4. Develop new regulations associated with each of the major program classifications, but develop such regulations so that they represent "minimum" standards for licensing. Such standards would be for the purpose of assuring safe operations, rather than defining details of operations. Minimums, for example, might address patient/staff ratios, physician coverage, patient rights and adequate physical space. This activity will also be a priority in 1989-1990;

5. Design and implement a performance contract procedure which relates the major Program Budget Categories to both fund allocations and performance factors. Performance factors which are primarily quantitative in nature will be developed and negotiated with providers as a condition of resource allocations and contracts. This will be a priority for 1990-1991;

6. Develop monitoring protocols to assure the adherence to minimum standards and to screen programs for compliance with standards for major program categories, activities and performance agreements. This activity will be a priority for 1990-1991;

7. Design Statewide program evaluation efforts which will use two primary approaches. First, "key" data sets will be developed as a screening mechanism for problems in program operations. For example, monitoring patient discharges and returns might provide early warning that patients are being prematurely discharged. Monitoring emergency rooms may indicate that some patients are being excluded from the service system and are using the emergency room when they experience acute relapse. Second, system-wide and long-term program evaluation of critical programs is needed to determine their effectiveness and to alter or eliminate programs which are ineffective. These activities will be priorities in 1990 through 1992;

8. Develop "normative" reports to State and local officials, public advocates and local providers which describe the set of services offered in New York and which give some descriptive data regarding program functioning. Such reports may include simple data regarding the average unit cost of service provided at
the local level, with such cost for a particular service being compared with State and regional averages. This activity will be a priority for 1991-1992.

Technology Infusion

Changes of the magnitude proposed require concurrent planning and investment in training and technical assistance. A coordinated effort with higher education is necessary to ensure that the future professional work force will have the necessary orientation and skills. To this end, OMH has enlisted the assistance of deans of schools of social work and chairmen of departments of psychiatry. Specific efforts are also underway in nursing. A major national foundation has awarded Hunter College in New York City a grant to begin training State and community staff in case management skills. This project has successfully developed and implemented a curriculum focusing on the key components of case management training. OMH is developing a State resource center to develop curriculum, promote linkages between programmatic needs and those with the necessary expertise, and develop closer connections between the work of State research centers and the service needs of the field. In addition, the Commissioner's Planning Advisory Committee has representatives of higher education including the Council of Deans Schools of Social Work, Council of Deans Schools of Nursing, and the New York State Psychiatric Association Education Committee.

Financing

Currently, the majority of the OMH budget for State operations is devoted to State psychiatric center expenditures of which approximately 10% is devoted to outpatient services. In addition, the State Medicaid program is utilized for certain State expenses and to support community operated inpatient and outpatient services. For the past several years, OMH has accepted increased responsibility for licensing, monitoring and setting rates for mental health services provided under the Medicaid program. With this knowledge and experience, OMH believes that significant changes can be made in the outpatient Medicaid program to permit major improvements in services for patients who are currently overreliant on State inpatient care and expensive local acute inpatient services.

Programs developed by OMH for fiscal year 1988-89 highlight the recognition that a small percentage of patients tend to use a disproportionate share of these expensive programs. By identifying these "heavy users," OMH is seeking to alter and improve their pattern of service utilization. Since most heavy users present during periods of crisis, the Office seeks to develop a system of community emergency services, especially in
urban areas, which can provide early intervention for these and other patients in crisis. In many cases, this may provide a diversion from inpatient treatment and a capacity to understand the reasons for recurrent crises. In addition, OMH proposes to assist community hospitals in placing patients for whom no reasonable community option has been found.
ICM

INTENSIVE CASE MANAGEMENT

A brief public report

DECEMBER, 1988
NEW YORK is joining several other states in adopting programs of intensive case management as a statewide initiative to improve the care of persons with severe and persistent mental illness.

Case management, per se, isn't new. It's been a part of psychiatric services for years. But New York's initiative is different because it gives its new Intensive Case Managers more wide ranging duties, greater responsibilities and guarantees access to services for their clients. Under the leadership of Mental Health Commissioner Richard C. Surles, Ph.D., New York has borrowed liberally from successful local case management programs from around the country and has organized them have access to the services and resources necessary to aid clients in meeting their personal goals and maximize their potential for independent living.

Although the key to the program is the corps of highly qualified case managers, the ICM program in reality represents an umbrella of services for people with severe mental illness who in the past were unable or unwilling to accept help, were poorly served or were rejected by the mental health system because they simply didn't fit the mold.

Importantly, intensive case managers must also be viewed as an adjunct to the clinician. The frequent contact required by the job generally leads to a stronger, trusting relationship between the ICM and the client. The relationship puts the case manager in a position to recognize early symptoms and signal the client's psychiatrist or primary therapist of the need for intervention. Intervention that's early enough could minimize the need for, or substantially shorten, any hospital stay. That's a plus for the client and the clinician.

Statewide statistical studies indicate that as many as 25,000 New Yorkers with severe and persistent mental illness could benefit from intensive case management services. Initially, however, the program is being targeted toward 5,000 individuals who have been identified by city and county mental health agencies as the people most in need of help. Local government has involved families and agencies in the identification

---

"I didn't come in trying to change the world. I just wanted to be someone who works with other people, help clients and professionals successfully."  

Case Manager Max Moise

One of Max's initial clients is David, 22, who was mentally ill and homeless on the streets of New York City. Over the previous three years, David had five admissions and spent 22 months in psychiatric hospitals. He was in Creedmoor Psychiatric Center's special homeless treatment unit when he was enrolled in the Intensive Case Manager program and became Max's client. David was subsequently discharged to a Bronx community residence and is attending a day treatment program five days a week and is enrolled in a special program for mentally ill chemical abusers as well. His next step will be a skills training program for re-entry in the job market. Max sees David at least twice a week and is available by phone the rest of the time.

Who is Served by ICM

as a single, but flexible, effort to reach out to thousands of people who in the past have been unserved or underserved by the mental health system.

The design of the ICM program makes it possible to serve very disabled clients in the community. Intensive case managers are being specially trained and will have a small caseload of up to ten people. Managers
of these individuals. This group, with a common thread of severe and persistent mental illness, includes people who:

- require intensive on-going support to live successfully in the community;
- will not use other mental health services and programs;
- repeatedly use emergency rooms or inpatient services for crisis resolution;
- or, are seriously and emotionally disturbed children and youth.

Successfully focusing efforts on high-risk groups reduces their over-reliance on expensive emergency room services and acute care beds, and thus helps to reduce pressures on acute care services while, at the same time, provide more appropriate treatment environments for the client.

For example, an OMH review of the distribution of reimbursement for psychiatric inpatient Medicaid claims in general hospitals in the state clearly showed that a relatively small number of “heavy users” accounted for nearly 70 percent of the acute inpatient care delivered during a nine month period. Aggressive case management intervention with such a group would drastically reduce their reliance on inpatient services by helping them obtain alternative services they might need.

**Heavy User Analysis:** Distribution of reimbursement for psychiatric inpatient Medicaid claims in general hospitals in New York State during 9 months in 1986.

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Reimbursement</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatients</td>
<td>$10,180,877</td>
<td>6.3%</td>
</tr>
<tr>
<td></td>
<td>$55,190,693</td>
<td>34.5%</td>
</tr>
<tr>
<td></td>
<td>$48,217,607</td>
<td>30.0%</td>
</tr>
<tr>
<td></td>
<td>$49,685,070</td>
<td>29.1%</td>
</tr>
<tr>
<td>Below</td>
<td>$15,001-</td>
<td>11.9%</td>
</tr>
<tr>
<td></td>
<td>$15,000-</td>
<td>11.0%</td>
</tr>
<tr>
<td></td>
<td>$30,000-</td>
<td>5.1%</td>
</tr>
<tr>
<td>Over</td>
<td>$30,000</td>
<td></td>
</tr>
</tbody>
</table>

**FOR: CLIENTS**

In terms of the client, the goal of the Intensive Case Manager is to increase his or her community tenure by avoiding unnecessary, inappropriate or lengthy hospitalization. At the same time, the client is assisted in developing and maintaining situations for living, working, and socializing in the community and enhancing the potential for growth and independence.

**FOR: PROVIDERS**

Several goals have been identified for providers of ICM. The first is to identify within every local community a “roster” of clients who are the most needy, the most difficult, and least well served by existing services. The second is to provide services and supports which are based on each client’s unique needs and circumstances. Third is to take responsibility for helping identified clients to meet their goals, regardless of setting or circumstance and, fourth, to provide services and supports for as long as needed.

**FOR THE MENTAL HEALTH SYSTEM**

As a system, a major goal of the Intensive Case Management program is the creation of an effective partnership among the Office of Mental Health, county mental health agencies and local services providers which is based on a strong commitment to meeting client needs. Other goals include identifying and remedying gaps and problems in the existing service system; developing an evaluation system which focuses clearly on client outcomes, and expanding the system’s capacity to train intensive case managers.
Is ICM intended to solve all of the problems of the mental health system?

No. ICM will help to solve some of our most pressing problems. More importantly, however, ICM will identify some of the gaps and problems in the existing mental health system. Information from the successes and failures of the ICM program will help the mental health system design more relevant and responsive services in the future, particularly for people who have not been well-served in the past.

Don't case managers just coordinate services? What good is case management if adequate services aren't available?

Intensive case managers do more than coordinate existing services, they provide services themselves whenever necessary. Moreover, the ICM program includes a supplemental fund which will be used to purchase services for individual ICM clients or to create new services if none are available.

How is ICM different from other case management services?

ICM is different because it is structured to start with the people who are being failed by the existing system and then figure out how to succeed with them. In the ICM program, local communities identify and agree to serve a "roster" of clients who are the most needy, the most difficult, and the least well-served by existing programs. No other mental health program takes this approach to identifying a target population.

ICM is also different because it provides the human and financial resources to respond to this group of clients. Intensive case managers will be experienced and well-trained, will have small caseloads, and will be responsible to their clients rather than to a particular agency. They will also have guaranteed access for their client to medical, clinical and supportive programs, and will have the opportunity to shape the development of new services and supports.

Does the emphasis on community living mean that ICM clients will never be admitted to an inpatient bed?

No. Overall community tenure should increase for most ICM clients because the availability of alternate supports should reduce the need for hospitalization. However, hospitalization will always be possible when medically indicated. For some ICM clients (for example, homeless individuals with major medical problems) hospitalization may be the first step towards successful community living.

How long will ICM clients stay on a caseload?

For as long as necessary. No pressure will be put on case managers to "close cases" or on clients to become completely "independent." On the other hand, many clients will need less support as they develop stable living situations and friendships in the community. Clients who no longer need the frequency and intensity of services offered by ICM may be referred to other programs or simply placed on "supporting" status. However, if at any time former active ICM clients want to reestablish contact, services will be provided immediately without having to re-enroll in the program.