

# Allegheny County HealthChoices Program

## **Recidivism: A Longitudinal Study of the Original Cohort**

presented by



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## Recidivism:

### A Longitudinal Study of the Original Cohort

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#### Executive Summary

In January 2001, Allegheny HealthChoices, Inc. (AHCI) produced an initial report comparing consumers who were admitted frequently for inpatient and intensive non-hospital services with consumers who had one or two admissions. The findings showed distinct differences in service utilization and diagnoses among people based on the number of admissions. The analysis yielded a general picture describing people who were readmitted more frequently and their behavior in terms of accessing services. Those individuals who experienced numerous admissions tended to have:

- A dual diagnosis of mental health and substance abuse;
- Lower utilization of less intensive services;
- Disengaged from services; and
- Received inpatient and non-hospital services from a variety of providers.

At the direction of the AHCI Quality Improvement Committee and Board of Directors, AHCI discussed the finding with representatives from Allegheny County and Community Care. In order to gain a better understanding of people with multiple admissions and learn how to improve their well being, the ad hoc group made the following recommendations:

- Continue to follow the cohort of people from the original study;
- Conduct a record review of all people with ten or more admissions and a random sample of people who had three to nine admissions during the study period;
- Conduct interviews with a sample of the same people who had a record review completed; and
- Conduct interviews with the Intensive Case Managers (ICM) assigned to the people interviewed and compare the survey results.

The following report addresses the first two bullet points. At the time of this report, the interviews have not been completed. The next study of this cohort will include analysis of the interview information.

The data analysis revealed significant changes between the two study periods in terms of the populations and their activity. The record review was also helpful in providing a better understanding of consumers on a more holistic level. Both of these activities resulted in some important findings:

- People who were readmitted more frequently accessed services sporadically, especially medication checks, partial hospitalization program, and outpatient mental health;
- The average length of stay (ALOS) for inpatient mental health, inpatient detoxification, and non-hospital detoxification for people who were readmitted more frequently was labile from quarter to quarter;
- The data suggests that recidivism was reduced for people who had a higher percent of outpatient service utilization as compared to others who required readmission; and
- Stable housing positively impacted people's ability to be maintained in the community and reduced readmission.

It is AHCI's desire that the knowledge gained will change provider's perceptions of and responses to consumers with frequent admissions for inpatient and intensive non-hospital services.

## Defining the Data

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### Cohort Description

The people included in this study were the same group of individuals that were studied in the original recidivism report produced in January 2001. The intent of revisiting these people is to better understand what happens to them over time and consider system approaches that may assist consumers to stay engaged in services and reduce recidivism over time. The criterion of the original study was any consumer with a minimum of one admission for inpatient or intensive non-hospital service.<sup>1</sup> In the first study, people were grouped into the following populations based on the number of admissions within the 12-month study period (July 1, 1999 to June 30, 2000):

- Population One- Consumers who were admitted once or twice times during the study period. The number of consumers in this population from the original cohort, known as study one, was 4,020.
- Population Two- Consumers who were admitted three to nine times during the study period. The total number of consumers identified in study one was 813.
- Population Three- Consumers who were admitted ten or more times during the original 12-month period. This population included 23 consumers.

The definitions of the consumer grouping remain unchanged for study period two, which began with the month immediately following study one (July 1, 2000) and ended March 31, 2001. The second quarter 2001 was not included in this report to accommodate for claims lag and ensure that readmissions within the 30-day period after discharge were included. The total number of consumers with one or more admissions for the second study period was: Population One = 907, Population Two = 408, and Population Three = 17. The change in the number of people within each population is discussed in the next section of this report.

### Data Source

Raw data used for aggregate comparison of the two studies was generated from claims or authorization reports. Admissions, readmissions, and the average length of stay (ALOS) for inpatient services were based on authorizations. Outpatient service utilization was based on adjudicated claims. The two types of data sources ensure greater accuracy regarding actual usage for various types of services.

The data source for member-level analysis was obtained from record review of Community Care's documentation for all consumers in Population Three and a random sample of people in Population Two. A standardized collection tool was used by five reviewers to ensure the reliability of the process. These findings are presented after the aggregate comparison of the two study periods.

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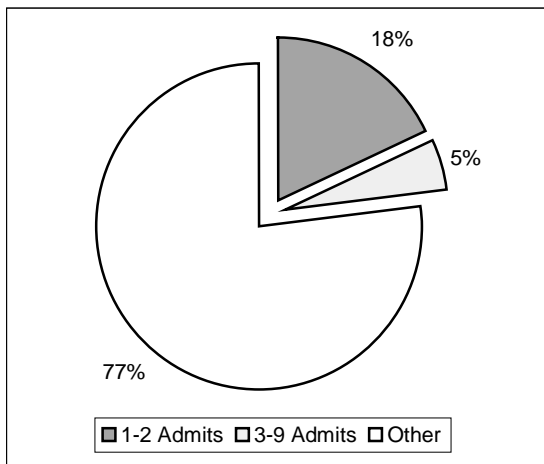
<sup>1</sup> Services include: inpatient mental health, inpatient detoxification, inpatient rehabilitation, non-hospital detoxification, and non-hospital rehabilitation.

## Changes Within the Cohort

### Shift in Utilization

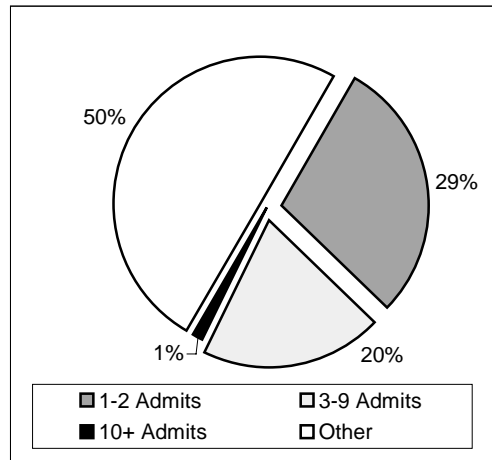
Persons originally assigned to a given population in study one remained in that population for study two, even though their number of admissions may have changed. The purpose of this grouping technique is to illustrate the shift in utilization by population. Charts 1.0 to 1.2 demonstrate the composition of each population for study two.

**Chart 1.0**  
Change in Volume For Population One



As chart 1.0 illustrates, only 18% of the original Population One had 1-2 admissions during study two. Five percent of people who originally had 1-2 admissions increased to 3-9 admissions. The “Other” category represents people who had no inpatient or intensive non-hospital activity. This includes people that received outpatient and other non-intensive services in addition to individuals who were no longer Medicaid eligible. The “Other” category will be presented in greater detail later in this report. The shift in Population One from study period one to two suggests that people may require an isolated admission for an acute event; however, one admission is often sufficient to stabilize them. As such, AHCI expects more

**Chart 1.1**  
Change in Volume for Population Two



consumers in Population One to move to the “Other” category over time.

**Chart 1.2**  
Change in Volume for Population Three

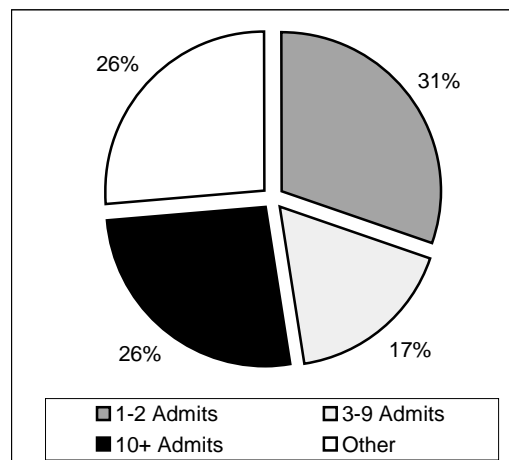


Chart 1.1 (Population Two) illustrates that the largest change from study one to study period two was the percent of people without inpatient or intensive non-hospital services. Half of the people represented in study one did not have inpatient or non-hospital activity during study two. Nearly 30% of people with 3-9 admissions during study one had only 1-2 admissions during study two. One percent of people from the original study increased to 10 or more admissions during the second study period.

The activity for Population Three was more evenly distributed as illustrated in Chart 1.2. The largest percent represents a decline in the number of admissions from 10+ to 1-2 during the 9-month period. Seventeen percent of people from the original group decreased to 3-9 admissions. The percent of individuals who continued to have frequent admissions (10+) was 26%. Individuals in Population Three who did not have inpatient or intensive non-hospital activity during study two represented 26%.

### Determining Ineligible Consumers v. Consumers of Less Intensive Services

As stated previously, the “Other” category represents people from the original cohort who did not have an admission during study two. This does not imply that all consumers improved and were maintained in an outpatient environment, although it may be characteristic of some consumers. Table 1.0 illustrates the percent of consumers in the “Other” category who received ambulatory services, the types of services that they received, and the total percent of individuals who accessed services by population.

**Table 1.0**  
**Service Mix for Cohort Members Without Admission During Study Two**

Service	Population 1 % of “Other”	Population 2 % of “Other”	Population 3 % of “Other”
Behavioral Health Rehabilitation Services	10%	6%	n/a
Case Management	49%	64%	67%
Medication Check	54%	58%	50%
Outpatient Mental Health	62%	67%	50%
Methadone Maintenance	8%	11%	0%
Supplemental	3%	9%	17%
% of “Other” with services	49%	59%	50%
Total in “Other” (n)	3,099	405	6

*Note: Services not included in the above table were accessed less than 10% by all populations. The percents represent duplicate numbers as one member may have received two or more services during the study period.*

Also included in the “Other” category are people who did not have an admission or access outpatient services during the second study period. They became ineligible to receive services for a variety of reasons, such as moving out of state, incarceration, or an admission to a state mental hospital. These reasons will be considered further during the record review section of this report.

**Utilization by Category of Aid**

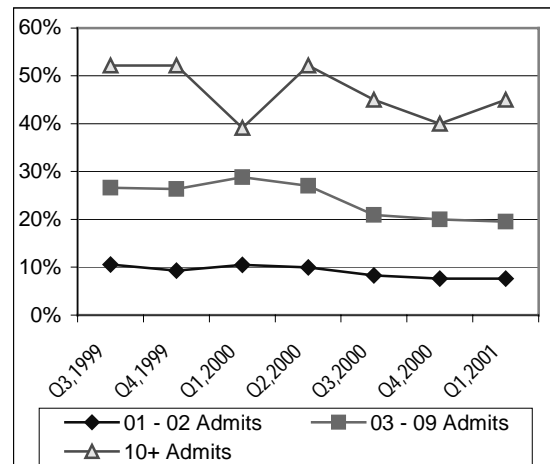
Charts 1.3 to 1.5 illustrate the specific categories of aid by populations that were most affected by the change. Social Security Income without Medicare (SSI) is the most common category of aid among the three populations and is representative of overall enrollment. The longitudinal trend shows a slight decrease in this category beginning the third quarter 2000 then stabilizing. Two factors may contribute to the decrease. First, a small change in the number of eligible members in Population Two and Three resulted in a more noticeable change on the graph because the population size was significantly smaller than Population One. Second, the number of consumers in the cohort who had at least one admission during study period two (beginning the third quarter 2000) decreased.

In contrast, the percent of consumers in Federally Assisted Medical Assistance for General Assistance Recipients (FGA) and Temporary Assistance to Needy Families (TANF) has gradually decreased since mandatory enrollment. This overall decrease, magnified by an incremental decrease for Populations Two and Three, resulted in a downward trend as observed in Charts 1.4 and 1.5.

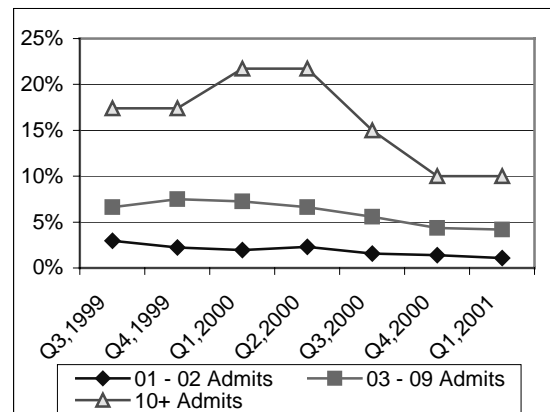
**Other Demographic Changes**

Changes were also observed in the demographic variables as a result of the shifts in utilization and/or the absence of inpatient and intensive non-hospital services. In terms of comparing the age of consumers between the two study periods, the percent of people ages 22-44 years increased 6% (to 58%) for Population One and Population Three decreased 9% (to 65%). People ages 45-64 years remained

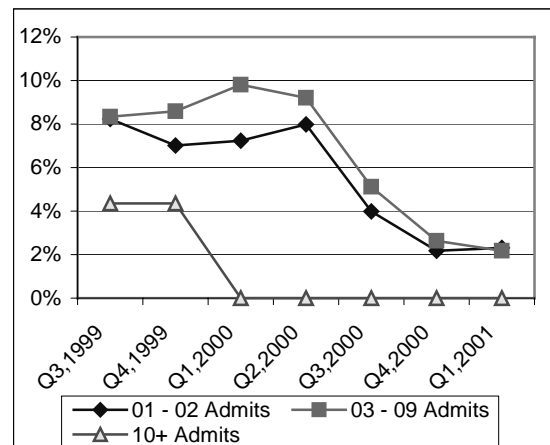
**Chart 1.3**  
**Category of Aid Trends- SSI**



**Chart 1.4**  
**Category of Aid Trends- FGA**



**Chart 1.5**  
**Category of Aid Trends- TANF**

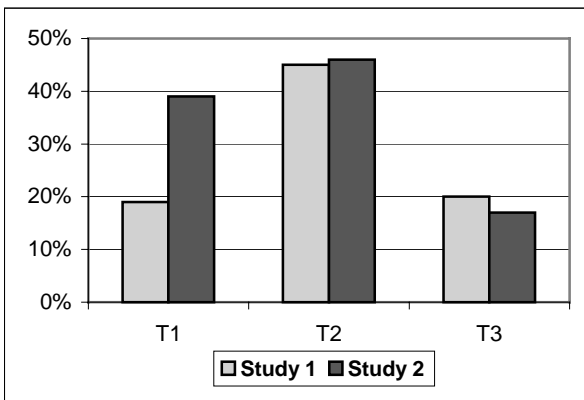


essentially unchanged for Population One and Two and increased by 15% (to 41%) for Population Three. The percent of children, adolescents, and people in transition years (18-21 years) decreased for all populations.

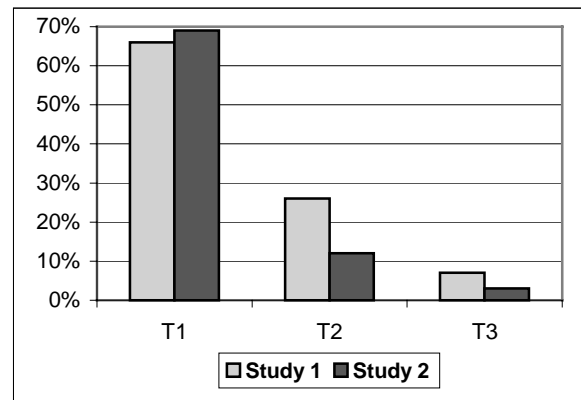
Gender composition of the cohort remained unchanged for all three populations (females represented 51% of Population One, 51% of Population Two, and 35% of Population Three). The race of people in Population One and Two remained unchanged; however, the percent of Caucasian consumers increased by 11% (to 76%) for Population Three.

Charts 1.6 and 1.7 illustrate the shift in tier distribution of people by population. People within each population were not reassigned to a different tier level; the changes are a result of people shifting into the “Other” category.

**Chart 1.6**  
**Tier Distribution for Population One**



**Chart 1.7**  
**Tier Distribution for Population Two**



**Key/Definition:**

*T1: Tier One- the highest priority consumers who have three or more inpatient or non-hospital admissions, and have a diagnosis consistent with DPW standards for Serious and Persistent Mental Illness (SPMI).*

*T2: Tier Two- people with a SPMI diagnosis, one inpatient admission, and meet the criteria for SSI or FGA category of aid.*

*T3: Tier Three- receive outpatient service, may have 1-2 inpatient admission, but do not meet criteria for Tier One or Two.*

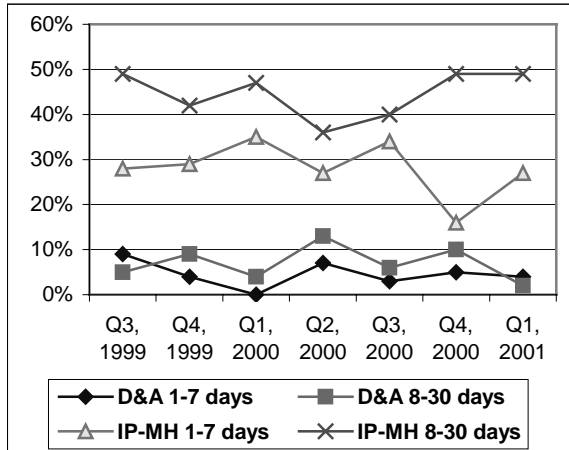
The change in Tier One was small for the people in Population Two. Tier One changes were two times greater for Population One. The denominator used to determine the percentage by tier was affected by the majority of people within Population One shifting into the “Other” category (refer to Charts 1.0 and 1.1). Population Three is not represented because there was essentially no change between the two study periods (Tier One represented 94%).



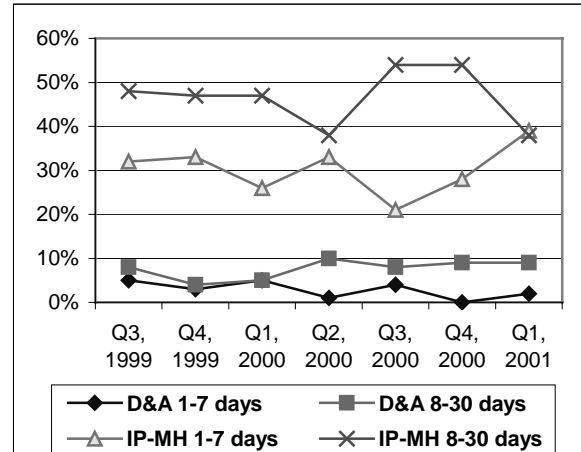
## Service Utilization Comparisons

Charts 1.8, 1.9, and 2.0 illustrate the percent of readmissions to a like service (i.e. non-hospital rehabilitation to non-hospital rehabilitation, etc.) by population. Drug and alcohol inpatient and intensive non-hospital services were combined due to the low individual volume.

**Chart 1.8**  
**Readmission for the Same Service**  
**for Population One**



**Chart 1.9**  
**Readmission for the Same Service**  
**for Population Two**



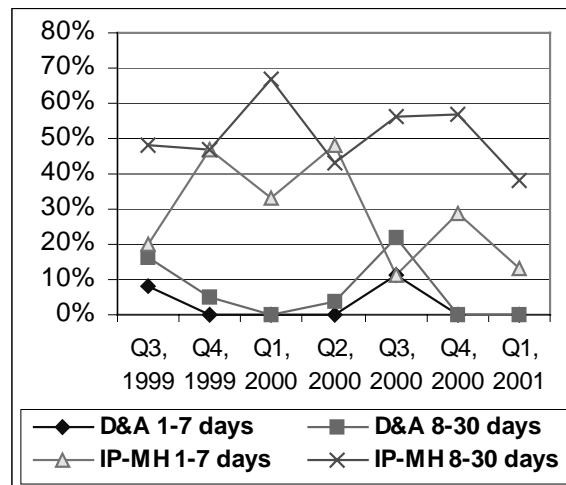
**Key:**

*D&A: Drug and alcohol services (Inpatient detoxification, inpatient rehabilitation, non-hospital detoxification, and non-hospital rehabilitation).*

*IP-MH: Inpatient mental health services*

Most readmissions occurred within an 8-30 day period after discharge for people in all three populations. AHCI has consistently reported this trend in past quarterly reports. Moderate variability was observed for inpatient mental health admissions for people in Population One and Two. Readmissions for people in Population Three, especially within seven days of discharge, fluctuated drastically. Readmissions for drug and alcohol services were relatively stable for individuals in Population One and Two, and varied moderately with people in Population Three. No cyclical patterns were observed for any service or population.

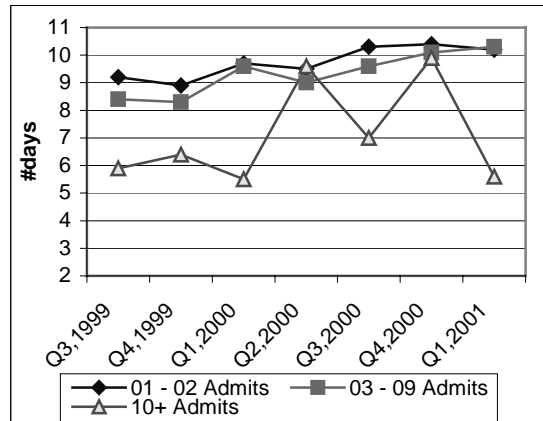
**Chart 2.0**  
**Readmission for the Same Service**  
**for Population Three**



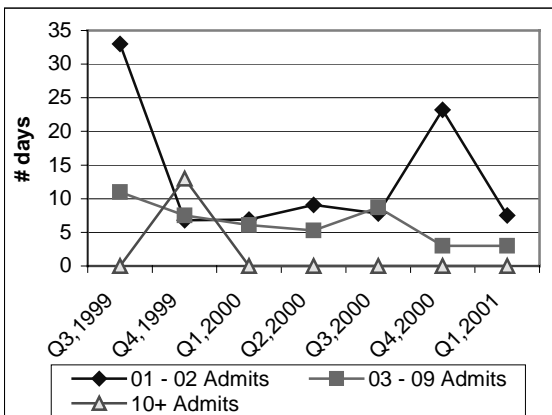
The average length of stay (ALOS) varied considerably by population for some of the five inpatient and intensive non-hospital services. People in Population Three should have a longer ALOS as compared to people in Population One, if the assumption is accurate that their illness tends to be more complex to manage. This theory held mostly true for non-hospital detoxification services; however, the ALOS was less than the other two populations or fluctuated for the other four service categories as seen in Charts 2.1 to 2.5. Research has shown correlation between longer ALOS and a reduction in readmissions for like services.

A factor that may influence variability is the percentage of people with a dual diagnosis who comprise Population Three as compared to the other populations. The fluctuations may also be explained by a substantially smaller number of consumers in Population Three as compared to Population One and Two. Another reason may be the impact of consumers leaving against medical advice (AMA) or requesting longer treatment as a result of post-discharge placement issues or exacerbation of symptoms.

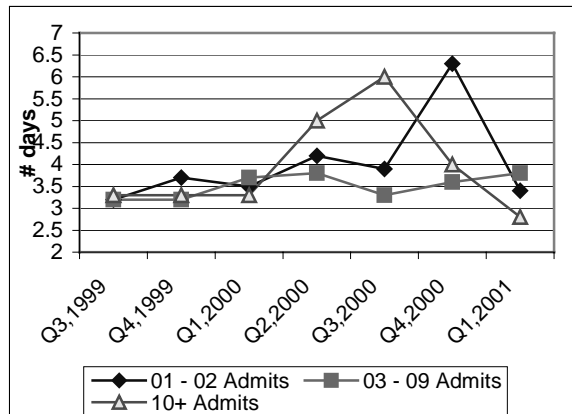
**Chart 2.1**  
**ALOS for Inpatient Mental Health**



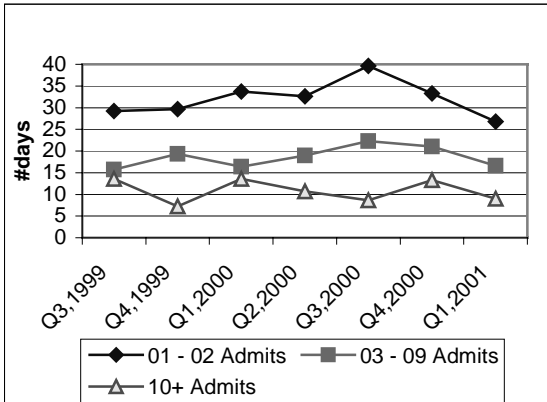
**Chart 2.2**  
**ALOS for Inpatient Rehabilitation**



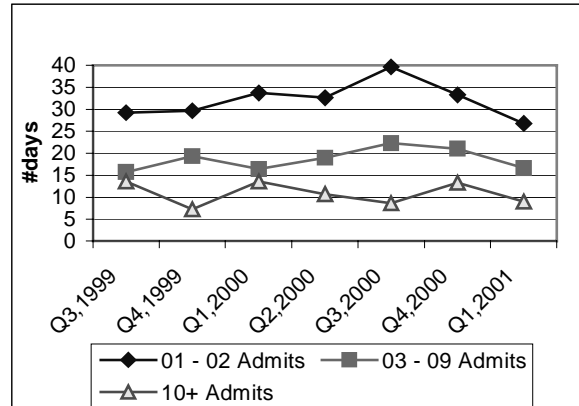
**Chart 2.3**  
**ALOS for Inpatient Detoxification**



**Chart 2.4**  
**ALOS for Non-hospital Rehabilitation**



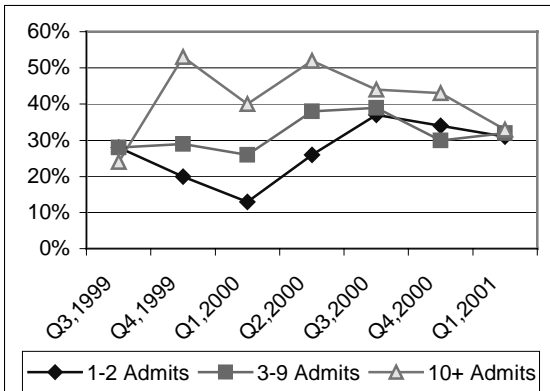
**Chart 2.5**  
**ALOS for Non-hospital Detoxification**



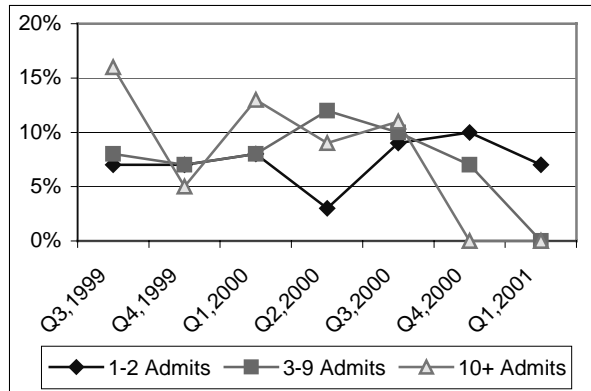
**Service Utilization Between Admissions**

Charts 2.6 to 2.9 illustrate some of the services that were accessed between discharge and readmission for each population. The percent is based on the number of members readmitted for a given population. Services not represented were utilized infrequently, did not show meaningful trends, or the utilization patterns for all populations were similar. The activity below is based on actual use and does not represent services that were authorized but never used.

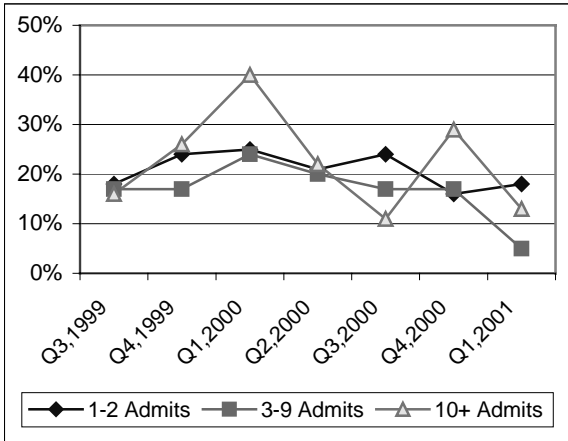
**Chart 2.6**  
**Utilization of Case Management Services by Population**



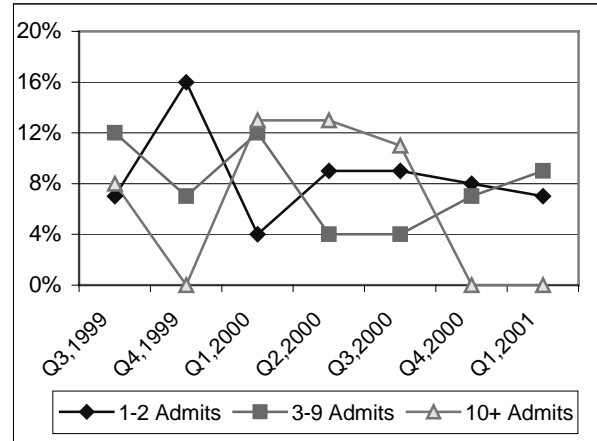
**Chart 2.7**  
**Utilization of Medication Check Services by Population**



**Chart 2.8**  
**Utilization of Outpatient Mental Health Services by Population**



**Chart 2.9**  
**Utilization of Partial Hospitalization Program–Mental Health by Population**



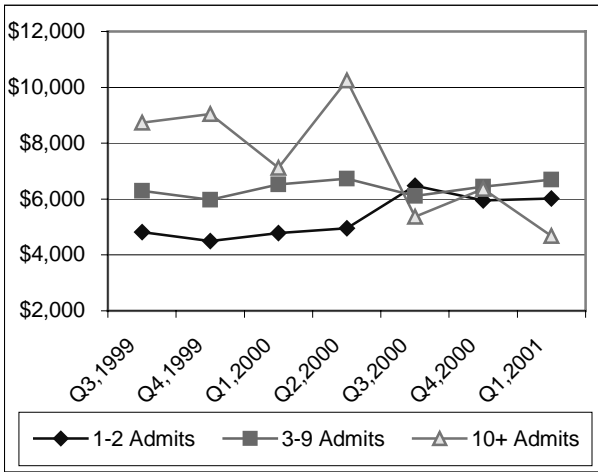
For the most part, trends identified for consumers in Population One and Two were similar for case management, medication checks, and outpatient mental health services. Wider fluctuations for these services were observed in Population Three. Partial hospitalization program for mental health yielded a chaotic pattern for all three populations. This may indicate a higher drop out rate than other services or denote differences in practice patterns among providers. A further analysis of available data is needed to determine probable causes.

In general, case management, outpatient mental health, and partial hospitalization program services were accessed within seven days of discharge. Medication checks occurred primarily within the 8-30 day period following discharge. This finding is an expected standard of care.

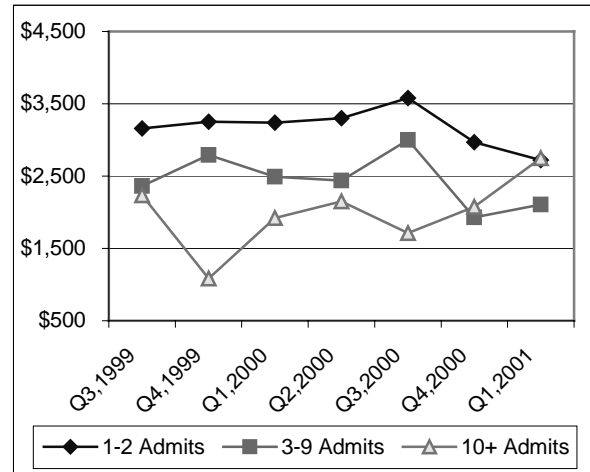
**Average Cost by Service**

The average cost per consumer was calculated by dividing the total cost for each service by the number of consumers that accessed the service. Charts 3.0 and 3.1 illustrate the costs for inpatient mental health services and non-hospital rehabilitation services.

**Chart 3.0**  
**Average Cost Per Consumer for**  
**Inpatient Mental Health Services**



**Chart 3.1**  
**Average Cost Per Consumer for**  
**Non-hospital Rehabilitation Services**

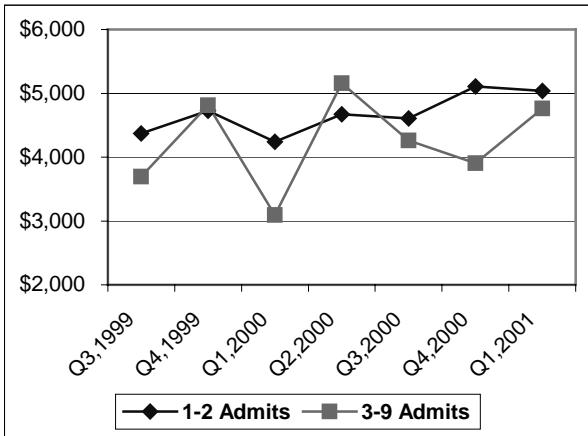


*Note: The scale (dollars) for each service is different.*

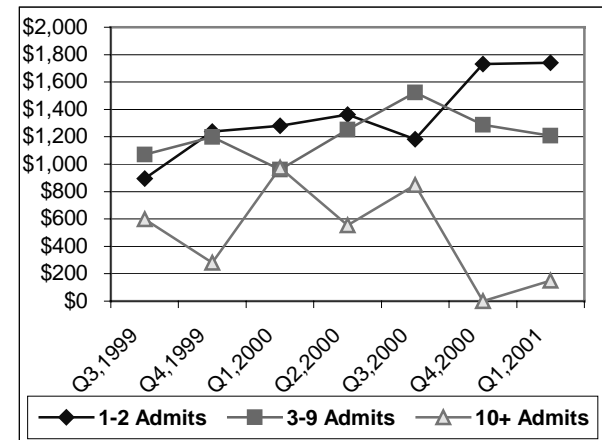
The average cost for inpatient mental health services for people in Population One and Two follows the same pattern as seen in the ALOS for the same service. Fluctuations observed for the average cost per consumer in Population Three reflect the readmission trends for this same group of people. The spike in the second quarter 2000 was the result of an individual with a prolonged stay (27 days). The average costs per consumer in Population One and Two were relatively stable. The low cost for non-hospital rehabilitation per consumer observed in Population Three was due to a small number of people accessing the service and their decision to disengage from the program after a short period of time.

The average cost per consumer for services other than inpatient and intensive non-hospital rehabilitation tends to fluctuate more dramatically as a result of the frequency in which the services were accessed and the number of units required. Charts 3.2 and 3.3 on the next page illustrate this dynamic.

**Chart 3.2**  
Average Cost Per Consumer for Behavioral Health Rehabilitation Services



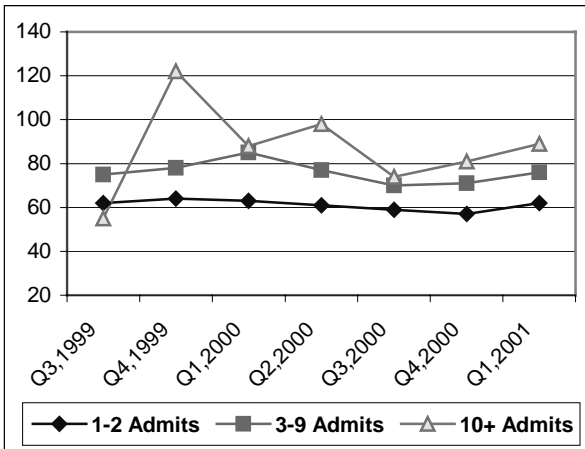
**Chart 3.3**  
Average Cost Per Consumer for Partial Hospitalization Program Services



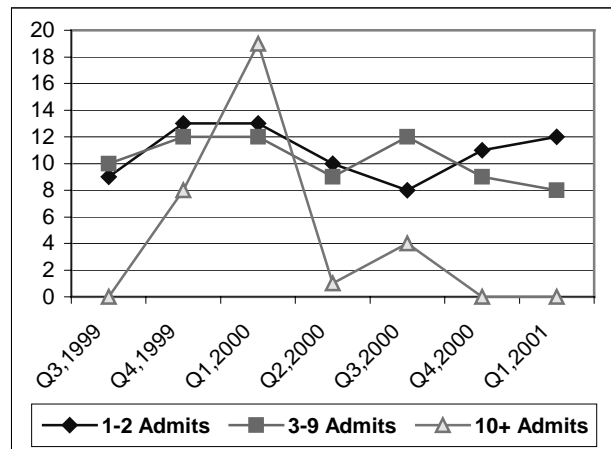
Note: No children or adolescents were in population three.

The average cost per consumer for services represented in Charts 3.2 and 3.3 show a slight increase ( $\leq$  \$1,000) for Population One. Greater volatility was observed for the average cost per consumer in Population Two who accessed behavioral health rehabilitation services and in Population Three for partial hospitalization program services. Charts 3.4 and 3.5 represent average units accessed for case management and crisis services.

**Chart 3.4**  
Average Units Per Consumer for Case Management Services



**Chart 3.5**  
Average Units Per Consumer for Crisis Services



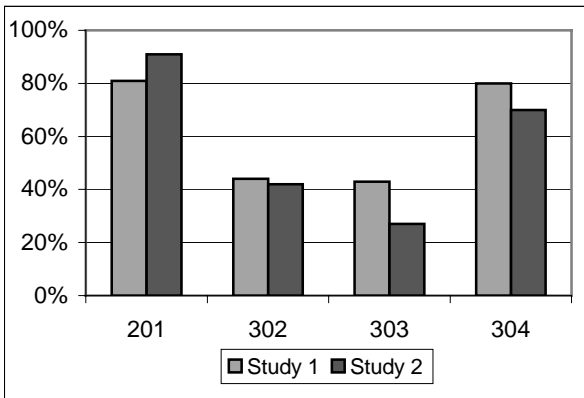
People in Population One and Two utilized both services consistently. People in Population Three accessed the services more sporadically. The peak in Chart 3.5 represents one individual, previously engaged in service, who used crisis services for two separate events at a two-month interval.

### Commitment Status of the Initial Admission and Readmission

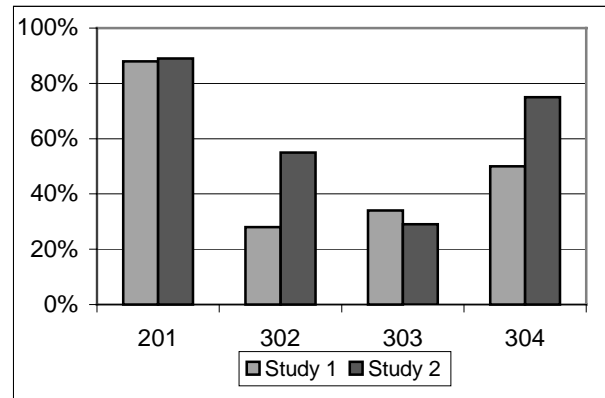
Charts 3.6 to 3.8 illustrate the percentage of consumers that were admitted then readmitted to the same commitment level. The percentage is based on the number of consumers within a given population who were readmitted.

The trends by commitment level for people in Population One increased for voluntary admissions and decreased for involuntary admissions when comparing the two study periods. The large volume of consumers, their infrequency of admissions, and their relative stability contributed to the changes observed.

**Chart 3.6**  
**Percent of Consumers Readmitted to the Same Commitment Level for Population One**

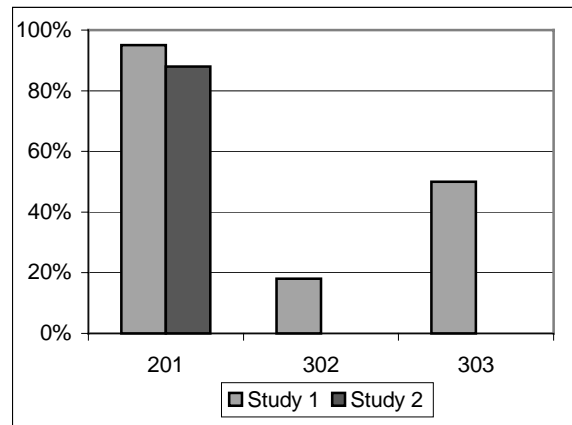


**Chart 3.7**  
**Percent of Consumers Readmitted to the Same Commitment Level for Population Two**



People in Population Two and Three had greater variability in the level at which they returned for inpatient mental health services: however, the trends were very different. People in Population Two had an increase in almost all involuntary admissions (except for 303 admissions) and no change in voluntary admissions. Although the percentage of voluntary admissions decreased slightly for people in Population Three, no one was involuntarily readmitted at the same level (i.e. from a 303 to a 303). The total percent of involuntary admissions for people in Population Three (from another level of commitment) during study two was 12% (2 involuntary admissions).

**Chart 3.8**  
**Percent of Consumers Readmitted to the Same Commitment Level for Population Three**



The large number of consumers who were no longer eligible, the total volume within each population, and the complexity of their needs, all contributed to the variability observed in Population Two and Three. The member-level analysis appearing later in this report addresses this phenomenon.

### Services Utilized by People Not Readmitted

AHCI compared the services accessed by people within Population One and Two who were not admitted during study period two to people in those same populations who had admissions. As Chart 2.6 indicated, an approximate average of 25% of people who were readmitted accessed case management services as compared to 25% of people who were not admitted. Approximately 8% of individuals with admissions had a medication check (Chart 2.7) compared to 35% of people not admitted who had a medication check. The difference between people admitted (20%) who utilized outpatient mental health services and those who were not admitted (40%) was half. The relationship between people who accessed partial hospitalization program services was unique in that the pattern of utilization for people admitted was very labile; however, people who were not admitted consistently accessed the service at an average of 5%. The higher utilization and consistency in utilization of the outpatient services may contribute to their ability to remain in a community environment.

### Authorizations v. Actual Utilization

Table 1.1 shows that of the people within a population who received an authorization for a service, the percent who actually used the service, as evidenced by a paid claim. Authorizations are compared to claims for the same service and the same time period (Q 3, 2000 to Q1, 2001) by population.

**Table 1.1**

**Percent of Authorizations With a Paid Claim by Population**

Services	Population One		Population Two		Population Three	
	# Claims	Percent	# Claims	Percent	# Claims	Percent
Behavioral health rehabilitation services	192	92%	31	91%	n/a	n/a
Residential treatment facility	47	98%	30	97%	n/a	n/a
Case management	922	92%	289	97%	10	83%
Non-hospital rehabilitation	229	91%	122	95%	10	91%
Partial hospitalization program	273	88%	93	82%	3	100%
Supplemental	234	84%	110	87%	7	100%
Outpatient mental health	1,489	67%	372	72%	13	68%
Medication check	1,185	59%	286	61%	8	44%
Outpatient drug & alcohol	157	43%	53	49%	2	40%

Overall, the percent of authorization for each population is relatively consistent for a given service. Three groupings emerged:

- Authorizations that matched claims  $\geq 95\%$ ;
- Authorizations that matched claims 87-94%; and



- Authorizations that matched claims < 87% (shaded areas).

The table clearly shows analyzing data based on claims versus authorizations can present very different pictures. AHCI recommends that providers and Community Care consider ways to engage people so they use the authorized services.

## Member-Level Analysis

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### Demographic Findings From Record Review

At the direction of an ad hoc group comprised of Allegheny County, Community Care, and AHCI representatives, a record review was conducted to determine factors that influenced the stability (or instability) of consumers with recurrent admissions. The following is a brief summary of the demographic findings taken from records of Community Care's documentation of all 23 consumers in population three and a random sample of 50 records of consumers in population two. Records of people in both populations were reviewed to try to ascertain their similarities and differences in an effort to prevent future decline and increased recidivism of people in Population Two.

#### Population Two

- 54% of consumers were female;
- 58% were Caucasian;
- 32% were African American females and 32% Caucasian males;
- 44% were between the ages 34-44 years;
- 42% were in the Tier One category;
- 76% were SSI without Medicare eligible; and
- 82% had a break in enrollment between 1-30 days.

#### Population Three

- 53% of consumers were male;
- 58% were Caucasian;
- 37% of consumers were Caucasian males;
- 53% were between the ages 34-44 years;
- 79% were in the Tier One category;
- 74% were SSI without Medicare eligible; and
- 68% had a break in enrollment between 1-30 days.

### Comparisons to the Total Population

In general, the findings from the record review were similar to the findings from the data of all consumers for each population. The following comments pertain to the exceptions. More male consumers were identified in Population Three for study period two in the data analysis as compared to the record audit. This may be a result of the differences in the two time periods. Study two includes activity from July 1, 2000 to March 31, 2001. The record review considered documentation for 1999, 2000, and January through April of 2001 (or periods during this time when the consumer was eligible).

The percent of Caucasian consumers in Population Three was substantially larger in the data analysis than the percent identified in the record review process. As stated on page

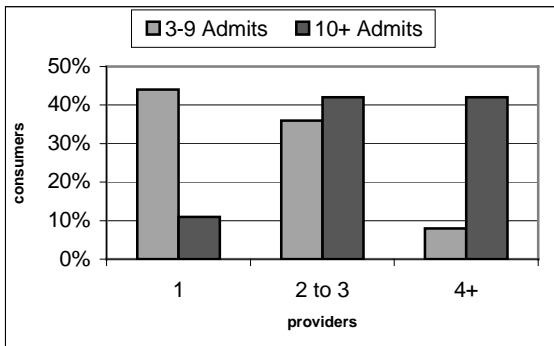
six, the percent of Caucasian consumers increased approximately 10% during study period two. The distribution of tier assignments for both populations was significantly different. Study two yielded a higher percent of consumers in Tier One category as compared to the record review findings for both populations. Although SSI without Medicare was identified as the most common category of aid in both analysis mechanisms, the percent of eligibility differs. Study one and two was 25-35% less than the record findings for Population Three and 40-50% less than Population Two. Factors influencing these discrepancies may include: the large number of people who became ineligible between study period one and two, and the shift in activity among the three populations.

**Service Utilization Findings From Record Review**

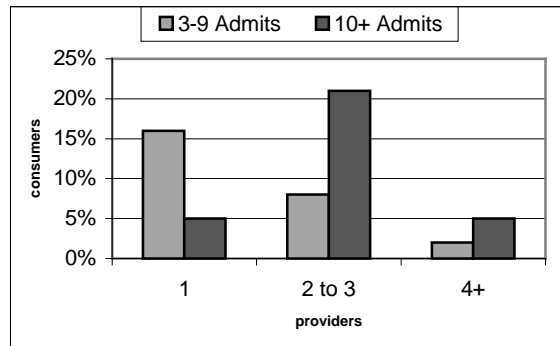
People with a dual diagnosis (mental health and substance abuse) were the most common for both populations (Population Two = 62% and Population Three = 63%). The second most common diagnostic category was two or more mental health diagnoses (Population Two = 20% and Population Three = 11%). Both populations had one individual with a substance abuse diagnosis exclusive of any other behavioral health diagnosis.

The number of providers accessed by population was similar for both populations for specific service categories including: outpatient mental health and partial hospitalization. Inpatient rehabilitation showed some variation; however, the greatest disparity occurred with inpatient detoxification and inpatient mental health services as illustrated in Charts 3.9 and 34.0.

**Chart 3.9**  
**Number of Providers Consumers Used for Inpatient Mental Health Services**



**Chart 4.0**  
**Number of Providers Consumers Used for Inpatient Detoxification Services**



The pattern for inpatient mental health services is nearly inverse for the two populations compared. The relationship for inpatient detoxification services was not as dramatic, but does indicate concern. Some people with multiple providers and admissions elected to leave AMA and/or terminate the services prior to meeting treatment plan goals.

### People Without an Admission

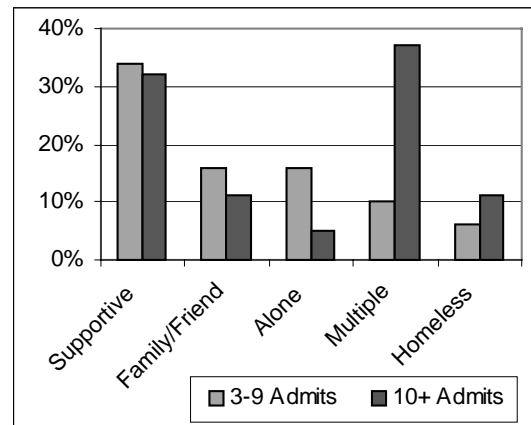
Earlier the report presented the aggregate changes in each population from study period one to study two. To better understand the reasons for these changes it is helpful to look at individual records. For example, there were six people in population three who did not have an admission during the second study. Two individuals became ineligible as a result of an out-of-state move. Another person was ineligible secondary to incarceration. A fourth person was involuntarily admitted during the nine-month study period to a state hospital. The fifth person became ineligible for the last five months of the study period for reasons unknown. The sixth person was assigned an intensive case manager, engaged in a one-month partial hospitalization program, received Clozapine management, and was successfully placed and maintained in a community residential environment.

### Living Situation and Stressors

Determining a person’s housing status and their stressors was often difficult to ascertain from the documentation. The majority of the notes were clinical in nature, addressing the presenting symptoms and behaviors. Chart 4.1 illustrates the most recent living situation as it appeared in the consumer’s record.

Chart 4.1 shows a possible relationship between unstable housing and more frequent admissions. Other common stressors consumers reported included: relationships with family/friends and finances. Record documentation suggested that improvement in housing occurred at the same time as a reduction of inpatient admissions for 14% of people in Population Two and 11% of people in Population Three. While 34% of people in Population Two lived in some form of supportive housing, their perception and expectations lead them to identify housing as a stressor. In a recent survey conducted by CART on homelessness, housing was expressed as an important issue. Some homeless individuals have resigned themselves to a lifetime of living on the streets because they do not feel that they “fit in” to society and are unaware of programs and services that can assist them.

**Chart 4.1**  
**Consumer’s Housing Status**  
**by Population**



**Key:**  
*Supportive includes: community residential, halfway house, supervised living, and, group home.*  
*Multiple includes: a variety of sources, often used on a cyclical basis (family - homeless - jail - friend - family - etc.).*

## **An Anecdotal Summary of the Record Review**

The record review afforded a unique opportunity to examine the scope of each individual's significant life events. Analysis conducted at the aggregate level does not often permit one to relate cause to effect or yield this level of understanding. For example, an Emergency Room (ER) provider who is unfamiliar with a consumer may have concerns of noncompliance based on his/her evaluation of symptoms, a previous ER visit, and a sub-therapeutic medication level. Inpatient treatment would include patient education regarding the importance of proper dosing of prescribed medications. The provider discharges the person feeling assured that s/he has met the person's needs. Piecing together the information contained in the consumer's record often provided reasons, other than noncompliance, that explained why the person presented to the ER.

Often, a tragedy beyond their control triggered the behavioral change. Examples of this are the death of a family member or significant other, a loved one's recent diagnosis of an incurable disease, and divorce within the family. Another cause cited was physical and sexual abuse. A common scenario observed in people with substance abuse was dependency that followed a traumatic injury resulting in chronic pain. Narcotics, initially prescribed to control the pain, were used in combination with other substances until the abuse developed into long term dependency.

Tragedies of this nature cause dysfunction to some degree to people with or without mental illness. It would appear that for people with mental illness, such stressors exacerbate symptoms.

## **Conclusions**

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Following the same group of people over time helps us to understand what services, supports, and practices are effective or ineffective. The study also provides a better understanding of the cycle of illness and system changes that influence practices and outcomes. The findings should also challenge us to use mechanisms to proactively identify persons with potential needs and apply effective strategies to engage them in services that will help reduce the frequency of inpatient and intensive non-hospital services.

The record review process was conducted in cooperation with Community Care's Care Management staff. The process, which included developing a collection tool, conducting the review, and analyzing the findings, was an educational experience. The daily interaction with providers and consumers often focuses upon the immediate need or request and may not consider the impact that each decision has on the broader scope of care and treatment. AHCI will communicate the findings contained in this report to Community Care, the County, and providers with the expectation that the information can be used to educate people and improve the service system.

In summary, the findings contained in this report should provide motivation to consider alternative approaches to consumer assessment, engagement in appropriate levels of service, and education to assist people in early recognition of symptoms and/or triggers

that, if left untreated, could result in hospitalization. Assessment efforts should focus on identification of people with a dual diagnosis from an information system and a clinical perspective.

Outreach efforts could be targeted at individuals within Population Two and Three who have a history of, or the potential to, use restrictive and intensive services. Outreach initiatives could include: proactive written or verbal contact with the consumer and the provider(s). Troubleshooting strategies could be developed through dialogue with the provider and the Care Management Associate as difficulties arise.

Helping people understand and recognize underlying issues that contribute to the decline in a consumer's well being is crucial to the consumer's ability to be maintained in the community. As entries from the consumer's record often suggested, a consumer may not be able or willing to share all the issues that prompted their hospitalization. Providers and Care Managers should encourage consumers to express their perceived concerns in all life domains.

The findings of this report should also guide providers to consider treatment that addresses the well being of the whole person. Grand rounds and case conferences could provide a forum to present the impact that the presence or absence of treatment/services has on unmet needs. Case examples of missed opportunities could be used to increase provider awareness of the benefits of services such as: targeted case management, crisis services, community treatment teams, psychiatric rehabilitation services, and supportive housing options.

Community Care will support many of the services above through a reinvestment plan. Since the reinvestment funds are limited to one year, Community Care should work cooperatively with providers, the County, and the State to identify future funding sources. Long term funding is imperative to support the long term goals and needs that consumers have, especially people in Population Three.