

Thoughts on Davis Ja Report: The Move Away from a Medical Model of Care

by *Benson Nadell*,

San Francisco Long-term Care Ombudsman

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The Ja report providing recommendations for Behavioral Health¹ services at Laguna Honda Hospital notes: “Staffing considerations should also include provisions for respite for staff experiencing stress from interacting with clients with challenging behavioral problems” (page 47, Section 3, Staffing).

Also mentioned in the Ja report is “... findings indicate the extensiveness of the numbers of patients with mental health and behavioral health needs ...”

This is an interesting standard, which in addition to noting the need for respite, could be used to justify increasing social workers and front line care-givers, as well. But the Ja report recommends, instead, enhancing existing behavioral health staffing resources through a “rebalancing of the staffing in a way that is cost neutral.”

How is this to be done? The Ja report mentions a desired Culture Change, and a shift away from a Medical Model of Care:

“DYJ is recommending that higher salaried physicians be replaced by registered nursing staff, social workers, and psychologists ...” (p. 47)

Disability rights advocates have a long and somewhat justified perspective on the “Medical Model of Care.” Disability often led to institutionalization, because disability was “medicalized” as an illness. Also, in a non-person centered system of care delivery, care was diagnosis-driven, the driver being the diagnosis.

For elderly who are hospitalized for illnesses, the DRG² and RUG³ systems put the diagnosis at the center of caps on Medicare reimbursement.

In some facilities, a Medical Model of Care mixes up disability and illness, sometimes for the purpose of getting reimbursement to serve as a funding stream for housing and treating individuals in a skilled nursing facility (SNF) setting.

This perspective also equates a medical model of care with fostering dependency and helplessness, including an uneasy confusion between getting people to a level of maintaining their functional independence and providing “custodial” care. Independent living skills are usually not provided as part of services under a Medical Model of Care.

¹ “Behavioral Health” generally includes both mental health and substance abuse services.

² DRG (Diagnosis-Related Group) is a system used to classify hospital cases into one of approximately 500 groups, referred to as DRGs, for patients who are expected to use similar hospital resources. It was developed for Medicare as part of the prospective payment system.

³ RUG (Resource Utilization Group) is a system mandated by the Balanced Budget Act of 1997, when the Health Care Financing Administration began phasing in a prospective payment system in July 1998 for Medicare-covered stays in skilled nursing facilities. The prospective payment is meant to cover nearly all costs of providing care, including routine service, and ancillary and capital-related costs, with only a few exceptions, such as physician services.

By contrast, there was to be a Social Model of Care, best exemplified by community living. A prime example was the Regional Center model for the Developmentally Disabled, through California's Lantermann Act, when California's state hospitals were closed. Part of that Social Model of Care proposed developing sufficient Community Care alternatives for placement.

But mostly, the Social Model of Care tends to be idealized, and the Medical Model of Care derided.

Observational Problems

Many clients in board-and-care homes and in free-standing nursing homes need ongoing management of their chronic care conditions. In free-standing SNFs, the doctor-patient relationship is attenuated, and mediated by the eyes and ears — and observational skills — of the Nursing staff.

One variable which contributes to indicators of poor care is this dimension of observation of changes in condition, and the response of visiting medical providers. Doctors in free-standing SNFs are only authorized under Medi-Cal to visit once a month, or every 60 days, unless there is a documented medical necessity. These doctors have huge case loads, often covering more than one free-standing SNF.

By contrast, LHH has a continued presence of in-house MDs that means, in practice, their case loads are relatively manageable. There is a consistent assignment of physicians, out of which grows a clinically-meaningful relationship between patient and doctor.

This helps keep instances of neglect to a minimum.

SNF Regulatory Requirements and Medical Necessity

The Davis Ja report only makes passing reference to the regulatory framework governing SNFs. In all SNFs, doctors write orders that are implemented by the Nursing staff and ancillary behavioral, social, or activity therapy staff. In free-standing SNFs where the doctor is the **absent** “captain” of this care, there is greater reliance on accurate and ongoing communication between Nursing staff and doctors.

The Ja report's recommendation to shift away from a Medical Model of Care doesn't seem to have considered an additive approach, where behavioral health enhancements are **added** to the Medical Model of care in a blended manner. Instead, the Ja report recommends a “replacement” approach; because of a preponderance of relatively younger patients with complex behavior and substance use needs, medical care is put on a back-burner position.

The reason, of course, is to present a “cost-neutral” recommendation (one of the goals of the Ja report).

The report uses diagnostic codes to select patients, rather than using the MDS⁴ system to assign patients into Ja's behavioral “Study Group” and control “Comparison Group.” Implicit in that selection process is, perhaps, a statement of the reliability of MDS-derived data. But more than that, also not factored in are the medical reasons why patients are admitted to LHH. They are not admitted for reasons of housing. The set of medical reason data is not presented in the Ja report.

⁴ The MDS (Minimum Data Set) is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare- or Medicaid-certified nursing homes. The MDS provides a comprehensive quarterly assessment of each resident's functional capabilities and helps nursing homes identify health problems of their residents. The MDS system captures the acuity level of, and “burden of care” required for, each resident, and helps identify each resident's functional capabilities and level of assistance needed for activities of daily living.

Are LHH patients admitted for behavioral reasons? The State of California issues renewable Long-Term Care TARs⁵, which are predicated on meeting criteria for “medical necessity⁶.” The Ja report didn’t question whether persons need to be at LHH based on TAR medical-necessity criteria.

Shifting Resources

But that was not the purpose of the Ja report. The report was written to address the needs of a relatively younger resident population, rather than the frail elderly⁷ or disabled populations with complex medical needs.

Ja segregates two samples from LHHs resident population during the years 2006–2008: Those who have behavioral health needs (the Study Group), and other residents used as a control group (the “Comparison Group”).

Ja’s recommendations against sustaining LHHs Medical Model of Care, however, impacts on this Comparison Group, by shifting resources from medical services towards enhancing the behavioral and substance abuse needs of the relatively younger population — a population more likely to be discharged into the community (provided housing is available). DPH pulled away from its previous commitment to build assisted-living housing at LHH, and closed LHHs Adult Day Health Care (ADHC) program — both moves contrary to providing a full continuum-of-care model of services at LHH.

In many ways, the Ja report is not about Culture Change, but about disenfranchising the residents in the “Comparison Group.” The Ja recommendations serve to further formalize patterns of admission of younger residents from San Francisco General Hospital into LHH.

One good thing in the Ja report is that its recommendations provide for mental health services in skilled nursing facilities, with an emphasis on the “recovery and rehabilitative” model. Even the elderly need some degree of mental health services, even if they are not alcoholic or using substances. There are alternative clinical models of counseling for the elderly who have lost their homes, independent functioning, and mobility, and who may be struggling with depression and social isolation. Depression is one of the greatest untreated clinical issues among the elderly. Social Workers at LHH recognize the quiet desperation of their elderly charges. Behavior management of those with mild- to moderate-dementia go untreated, except for medication management, in most SNFs. Behaviors among those with dementia are seen as a form of communication by clinical experts, but even at LHH these behaviors are seen as “problems” that require “management.” Regulations governing skilled nursing facilities require resident-centered approaches, even if LHH is seen as having a medical model of care. The new F-tags⁸ for therapeutic activities (a.k.a., “Activity Therapy”) in Federal regulations require resident-centered activities for those who do not wish to join groups. Even newer F-tags require greater care-planning for Quality of Life measures for all residents.

But the Ja report does not address those residents’ behavioral or clinical needs. Those residents are in the Comparison Group, which is used as a quasi-control group. By shifting resources towards a younger population, more likely to be discharged (if there is housing and similar treatment available in the

⁵ Long-Term Care TARs [Treatment Authorization Requests] are used to request prior authorization from the Medi-Cal field office for all Medi-Cal recipients admitted to a long-term care nursing facility. The length of stay authorized for long-term care is based, in part, on data from the MDS system. Long-term care facilities are licensed, and are required, to provide services under the supervision of physicians. A medical necessity is required for TAR approval.

⁶ Medical necessity is defined as “reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.”

⁷ “Frail elderly” are the oldest-old, and typically refer to those 85+ years old.

⁸ A catalog of F-tag topics are used during on-site surveys by licensing agencies to identify sub-standard quality of care. Increased severity of F-tag violations affect overall results of annual site visits and continued licensure.

community post discharge) the residents in the Comparison Group who **do** have complex medical and chronic care management needs may be adversely affected.

Another Segregated Silo?

Good policy should be inclusive of all populations, and weigh the consequences on all groups. Admitting persons who do not necessarily have an Axis I diagnosis⁹ to LHH will help clear the streets and expand behavioral services to those who wander around the communities of San Francisco, but how long can they stay in such a segregated setting at LHH, and when will the kind of structured and bundled services be available in the community?

(**Note:** For the JA report, ICD-9 diagnoses¹⁰ are used. The use of DSM and ICD codings for reimbursement of certain diagnoses should have been better explained in the Ja Report, since the use of the LHH Medi-Cal reimbursement was to be used to cover these Behavioral Health Services.)

These younger patients have greater discharge potential. But what will their recidivism rates be if community-based services are insufficient?

One implication of the Ja report's recommendations is to potentially create a new segregated setting at LHH for persons with behavioral problems, rather than initially integrating them into the community at the outset. Does one of the recommendations in the Ja report suggest such a segregation-based "behavioral service plan," providing behavioral services at LHH? Or is there a new, non-medical rehabilitation model being proposed, which allows people in this modality to be stuck at LHH, without housing? What is the post-LHH discharge plan for these clients?

Sweeping people with behavioral problems into an institutional setting, simply because of an absence of housing, is reminiscent of a case¹¹ in New York City, which had been placing people with mental illness into large "adult homes." Segregating services for those targeted as needing them, is, paradoxically, against the spirit of the *Davis* and *Chambers* lawsuits. One question, however, is whether those behavioral services mentioned as needing enhancement are meant to be transitional back to the community? If so, then similar services should be available in community settings, since LHH is not housing. This is not addressed in the Ja report.

⁹ Axis I diagnoses are clinical disorders, including major mental disorders, as well as developmental and learning disorders. Historically, with both DSM and ICD classifications, behavioral "reactions" to situations was replaced by an "innate" personality disorders — a shift from looking at life-narratives and personal contexts to inherent mental states. (See Christopher Lane; *Shyness: How Normal Behavior Became a Sickness*; Yale University, 2008.)

¹⁰ The International Classification of Diseases (ICD) is published by the World Health Organization (WHO), which is used worldwide for morbidity and mortality statistics, reimbursement systems, and automated decision support in medicine. It was developed in conjunction with the U.S. Alcohol, Drug Abuse and Mental Health Administration to refine classification. This system is designed to promote international comparability in the collection, processing, classification, and presentation of these statistics. The ICD is a core classification of WHO's Family of International Classifications.

¹¹ *Disability Advocates, Inc. v. Paterson*, September 8, 2009. Disability Advocates, Inc. sued New York State using the same general arguments used by Disability Rights Advocates against LHH in the *Davis* and *Chambers* lawsuits, citing violations of the Americans With Disability Act and the U.S. Supreme Court's *Olmstead* decision. The Court found that New York State had discriminated against DAI's constituents in violation of the integration mandate of the Americans with Disabilities Act and the Rehabilitation Act by denying thousands of individuals with mental illness in New York City the opportunity to receive services in the most integrated setting appropriate to their needs. The Court ruled that persons with behavioral health issues should not be segregated in such group homes and nursing homes.

Culture Change and Blending Models of Care

LHH as a public institution (yes it is, in the good as well as in the segregated sense), requires admission of a heterogeneous population. The recommendations of the Ja report implicitly say something else: Let's change the culture of LHH and not admit persons who cannot be discharged. The Ja report sort of suggests that LHH should not admit persons who would benefit from a Medical Model of Care, which is embedded in a regulatory structure that requires person-centered and person-driven care based on a comprehensive assessment process of all needs.

Returning to the community should always be an option. Services as are recommended in the Ja report should not be found only in such a segregated setting at LHH.

Also, ironically, with a return to the community, there needs to be access to ongoing primary care and a blending of the social and medical models of care in community-based settings. Admitting patients to LHH for behavioral care requires great social controls, despite the regulations which require consent to treatment. There must be a plan for such care in the community that also guarantees such social and structural care in a way that balances the dangers of self-neglect with the consumer's right to choose.

These complex issues are left out of the Ja report. This is understandable, given its stated focus. Good health care planning, however, requires looking at the impact on other patient populations. And if transitions to the community are to increase, health care planning has to be consistent across settings, to avoid any segregation of services. Specious Culture Change arguments should not mask the same old notions of economy of scale with an inherent competition for direct care workers, and a glossing over of consent issues.

Addiction-related treatment plans may or may not be a form of social rehabilitation. Individual choice, and all the "rights-to-folly" embedded in ethics reviews are not really "fleshed out" in the Ja report.

Many disabled-rights advocates point to the implicit mechanisms of control within institutions (see Goffman, "Asylums"¹²). Addiction services are particularly aimed at instilling self-controls and consequences, often using behavioral "contracts," which are embedded in care plans. Any focus on regulatory resident rights is off-set by the resident's responsibilities, as defined by the interdisciplinary care team. Enhanced staffing for that population which wrestles with such controls could change the culture of LHH in a retrograde, where the institution makes explicit its mechanisms of control.

If such a behavioral health model were the only one at LHH, what about the other potential models predicated on self-efficacy, independent living, counseling for loss, and happiness therapy (in the sense of Seligman¹³)? What becomes of the model of care based on compassion and the politics of the heart, when control of addictive behaviors becomes the primary modality? Culture change can only occur when there is such a choice of options. Culture change is predicated on that and is not uni-dimensional.

Good policy should not derive its directions from an argument based on the dialectical opposition of the Medical Model of Care versus the Social Model of Care, but aspire towards a synthetic approach of blended services across all settings.

¹² Goffman, Erving. (1961). *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. A series of four essays that focus on the relationships between the inmate and the institution, how the setting affects the person, and how the person can deal with life on the inside. *Asylums* presents Goffman's theory of the "total institution" and the process by which it takes efforts to maintain predictable and regular behavior on the part of both "guard" and "captor," suggesting that many of the features of such institutions serve the ritual function of ensuring that both classes of people know their function and social role. The book concludes that adjusting the inmates to their role has at least as much importance as "curing" them.

¹³ Seligman, Martin. (2002). *Authentic Happiness*.

Addendum

The Ja report is short on the description of behavioral health services at LHH and linkages to similar Recovery Services in San Francisco. Much is left out of Ja's report and there is too much on the re-allocation of resources, which are not even described.

The focus on a younger cohort of residents who are admitted to LHH does create a sense of segregated services. The Ja report does not even address the stigma of homeless adults and their undetected mental health needs, nor does it address therapeutic approaches used by behavioral health specialists as a matter of resource allocation within DPH.

Homelessness has many causes, but one of the most common is untreated behavioral health diagnoses, which are not always of the traditional Axis I type. Homeless patients who are admitted to LHH from SFGH — initially for medical reasons — are then provided a set of services that provide a type of rehabilitation, which must accompany each resident when they are transitioned back to community living.

The Ja report would have been better if the recommendations left out the cost-neutral discussion.

Rehabilitation strategies that address post-discharge services, and not locations, should have been highlighted.

For instance, from the Mental Health Act (Proposition 63) Full Service Partnerships were created — modeled on Dr. Mark Ragins' work at *The Mental Health Village* in Los Angeles — and made available in San Francisco, with the Hyde, Westside, and Family Service Agency of San Francisco as the main providers of such services.

These services have the potential to provide some structure for the homeless population who are admitted to LHH to seek rehabilitation, and be discharged back into San Francisco. Housing, however, has always been a concern. San Francisco will eventually provide 500 affordable housing sites under the *Chambers* settlement agreement. In addition, through DPH's Housing Chief, Mark Trotz, hotels like the Plaza have been leased and modified into supportive housing to provide additional housing options for this younger population who have been admitted to LHH for rehabilitation services.

Once housed, and stabilized, these residents could be linked to the Full Service Partnerships.

The Ja report leaves out of its Description and Recommendations any narrative of these available services. Are these behavioral health services based on a one-to-one therapeutic interaction, where Motivational Interviewing and Cognitive Behavioral Therapy are provided? What therapeutic roles do LHHs interdisciplinary teams play in a resident-centered and resident-directed care plan? What is the relationship between resident choice, and behavioral management? What treatment modalities occur in the SATS (Substance Abuse Treatment Services) meetings, and are they an adjunct to 1:1 therapeutic interventions?

Instead, like LHH, this consultant report has its own "silo-like" perspective, and by recommending a shift away from medical services in a cost-neutral way, shifts attention from those residents in the Comparison Group who were admitted for an array of chronic medical conditions.

The Ja report also skips over any mental health services for this Comparison Group population: Depression management, self-efficacy, dementia services, and finally the role of activity therapy programs in improving quality of life.

When the Department of Public Health attempted to merge mental health services into “medical homes” at DPH’s primary care clinics in an integrated approach, many community healthcare advocates were concerned. They remain concerned that the Ja report’s recommendations regarding LHH are somewhat parallel: To piggyback Behavioral Health services onto a system of chronic care management, but with a paradoxical move away from a Medical Model of Care.

Some of them voice concern that the silos between Mental Health and Medical Health have been too separated — with Behavioral providers in one branch of Public Health not communicating enough with Medical providers in another DPH branch, and vice versa. These healthcare advocates express concern because they have seen too many Mental Health consumers placed for years in board and care homes medically neglected as they age, and who continue to be given multiple psych medications.

For many of the reasons in these Thoughts, the Ja report has created a strong reaction on the part of those who advocate or treat the varied residents in the Comparison Group.



The Ja Report should have considered an additive approach to blend model-of-care delivery, rather than a subtractive, cost-neutral approach.

Potentially, blending a medical model of care with a social model of care could lead to improved outcomes for all patient populations ... *decreasing functional limitations*, while allowing for increased adaptation to independent living, improving health outcomes, and reducing mortality. Good policy should aspire towards synthetically blending medical model of care with social model of care services across all settings.

Disclaimer

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Under the Federal Older American Act, the local Long Term Care Ombudsman Coordinator is expected to comment on laws, regulations, and policies that may affect residents of long-term care facilities. This includes comments on any evolving local policies that may potentially impact residents in nursing homes or residential care facilities.

The goal of the State Long-Term Care Ombudsman Program is to advocate for the rights of all residents in long-term care facilities. The Ombudsman’s advocacy role takes two forms: 1) To receive and resolve individual complaints and issues by, or on behalf of, these residents; and 2) To pursue resident advocacy in the long-term care system, its laws, policies, regulations, and administration through public education and consensus building.