Comments on Zhang, "Strategies Used by Managed Behavioral Health Organizations to Reduce Hospital Care" A Literature Review Submitted to the Myers-JDC-Brookdale/Brandeis Collaboration on Mental Health

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The article reviews strategies of reducing hospitalization, lending, in my view, excessive weight to economic aspects and sending the sweeping message that hospitalization is not beneficial to patients and, of course, costly. Consequently, it neglects other important aspects that may potentially reduce hospitalization without the risk of side-effects to specific populations, mainly patients with complex diagnoses, who require lengthier periods of hospitalization. Focusing on economic aspects, it omits the construction of a strategy to prevent hospitalization with a patient-centered emphasis.

Some of the strategies presented in the article are already in use in Israel. Some, we would very much like to expand, and some we would like to develop via an ambulatory service. More on this below.

I would also like to relate to the term "managed-care organizations." In my opinion, the term is equivalent to that of the "controllers" used by the health plans in the framework of the mental-health reform. In Maccabi and Leumit, for instance, they are called "continuum staff," which has the connotation of greater connectiveness and comprehensiveness. It also emphasizes the importance of ensuring the treatment-rehabilitation continuum, with all that this implies and all its positive effects on the patient and family, and with less labelling in the direction of control, which arouses antagonism. For this reason, I find this term preferable.

As to the suggested strategies:

Effective transition from hospital to community *- The article relates exclusively to follow-up programs and to the point of discharge. I would like to note that as part of a pilot in the northern district to promote the treatment-rehabilitation continuum, a kit of guidelines was constructed for all the active players on the continuum, which relates to all the aspects, junctures and stations traversed by patients and families from the hospital to the community, and from the community to the hospital. These junctures and stations go far beyond follow-up of appointments at mental-health clinics after discharge. While this juncture is highly important, there are many others that should be considered. Furthermore, a comprehensive program of discharge planning was developed, including the utilization of cure-promoting rehabilitation-treatment interventions during hospitalization, and additional strategies to assist optimal discharge process and transition from the hospital to the community.*

Selectivity in choosing a supply network *– Here, too, as far as I'm concerned, the ways that matters are managed in Israel are more desirable and patient-focused. In Israel, providers are not chosen for patients; everyone has the right to choose where to be hospitalized – and this is as it should be. Moreover, the strategy presented in the article not only has the state choosing suppliers for patients, but in this choice more weight is given to economic factors. It seems to me that individuals should be given the right of choice and that the criteria determining their choice should go well beyond the economic aspects and the hospital's capability of providing intensive care. Criteria of quality of care must be created to address the principles of rehabilitation and cure, starting from within the hospital system itself, and surveys should be conducted of patient and family satisfaction.*

Risk sharing so as not to encourage hospitalization – *problematic in my eyes…*

Special programs for people at high risk of hospitalization *- Some of the suggested interventions are certainly practiced in Israel today, but we would very much like to develop the area of community models to prevent hospitalization. In our thinking, the ambulatory system should be the one to develop these models, a course vigorously championed by the rehabilitation system, by various means.*

The article presents the topic of ongoing support from hospital staff. In conjunction with the National Insurance Institute we are currently conducting a pilot in two hospitals, of having specialist associates in hospitals. We are very interested in expanding the pilot as a further step to all the psychiatric hospitals in the country.

With respect to community models to prevent hospitalization, the article does not address models for young patients after a first episode. In this regard, we have launched the NAVIGATE model, which is part of the broader RAISE project imported from the US, and we are currently examining its feasibility at a number of mental-health clinics in Israel.

The views expressed here are the personal views of the author and do not necessarily reflect the position of the organization in which the author works or of the Myers-JDC-Brookdale Institute.