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 important, interesting review at hand stresses the systemic-management aspect. I will try to relate to the factors cited therein from two different points of view: the clinical, which places somewhat different emphases on the systemic angle, and the angle examining systemic and public realities in Israel.

I will relate to the following factors:

1. *The rehabilitation system and significance of the therapeutic theory on which it rests*
2. *Professional and systemic gaps in knowledge*
3. *The influence of human rights organizations and family representatives*
4. *The stage of primary implementation of the reform and its impact*
5. *The significance of costing and the overheads of complex therapeutic models.*

1. ***The community rehabilitation system*** *– Let me say outright that in my view, this system has been the most significant contributor to stabilizing and improving the clinical state of the mentally ill in the past decade. It has advanced tens of thousands of patients on a wide range of planes (social, employment etc.) while demonstrating real success in reducing the duration of their hospitalization.*

   And yet – the theory of cure, which is the theoretical foundation and professional compass of the rehabilitation system, is suited to patients qualifying for community rehabilitation – although the threshold is high, given the extent of patients suffering from mental impairment or chronic illness.

   In reality – a gap has remained with no satisfactory response, which significantly affects the extent of patients hospitalized in Israel at any given moment.

2. ***Professional and systemic gaps in knowledge*** *– With reference to patients suffering from chronic mental disorder accompanied by severely defective functioning, there are no known therapeutic theory or principles of institutional rehabilitation the aims of which are more modest than those of community rehabilitation. In other words, for this vulnerable population – there is no complete theory parallel to theory of cure for example. One interesting attempt at constructing such a theory, designed by the national supervisor and staff of occupational therapy at the Ministry of Defense, is currently being implemented at the private Ilanit Hospital though its validity and the experience accumulated are very limited at this stage.*

3. ***The influence of human rights organizations and public representatives*** *– Systemically, the question of what kind of residence and therapy are most suitable for this*

population has not yet been decided. Human rights organizations involved in the field of mental health adhere to an ideology negating the right of existence of broad institutional frameworks and exert highly significant public pressure in favor of community integration in settings that are "homelike" in size. Potentially, this creates a burden of overhead costs in the response provided by broader frameworks such as the abovementioned Ilanit Hospital, the existence of which is constantly under threat. All this works against finding a solution on an adequate scale. Concomitantly, it works against the possibility of constructing an organized theory consistent with the nature of the systemic response to be decided.

All the above directly impact on the proportion of patients who are hospitalized for a long term, or are severely ill. This is also relevant to the short-term hospitalizations that they periodically require.

4. ***The stage of primary implementation of the insurance reform*** *– We are at a learning stage that creates difficulties which are important to define and deal with, and which directly relate to the main substance of the review in question:*

   Lack of clarity about the identity of the treatment provider: Changing the state service, especially its clinics, from one that considered itself a full, integrative provider as a community clinic to a service provider and part of a commercial unit, created a significant gap in the area of all-inclusive personal management. At this stage, the health plans are busy setting up their community facilities and inspecting the work of the state clinics on a case-by-case basis. Their identity as integrators/managers of care is still incomplete.

   In my opinion, one factor contributing to the delay is the cumbersome, wearying reckoning unfortunately inherited from the 2006 agreement between the Health and Finance ministries, which rests on three types of vouchers for each patient. It leads the system to deal in administrative micro-management, burdens all players with work that is mostly technical, and further removes the health plans from a real focus on managed care and quality assurance. The desire to rein in budgets would be better served differently: by setting a floor, a ceiling and an alpha formula – instead of the current annoying procedures; annoying for the service providers, the insuring parties, and most importantly – for the patients themselves.

5. ***Costing and overheads, complex therapeutic models*** *– Although the reform held out real promise of additional funds for the health plans, the additions were calculated on the basis of a well-defined goal: doubling the number of ambulatory patients, both minors (from 1% to 2% of the total population) and adults (from 1.5% to 4% of the total population). No calculations or budgetary allocations were made for expansion of frameworks with heavy overhead such as daytime hospitalization, daytime care, and daytime provisions for specific complex populations with special needs, such as patients suffering from eating disorders etc. Consequently, a continuum of care in its richer, more diverse sense is largely absent, leaving most of the help dichotomous – to hospitalization or clinical care.*