

"Data for 1996 has been requested, and we expect even more aberrant results," Price reported.

[Excerpts from recent publications of the Association for Ambulatory Behavioral Healthcare, Inc.]

The huge and expanding older adult population continues to pose a tremendous challenge to the mental health delivery system, including payers, providers, and purchasers. As the elderly cohort grows, the demands on all levels of services grows exponentially. Depression and other later life psychiatric issues such as anxiety secondary to loss of health or a permanent change in physical condition, difficulty coping with dementia in a spouse, severe grief and loss, and panic over the inability to live independently and the subsequent placement in a nursing home facility are all common events. These problems are generally acute and debilitating and frequently present themselves simultaneously as well as in the context of a limited or nonexistent social support system. At the same time, it has been well documented that the elderly tend to underutilize mental health services because of stigma surrounding psychiatric care, cost and transportation limitations, and both patient and professional bias and misunderstanding that surrounds the detection, need for treatment, and cooperation with follow through for care.

Geriatric partial hospitalization programs are a viable option to improve the mental health services available to the elderly population. First, partial hospitalization addresses the problems of accessibility and acceptability. Generally transportation for patients is provided, and since patients return home each day the stigma associated with an inpatient stay in a psychiatric care facility is averted. Additionally, the treatment takes place in the environment of an age-similar group which has been shown to foster cohesion, therapeutic learning, and consistent application to daily life problems. Second, a geriatric partial hospitalization program is able to respond to diverse patient needs on both the individual and group level, as each patient receives a specifically tailored personalized treatment plan, and the therapy provided in the groups is relevant to a wide variety of patient problems. Treatment specifics are flexible within the standards set forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO, 1995) and the Medicare revisions of the guidelines for partial hospitalization (HCFA, 1995). Third, the availability of intensive treatment in partial hospitalization will often avert the need for inpatient care. This fact allows the health care provider to treat the patient at the most appropriate level of care, maintain him or her in the least restrictive environment, and places less stress on the patient, as the partial hospitalization program allows the patient to participate in an intensive psychiatric care program while still maintaining outpatient status. Finally, a geriatric partial hospitalization program is designed to reduce and control psychiatric symptoms, prevent relapse or exacerbation of problems, and improve mental, emotional, and physical functioning, all of which contribute to building in the patient the ability to live as independently as possible while enjoying the highest level of health.

A geriatric partial hospitalization program should be a separate, identifiable, organized unit that provides a significant link within a comprehensive continuum of mental health services, and thus, improves the overall continuity of care for the elderly patient. It is defined as a distinct, organized, time-limited, ambulatory, coordinated, active treat-

ment program that offers structured, therapeutically intensive clinical services, less than 24 hours per day, to elderly patients.

... The partial hospitalization program is a complex treatment that is intended for patients who exhibit profound or disabling conditions related to an acute phase of mental illness or an exacerbation of a severe and persistent mental disorder. The program generally operates as an outpatient unit in a hospital or as a part of a community mental health center and is to operate under the direct supervision of a physician. The program is to provide regular, coordinated, diagnostic, medical, psychiatric, psychosocial, occupational therapy, and multi-disciplinary treatment modalities on a more intensive level than is generally provided in an outpatient clinic setting.

Geriatric partial hospitalization programs are designed to serve elderly patients with appropriate clinical diagnoses, diverse medical problems, and a broad band of variability in socioeconomic and educational backgrounds. The geriatric partial hospitalization program must provide active psychiatric treatment and should be clearly distinguishable from an adult day care program, which provides primarily social, custodial, and respite services. An appropriate geriatric partial hospitalization program employs an integrated, comprehensive, and complementary schedule of active treatment approaches that are behaviorally tied to the identified problems and the specific goals contained in the individualized patient treatment plan. Specifically, active treatment refers to the ongoing provision of clinically recognized therapeutic interventions which are goal-directed and based on a written treatment plan. For treatment to be considered active the following criteria must be met:

1. treatment must be directed toward the alleviation of the impairments that precipitated entry into the program, or which necessitate this continued level of intervention,

2. treatment enhances the patient's coping abilities, and

3. treatment is individualized to address the specific clinical needs of the patient.

Geriatric partial hospitalization programs typically serve individuals 65 years of age and older who are experiencing acute psychiatric problems or decompensating clinical conditions which markedly impair their capacity to function adequately on a day-to-day basis. Usually outpatient therapy has not been effective, and without the ongoing structure, support, and active treatment provided by the geriatric partial hospitalization program these patients would require inpatient psychiatric care.

Ambulatory behavioral health services are designed for persons of all ages who present with a psychiatric and/or chemical dependency diagnosis and the need for treatment which is more intensive than outpatient office visits and less restrictive than 24-hour care.

Ambulatory behavioral health services consist of a coordinated array of active treatment components which are determined by an individualized treatment plan based upon a comprehensive evaluation of patient needs.

Ambulatory behavioral health services treat patients requiring intensive therapeutic intervention in a manner which simulates real-life experience and with the least amount of disruption to their normal daily functioning.

Ambulatory behavioral health services are available to patients on a consistent basis and are augmented with 24-hour crisis backup.

Ambulatory behavioral health services require active involvement of the service team

and patient with both community and family resources.

Finally, due to the matching of patient needs with targeted interventions, the provision of treatment in the most appropriate, least restrictive environment, and the reliance on patient strengths, resources and family and community support systems, ambulatory behavioral health services are cost efficient.

[From Medicare Explained, 1996, published by CCH Inc.]

PARTIAL HOSPITALIZATION COVERAGE

Medicare also covers partial hospitalization services connected with the treatment of mental illness. Partial hospitalization services are covered only if the individual otherwise would require inpatient psychiatric care. [Soc. Sec. Act §§1833(c), 1835(a)(2)(F), 1861(s)(2)(B).]

Under this benefit, Medicare covers: (1) individual and group therapy with physicians or psychologists (or other authorized mental health professionals); (2) occupational therapy; (3) services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients; (4) drugs and biologicals furnished for therapeutic purposes that cannot be self-administered; (5) individualized activity therapies that are not primarily recreational or diversionary; (6) family counseling (for treatment of the patient's condition); (7) patient training and education; and (8) diagnostic services. Meals and transportation are excluded specifically from coverage. [Soc. Sec. Act. §1861(ff)(2).]

The services must be reasonable and necessary for the diagnosis or active treatment of the individual's condition. They also must be reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization. The course of treatment must be prescribed, supervised, and reviewed by a physician. The program must be hospital-based or hospital-affiliated and must be a distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care. [Soc. Sec. Act §1861(ff).] Effective October 1, 1991, partial hospitalization services also are covered in community health centers (see ¶382). [Soc. Sec. Act §1861(ff)(3).]

HONORING PETER DANNER

HON. DALE E. KILDEE

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, October 8, 1997

Mr. KILDEE. Mr. Speaker, I rise today to honor the recipient of the 1997 Golden Door Award, Mr. Peter Danner. The award will be given posthumously to Mr. Danner at the annual dinner meeting of the International Institute of Flint on Tuesday, October 14. The International Institute of Flint presents this award annually to a foreign-born citizen who has substantially improved life in the Flint community.

Peter Danner was born in Hungary in 1931. His family owned a wholesale grocery business serving southern Hungary. During World War II the business was invaded first by the Germans and then later by the Russians who looted the food for the soldiers. After graduating from high school Peter joined the Hungarian military. He planned to study engineering but the military did not cooperate and he was assigned to work in an office.

In 1956 Peter started his long journey to the United States. Leaving Hungary during the

revolution he arrived in this country on December 24, 1956. Peter often reminisced about his arrival on Christmas Eve. He was living in New Jersey and the decorations fascinated him. Peter was excited to leave behind the drab Communism of Hungary for the bright cheerfulness of his new home.

Pursuing his dream of studying engineering, Peter enrolled in Bard College in New York. The lure of abundant jobs with General Motors prompted him the move to Flint in 1957. His first job there was not with the automotive giant but as a bellboy at the Durant Hotel. Peter still held onto his dream and enrolled

that same year at the University of Detroit. He studied engineering in earnest and eventually graduated and became employed by General Motor. He worked as a design engineer for many years.

In 1963 Peter became a U.S. citizen and 1 year later he met and married his wife, Martha. They have three children, Dr. Stephanie Danner Paluda, Ava Danner, and Nicholas Danner.

Peter lived his life guided by the principles that family, community, education, and harmony of existence were of the utmost importance. His involvement with the International

Institute of Flint, the Rotary Club of Flint, the Boy Scouts, the Saginaw Valley Engineering Council, Holy Cross Hungarian Church of Detroit and Most Blessed Sacrament Church exemplified his beliefs. Out of his experience as a immigrant forty years ago came his compassion for those seeking a new life in this country.

Mr. Speaker, it is with great honor that I ask the House of Representatives to rise with me today and pay tribute to a great American, Peter Danner. He will be missed by his family, his friends and his community but his legacy lives on.