F I S C A L I M P A C T R E P O R T

SPONSOR SJCS **ORIGINAL DATE** 02/06/15 **LAST UPDATED** 03/17/15 **HB**

SHORT TITLE Assisted Outpatient Treatment Act **SB** 53/SJCS/aSFC/aSFI #1/aHHC

ANALYST Dunbar/Sallee/Daly

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY15	**FY16**		
	NFI See SFC Amendment		

(Parenthesis ( ) Indicate Expenditure Decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY16	FY17	FY18	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total	*Indeterminate	*Indeterminate	*Indeterminate	*Indeterminate	Recurring	General Fund

*Reference is made to AOC and HSD concerns in Fiscal Implications.

Relates to Appropriation in the General Appropriation Act

SOURCES OF INFORMATION

Responses Received From
SB53
Department of Health (DOH)
University of New Mexico (UNM)
Administrative Office of the Courts (AOC)
Attorney General (AG)

Responses received for CS/Senate Bill/53/SJCS
Human Services Department (HSD)
New Mexico Corrections Department (NMCD)
University of New Mexico (UNM)

SUMMARY

Synopsis of HHC Amendment

The House Health Committee amendment to the Senate Judiciary Committee substitute for

Senate Public Affairs Committee substitute for Senate Bill 53 amends the definition of assisted outpatient treatment to expressly include care coordination.

Synopsis of Senate Floor amendment # 1

The Senate Floor Amendment # 1 to CS/53/SJCS/SFC moves to insert a new Section 19. The section provides for a "Delayed Repeal" of Sections 1 through 15 of the act which are repealed on July 1,2020.

Synopsis of Senate Finance Committee amendment

The Senate Finance Committee Amendment to CS/53/SJCS moves to strike the appropriations.

Synopsis of SJCS Bill

CS/53/SJCS appropriates $275,000 from the general fund to AOC for FY16 to hire personnel and to conduct necessary training to compile and report data relating to court-ordered mental health treatment and proceedings to appoint treatment guardians as required by the Mental Health and Development Disabilities Code, and to contract for attorney services required by the Assisted Outpatient Treatment Act.

Additionally, CS/Senate Bill/53/SJCS appropriates $200,000 to the Behavioral Health Services Division of the Human Services Department for expenditures in FY 16 through 18 to contract with a state university for a study to evaluate the implementation and effectiveness of assisted outpatient treatment in New Mexico for the period of July 1, 2015 through December 31, 2017.

CS/Senate Bill/53/SJCS, modeled after Kendra's Law in New York State, creates the authority for a District Court judge in New Mexico to order people diagnosed with mental illnesses who meet certain criterion into mandatory "Assisted Outpatient Treatment" programs for up to one year. "Assisted Outpatient Treatment" is defined by the bill as categories of outpatient treatment ordered by a District Court which include: case management or assertive community treatment services; medication; periodic blood tests or urinalysis to determine compliance with prescribed medication; individual or group therapy; day or partial day programming activities; education and vocational training and activities; alcohol and substance abuse treatment and counseling; periodic blood tests or urinalysis to check for the presence of alcohol or illegal drugs in a patient with a history of substance abuse; supervision of living arrangements; and any other services prescribed to treat the patient's mental illness and assist the patient in living and functioning in the community, and to attempt to prevent a deterioration of the patient's mental or physical condition.

Of the above list, the only services a court must order are the case management or assertive community treatment services. Assertive Community Treatment Services is a new term defined in the bill as a team treatment approach designed to provide comprehensive community-based psychiatric treatment, rehabilitation and support to a person with a serious and persistent mental illness.

CS/Senate Bill/53/SJCS creates the Assisted Outpatient Treatment Act and provides for treatment proceedings. The Act provides for sequestration and confidentiality of records. CS/Senate Bill/53/SJCS amends the mental health and developmental disabilities code to require data

collection for certain proceedings.

CS/Senate Bill/53/SJCS creates a legal mechanism for the following people:

1) persons over 18 that live with an individual;
2) the parent or spouse of an individual;
3) the adult sibling or child of an individual;
4) the director of a hospital where an individual is hospitalized;
5) the director of a public or charitable organization, agency or home where an individual resides and is receiving mental health treatment;
6) a qualified professional who either supervises the treatment of or treats the respondent for one or more mental disorders or has supervised or treated the respondent for one or more mental disorders within the past forty-eight months
7) a surrogate decision- maker

A person may be ordered to participate in assisted outpatient treatment if the court finds clear evidence that the person:

- Is an adult with a primary diagnosis of mental illness;
- Has demonstrated a history of lack of compliance with treatment for a mental disorder that has:
    - at least twice within the last 48 months, been a significant factor in necessitating hospitalization or receipt of services in a forensic or other mental health unit of a correctional facility;
    - resulted in one or more acts of serious violent behavior toward self or others or threats of, attempts at, serious physical harm to self or others within the last 48 months; or
    - resulted in the person being hospitalized or incarcerated for six months or more and the person is to be discharged with the next thirty days or was discharged or released within the past 60 days.
- Is unwilling or unlikely as a result of mental illness to participate voluntarily in outpatient treatment;
- Is in need of assisted outpatient treatment as least restrictive appropriate alternative to prevent relapse or deterioration that would likely result in serious harm to the person or another person;
- Will likely benefit from treatment.

FISCAL IMPLICATIONS

HSD observes that CS/SB/53/SJCS:

- Does not make any appropriation to cover the cost of court-ordered services and is silent as to who would be responsible for the cost. Insurance or Medicaid may reimburse providers for some of the services, but the individual could still be responsible for the non-covered services (e.g. supervision of living arrangements) and any co-pays or deductibles

- Services discussed in section 7 related to treatment planning may not be either billable or medically or clinically necessary services reimbursable by existing fund sources. Many of the services listed as the types of services that can be court-ordered may be covered by Medicaid for those individuals that are enrolled. MCOs have restrictions on many non-formulary medications. Services listed in CS/SB/53/SJCS that are not covered in Medicaid benefits include case management, drug testing for illegal drug use, drug use for medication compliance, education and vocational services, and supervision of living arrangements. The Medicaid program is unable to estimate the cost to provide these services with the information currently available.

UNM comments that the implementation of Assisted Outpatient Treatment (AOT) would require dedicated resources from providers to assure access to needed services and compliance with treatment plans as mandated.

UNM notes that in Pima County Arizona (Tucson), which has extensive experience with AOT and a well-developed system of care. There are currently around 600 patients annually managed under this status. According to UNM, the number of patients in need of AOT services could approach this number over the long-term in Bernalillo County. However, unlike Arizona's law, this legislation would require more specific criteria for ordering AOT that could impact the number of people managed through this approach.

UNM suggests that in order to manage this population in Bernalillo County a dedicated treatment team consisting of community support workers, peer specialists, therapists, nursing and physician services be developed. In addition, it would be important for the team to have other resources that would allow for mobile crisis response for patients similar to those found with Assertive Community Treatment (ACT).

The following estimated budget was provided by UNM. The budget is for year one of the program, assumes a phased in AOT population with a maximum of 300 patients in year one. This model would need to be scaled going forward to account for growth in the program.

Table: Estimated Budget for Bernalillo County

Position	**FTE**	**Salary and Benefits**
Community Support Worker	10.0	$550,368
Peer Specialist	4.0	$165,739
Clinical Counselor/Clinical Social Worker	4.0	$282,522
Psychiatric RN	3.0	$238,309
Advanced Practice Provider (NP)	1.0	$126,000
Physician Provider	.25	$62,500
Total Staffing	22.25	**$1,425,438**
Vehicles and Fuel Year One (3 vehicles)		$67,200
Computers/Other Supplies/ Other Expenses		$106,000
Total Year One Estimated Budget		**$1,598,638**

AOT census: 300
Average cost per respondent (excluding vehicles and computers): $4,751

UNM budget was based on dedicated treatment team consisting of community support workers, peer specialists, therapists, nursing and physician services be developed. In addition, it would be important for the team to have other resources that would allow for mobile crisis response for patients similar to those found with Assertive Community Treatment (ACT).
However, the intention of this legislation was not to provide for a dedicated treatment team for this program. The legislation establishes court proceeding for the AOT program to be supported by current treatment providers. Therefore, an alternative budget is being provided, from a county in Texas with identifiable costs to the program. This budget is more comparable to the program that is being discussed in the presentation of this bill.

The following budget information was provided by Bexar County. The budget is for year one of the program,

Table: Bexar County Assisted Outpatient Treatment Program-Judge Oscar Kazem

Position	FTE	Salary and Benefits
Psychiatrist	.5	$126,190
RN	1.0	$76,975
Court Liaison	1.0	$50,372
BSW Discharge Caseworker	1.0	$42,904
Clinical Practitioner (caseload 1:18)	1.0	$50,372
Clinical Practitioner (caseload 1:18)	1.0	$50,372
Clinical Practitioner (caseload 1:18)	1.0	$50,372
Clinical Practitioner (caseload 1:18)	1.0	$50,372
Clinical Practitioner (caseload 1:18)	1.0	$50,372
Total Year One Estimated Budget		**$548,301**

AOT census: 90
Average cost per respondent: $6,092

It is anticipated that billings to Medicaid and other payer sources will cover the program costs.

The following information was received from Judge Oscar Kazen of Bexar County Texas.
After studying 100 participants there was a combined lifetime bed utilization of 67,301.

In the year prior to the court order

- Total admissions for the year prior to the court order: 164
- Total bed day utilizations: 8873

During the year of the court order

- Total admissions during the year of court order: 61
- Total bed day utilizations: 4577

During the year after the court order expired

- Total admissions after completion of the court order:38
- Total bed day utilizations: 3418

Agnes Zacarias, LPC, NCC is the Clinical Programs Director, Mental Health Outpatient and Specialty Court Programs for the Texas AOT program reports that a snapshot of 10 clients the hospital saved approximately $1.3 to $1.4 million in state hospital bed day dollars.

A New York State AOT program evaluation of June 30, 2009 notes that the probability of hospital admission was reduced from 14% to 11% per month during the first six months of AOT and to 9% during the 7 to 12 month period of AOT. Another evaluation published in the American Journal of Psychiatry (2013) noted significant net cost decreases of 43% in the first year and an additional 13% in the second year in the New York program.

These reports provide positive outcome data for the respective AOT programs and should be taken into account. However, information on program structure was not addressed and this is being noted.

However, CS/Senate Bill/53/SJCS requires that all respondents have legal counsel, but does not address how said counsel will be paid for their services. CS/Senate Bill/53/SJCS directs the administrative office of the courts (AOC) to "contract for attorney services" that CS/Senate Bill/53/SJCS requires. The AOC already administers a court appointed attorney fund for neglect and abuse cases, and its $4,000,000 budget for this fiscal year is forecasted to be deficient. According to AOC, the $275,000 appropriated in the bill will cover administrative and training costs, but would not be adequate to pay for attorneys. To the extent AOT prevents additional commitment proceedings due to successful respondent outcomes court costs could be avoided.

Court-ordered assisted outpatient treatment for certain probationers and parolees could help prevent these individuals from committing new crimes or otherwise violating their supervision conditions, preventing these individuals from having to be revoked by the Parole Board or sentencing judge and sent back to prison for violating their supervision conditions. Currently taxpayers pay approximately $30,000-$40,000 to incarcerate a felony in the NMCD. The NMCD provides through its Probation and Parole Division's budget some eligible services called for in the bill. Even though NMCD would not be a petitioner, some offenders under state supervision could fall under this legislation. The bill could thus increase utilization of NMCD behavioral health funding for these offenders should providers agree to participate in the treatment plan. NMCD has a set budget and is stretched over the number of offenders who need services. However, NMCD analysis did not make assumptions over how many offenders may managed under AOT.

Additionally, the New York State evaluation indicates that arrests in any given month were reduced from 3.7 % to 1.9% which supports the above statement.

In summary, general fund issues have been described by AOT and HSD, agencies are also concerned about services described in the AOT legislation that are not billable to Medicaid or other sources and the possibility of the unavailability of AOT services in rural communities. Another issue identified by agencies is the quality of service available in communities.

SIGNIFICANT ISSUES

UNM mentions that one of largest single issue impacting the implementation of AOT in New Mexico is the lack of provider resources in many areas of the state and the service gaps in needed levels of care. Over time the behavioral health infrastructure in New Mexico has degraded significantly, which has created significant challenges for behavioral health patients being able to access needed services. In order for AOT to work, patients must be able to access needed treatment services in a timely and efficient manner. Currently there are large infrastructure gaps in need levels of care for patients in Bernalillo County, and more so in other parts of New Mexico. In order for AOT to be successful it is equally as important for services be developed to meet the needs of patients.

NMCD also express concern that the lack of community services around the state would be a significant factor impacting this bill.

This concern is repeated by DOH by stating that the courts may only be able to initiate AOT for individuals that are already tied into a provider system, who have a payor source, who have interested parties in their life that can access the courts and who have treatment services available in their community; as such CS/SB/53/SJCS may not be equally accessible for all New Mexicans and perhaps the least accessible to individuals in rural areas of the state and / or those that are indigent.

DOH comments include the following:

- Some services allowed in an AOT order outlined under the definition of "assisted outpatient treatment" may not all be billable services, which could lessen or eliminate their availability or the practical application of this legislation. A study of the New York state AOT Program found that, to be successful in reducing inpatient hospitalization and reducing violence, an AOT program was dependent on the availability of high –quality services in the community. (Duke University School of Medicine Study, American Journal of Psychiatry, 2013)
- With an AOT order, there isn't a routine review of a person's capacity to make mental health treatment decisions built into the process as there is with civil commitment (See NMSA 43-1-11 F.). This review would be helpful to identify if the person has capacity to make decisions or if they need an alternate decision maker; as that would benefit further treatment and give context and information about their "voluntariness" and could ultimately assist in the provision of services given the need for informed consent.
- There is explicit language regarding the fact that medications cannot be forced, but language regarding no forced drug or alcohol testing might also be considered.

The following is a summary of sections of the bill and includes some comments from HSD in some sections.

<u>Section 2 includes:</u>

Includes definitions as used in the AOT

According to HSD, CS/SB/53/SJCS requires an evaluation of the respondent by a "qualified professional," defined on page 5 to include physicians, licensed psychologists, prescribing

psychologist, certified nurse practitioners or clinical nurse specialists with a mental health specialty, or physician assistants with a mental health specialty. Inexperience with the court and AOT processes among those groups might lead to confusion in the courts, so requiring additional training for the new responsibilities would be appropriate before participating. Expanding the category to include independently licensed mental health professionals would make services more accessible in some communities. Expanding that category would also make those professionals eligible to file petitions to order AOT, and that could improve the AOT process because those could be the most appropriate persons to file if they happen to be the only professionals who have treated the respondent within the past forty-eight months (as provided on page 8).

Many respondents might have co-morbid physical conditions or co-occurring substance abuse disorders, and the AOT process might function better in those cases if judges were allowed to order the participation of more than one qualified professionals in certain cases, to best address complex needs.

CS/SB/53/SJCS adds a definition of Least Restrictive Alternative that would not allow restraint of physical movement or involuntary residential care, except as reasonably necessary for the administration of treatment or protection of the patient (page 3 line 25). HSD states that generally, restraint and involuntary residential care are not included in outpatient services, and they are not allowed in federally regulated hospitals, nursing homes, or other facilities except to prevent imminent physical injury when other measures have failed. The bill language should be amended to make the allowed actions and restrictions on their use more explicit, according to HSD.

Section 3 includes:

Criteria defining when a person may be ordered to participate in AOT.

Section 4 includes:

Requirements for the petition itself including a requirement for a qualified professional to provide an affidavit along with the petition indicating they have personally examined the individual no more than ten days prior to the filing of the petition, the individual needs assisted outpatient treatment and the qualified professional can testify or that the qualified professional has made attempts to engage the individual in an assessment but has been unsuccessful.
By allowing categories of individuals to petition for an AOT order, HSD is concerned that protection from or review of potential conflicts of interest is not addressed, for example when the petitioner is a family member also involved in divorce or other asset disputes.

Section 5 requires

That the petition also be accompanied by a "qualified protective order" that allows for the sharing of protected health information about the respondent for the purposes of the petition and getting the respondent treatment.

Clarifying the protection of confidential protected health information throughout the process will protect the respondent from disclosure of information.

Section 6 establishes:

Hearing rights and procedures. The rights include notice and an opportunity to present evidence, and a hearing on the record. Of note is the establishment of a right to counsel at the hearing on the petition. If the respondent fails to appear, the court may proceed anyway if the respondents counsel is present. At a minimum, the court may not impose an order of assisted outpatient treatment unless there is a statement in evidence from a qualified professional who assessed the respondent within ten days of the filing of the petition. If the circumstance is that the respondent has refused to be assessed, the court may instead direct law enforcement to take the respondent into custody for the purposes of being assessed. Section 6 limits the time in custody to 24 hours.

Section 7 describes:

The treatment plans ordered by a court. The plan must account for any advanced directives, and must include input from the respondent, the treatment provider, anyone the respondent chooses to be there who is concerned with the respondent's welfare, and any guardian or treatment guardian involved with the respondent's care. Some components of the plan include:

- It must include case management services or "an assertive community treatment team,"
- It must include specific directions on any medication, e.g., whether they shall be self-administered or administered by an authorized professional,
- It may include substance abuse testing in appropriate cases, and
- In no event shall the plan recommend the use of physical for or restraints to administer medication to the respondent.

Section 8 requires:

That any disposition order be supported by clear and convincing evidence that the respondent meets all the criteria in Section 3. The treatment plan may be a maximum of one year in duration. The treatment plan may not include any components that were not recommended by the qualified professional or included in a recommended treatment plan. The plan also takes into account the decision of surrogate decision makers. The substitute adds language directing the court to follow an advance directive or directives of a surrogate with respect to treatment, unless there is good cause shown to order otherwise.

Although this section lists the type of services that may be included in the AOT court order, HSD notes it does not address the requirement that the services be evidence-based and culturally sensitive. It also requires the designated provider(s) to provide or arrange for all AOT during the period, but funding may not be available for that AOT, or some of the specified AOT services may become unavailable during the period. However, the order may be vacated or modified.

Section 9 establishes:

A right of expeditious appeal from the final order.

Section 10 makes clear:

Provides that an order requiring assisted outpatient treatment may not be considered an

adjudication of incompetence.

Section 11 authorizes:

The party or respondents surrogate decision-maker to petition for an extension of the order. The petition acts as a stay of the status quo – so that the respondent will continue to receive care pursuant to the existing order until the court disposition.

HSD remarks that although the bill allows extending AOT in one-year intervals, it does not provide explicit provision for re-evaluation or review of the treatment plan. Current Medicaid standards provide for plan review and revision at least every six months.

Section 12 authorizes:

The party or the respondent surrogate decision maker to apply for a stay of the order, or move to vacate, modify or enforce the order. Nonmaterial changes to the treatment plan may be made by the provider. The section authorizes the qualified professional to unilaterally suspend drug or alcohol testing after six months if appropriate.

Section 13 addresses:

The circumstances surrounding when a respondent refuses to comply with an assisted outpatient treatment plan. The qualified professional may conclude there is a failure to comply with the AOT plan and believes that respondents present a likelihood of serious harm to self or others. In such a circumstance, the qualified professional may initiate transport the respondent for emergency mental health evaluation.

A respondent's failure to comply does not constitute grounds for involuntary civil commitment, contempt of court or for use of physical force or restraints to administer medication to the respondent.

Section 14 creates:

A new provision regarding sequestration and confidentiality of records. The section expressly makes any protected health information involving the respondent confidential. A list of persons who may view the information is included in the section as well. The list includes court staff, law enforcement, surrogate decision makers, qualified professional, providers, and other persons indentified by the court as having a legitimate interest.

Section 15 tasks:

The division and the interagency behavioral health purchasing collaborative in consultation with the AOC to prepare educational and training materials to be made available by January 1, 2016.

Section 16 makes changes:

To the mental health and developmental disabilities code. It includes a new definition for "protected health information."

Section 17 makes it clear:

That protected health information may be disclosed when such disclosure is made pursuant to the AOT.

Section 18 creates:

New requirements for data reporting. Staff from each district court must report to the administrative office of the courts (AOC) how many petitions are filed for assisted outpatient treatment, involuntary commitment, extended commitment, and treatment guardianships, as well as dispositions. The AOC must then quarterly aggregate this data and report it to the department of health and the behavioral health purchasing collaborative. The section expressly allows this reporting to de-identify the information reported.

ADMINISTRATIVE IMPLICATIONS

According to AOC the courts will likely be able to administer these cases with existing resources. However, because they are relatively unique and contemplate continual monitoring, these cases will create some significant startup issues until judges and staff members become proficient with processing these cases. In particular, the Second Judicial District Court, which expects to see most of these cases statewide, and many of them immediately, has the capacity to process these cases but not the trained, experienced staff and judges to do so.

AOT will likely require increased administrative tracking and reporting activities to the court system. In addition, a care management infrastructure would need to be established to assure tracking and compliance with treatment plan requirement for AOT patients

According to HSD, Medicaid would have to change Centennial Care contracts and regulations to account for this new type of service and facilitate timely enrollment, to the extent possible. MCO's would have to adjust care coordination and utilization management processes to accommodate AOT. The bill appears to involve the existing service array.

To the extent that disputes arise between Medicaid-eligible patients and either the MCO's or Medical Assistance Division about coverage for court-ordered services, the HSD Fair Hearings Bureau would be responsible for providing administrative hearings regarding adverse actions, and the HSD Office of General Counsel would provide representation in hearings and appeals. There is no appropriation to HSD for these responsibilities.

Even though NMCD would not be a petitioner, some offenders under its supervision could be part of an AOT. In those cases, the NMCD would need clarification on if the offender eligible for AOT would remain under the authority and supervision of the assigned probation and parole officer, or is the supervision suspended, and the details of the suspension. If the supervision remains intact, to ensure public safety at what point would the officer be able to file a revocation report if the offender, who is on assisted outpatient treatment, violates or continues to violate his supervision conditions.

PERFORMANCE IMPLICATIONS

No direct implication for DOH; however, there would be an impact if DOH agrees to provide services for a person under AOT or if DOH chose to file a petition for a patient or client of our

facility or community based services.

TECHNICAL ISSUES

CS/Senate Bill/53/SJCS does not address the application of the AOT procedure in tribal communities, nor does it provide an exemption.

There is a reference to court appointed special advocates and it is unclear what role they would play in the AOT process because they are only mentioned in Section 14 (page 22, line 12).

OTHER SUBSTANTIVE ISSUES

Other issues raised by DOH are as follows:

> There could be constitutional issues with the fact that testimony by the qualified provider would be allowed by video or other method. There have been challenges to such processes in the criminal realm as a violation of the confrontation clause. These hearings of course could result in compromise to a person's civil liberties due to detention for assessment; therefore the individual and their counsel's ability to confront that witness may critical to due process.
>
> All court findings in support of an initial order for AOT should be explicitly required for any subsequent orders for AOT to avoid creating different criteria for initial and subsequent orders for AOT. Subsequent petitions might further be required to include an updated treatment plan which outlines the treatment that will be provided in the timeframe of the new order; consistent with 43-1-12 (which addresses subsequent orders for inpatient commitment).
>
> CS/SB/53/SJCS has been described as an enabling statute that would allow courts to opt in or out but nothing in the bill actually spells that option out, according to DOH analysis. The bill as written creates a cause of action that could be filed in any judicial district in New Mexico if passed, as such, wherever the matter was filed the courts would have to hear and otherwise dispose of the petition. There is a requirement for testimony on the subject of availability of resources, but there is no indication of a remedy if the services are not available in that community or for that individual.

However, if services are not available then it appears AOT would not be a viable options in those cases.

HSD is concerned that CS/SB/53/SJCS does not require the Court to ensure that individuals addicted to drugs (opioids) will have the right to access medication-assisted treatments. Section 13 (page 20) permits requiring the individual to be taken into custody for emergency evaluation if a qualified professional determines that a respondent fails to materially comply with treatment. HSD raises concerns over individuals with co-occurring behavioral health diagnosis that could, after failing just one test, face severe consequences due to the nature of addiction, that severe consequence for one event might be clinically counter-productive. However, the bill requires the qualified professional to certify the need for detention and transport of the respondent for emergency mental health evaluation and care pursuant to the provisions of Paragraph (4) of Subsection A of Section 43-1-10 NMSA 1978.

ALTERNATIVES:

DOH offers the following alternative:

Develop a more robust community provider system, including housing options and treatment guardians and utilize laws currently on the books to better effectuate care such as 43-1-15 and the related enforcement orders and 43-1-21 for continuity of care from inpatient to outpatient status.

BD/bb/aml