

## Safety Net 2004 Access Report

### Adult Services Access

#### *Introduction*

Forty-seven boards submitted data in 2004 on adult access to state and community hospitals, intensive and routine clinical services, housing and other support services, and staff caseloads. For the purpose of this report, a denominator of 50 boards will be used. Access information will be reported on *gaps* in the clinical service array, *wait times* for clinical services, wait times for housing services and *capacity to meet demand* for other support services, and psychiatric and CSP worker *caseload size*.

#### *Gaps in Clinical Service Array*

**Over one-third (N=19) of boards do not have a contract for inpatient care at a community hospital.**

- ✓ Six boards (two urban, four rural) without contracts also report there are no indigent beds available at community hospitals with psychiatric units.

Reasons for this lack of access include refusal of some hospital psychiatric units to accept consumers with serious, persistent mental illness and fewer hospitals with psychiatric units in the community.

- ✓ Among boards (N=26) with contracts for community hospital beds, about one-fourth (N=7) report a growing problem with access due to inpatient use by consumers from boards without contracts and/or without psychiatric beds in the community.

Because of fewer psychiatric beds at community hospitals, about 30% (N=15) of boards report increased use of state psychiatric beds for acute, short-term care. Slightly fewer than half the boards (N=21) expect their use of BHO beds to remain the same in the next 12 months.

**Consumers living in 23 counties (13 board areas) cannot access beds at a crisis care facility or at a community hospital emergency room because crisis bed care is not available.**

- ✓ In eight board areas, there is no crisis bed care and no community hospital emergency room services available.

**In three board areas there is no crisis bed care, no hospital ER services, and no 24/7 on-call psychiatrists available.** Although an on-call psychiatrist is available 24/7 in 39 board areas, the number of boards where this is the case has decreased by 10% in the last two years. Six boards report access to the on-call psychiatrist takes longer than two hours.

*Wait Times for Clinical Services*

**In the past two years, there has been a four-fold increase in the number of boards where consumers must wait longer than two weeks to access ACT services.** Because ACT is a service designed for the most seriously disabled people, a wait greater than two weeks has enormous implications. In addition, in the nine board areas that offer intensive CSP in combination with intensive psychiatric service, half report wait times greater than two weeks.

- ✓ The typical wait time for both forms of intensive service (ACT & CSP/Psychiatry) is three weeks.

**In the past two years, there has been a significant increase in the number of boards where consumers must wait longer than two weeks to access routine outpatient care.**

- ✓ Typical wait time for CSP is now three weeks in most board areas—an average increase of five days since 2002.
- ✓ Typical wait time for diagnostic assessment is three to four weeks in the majority of areas throughout the state.
- ✓ Typical wait time for psychiatric service is five to eight weeks in the majority of areas.
- ✓ Typical wait time for counseling is four to five weeks in just under half of board areas.

*Gaps in Housing Services and Wait Times*

**Thousands of Ohio citizens with serious, persistent mental illness cannot access housing and related support services.** Long wait lists are widespread in three major housing access programs.

- ✓ Eight boards report supported housing services are not available to consumers in their area.
- ✓ Among boards with supported housing services, the majority report wait lists with a three to six-month wait time for service. An estimated 2,400 consumers currently are waiting.
- ✓ Boards estimate approximately 11,700 Ohio citizens with serious, persistent mental illness (SPMI) are homeless.

- ✓ In most of Ohio, persons with SPMI wait over one year to access public housing. Boards estimate approximately 4,700 Ohio citizens with SPMI are waiting for public housing.
- ✓ Approximately 2,150 persons with SMPI are waiting to access the Department's Housing Assistance Program (HAP). In about half of the board areas, these consumers will wait six months or longer.

### Other Support Services

**Demand for the following support services has increased, but capacity of most boards to meet demand has not:**

- ✓ Integrated Dual-Diagnosis Treatment
- ✓ Supported Employment
- ✓ Transportation
- ✓ Anger Management/Domestic Violence Programs
- ✓ Consumer and Family Psycho-education
- ✓ Peer Support
- ✓ Elderly Services

### *Staff Caseloads*

**Psychiatric caseloads have increased between 16% to 25% in the past two years.**

- ✓ Depending on the severity of patient need, psychiatric caseloads range between 1:300 and 1:525. With caseloads in excess of 500 patients, the psychiatrist who works at 65% productivity will average only 15 minutes of face-to-face contact with each patient over a period of 30 working days (6 weeks). This leaves just 35% of the doctor's time for additional individual contact (if the patient needs more than 15 minutes), administrative responsibilities such as clinical record keeping, inter-professional staff communication regarding patient care, and clinical case reviews for quality assurance purposes.

**CSP caseloads for the consumers with the most intense needs have increased in the past two years.**

- ✓ CSP caseloads serving the most acute consumers have increased by as much as 27%. Caseloads for the most-in-need currently range between 17 and 27 consumers per CSP worker. Recommended caseloads for most-in-need are 1:14.

## Child & Adolescent Access

### *Introduction*

Forty-seven boards submitted data in 2004 on child and adolescent access to state and community hospitals, intensive and routine clinical services, housing and other support services, and staff caseloads. For the purpose of this report, a denominator of 50 boards will be used. Access information will be reported on *gaps* in the clinical service array, *wait times* for services, psychiatric, counselor, and case manager *caseload size*, and *capacity to meet cross-system demand* for services.

### *Gaps in Clinical Service Array*

**There are widespread gaps in acute care bed capacity.** “Acute care bed capacity” is defined as out-of-home care occurring in the following settings: 1) psychiatric hospitals, 2) crisis stabilization units, 3) residential treatment centers, 4) respite foster care. Acute care is distinct from residential treatment inasmuch as acute care is short-term (23 hours to two weeks) treatment aimed at symptom reduction. Crisis care at a stabilization unit is a form of acute care that it is shorter term (23 hours to 48 hours). The child may be placed outside the natural or foster home for a short time, but not outside the community.

- ✓ Forty-seven percent of boards (23/50) report they do not have a contract for child and adolescent hospital beds in the community. The board’s geographic type is not a significant factor. All boards—urban, metro-urban, trans-urban, trans-rural, and rural—are equally affected by lack of contract access to hospital beds in the community.
- ✓ Children under 13 are the single largest group in need of beds for whom hospital care is not currently available. Forty-five percent of boards (22/50) report that age is a factor limiting access to community hospital beds.
- ✓ Thirty percent of boards (15/50) report that it takes longer than one hour driving time to access admission to a hospital bed. This access issue is significant for all board types except urban and metro-urban.
- ✓ Sixty percent of boards (30/50) report there are no crisis care beds available at a facility in the community. This is a significant capacity gap for all board types except urban.
- ✓ Thirty-four percent of boards (17/50) report there are not emergency room services available at a community hospital for children and adolescent in psychiatric crisis. Fourteen of those boards do not have any crisis care beds available in the community. This capacity gap impacts all board types except urban.

**Acute care capacity gaps in the community affect the utilization of residential treatment centers outside the community.** Residential treatment centers (RTC) that provide crisis and/or acute care beds are predominantly located in urban board areas. All boards without acute care beds are non-urban.

- ✓ Thirty percent of boards (15/50) that do not have a contract for hospital beds report there are also no crisis beds available in the community.
- ✓ Fifty percent (25/50) report an out-of-county placement for all children & adolescents who are served in residential treatment centers (RTC). Of the 25 boards that make all RTC placements with out-of-county providers, 18 do not have crisis beds and 10 do not have crisis OR acute care beds available in the community.
- ✓ Fifty-eight percent (29/50) report there are not enough beds available in residential treatment centers to meet demand. Of the 29 boards reporting insufficient RTC bed capacity, 20 do not have crisis beds and 10 do not have crisis OR acute care beds available in the community.
- ✓ Fifty-two percent (26/50) report that demand for RTC beds is increasing. Of the 26 boards that report increasing demand, 21 do not have crisis beds and 10 do not have any acute care beds available in the community. The lack of crisis care and intensive community based services contributes to the increased demand for RTC; one-third of boards (N=16) stated that lack of intensive community and home-based services contributed “quite a lot” to the need for out-of-home and out-of-county RTC placements.
- ✓ Three boards report there are no intensive services available. Intensive services missing in this array include acute and crisis care, community-based partial hospitalization, IHCBS, and treatment foster care.

#### *Wait Times for Clinical Services*

**Lengthy waits impact access to intensive outpatient services.** Types of intensive services affected by lengthy waits are Intensive Home & Community Based Service (IHCBS), intensive case management with psychiatric support, treatment foster care, and community-based Partial Hospitalization (PH).

- ✓ Forty-two percent of boards (21/50) report a wait length greater than 11 working days for IHCBS, with the median wait being 30 days. Seven boards reported an average wait of 15 days, seven reported an average wait of 30 days, and seven report that consumers wait from 45 to 90+ working days for this intensive service.

(More boards are providing IHCBS in 2004 than in 2002. Twenty-nine boards currently provide IHCBS; in 2002 the number was 16.)

- ✓ Fifty-eight percent (29/50) report the availability of intensive CSP with some level of psychiatric support. Of these, 21 boards report a wait length of 11 working days or more. Eight boards report a three week wait for services; four report a four week wait; six report a six week wait; one reports a nine week wait; and two report that consumers wait up to three months for this intensive service.
- ✓ Wait length for intensive psychiatric care at 10 boards providing this service ranges from a minimum three weeks to three months. Median wait is five weeks.

**In 12 board areas with treatment foster care, children and adolescents wait over two weeks for a placement.** Treatment foster care is available in 30 board areas.

**School-based partial hospitalization programs have wait lengths greater than two weeks in one-half of all boards offering the service.**

Partial Hospitalization (PH Type I) is brief, time-limited acute care treatment aimed at preventing out-of-home placement at an RTC or hospital. It can also be used as a “step down” from residential or hospital care prior to discharge. Nine board areas offer this type of PH. In one-third of those boards (3/9), wait lengths exceed 11 working days.

PH Type II (also known as “school-based day treatment”) is a longer term intensive treatment aimed at preventing school suspension or failure due to a psychiatric condition. Sixteen boards areas offer this type of PH. In slightly over half of those boards (9/16), wait lengths exceed 11 working days.

PH Type III (a three-hour block of treatment outside of instructional time that can occur two to five times weekly) is offered in nine board areas. In about half of those boards (4/9), wait lengths exceed 11 working days.

**There has been a 70% increase in the number of boards where access to routine outpatient services exceeds 10 working days.** In 2004, 32 boards (two-thirds) reported average wait lengths greater than two weeks for access to routine outpatient services. In 2002, less than a quarter (23 boards) reported average wait lengths greater than two weeks. In board areas with wait lengths greater than two weeks, access time for diagnostic assessment, psychiatry, counseling, and case management in 2004 are as follows:

| <i>Service</i>        | <i>Median Wait</i> | <i>Range</i>  |
|-----------------------|--------------------|---------------|
| Diagnostic Assessment | 4 weeks            | 3 to 18 weeks |
| Psychiatry            | 9 weeks            | 1 to 5 months |
| Counseling            | 4 weeks            | 3 to 18 weeks |
| CSP                   | 4 weeks            | 3 to 18 weeks |

### *Staff Caseloads*

Average caseloads for psychiatric, counseling, and case management staff is a measure of service access inasmuch as it impacts availability and quality of clinical care.

- ✓ Psychiatric caseloads for the most acute patients are currently three times the recommended threshold of 100 patients per doctor. Psychiatric caseloads are five times the recommended threshold for quality care to the general outpatient population. These ratios have not changed since 2002.
- ✓ Caseloads for child therapists working with the most acute child & adolescent consumers average fifty patients per clinician (1:50). Assuming 65% of the clinician's monthly workweek involves face-to-face contact, therapists average 128 minutes in direct monthly contact with each patient per month. For the most acute patients, 240 minutes per month is the expected minimum dosage. Current caseloads allow for approximately half the expected treatment dosage.
- ✓ Current CSP caseloads for the most acute consumers are more than three times the recommended threshold of 12 patients per case manager. For general outpatient care, CSP caseloads are 66% larger than the recommended threshold of 35 patients per case manager.
- ✓ In 2002, 14 boards reported the availability of advanced nurse practitioners with prescriptive authority. In 2004, only nine boards reporting having advanced nurse practitioners available.

### Gaps in Service Array Related to Staffing

**Urban boards report significantly more child and adolescent services than the other four demographic groups of boards.**

- ✓ There is no correlation between levy resources and number of services available to children and adolescents. A statewide capacity gap in child & adolescent clinicians available for hire may account for the lack of a relationship between levy resources and size of service array.

### *Demand for Service from Other Child-Serving Systems*

**Boards have reported increased demand for services from Juvenile Courts, Child Welfare, and Schools since 2001.** For the past four years boards have also reported they are unable to meet increased demands for services from other child-serving systems

- ✓ For the past four years, over 80 percent of boards report increased demand from Juvenile Courts, Child Welfare, and Schools, and 60 percent say they cannot meet the mental health service needs of these other child-serving systems.
- ✓ The most “in demand” services from other child-serving systems are intensive treatment programs (e.g., IHCBS, residential treatment, treatment foster care, partial hospitalization) and diagnostic assessment.

**APPENDIX**  
**Boards by Demographic Type**

**RURAL BOARDS:**

ATHENS-HOCKING-VINTON  
BELMONT-HARRISON-MONROE  
GALLIA-JACKSON-MEIGS  
COSHOCTON-GUERNSEY-MORGAN-MUSKINGUM-NOBLE-PERRY  
PUTNAM  
VAN WERT-MERCER-PAULDING

**TRANS-RURAL BOARDS:**

ASHLAND  
ASHTABULA  
BROWN  
DEFIANCE-FULTON-HENRY-WILLIAMS\*  
HANCOCK  
HURON  
LOGAN-CHAMPAIGN  
MEDINA  
MIAMI-DARKE-SHELBY  
PICKAWAY-FAYETTE-HIGHLAND-PIKE-ROSS  
PREBLE  
SCIOTO-ADAMS-LAWRENCE  
SENECA-SANDUSKY-WYANDOT  
TUSCARAWAS-CARROLL  
UNION  
WASHINGTON  
WAYNE-HOLMES

**TRANS-METRO BOARDS:**

ALLEN-AUGIAIZE-HARD  
CLARK-GREENE-MADISON  
COLUMBIANA  
DELAWARE-MORROW  
ERIE-OTTAWA  
FAIRFIELD  
GEAUGA  
JEFFERSON  
KNOX-LICKING  
RICHLAND  
WARREN-CLINTON  
WOOD\*

**METRO-URBAN BOARDS:**

BUTLER  
CLERMONT  
LORAIN  
MAHONING  
MARION-CRAWFORD  
PORTAGE  
STARK  
TRUMBULL

**URBAN BOARDS:**

CUYAHOGA  
FRANKLIN  
HAMILTON  
LAKE\*  
LUCAS  
MONTGOMERY  
SUMMIT

\*Board did not provide Safety Net data in 2004.