

**2002 Safety Net Survey
Report of Major Findings
With Policy Implications**



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Description of Sample

Forty-seven boards responded to the 2002 Safety Net Survey, although one of these surveys was only 33% complete. Respondents included nine urban, 22 rural, and 16 mixed urban/rural boards (see endnote). Surveys came from 12 Central, 9 Northeast, 11 Northwest, 8 Southeast, and 8 Southwest regional boards.

I. Adult Services

A. Hospitalization

More than 50% of boards reported that admission criteria (N=27), reimbursement (N=26), and unit capacity (N=25) were the access issues for consumers seeking admission to community hospitals. Slightly less than half the boards (N=22) cited budgeted bed days as a significant access issue for consumers seeking admission to the state hospitals. Prominent among outliers, a handful of boards described the impact of local jails using state hospitals as a consequence of Medicaid rules that exclude incarcerated consumers from benefits. The likelihood of community hospitalization is greatly reduced as a consequence of Medicaid exclusionary criteria. Others mentioned the problem of out-of-state and transient clients as presenting additional access issues for Ohio consumers. While concerns expressed by these boards currently represent a small impact on total bed days, the use of state hospitals by local jail systems and transient populations may become significant variables over time.

Boards said admissions to psychiatric units at community hospitals were generally limited to short-term, acute-care cases of less than ten days for non-indigent consumers who did not have co-existing medical conditions, were not chronic, homeless, dually-diagnosed, or behavioral problems. Like other boards that had lost community inpatient units, one respondent reported “private hospital rejection of SMD admissions, increased admission time at out-of-area hospitals, poor coordination of clinical care, increased transportation time and costs, including unbillable time for case managers.” When asked about the potential impact of a state hospital closure, one rural board observed that local clients “would not have adequate access in vying for inpatient beds located in other parts of the state. Transportation would be a major

concern as the distance would be greater. Many Sheriff's Departments will not transport more than one county away. The increased cost for transportation alone would take up program dollars for direct services.”

B. Crisis Care

When asked about the potential loss of community hospital psychiatric units, one rural board noted that “crisis beds would be essential and need to be board-based facilities.” Thirty-eight (81%) described centralized access to crisis services through a phone line, although several also described the existing service as “inadequate.” Ten boards cited staffing shortages as a major factor limiting access to crisis care, with three boards specifically concerned about a lack of 24/7 access to medications.

While 13 boards reported the availability of mobile crisis units, ten boards—primarily rural and mixed urban/rural—specifically mentioned a lack of or limited coverage by mobile units as a significant access gap. Twenty-one boards (45%) mentioned contracts, collaboration, and dependence on local hospital emergency rooms for crisis care. At the same time, 18 boards (38%) described a lack or limited capacity of crisis beds as alternatives to inpatient hospitalization.

C. Intensive Care

Six boards reported PACT availability. Of these six, three reported wait lists, with two involving waits greater than ten working days. Sixteen boards reported ACT availability. Of these, five reported wait lists, with two involving waits longer than ten working days. Twenty-six boards reported day treatment or partial hospitalization. Of these, five reported wait lists, with two involving more than ten working days.

Sixty-eight percent (N=32) reported psychiatric wait lists for intensive clients, with a mean wait time of 40 days and a range of 7 to 90 days. Thirty percent (N=14) reported wait lists for intensive case management, with a mean wait period of 45 days within a range of 11 to 180 days.

D. General Care

Thirty-eight boards (81%) reported wait lists for general care psychiatry, with 35 reporting wait periods longer than ten working days. Twenty-seven boards (57%) reported wait lists for general care counseling, with 18 of these reporting periods longer than ten working days. Twenty-four boards (51%) reported wait lists for diagnostic services, with 16 of these reporting wait periods longer than ten working days. Eighteen out of 45 boards reported wait lists for case management for low intensity consumers, with nine of these reporting wait periods greater than ten working days. (Two boards do not offer case management services to general care consumers.)

E. Housing

Two broad categories of housing were measured as “staff supervised” under the survey section on Adult Intensive Care and as “subsidized” under the section on Adult General Care. The survey did not provide definitions of the two terms, and the two measures of housing were intended as gross indicators of unmet need for consumers at the two categories of service intensity. Information about housing wait lists does not reflect the status of consumers while on the lists, e.g., hospitalized, homeless, inadequate housing, etc. In addition, information about wait lists does not reflect whether consumers are waiting for housing units or subsidies.

Under the section on Adult Intensive Care Services, 36 boards (77%) reported the availability of “staff supervised housing.” This category could be interpreted to mean housing with resident managers, or housing with paraprofessional but non-clinical staff, or housing with clinical staff. Of the 36 boards that reported “staff supervised housing” for intensive care consumers, 26 indicated wait lists, with 22 involving waits longer than ten working days.

Also under the open-ended section on Intensive Care Services, 31 boards provided information about wait lists for “subsidized housing.” Inasmuch as this information was volunteered as a response to an open-ended question about wait lists for “other

services” provided to intensive care consumers, it differed from the check-box question about the availability of such housing for consumers in the General Care category. Data provided in connection with the “subsidized housing” term were interpreted to mean waiting for board, ODMH (HAP) or federally subsidized housing units or vouchers. Within the group of 26 boards that volunteered information on subsidized housing for intensive care consumers, wait lengths ranged from 10 to 548 days¹. Twenty-two (85%) of these boards reported estimates within a low-high range of 10 to 180 days. The respective mean, median, and modal wait times for these 22 boards was 87 days, 60 & 60 days. When the four outlier boards were entered into the analysis, the mean, median and modal wait times were 144 days, 90 days, and 60 days respectively.

Under the survey section on Adult General Care Services, 43 boards (94%) reported the availability of “subsidized housing.” As previously noted, data provided in response to this category could have meant availability of board, ODMH (HAP) or federally subsidized housing units or vouchers. Thirty-one boards (66%) reported wait lists for subsidized housing for non-intensive consumers, with 27 reporting wait periods longer than ten working days. Among urban boards, average wait times for housing is 135 days; among rural, average wait times are 270 days; among mixed urban/rural boards, average wait times are 145 days.

Housing Assistance Program (HAP) data suggest a significant increase in the number of households facing unmet housing needs. In FY01, boards reported an unmet need of 10,788 households, a 47% increase over the number of households waiting for HAP assistance in FY00. However, among the 5,075 households who received HAP assistance in FY02, data show that 36% have moved off of 508-H assistance and are no longer dependent on the mental health system for housing.

¹ Several boards provided variable range estimates, such as “90 to 730 days.” 730 days (2 years) was the upper limit of the variable range estimates. Median points in range estimates were used for data analysis. For example, a range estimate of 90 to 730 days was entered as “410”. There were four outlier boards (two rural, one urban, and one mixed rural/urban) that reported range estimates with medians equal to or greater than 410.

F. Adult Services Policy Implications

1) Continuity of Care

When boards were asked about the potential impact of a state hospital closure, continuity of care emerged as a major area of concern. Although state hospital closures were avoided with passage of HB405, community psychiatric unit closures and limited access to existing units draw attention to the role of community hospitals as short-term stabilization facilities. More than half the boards reported wait times longer than two weeks for core services to adult consumers. A significant proportion of boards currently depend on community hospital emergency rooms for psychiatric crisis care. Given average psychiatric and case management wait lists that exceed one month, service coordination with local hospital emergency rooms and inpatient units is difficult but essential if consumers are to be kept from slipping through potentially fatal holes in the safety net.

2) Housing

Gross measures of unmet need such as housing wait lists for intensive and general care consumers may be used for advocacy purposes, but lack the refinement necessary for specific kinds of policy decisions. ODMH Program and Policy staff has developed housing performance measures for this purpose. These measures, which were piloted in 13 board areas during FY00-01 and implemented with all 50 boards in FY 02, track such things as numbers of households with at least one person with serious and persistent mental illness which move off dependency on the state mental health system for housing subsidies; and, achievement of economic independence such as home ownership and employment income sufficient to cover housing costs. The measures also track costs of housing and measure improvements in cost efficiency and numbers of people served with level funding.

Analysis of mid-year data shows a great deal of variation from board to board in how much a consumer receiving HAP assistance pays out of pocket. This variation in administrative efficiency may be reduced as boards become better versed in housing finance best practices as well as federal housing regulations and policy implications.

It is important to inform advocates about wait lists for housing, but it is also important to show how boards are maximizing their use of existing resources.

II. Child & Adolescent Services

A. Hospitalization

Twenty-two boards (47%) reported community hospital psychiatric inpatient units within a half hour drive of their service area. Less than half (N=41) of Ohio's 88 counties appear to have regional access to child and adolescent (C&A) psychiatric hospitalization. Twenty-two boards estimated the number of community hospital psychiatric beds with a half-hour commute at 466. Because this estimate is fairly close to the total number of licensed C&A psychiatric beds of 501, board perceptions of service system resources appear to be reliable. The official count of licensed beds may be an inflated number, as it does not reflect the number of beds that hospitals actually make available to the community.

More than half of all boards listed distance (N=27) and transportation (N=24) as an access barrier to inpatient treatment. More than half (N=26) also listed reimbursement as a barrier to inpatient care. Twenty-four boards also cited unit capacity as an access barrier.

Boards noted that lack of access often "causes the condition to escalate and complicate treatment. With all hospitals over an hour away, there is a lack of coordination of care with discharge planning back to the community. Many kids go unserved." Reimbursement issues result in lengths of stay that are too short to adequately stabilize young consumers. Given the inpatient access issues, many young people who pose a danger to self or others "end up in detention centers when they need hospitalization, or parents keep them home under unsafe conditions."

B. Crisis Care

In general, descriptions of child and adolescent (C&A) crisis care systems were less elaborate and detailed than descriptions of adult crisis care systems. Given the assumption that C&A crisis care involves types of interventions and a range of providers different than those in the adult system, it is a concern that eight boards described C&A crisis care by stating “same as with adults.” The tension between the competing resource demands of the adult and C&A crisis systems was more explicit in the remarks of a multi-county rural board, which described its 24/7 phone access as under-funded and inadequate. “Kids in need of crisis care have substantially increased demands on resources. Their needs are more complex, expensive, and there are not many options. We use considerable time dealing with kids' issues, which impacts resources available to adults.”

Thirty-six boards reported centralized access to crisis care through a phone line, while 21 (46%) noted the lack or limited availability of crisis beds. As one rural board stated, “short-term crisis and respite facilities for children and adolescents are nonexistent.” Rural, mixed and urban boards all concurred that “a limited number of licensed staff (are) available for crisis intervention.” Among nine boards describing gaps in centralized access to a system of crisis care, one commented on “the lack of resources (that) strains our partners—police, hospitals, and schools—in attempts to deal with increased demand.”

C. Intensive Care

On the whole, there were more missing data on C&A services than adult services, with one board dropping out of the analysis due to incomplete information. From a total of 46 boards, 29 (58%) reported the availability of partial hospitalization or residential treatment within their service area². Seventeen boards reported wait lists, with 14 reporting wait times longer than ten working days. Day treatment is available in nineteen board areas (43%), with eight boards reporting wait lists, seven of which reported wait times greater than ten working days.

² More detailed information available through the Board Association Child & Adolescent Services Survey indicates that clients in 10 board areas (22% of the sample) have access to school-based partial hospital programs located within the service area.

Ten boards reported the availability of MST, among whom five had waiting lists. Two boards' wait lists were longer than ten working days. By contrast, thirty-six boards (78%) said intensive home-based care was available in the service area. Twenty-one of these boards reported wait lists, with 14 reporting wait times greater than ten working days.

Although community-based intensive care housing options are not widely available for C&A consumers, six boards reported wait lists of 10-180 days for transitional living arrangements. Eleven boards reported 10-540 day waits for treatment foster care, and three reported minimum 10 day waits for respite care.

D. General Care

Thirty-nine out of 44 boards (89%) reported wait lists for psychiatry. Ninety-five percent of the 39 reporting boards indicated wait times greater than ten working days. The wait time range was 10 to 180 days, with a mean of 45 days. Sixty-five percent (29/45) of boards reported wait lists for diagnostic assessment, with 14 indicating wait times greater than ten working days.

Fifty-two percent (23/44) reported wait lists for case management, with 14 indicating wait periods greater than ten working days. Seventy-three percent (33/45) reported wait lists for counseling, with 20 indicating wait periods greater than ten working days. Fifty-two percent (24/46) reported wait lists for family counseling or psychoeducation, with 14 indicating wait periods greater than ten working days.

E. Cross-System Issues

1) Schools

Ninety-one percent of boards (42/46) said they had school-based *assessment and referral* services. Among the four boards (three rural and one mixed urban/rural) reporting the lack of school-based referral, three indicated that contract agencies worked extensively with local schools but did not have the resources to do formal,

on-site assessments. In a survey distributed under the auspices of the Board Association Child & Adolescent Services Committee in which measurement of assessment and referral were measured separately, 24 of 45 boards (53%) reported the availability of on-site assessment services in schools. While most boards appear to have a mechanism for school-based referrals, it appears they do not all have the capacity for on-site diagnostic assessment. This limitation appears to be a capacity issue primarily among rural and mixed urban/rural boards.

Fourteen boards reported wait lists for school-based assessment and referral. Proportionately, there were more mixed rural/urban boards (6/16 or 38%) reporting wait lists than rural (5/21 or 24%) or urban (3/9 or 33%) boards. The three urban boards with wait lists reported wait periods greater than ten working days, as did two of the mixed rural/urban boards and one of the rural boards.

Eighty-nine percent of boards (41/46) said that the schools' demand for services was increasing. Among these, 72% (33/46) said they were not able to meet the schools' demand for mental health services. "There has been a dramatic increase in referrals since Columbine," said one rural board. The need for greater collaboration between schools and mental health providers was the most frequently cited reason for the gap between demand for services and boards' ability to meet demand. In fact, eleven boards specifically mentioned the goal of increased partnering with schools. However, boards also said it was difficult to negotiate contracts with schools because services and referrals often are not Medicaid reimbursable. Some boards noted that schools with funding earmarked for mental health intervention services often choose to hire their own staff rather than contract with agencies.

Among 40 boards that described prevention activities, 65% (N=26) discussed school-based programs in some detail³. These programs run the gamut from physical violence and sexual assault prevention to life skills training, peer support and mentor-

³ In the Board Association C&A Services Survey, 90% of boards (40/45) reported Consultation, Education and Prevention (CE&P) programming to local schools.

ing, suicide prevention, and truancy prevention with at-risk children. Nearly all boards with school-based prevention programs were considering cutbacks if additional funding is not available.

2) Juvenile Justice

Seventy-six percent (35/46) of boards said they had court-based services, with 12 reporting wait lists, four of which involved wait times greater than ten working days.

Ninety-one percent (42/46) of boards said there was increased demand for mental health services from juvenile justice system, but 70% (32/46) also said they were not able to meet that demand. In addition to funding limitations, boards primarily attributed the service gap to a lack of trained staff and a limited range of treatment settings and programs that could meet the treatment needs of younger and more seriously disturbed children⁴. As one rural board noted, “It is difficult to recruit specialists in home-based care and sex offending.” Eleven boards specifically stated a goal of increasing their alliance with juvenile justice systems.

3) Public Children’s Service Agencies

Eighty-five percent of boards (39/46) reported increased demand for services from PCSAs, and 72% (33/46) said they could not meet this increased demand. As with referrals from Juvenile Justice, PCSA referrals are also perceived as involving increasing numbers of “younger, sicker” children needing a range of intensive care options for which there is not a community-based infrastructure. When identifying the intensive service needs of consumers from PCSA referrals, boards frequently mentioned the necessity of a level of care system to triage care and manage limited resources. One mixed urban/rural board stated that they “sometimes have resources, but not needed staff or the funding to attract such staff.”

⁴ Analysis of 2001 MACSIS data indicates approximately 13 percent of C&A consumers have a diagnosis in the conduct disorders category. While diagnoses in this category do not directly measure involvement with Juvenile Justice, it suggests a proportion of consumers with high probability of justice system involvement.

F. C&A Services Policy Implications

Relatively few boards described comprehensive, community-based C&A service systems that were on par with descriptions of their adult service systems. The lack of a service system infrastructure touches all aspects of C&A mental health and support services delivery—from hospitalization to crisis, intensive and general care. While the lack of a cohesive mental health system for children has become a crisis, development of a child and adolescent system of care cannot come at the expense of the adult system infrastructure.

Reasons for the disparity between the adult and C&A systems of care are multifaceted, including (but not limited to) historic funding gaps, lack of strong coordination on cross-system and interagency issues, and weak advocacy for community-based care. These problems are further compounded by social factors (e.g., poor parenting, child abuse, school drop-out and expulsions) that have produced “younger, sicker” children and adolescents in need of intensive services as well as increasing pressure to provide treatment to children and adolescents with antisocial behavior problems as opposed to young people with Axis II mental illnesses.

A system of care for children and adolescents is different from an adult system of care for a variety of reasons, among the most important of which is the mandatory nature of family engagement. Simply put, children and adolescents do not get treatment unless parents or legal guardians agree to pursue it. Furthermore, the effectiveness of treatment improves significantly when adult collaterals are actively engaged. Therefore, Departmental leadership is paramount in promoting and fostering development of funding streams and treatment approaches that support family-centered care.

The necessity of cross-system involvement is a fundamental complexity of care that has few parallels in the adult system. Both Department and Board leadership must develop a mental health service system and vision that integrates with the child-serving systems of juvenile justice, child welfare, and education. Data on school-

based services provide a startling example that warrants cross-system policy coordination. The majority of boards report an increased demand for school-based intervention services that cannot be met at the same time they project cutting back on existing Consultation, Education & Prevention programming in the schools. Given survey descriptions of the quality and quantity of prevention programs currently being provided, it seems unlikely that schools demanding increased services would tolerate programmatic cuts, particularly in view of the availability of state monies earmarked for mental health services in schools. The significant minority of boards (24%) that said they were taking an aggressive approach toward tapping educational funding streams earmarked for mental health services undoubtedly have learned to think outside the traditional service delivery box to collaborate with schools in developing innovative approaches to service provision.

Another area where need for greater cross-system coordination is apparent was in board descriptions of crisis care. Due to the interface between child protective services (PSCAs) and mental health—an interface that often drives C&A crisis care—this level of service provision is qualitatively different from what is typically available for adults. Ten day wait lists for respite beds and the widespread lack of crisis beds raise serious questions of resource allocation in a state that received over \$71 million in Social Services Block Grant funds in FY2001⁵.

⁵ <http://www.acf.dhhs.gov/programs/ocs/ssbg/index.htm>

III. Staffing

A. Psychiatrists

1) Adult Consumer Psychiatric Caseloads

Forty-four boards estimated a mean caseload ratio of 1:425 adult consumers per 1.0 FTE psychiatrist. The mode was 1:430 and median 1:280 consumers per psychiatrist. The mean was influenced by four boards with extremely large client to doctor ratios. Rural boards reported a mean ratio of 1:461; mixed urban/rural reported 1:448; and urban, 1:307. The lower caseload ratio among urban boards was significantly different than the mean caseload ratios in rural and mixed urban/rural boards.

Board estimates of adult consumer-doctor ratios were tested through a separate means of calculation, where client counts of a board's FY2001 med/somatic claims in MACSIS were divided by the number of filled psychiatric FTEs the board reported in the survey. When all adult consumers were entered into the analysis, med/somatic claims indicated an average patient/doctor ratio of 1:453, which is not significantly different than the mean estimate of 1:425 provided by the boards. However, when only those consumers with SMD status were entered into the analysis, the resulting patient to doctor ratio of 1:251 was significantly different.

2) C&A Consumer Psychiatric Caseloads

Forty-three boards estimated a mean caseload ratio of 1:365 C&A consumers. The mode was 500 clients per doctor, and the median was 280 per psychiatrist. The mean was influenced by extreme variability in the client/doctor ratios reported by the rural and urban boards, which reported caseloads ranging from 1:20 to 1:1200. (The larger ratios appear to be based on general population estimates.) There was no significant difference in the means of urban, rural and mixed boards. These respective means are: 1:312 urban, 1:361 rural, and 1:402 mixed urban/rural.

When doctor-to-patient ratios were calculated on MACSIS service data for consumers who received med-somatic services in 2001, there was a mean of 1:559 for all C&A consumers and 1:419 for SED consumers. While there was a significant dif-

ference between a mean of 1:559 and 1:419, there was no significant difference between the patient/doctor ratio of 1:419 for SED consumers and the estimated mean of 1:365 reported by boards. A possible interpretation of this result is that C&A psychiatrists are carrying caseloads of 365 to 419 SED consumers with a caseload mix of an additional 94 to 140 non-SED clients. Because SED designation is determined almost solely by number of service contacts, those clients who remain on the psychiatric caseload for any length of time will obtain SED status by default.

3) Psychiatric Staffing Gaps

Staffing gaps were calculated by subtracting the number of staff FTEs the boards reported as filled from the number of staff FTEs reported as budgeted. Among the 46 boards, 17% to 22 % reported psychiatric staffing gaps, but the majority of boards reported a zero balance of budgeted FTEs to filled FTEs. One urban board showed evidence of having done an extensive survey of providers' current staffing patterns. In some staffing categories (e.g., psychiatry and case management), this board's responses may have skewed results, particularly among the urban boards.

a. Adult Care

When the number of filled psychiatric FTEs dedicated to adult consumers was subtracted from the number of budgeted psychiatric FTEs, ten boards (22%) reported a gap of 12.06 FTE psychiatrists. With six unfilled FTEs, the largest gap was in the number unfilled positions in three urban boards; five mixed urban/rural boards reported a gap of 4.45 FTEs, and three rural boards reported a gap of 1.11 FTEs.

Prevalence estimates by ODMH/OPER staff on the number of adults at or below the poverty level in the general population who were at risk for serious mental illness in 2000 was 55,566 or .0072 of Ohioans in the general population. The MACSIS 2001 count of adult clients with an SMD designation who received psychiatric care was 50,573, or .0066 of Ohioans in the general population. The currently budgeted total number of adult psychiatric FTEs system-wide (N = 204.79) is adequate to meet the needs of consumers with SMD who are "most in need." However, demand for

med/somatic services in 2001 indicates that an additional 49.5 psychiatric FTEs system-wide would be needed if psychiatrists carried caseloads of 1:340.

b. C&A Care

Eight boards (17%) reported a gap of 3.92 psychiatric FTEs assigned to C&A consumers, with no significant difference in shortfalls reported by urban, rural and mixed rural/urban boards. The total number of budgeted C&A psychiatrists was 58.93 FTEs, an estimate that was validated by data collected in a more detailed survey distributed under the auspices of the Board Association Child & Adolescent Services Committee. Because reported wait lists for child psychiatric services were longer than those for adult consumers, while the ratio of budgeted-to-filled positions assigned to C&A consumers was much smaller than for the adult psychiatric FTEs, it was assumed that the system's estimated 59 FTE C&A psychiatrists do not represent what is needed to meet service demand, but simply what is currently available. This hypothesis concerning FTE budgeting is based on the difference between the number of C&A clients with SED receiving any services in 2000 ($N = 38,710$) and the estimated number of children & adolescents with SED in the general population in 2000 ($N = 133,853$).

To further explore the hypothesis that boards may have quit budgeting for C&A psychiatric FTEs they have little hope of filling, MACSIS and SED prevalence data were analyzed to determine how many additional C&A psychiatrists would need to be budgeted if each board increased the number of its consumers with SED by a growth factor of 16%. Selection of the 16% growth factor was based on the net increase in clients receiving med/somatic services in FY2000 and FY2001 [$1.00 - (19,356/26,425) = .16$]. Thirty-seven boards that reported child psychiatric budgeting data were entered into the analysis. The boards' current service penetration was calculated as a proportion by dividing the estimated number of SED youth in the service area by the number of SED clients for that area in MACSIS utilization data. A 16% increase in the number of SED youth receiving psychiatric services was projected for each board area based on current service. For example, if a board cur-

rently serves 35% of the estimated youth with SED its community, a 16% increase over current service delivery resulted in a net increase of 6%. The resulting med/somatic service capacity increases, which varied from board to board, were used to calculate number of additional FTEs that would need to be budgeted if the board were to maintain psychiatric caseloads of 1:365 and increase med/somatic service capacity by a factor of 16% during 2002.

If each board increased the number of clients served by a growth factor of 16%, a mean 34% of Ohio youth with SED in the general population would receive C&A psychiatric services through the public mental health system. A service penetration of 34% represents a net 5% increase in service delivery over the present system-wide delivery to 29% of Ohio youth with SED in the general population. When calculated on a 16% growth factor, net increases in the service delivery of the 37 boards ranged from 1% to 8%. Six boards (one urban, one mixed rural/urban, and four rural) currently are budgeted for enough psychiatric FTEs to absorb the projected increase in the number of SED clients on caseloads of 1:365 without additional allocations for psychiatric staffing. The remaining 31 boards in the analysis (84%) could not absorb the projected increases in clients without increasing their budgeted number of psychiatric FTEs. To increase C&A psychiatric service capacity throughout these 31 boards by a factor of 16%, planners would need to budget for a total increase of 30.64 FTEs (mean = .99 FTE, range .03 to 2.87, SD = .75).

B. Case Managers

1) Adult CSP Caseloads

Thirty-eight boards reported a mean of 44 adult consumers per case manager, with a mode and median of 40. Rural boards reported the highest average ratio (1:49) and mixed urban/rural boards the lowest (1:38). Urban boards reported 1:41. There was no significant difference between the board types and the caseload ratios.

Data from the boards about caseloads for low and moderate intensity consumers were not reliable. Despite the request that boards provide either a general caseload

estimate or tiered caseload estimates of varying intensities, many respondents answered both questions. Responses to both questions were not consistent and lacked face validity with regard to low and/or moderate intensity estimates. Estimates of high intensity caseloads were consistent and had face validity. For consumers with high intensity CSP, twenty boards reported a ratio of 1:14. This estimate is on target with recommendations by the National Association of Case Management (NACM).

Board estimates of adult consumer-CSP ratios were tested through a separate means of calculation, where the total client counts of boards' FY2001 individual and group CSP claims in MACSIS were divided by the total number of filled CSP FTEs reported by the boards. When all adult consumers were entered into the analysis, MACSIS CSP claims indicated an average client to case manager ratio of 1:43. This result is not significantly different than the mean estimate of 1:44 provided by the boards. However, when only those consumers with an SMD designation were entered into the MACSIS CSP claims analysis, a resulting client-CSP ratio of 1:27 was significantly different from the general estimate of 1:44.

2) C&A CSP Caseloads

Thirty-six boards reported a client-CSP mean ratio of 1:32, with a mode and median of 30. There was not a big range of difference between the types of boards on C&A caseload ratios, with mean urban caseloads slightly smaller at 1:30 than the mean rural and mixed caseloads of 1:33.

Data from the boards about caseloads for low and moderate intensity consumers were not reliable and lacked face validity for reasons previously explained. Sixteen boards reported a mean CSP caseload of 1:14 for consumers at the high intensity service level. No more than 12 clients per case manager is the caseload size for high intensity care recommended by the Office of Children's Services and Prevention.

Board estimates of C&A consumer-CSP ratios were tested through a separate means of calculation, where client counts of a board's FY2001 individual and group CSP

claims in MACSIS were divided by the number of filled CSP FTEs reported by the board in the survey. When all C&A consumers were entered into the analysis, CSP service claims indicated an average client ratio of 1:55, which is significantly different than the mean estimate of 1:32 provided by the boards. When only those consumers with SED status were entered into the analysis, the resulting ratio of 1:35 was not significantly different from the survey estimate of 1:32. Because the SED designation is determined by number of service contacts, those clients who remain on CSP caseloads calculated with MACSIS service data obtained SED status by default.

3) CSP Staffing Gaps & Tenure

Staffing gaps were calculated by subtracting the number of staff FTEs the boards reported as filled from the number of staff FTEs reported as budgeted. One urban board provided evidence of having done an extensive survey of providers' current staffing patterns. In some staffing categories (e.g., case management), this board's responses may have skewed results, particularly among the urban boards.

a. Adult Care

Twenty-four boards reported a shortage of 106.02 FTE CSPs. Ten rural boards reported 23.89 FTEs; 10 mixed boards reported 21.68 FTEs, and five urban boards reported a gap of 59.4 FTEs. T-tests found a statistical difference between the urban and other board types, but this difference may be due to idiosyncratic data from one urban board.

Forty-one boards reported an average length of employment for adult case managers as 41 months, with a median and mode of 36. Range of average employment length was 12 to 108 months. Eight urban boards reported an average of 44 months (median 36 and mode 24, range 24-96 months). Fifteen mixed urban/rural boards reported an average of 41 months (median = 36, modes = 24 & 36, range 12-36

months)⁶. Twenty-one rural boards reported an average of 41 months (median and modes both 36, range 12-108 months). Although there was no statistical difference between types of boards on average length of employment, boards did differ according to demographic type in their upper and lower ranges of average employment. Because of the mean is heavily influenced by outliers, the median and mode of 36 months is a more accurate picture of central tendency.

b. C&A Care

Fifteen boards reported a gap of 47.4 FTEs designated for C&A CSP. Five rural boards reported a shortage of 14.5 FTEs, six mixed urban/rural reported 13.9 FTEs, and four urban reported 19.0 FTEs. T-tests found no statistical difference in C&A staffing shortages according to board type. The urban board with idiosyncratic adult staffing data did not provide C&A staffing data.

Thirty-eight boards reported an average length of employment for C&A case managers as 34 months, median 29.5 and mode of 36. There was a wide range in CSP turnover, with a minimum of four months and a maximum of 120 months. Because of this range effects the median and due to the proximity of the mean and mode, 36 months is a more reliable estimate of central tendency.

C. Additional Staff

1) Nurses

Twelve boards reported a gap of 10.51 FTE nurses designated for adult services. Six boards reported a gap of 3.1 FTE nurses designated for C&A services.

Among 43 boards, 33% (N=14) reported they had access to **advanced nurse practitioners** with prescriptive authority. These staff primarily are dispersed in the urban areas (six boards), while five rural boards and three mixed urban/rural reported the availability of advanced nurse practitioners. A possible relationship between greater

⁶ A bi-modal turnover rate was validated in a study of case managers conducted by OSU faculty Catherine Heaney & Celeste Burke. See "Ideologies of Care and Management Practices" in *New Research in Mental Health, Vol 14*, pp. 408-416.

availability of nurse practitioners in urban areas and the significantly smaller doctor-patient caseload ratios reported by urban boards should be analyzed with a complete sample of boards.

2) Clinicians (Psychologists, Social Workers or Counselors)

Twenty-five boards (54%) reported a gap of 87.63 FTE clinicians designated for adult services. This result is consistent with the large number of boards reporting wait periods longer than ten working days for counseling. Nine boards reported a gap of 57.18 FTE clinicians designated for C&A services. The relatively small number of boards (N=9) reporting staffing gaps is half the number of boards (N=18) reporting wait periods longer than ten working days for C&A counseling. The apparent inconsistency between a handful of boards reporting clinical staffing gaps and the larger number reporting lengthy wait lists for counseling services could be explained by a number of factors, including an under-estimation of staffing gaps. This under-estimation would occur because providers are unable to budget for needed staff in the current financial environment. As with the C&A psychiatric staffing pattern associated with under-budgeting, there also appear to be an insufficient number of appropriately trained and credentialed C&A clinicians available for hire.

3) Support & Other Staff

Eighteen boards reported a gap of 54.89 FTE support staff designated for adult services. Sixteen boards reported a gap of 14.40 FTE support staff for C&A services. Nine boards reported a gap of 22.35 other staff for adult services. Four boards reported 34.41 other staff for C&A services.

D. Staffing Policy Implications

1) Psychiatric Caseloads

Goldman, Faulkner, and Breeding⁷ suggested a ratio of one psychiatrist per 225 adult consumers in ongoing care as an ideal caseload for psychiatrists in community mental health settings. If the percentage of persons with severe, persistent mental illness (SPMI) and significant functional impairment who receive services were estimated at .017 of the general population⁸, the ideal outpatient caseload per 10,000-20,000 population would fall in the range 1:170 to 1:340. The estimated average caseload of 1:251 for consumers with an SMD designation falls at the median of this range for “most in need” adult consumers in ongoing care. In the present analysis of psychiatric caseloads, it would appear that doctors maintain an average caseload of approximately 250 SMD consumers with an additional caseload mix of approximately 175 to 200 non-SMD clients. The “non-SMD” group may constitute new intakes and/or emergencies. It is important to remember that SMD status in MACSIS occurs as a consequence of diagnosis in combination with number and type of service contacts. Further analysis should be done on the non-SMD population appearing on psychiatric caseloads to determine whether they are consumers with SMD-eligible diagnoses who aren’t receiving enough services to obtain an SMD designation in MACSIS.

Average adult psychiatric caseloads of 1:425 to 1:450 are well above desired thresholds of 1:250 to 1:340 for medication/somatic care. If we accept 1:340 as the highest upper limit for psychiatric caseloads in community mental health settings, we must ask about the impact of an additional 85 to 110 consumers on current psychiatric caseloads. If one FTE adult psychiatrist can serve a maximum of 340 clients, an additional 25 percent of adult consumers receiving med/somatic services most probably affect quality of care to the point that the safety and health of all consumers is at risk.

⁷ Goldman, C.R., Faulkner, L.R., & Breeding, K.A. (1994) A method for estimating psychiatrist staffing needs in community mental health programs. *Hospital and Community Psychiatry*, 45:4, 333-337.

⁸ SAMSHA estimates SPMI who also receive services at .017 of the general population. “Estimation Methodology for Adults with Serious Mental Illness,” 1999, Federal Register: Vol 64, No. 121, 33890-33897.

Where C&A psychiatric caseloads are concerned, the picture is even more distressing. The Graduate Medical Education National Advisory Committee recommends 14.38 psychiatrists per 100,000 children and adolescents in the general population⁹. If 5% of the general population meets criteria for SED and turn to the public mental health system for psychiatric care, resulting caseloads would be 1:350. This number is similar to modal caseloads reported by boards and average caseload estimates calculated with MACSIS service data. Based on the ideal ratio of 1:225 for adults, Hastings, Gorth and Ghuman¹⁰ set a ratio of 1:100 for C&A psychiatrists at the University of Maryland's outpatient clinic. In setting the 1:100 ratio, they took into consideration the greater labor intensity characteristic of work with children and their families. At 1:419 or 1:559, current C&A psychiatric caseloads are four to five times the ideal ratio for high quality child and adolescent care, two times the ideal ratio for community-based adult care, 60% larger than population-based estimates for child and adolescent needs, and about 20% larger than the current adult psychiatric caseloads. Although there was no difference between mean caseloads according to demographic grouping (urban, rural and mixed), C&A psychiatric caseloads are also extremely variable throughout Ohio on an individual board basis. This suggests highly uneven access to care.

2) Psychiatric Staffing Gaps

If currently unfilled adult care psychiatric positions were filled and the number of consumers held constant, the demand for med/somatic service delivery would still exceed caseload standards for quality care. This conclusion also is based on the assumption that adult psychiatric caseloads should include both SMD and non-SMD consumers. Whether or not this assumption is correct, mental health administrators must ask what can be done to increase current capacity and quality of med/somatic services.

⁹ See Thomas, C. & Holzer, C. (1999). National Distribution of Child and Adolescent Psychiatrists. *Child and Adolescent Psychiatry*, 38:1.

¹⁰ Hastings, E., Gorth, M., & Ghuman, H.S. (1998). Child and Adolescent Services in a Community Mental Health Center: Transition, Organization and Staffing Issues. In Ghuman & Sarles (Eds.) *Handbook of Child and Adolescent Outpatient, Day Treatment and Community Psychiatry*. Brunner/Mazel: Baltimore, MD. pp. 21-31.

Although the finding that psychiatric caseloads in urban areas are significantly lower than those of rural and mix urban/rural boards is qualified by need for further study, the correspondence of nurse practitioners with prescriptive authority working in urban areas must be viewed as a hopeful trend.

It is important to keep in mind that estimates of unmet need in the child and adolescent population are much larger than similar estimates for adult consumers. While more is known about risk factors that predict community psychiatric service use among adults (e.g., age and marital status), it is hoped that estimates of underinsured or uninsured children and adolescents with SED will guide service planning in the coming year. However, based on analysis of a net increase in service penetration ranging from three to 13 percent among 37 boards, the majority appear to have under-budgeted C&A psychiatric FTEs. Qualitative data provided in the 2001 Safety Net indicates that C&A psychiatrists simply aren't available to hire.

According to information from ODMH Office of the Medical Director, job satisfaction, career development, and employee versus contract status are issues affecting the availability of psychiatrists for hire in the public mental health system. Additional concerns expressed by psychiatrists involve using a full range of professional skills as treatment team members rather than the limitation of their involvement to just med/somatic care. The exercise of professional latitude in community treatment settings is critical to better patient care, quality of psychiatric staff, retention, and the training of residents, such as child fellows. Boards and agencies are advised to review APA guidelines for psychiatrists working in community mental health care.

3) Adult CSP Caseloads

It is important to note that survey and MACSIS measurement reflected caseloads of mixed intensity. A ratio of 1:30 is widely accepted for general case management. The National Association of Case Management (NACM) recommends caseloads of 20-25 clients per case manager for SMD clients of *moderate* intensity service needs.

While an average case ratio of 1:27 for clients with an SMD designation appears to be in line with NACM recommendations, this result says nothing about the average number of face-to-face contacts, which have a recommended range of 4 to 11 per month to meet the definition of moderate service intensity. Furthermore, the analysis leaves unanswered the question of why approximately 40% of adult consumers who received case management services in FY2001 did not meet criteria for an SMD designation. Further analysis should be done on the average number of CSP contacts per client to determine whether the non-SMD consumers on CSP caseloads are consumers with SMD-eligible diagnoses who aren't receiving enough services to obtain an SMD designation in MACSIS.

According to NACM guidelines, clients on low service intensity caseloads of 60-80 persons per case manager must meet criteria for an SMD designation and have moderate to mild functional impairment. Low intensity caseloads have a NACM standard of one service contact (one hour) per month, which is enough to meet MACSIS service criteria for an SMD designation. More could be learned about the non-SMD consumers making up 40% of the average caseload through an analysis of the CSP service contacts and client functioning scores on the Provider A Outcomes instrument. Because measures of psychosocial functioning are a better indicator of service need than diagnosis, the suggested analysis could determine what percent of consumers on adult CSP caseloads are receiving an appropriate type of service or adequate service intensity. Unfortunately, the necessary data elements are not readily available at this time for analysis by Department or Board staff.

4) C&A CSP Caseloads

C&A CSP caseloads of 1:12 are an established norm for high intensity care. Hastings, Gorth and Ghuman¹¹ set a ratio of 1:30 for C&A CSP at the University of Maryland's outpatient clinic. This ratio carried an expectation of 18 to 20 hours per

¹¹ Hastings, E., Gorth, M., & Ghuman, H.S. (1998). Child and Adolescent Services in a Community Mental Health Center: Transition, Organization and Staffing Issues. In Ghuman & Sarles (Eds.) *Handbook of Child and Adolescent Outpatient, Day Treatment and Community Psychiatry*. Brunner/Mazel: Baltimore, MD. pp. 21-31.

week face-to-face contact per FTE. These contact hour thresholds are undoubtedly lower than the apparent CSP productivity per FTE in MACSIS.

At the time criteria for SED designation in MACSIS were developed, it was recognized that level of functioning is a better indicator of service need than diagnosis¹². Because child & adolescent diagnoses are notoriously unreliable, this particular criterion for SED designation in MACSIS is very broad and inclusive. In lieu of an integrated database where functioning scores and utilization data are merged, current SED criteria posit number of service contacts as a proxy for level of need. Even more than with adult criteria for SMD, number of service contacts drives a determination of SED status in MACSIS.

The picture is similar to that displayed in the adult CSP caseload and service data: estimated mean caseloads provided by boards and calculated for SED consumers in MACSIS CSP service data are slightly above but close to recommended standards for quality care. However, when all clients who received case management in 2001 are entered into the equation, approximately 35% do not meet criteria for an SED designation. There are at least two possible explanations for this anomaly. As with the previous discussion of adult CSP, it is possible these clients are not linked to an appropriate service or that they received too few service contacts to qualify for an SED status in MACSIS. Further analysis of this issue is not possible given the current state of MACSIS and Outcomes database development.

5) CSP Staffing Gaps and Tenure

Turnover rates of 36 months for adult and C&A CSP staff are virtually identical and more telling than tedious analyses of CSP staffing gaps vis-à-vis estimates of unmet need. The 2001 Safety Net survey articulated a number of reasons for CSP turnover: noncompetitive pay scales, lack of career advancement opportunity, and burnout

¹² See Vander Stoep, A. Weiss, N., McKnight, B., Beresford, S., & Cohen, P. (2002). Which measure of psychiatric disorder—diagnosis, number of symptoms, or adaptive functioning—best predicts adverse young adult outcomes? *Journal of Epidemiology and Community Health*, 56: 1, 56-65.
<http://jech.bmjournals.com/cgi/content/full/56/1/56>

from productivity and paperwork demands. Although mental health administrators recognize the impact of this turnover rate on quality of care and consumer satisfaction, a calculation of human resource operational inefficiency is warranted. We do not know what percentage of Board and agency budgets are being consumed by operational inefficiencies associated with the 36-month cycle of recruitment, training, supervision and under-productivity of new hires. Effective advocacy of increased appropriations for staff development requires a demonstration of operational costs incurred by the financial inefficiency of a 36-month case management turnover rate as well as strategic planning that addresses CSP job satisfaction issues.

IV. Funding & Resources

A. Increase in Medicaid-only Providers

Among forty-six boards, 78% (N=32) said there had been an increase in the number of Medicaid-only providers billing for services within the last year. Fourteen boards reported the number of Medicaid-only providers had remained the same. Of the 32 boards that reported an increase, 27 indicated an average growth of 37% in the number of Medicaid-only providers. This was similar to the 34% mean increase reported by six urban boards (median=28%, no mode) and was influenced by the high mean increase reported by rural boards. However, the total response (N=27) mode of 20% and median of 25% were influenced by significant differences in the increases reported by rural and mixed urban/rural boards. Eleven rural boards reported a 52% mean increase (median 40%, mode 20%), while ten mixed boards reported a 22% mean increase (median 12%, no mode). These results suggest a wide range and variability in the growth of Medicaid-only providers according to demographic markets. Because only 59% of the sample provided data, a one-year mean increase of 20%-25% in the number Medicaid-only providers throughout Ohio is a reliable and conservative estimate of growth.

B. Funding Trends

1) Medicaid Match

Forty-three boards provided estimates of projected changes in Medicaid match requirements. Among these, all but one who said “no change” projected a change in the positive direction. The majority (N=22, 51%) estimated a change greater than +5%; eleven (26%) projected change in the +3 to +5% range; and the remaining nine (21%) estimated change in the +0-3% range.

2) Resources for Non-Medicaid Services

Forty-five boards provided estimates of the net change in levels of available resources for non-Medicaid services. The majority (N=30, 66%) projected a loss in resources, with the greatest number (N=13, 28%) estimating a negative net change greater than -5%. Eleven boards (24%) estimated a negative change of -3 to -5%, and six (13%) suggested a negative change as great as -3%. Eight boards (18%) said they expected “no change” in resources. Five indicated a positive increase as high as +3%, while two (with levies) predicted positive increases in the +3 to +5% range.

3) GRF/Levy funding

Forty-four boards provided estimates of expected changes in GRF/levy funding in FY03. Among these, 12 (27%) said they expected a positive change as high as +3%, and 10 (23%) said they expected no change. The greatest expected increase was in the +3% to +5% range, as predicted by two boards with levies. Among the 20 boards (46%) that predicted a negative change in GRF/levy funding, nine estimated a deficit as great as -3%, seven estimated a deficit as great as -5%, and four said more than -5%.

4) Hospitalization Costs

Forty-two boards estimated change in hospitalization costs if the per diem remains unchanged. Twenty (48%) projected “no change,” and three (7%) estimated a change as high as -3%. The remaining 19 boards (45%) projected increased costs,

with seven (17%) estimating a change greater than +5%. Ten (24%) estimated change as great as +3%, while two (5%) projected change in the range of +3 to +5%.

5) Levies

Approximately 28% of boards (13/47) reported they had engaged in some level of levy activity in 2002. Six boards placed levies on the May 2002 ballot. Among these levy proposals, four were for new monies and two were renewal or replacement levies. All four of the new levies failed in the May election, but the two replacement or renewal levies passed. Four boards said they planned to put a replacement or renewal levy on the November 2002 ballot, and an additional three boards said they were considering a levy in the fall. One board indicated plans for a 2003 levy.

6) Strategies

Forty-two boards provided information on how they were responding to the current financial picture for their service area. Sixteen boards discussed the existence of formal plans and another 12 boards said they were in the process of developing plans. Six boards indicated a default position whereby agencies and market forces would determine resource utilization, while eight boards said they had no plan to either ration services or designate priority populations.

The majority of boards that had developed or were developing formal plans leaned toward the prioritization of “most in need” and “Medicaid first” populations. Many survey respondents struggled over the distinction between a “most in need” status and “Medicaid eligible.” One such respondent indicated that the Medicaid group “has absolute priority and may squeeze out other populations” while another asserted that “the most vulnerable will be served first.” There was no consensus among the boards about how to handle the conflict over “most in need” versus “Medicaid eligible.” It is a conflict between competing statutory requirements. As one board put it, “We currently do not have a ‘most in need’ policy. We have increased services to

adolescents, but out-of-county services are for Medicaid-eligible only—except in crisis cases.”

Among the boards with formal strategies, seven discussed the actual implementation of their rationing and prioritization tactics. In every case, the boards that were actually carrying out a “cut and queue” strategy had a combined approach of prioritized populations and service rationing. Approaches to service rationing included “stricter triaging” and “benefit packages” for most severe versus general population consumers. Boards also mentioned cutting back on the availability of general care, “non-Medicaid services” and “non-essential services,” such as those with an “historical trend of underutilization” and prevention programs.

Eight boards talked about managing resources more effectively through “zero-based” budgeting strategies, increased productivity standards, system re-engineering, improved care coordination through best practice models, and quality assurance and improvement. These boards were not among those that discussed actual implementation of rationing and prioritization strategies. Thus, a “better management” strategy appears to precede implementation of the “cut and queue” strategy. If the data are viewed through the lens of a planning stage model, it would appear that 17% (7/42) of the sample are implementing a rationing or prioritization strategy, 38% (16/42) are prepared to implement some type of formal strategy, and 29% (12/42) are reviewing options.

The perspectives of six boards with a default strategy were closer to the 28 boards with formal plans in place or under development than the eight boards that said rationing and prioritization were not in their strategic agendas. Among the six boards with a default position, there was a perception that the Medicaid entitlement provided unlimited access: “Since we cannot deny any Medicaid services, there is no way to have a most-in-need policy. What little is left over after the match is put into services for SMD and SED.” In other cases, there was an assumption that Medicaid eligibility conferred priority: “We have a most-in-need policy, but it is difficult to

enforce given Medicaid rules where an individual with a card has an entitlement that may move him/her to the front of the line in times of limited resources.”

The eight boards who did not plan to ration or prioritize fell into two groups: those who had enough levy money to cover the Medicaid match and essential services (N=4), and those (N=4) who offered no discussion beyond simple statements like “We have no policy” or “Services are not restricted on the basis of Medicaid eligibility.”

C. Pharmacy Resources

1) 419 Funding

Forty-four boards reported that an average 12% of all consumers receive medications through Central Pharmacy (mode and median both 10%, ranging from 1% to 50%). Although the range was wide, there was little difference between the means reported by urban, rural and mixed urban/rural boards.

2) Pharmacy Samples, Indigent Programs, and Other Sources

Forty boards reported an average 23% of consumers obtaining their medications through pharmacy company samples (mode 15%, median 18%, range 1% - 75%). Forty-one boards reported an average 16% of consumers relying on indigent programs for their medications (mode and median 10%, range 1% to 61%). Twenty-two boards reporting “other” sources of pharmacy funding said that an average 33% of consumers obtained their medications by means of self-pay, Medicaid and private insurance, and board supplements.

D. Funding & Resources Policy Implications

1) Medicaid-only Providers

A mean increase of 20% to 25% in the number of Medicaid-only providers suggests an immediate policy implication: These are providers who often do not focus on individuals with serious and persistent mental illness, but for whom boards must nonetheless provide matching funds. Upon further reflection, a significant mean increase in the number of such providers in rural service areas suggests an expansion in con-

sumer choice. Beyond the present estimate of annual increase, little information has been gathered on the nature of this growth in Medicaid-only providers. What kind of services are they providing and who is receiving these services? To what extent do boards recognize the unmet need apparently served through a growth in the number of these providers? More information and analysis is needed to set forth policy implications and recommendations.

2) Funding Trends

The fact that only 28% of boards said they had engaged in levy activity in 2002 suggests that more could be done with mental health advocacy. Why have mental health advocates been unsuccessful in passing a new levy since 1990? Is it a phenomenon of strong anti-tax sentiment in local communities, or have mental health advocates largely given up hope of gaining community acceptance and support for persons and services that are greatly affected by stigma? Given the data collected, it is not possible to determine how much explanatory power either hypothesis might have for the recent lack of success of new mental health levies. More information and analysis is needed to determine what accounts for a 10-year pattern in new levy initiatives and what is needed to reverse this trend.

3) Medicaid Match, Non-Medicaid Services and GRF/Levy Funding

There was broad consensus among boards that consultation, education and prevention programs would be eliminated first as a consequence of Medicaid match requirements and reductions in GRF allocations and/or levy dollars. As a group, boards said very little about how they plan to prioritize spending cuts for non-Medicaid services such as housing, employment and vocational services, social support programs, or consumer operated services. One mixed rural/urban board described employment as a fundamental strategic goal designed to alleviate financial strain from deficit funding and Medicaid match requirements. This board also had directed significant resources to its employment initiative.

4) Strategies

Boards clearly recognize the difficulty in defining “most in need” within the context of a service system that is increasingly driven by Medicaid eligibility and entitlement. It is important to remember that while Medicaid coverage is an entitlement, service provision is bounded by medical necessity. Some boards are working closely with providers to develop triage policies and protocols around a common understanding of medical necessity, while others appear increasingly disengaged from working with providers on defining “most in need” in the context of a medical necessity requirement. Because there is no direct relationship between medical necessity and “most in need” in the current system of care, it is important to recognize the significance of boards and providers who are developing a shared understanding of medical necessity set forth in triage policies and protocols.

In lieu of a Medicaid waiver or the technical capacity necessary for concurrent utilization management, ODMH staff and Finance Committee board representatives have proposed the concept of Medicaid service packages. The service package concept is based on linkage of a retrospective utilization review to demographic and clinical variables known to predict service use, including client functioning level—the best available measure of service need. This approach, which is sometimes referred to as risk pool analysis, entails a baseline assessment of risk factors associated with utilization patterns. The modeling of an adult consumer service package is in its infancy, but piloting is expected to occur within FY03. Modeling of a child and adolescent service package is at least a year or more away due to the need for basic research on risk factors associated with service patterns.

Risk pool analysis and service package modeling are basic and necessary steps toward developing a system of care management. Because the service system does not have the appropriate tools for concurrent utilization management, it is important to recognize the limitations of service delivery in the current fiscal environment. Despite the lack of clear boundaries regarding care management roles, several boards

described relationships with providers that assure clients have access to services that support recovery.

5) Pharmacy Resources

The reliance of approximately 15% to 20% of consumers on pharmacy company samples raises two areas of concern. The dependence of public behavioral health-care providers on the largesse of commercial enterprise has both ethical and practical implications. The availability of corporate charity from the pharmaceutical sector may vary with economic conditions. Pharmacy samples also represent a marketing strategy designed to influence prescriptive practices. Thus, uninsured consumers served by providers with inadequate subsidies may be relying on patented medications that are not covered under Medicaid or private insurance formularies.

V. Recovery

A. Employment

1) Expenditures

Twenty-eight boards reported spending money on supported employment services. On average, boards that reported expenditures on supported employment spent approximately \$280,000 per year. However, 21 of these boards reported spending less than \$190,000 (median \$89,000). The average was heavily influenced by four urban boards reporting annual expenditures over \$1,000,000. Urban boards (mean = \$998,125) spent significantly more money on supported employment than both rural and mixed urban/rural boards (combined mean = \$82,145).

The number of boards reporting expenditures was compared to MACSIS data for vocational and employment services provided by contract agencies in 2001. Although there is evidence that providers under-report their non-Medicaid billable services in MACSIS, available information offers a limited measure of contract services and point of reference to the survey data on employment expenditures. In 2001, agencies for 19 boards reported entered billing data for vocational and/or employment services. Agencies in 10 of those board areas reported providing both vocational and

employment services. In five board areas, agencies reported providing only vocational but not employment services. In four board areas, agencies reported only employment but not vocational services in 2001. Thus, a minimum 38% of boards (19/50) appear to have allocated resources to contract agencies for vocational and/or employment services in 2001. The mean yearly expenditure reported by agencies in 19 board areas for vocational and employment services was approximately \$246,000. As with the survey data, this mean was heavily influenced by the expenditures of four urban boards.

2) Measurement

Based on the following definition of employment--*any activity conducted in a competitive community work setting for which an individual is paid at least minimum wage*—15 boards said they had the data needed to calculate the number of SMD consumers employed in their service area. On average, these boards estimated that 16% of SMD adults were employed (median 14%, ranging from 1% to 40%). Among these board areas, there were no significant differences in the estimated number of employed adults among the rural, mixed and urban areas.

An additional eight boards estimated the percentage of consumers currently employed even though they responded they did *not* have the data necessary to calculate employment rates using the aforementioned definition. When data from these boards were included in the analysis, the mean remained virtually the same.

These results provide support for the 16% employment rate reported for the sample of 365 consumers in the Longitudinal Consumer Outcomes Study. Preliminary analysis of information in the Outcomes database, which represents approximately 8% of adult consumers with SMD in FY02, suggests that 13% of consumers with SMD have either part-time or full-time jobs. While this finding is highly tentative and qualified by the need to analyze a larger sample of client records in the Outcomes database, it appears as though there has been some improvement over earlier estimates from the MHIS database in the 7%-9% range.

3) What Is Needed

Several themes emerged from responses to the question, “*What four things would your system need to increase the number of consumers employed?*” The most frequently occurring response indicated a need for increased funding (N=30), with an additional five responses indicating that the ability to bill Medicaid for vocational services is necessary.

Twenty-four boards indicated a need for increased availability of employment opportunities, including those that match the needs of adults with SMD, e.g., transitional and supported employment, part-time positions, etc. Many responses (N=15) illustrated a need to remove financial disincentives that working consumers face, such as maintenance of affordable health insurance. In addition, four responses suggested the need for education on the impact that employment may have on disability and/or Medicaid benefits. Others indicated the need for vocational staff and programming, while still more talked about the need to coordinate employment services with other services the consumer may be receiving. Some also pointed out the need to provide training on employment to service providers.

To increase the number of employed consumers, many respondents said access to reliable transportation is necessary. Many illustrated the importance of valuing work and the role it plays in the recovery process. Educating employers about mental illness, as well as developing relationships with employers, were also seen as necessary. In addition, respondents mentioned the need for anti-stigma campaigns throughout the community.

B. Cultural Competence

Forty-four boards responded to the questions on cultural competence. Two boards (e.g., one with urban and rural population bases, the other with an urban population base) did not provide any qualitative responses to the questions nor did they identify cultural populations who accessed services within their areas. Two additional rural boards also did not identify any cultural populations accessing services within their

areas. It was unclear whether these boards understood the meanings of culturally deliberate services and cultural competence that were provided in the survey.

1) Range of Diversity

Approximately 94% (N=41) of the boards identified a total of 20 different cultural populations who accessed services within their areas. These populations included African-American, Appalachian, Hispanic, Amish, deaf/hearing impaired, hard of hearing, gender, mentally retarded and/or developmental disabilities, children, victims and/or perpetrators of abuse, migrant populations, young adults, substance using/abusing/dependent, homeless, Russian/Jewish, Moslem, Asian immigrants, non-English speaking, and native American populations. Interesting enough, no boards identified individuals from Ethiopian and/or Somali, various sexuality orientations, blind/visually impaired or forensic populations as accessing services within their areas.

2) Service Delivery

Only eight boards provided extensive comments regarding their service delivery systems. In addition, 18 boards talked about cultural issues but provided no specific plans or direction in order to achieve culturally deliberate and/or competent service delivery. Comments from these boards included the following:

“The Board conducts utilization reviews that includes fiscal, administrative, and clinical components.”

“We are a very homogeneous area; however, we are aware of limited cultural differences in our population and provide training for such.”

“Cultural competence is achieved through maintenance of client rights and grievances’ databases.”

“We aim to address this in our next needs assessment. Given the population make-up, we do little other than encourage hiring of staff who are culturally competent.”

Three boards explained their status and plans for future development in the areas of service delivery for a variety of populations in a culturally competent manner. These boards were very specific regarding their plans and had a clear understanding of the components of cultural competence. One of these boards listed additional at-risk cultural groups to access, among which included battered women and “young consumers” aged 16 –22 years. Another board was extending their initial programs for African American consumers based upon feedback on increasing needs of within their geographic areas. In addition, they were working on developing an outreach program for consumers from Amish populations.

Overall, the data indicated that the majority (81%, N = 38) of the boards may not have clear understanding of the definitions provided within the survey and/or have not grasped and/or “enculturated” the meaning of cultural competence.

C. Community Well-Being

1) Consultation, Prevention & Education

"Without prevention activities, individuals and communities are at risk for more extensive problems." Forty boards described prevention programs. In several cases, the prevention activities described were “bare bones” community education, e.g., a particular staff person or speaker’s bureau providing mental health education and awareness services, or a singular grant-funded initiative such as infant mental health. On the other end of the continuum, there were a couple of boards that described a full range of primary, secondary and tertiary prevention activities in the community. The majority of boards (85%, N=34) described programs aimed at children and adolescents, although 18 boards also described programs inclusive of adult populations, i.e., domestic violence, parenting, critical incident debriefing, suicide prevention and depression screening. Three boards specifically mentioned programs for older adults. However, one of these boards reported “the older adults prevention program was cut last year due to budget cuts.”

“Prevention does not have the priority of treatment and is most subject to being cut.” When asked how funding cuts for FY 02-03 might impact the delivery of prevention services, 65% (N=26) of boards indicated the likelihood of programmatic cutbacks. Although seven boards said they would not cut funding for currently existing prevention activities, none of the respondents indicated there would be increased spending or new program initiatives in FY 02-03. By contrast, the need to shift funds from non-Medicaid eligible services to meet Medicaid-match requirements prompted remarks that “due to the mandatory priority of serving our most severely and seriously disturbed citizens, we will need to divert any fund currently being used to support prevention activities into treatment for the prioritized population.”

2) Community Partners

Forty-one boards reported increased pressure for services from law enforcement. Among all boards, 30 said they were more likely to align with law enforcement. After law enforcement, “Other” was the single largest category (N=29) of responses to the questions about pressure for services from community partners and the likelihood of enhanced alignment. The “Other” category encompassed schools, juvenile courts, adult jails and justice systems, Jobs & Family Services, Families & Children First councils, employers, county commissioners, adult care facilities and guardianship services, general hospitals and emergency rooms, and ministerial associations. In other portions of the survey, several boards commented that pressure for services from JFS often is characterized by the expectation that their referrals be given priority and/or be scheduled for assessment more quickly than contract agencies could accommodate.

Domestic violence/battering programs made up the third largest category of responses, with 58% of boards (N=24) indicating increased pressure for services. Next were homeless shelters (N=18), county health departments (N=14), emergency squads (N=10), and runaway shelters (N=6).

Endnote

The assignment of Urban, Mixed and Rural categories for board areas were based on county population data available at the Ohio Department of Development website (<http://www.odod.state.oh.us/osr/copopmap.pdf>). Rural boards are those in which the county population is less than 99,999, or, in the case of multi-county boards, no individual county's population is greater than 99,999. Urban boards are those in which the county population is greater than 250,000. Mixed urban/rural boards are those in which the county population ranges from 100,000-249,499, or, in the case of multi-county boards, at least one county has a population between 100,000-249,999.

Participating Board/County Urban (U), Mixed (M) and Rural (R) assignments:

M	Allen-Auglaize-Hardin	U	Lucas
R	Ashland	U	Mahoning
M	Ashtabula	M	Medina
R	Athens-Hocking-Vinton	M	Miami-Darke-Shelby
R	Belmont-Harrison-Monroe	U	Montgomery
R	Brown	R	Muskingum Area
R	Champaign-Logan	M	Portgage
M	Clark-Greene-Madison	R	Prebel
M	Clermont	R	Putnam
M	Columbiana	M	Richland
U	Cuyahoga	R	Ross-Pike-Pickaway-Fayette-Highland
R	Defiance-Fulton-Henry-Williams	R	Scioto-Adams-Lawrence
M	Delaware-Morrow	R	Seneca-Sandusky-Wyandott
R	Erie-Ottawa	U	Stark
M	Fairfield	U	Summit
U	Franklin	M	Trumbull
R	Geauga	R	Tuscarawas-Carroll
U	Hamilton	R	Union
R	Hancock	R	Van Wert-Mercer-Paulding
R	Huron	M	Warren-Clinton
R	Jefferson	R	Washington
M	Lake	M	Wayne-Holmes
M	Licking-Knox	M	Wood
U	Lorain		