

2002 Safety Net Survey Executive Summary



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Office of Program Evaluation & Research
Carol Carstens, PhD, LISW
Emily Bunt, MS
Barbara Warren, PhD, RN

In February 2002 the Ohio Department of Mental Health (ODMH) and the Ohio Association of County Behavioral Health Authorities sent a 58-item survey to the state's 50 regional mental health authorities (boards) requesting information on service demand, access, capacity, quality, and financial and intersystem issues affecting the infrastructure of public behavioral healthcare in Ohio. Many questions in the 2002 Safety Net Survey—particularly those concerning wait lists for services, psychiatric and CSP caseloads, and CSP staff turnover—quantified measurement of issues described in qualitative information boards provided a year earlier. Data provided by 47 boards in response to the 2002 survey was augmented with information in MACSIS and other sources. This Executive Summary highlights information detailed in the Report of Major Findings with Policy Implications.

◆ **The behavioral healthcare safety net is stretched very thin with too few doctors and case managers caring for too many consumers.**

Psychiatrist's caseloads for adult consumers are nearly twice the recommended ratio for adults in community mental health settings and three and a half times the ideal ratio for child and adolescent consumers. Forty-four boards reported a mean caseload ratio of 1:425 for adult consumers. Experts in community psychiatry have recommended a caseload for adult consumers of 1:250. Forty-three boards estimated a mean caseload ratio of 1:365 for child and adolescent (C&A) consumers. Based on the adult benchmark of 1:250, a recommended ratio of 1:100 for children and adolescents takes into consideration the greater labor intensity characteristic of work with seriously emotionally disturbed (SED) children and their families.

Although boards are under-budgeted for the number of psychiatric positions necessary to meet estimated need for psychiatric services in the general population of adults, the current under-budgeting for child and adolescent psychiatrists reflects a thin and distressed service infrastructure. Reasons for the under-budgeting of C&A psychiatrists include lack of available professionals to hire and a 16% growth in service demand between FY00 and FY01.

Boards reported means ratio of 44 adult consumers and 32 C&A consumers per case manager. When adult caseloads were evaluated against 2001 service information in the MACSIS database, similar ratios were found for all consumers who received case management in 2001. A

ratio of 1:30 is widely accepted for general case management. The C&A caseload ratios of 1:32 reported by boards was not consistent with MACSIS ratios of 1:55 for all C&A consumers who received CSP in 2001. It is important to note that survey and MACSIS measurement reflected caseloads of mixed intensity. There is a universally accepted standard for adult and C&A caseloads of a 1:12 ratio for intensive case management, e.g., ACT or MST.

Boards estimated an average 36-month turnover rate for both adult and C&A case managers. With increasing caseloads, case managers are caught between the conflicting expectations of increased productivity (billable time for direct care) and increased accountability (non-billable time for paperwork).

◆ The system of care for adult consumers is thin across all services: deficiencies in any single service component threaten to topple 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 drew attention to the role of community hospitals as short-term inpatient and transitional 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.

Along with medication and case management, housing is among the most critically stretched resources in the adult service delivery system. Of the 36 boards reporting the presence of “staff supervised housing” for intensive care consumers, 26 indicated wait lists, with 22 reporting waits longer than ten working days. Thirty-one boards (66%) reported wait lists for “subsidized housing” for non-intensive consumers, with 27 reporting wait periods longer than ten working days. The pervasiveness of wait lists for housing is supported by Housing Assistance Program (HAP) data, which indicate a 47% increase in the number of households with

unmet housing needs between FY00 and FY01. However, there is also evidence of increased operational efficiency in transitional housing supports. Among those households which received HAP assistance in FY02, mid-year data show that 36% moved off of 508-H assistance and are no longer dependent on the mental health system for housing.

◆ The lack of a service system infrastructure touches all aspects of behavioral health and support services delivery for children.

Relatively few boards described comprehensive, community-based child and adolescent service systems that were on par with descriptions of their adult service systems. Reasons for the disparity between the adult and child and adolescent systems of care are multi-factored, 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 expulsion) that have produced larger numbers of “younger, sicker” children and adolescents in need of intensive services. There is also increasing pressure to provide treatment to children and adolescents with antisocial behavior problems as opposed to young people with Axis I mental illnesses. Seventy percent of boards in the survey reported that they did not have the capacity to meet increased demand for services from public child-serving agencies, juvenile justice, or schools.

The necessity of cross-system collaboration is a complexity of child and adolescent behavioral healthcare that has few parallels in the adult system. Data on school-based services provide a startling example. The majority of boards report an increased demand for school-based intervention services that cannot be met. At the same time, many boards project cutting back on existing Consultation, Education & Prevention programming in the schools. One board described the tradeoff of placing resources into school-based programs such as therapeutic classrooms and onsite counseling and case management: “At this point our system of care is at capacity and, as school consumers and assignments take up staff time, waiting lists for (community-based consumers) are increasing.”

◆ **Many boards are caught in a downward fiscal spiral of flat funding, reduced or inadequate reserves, levy failures, and Medicaid-match requirements.**

Among forty-six boards, 78% (N=32) estimated that number of Medicaid-only providers billing for services within the last year had increased on average in the range of 20%-25%.

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. All boards except one estimated an increase in Medicaid match up to or exceeding 5% over last year's requirements. The majority of boards also estimated a debit in resources for non-Medicaid services up to or exceeding 5% over last year's loss. Most boards (30/47) predicted either no change or losses in GRF and levy funding during FY03. Among six boards that had placed levies on the May 2002 ballot, four included new levies that failed and two were replacement levies that passed. Only 28% of boards (13/47) indicated that they had plans to participate in levy activity during 2002.

When asked what strategies they had developed to survive in the current fiscal environment, 28 boards said they had developed or were developing formal plans involving 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.

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. Some boards reported working closely with providers to develop triage policies and protocols around a common understanding of medical necessity, while others appeared to have disengaged from working with providers on defining "most in need" in the context of a medical necessity requirement. As one board put it, "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."

◆ **With so much focus on how to survive, boards are giving less attention to how to help consumers recover and thrive.**

"Without prevention activities, individuals and communities are at risk for more extensive problems," wrote one board respondent. At the same time, another respondent commented 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." When asked how funding cuts might impact the delivery of prevention services, 65% (N=26) of boards indicated the likelihood of programmatic cutbacks.

As a group, boards said very little about how they plan to prioritize spending cuts in other non-Medicaid services such as housing, employment and vocational services, social support programs, or consumer operated services. Although one mixed rural/urban board described employment as a strategic goal designed to alleviate financial strain from deficit funding and Medicaid match requirements, data indicate that as few as 19 and no more than 28 boards spent any money on employment and vocational services in 2001.

Boards reported a very low capacity for culturally competent service delivery, a major policy aimed at supporting consumer empowerment and recovery. Although 44 boards responded to questions on cultural competence, only eight provided extensive descriptions of their service delivery systems. Nevertheless, 94% of boards in the survey (41/47) identified a total of 20 different cultural populations accessing services throughout Ohio.

◆ **The safety net of public behavioral healthcare continues to deteriorate.**

On the whole, the evidence points to a system of care that is losing ground. Psychiatrists' and case managers' average caseloads are above acceptable standards, more than half of service areas report wait lists for core services, the underdeveloped infrastructure of the C&A system faces an increasing demand for community-based services, and boards are caught in a downward financial spiral driven largely by factors beyond their control.