

Safety Net 2004 Executive Summary

To better understand system-wide access and capacity issues, forty-seven boards submitted information covering five broad areas of concern. In several areas of measurement, the information in the 2004 survey could be compared to information reported in 2002. For the most part, there has been little improvement in access and capacity over the past two years, and in many cases access and capacity have decreased.

Board Classification by Demographic Groups

The Ohio Department of Development, Office of Strategic Research, prepared a board classification map (see Figure 1) based on average population density per square mile. This five-group classification system was used to analyze differences between boards.

Adult Services

- In four key clinical services (diagnostic assessment, med-somatic, counseling, and CSP), significantly more boards in 2004 reported wait times in excess of 10 working days than in 2002. In half of all boards[†], consumers can wait up to 20 working days for a diagnostic assessment, 45 days for a psychiatric appointment, 20 days for a counseling session, and 15 days for CSP assignment.
- An estimated 11,200 persons with SMD are among the chronically homeless population in Ohio. Over 80% of all boards report wait lists for public housing, and two-thirds of all boards report wait times of a year or longer for public housing.
- Urban and metro-urban boards reported significantly more services than the trans-metro, trans-rural and rural boards. Of the five board types, the trans-rural demographic group had the lowest average number of services.
- There was a moderate, positive correlation between size of the adult service array and levy resources; however, there was no relationship between demographic group and levy resources.

Child & Adolescent Services

- An estimated 2,000 children and adolescents were placed in Residential Treatment Facilities over a 12-month period. Over half of all boards report increased demand for residential placements and insufficient RTC bed capacity to meet increased demand.

[†] “All boards” refers to a denominator of 50

- Forty percent of all boards in the system of care report that C&A consumers do not have access to crisis care/observation beds at a designated facility or local hospital. This has not changed since 2002.
- Between 2002 and 2004, the number of boards increased in which Intensive Home and Community-based Service (IHCBS) is available. However, consumers typically wait between 15 to 30 working days to access this service. Boards also report that IHCBS is the most requested service by Juvenile Justice and Public Child Serving Agencies (PCSAs) for which demand exceeds capacity.
- Between 2002 and 2004 there has been a dramatic increase in the number of boards where C&A consumers wait longer than 10 working days for the key clinical services of diagnostic assessment, psychiatry, counseling and CSP. In over half of all board areas, C&A consumers wait up to 20 working days for diagnostic assessments, counseling and CSP. They wait between 45 to 60 days for psychiatric appointments.
- Urban boards reported significantly more child and adolescent services than the other four demographic groups of boards. However, there was no correlation between levy resources and number of services. 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.

Cross-System Issues

- Most boards are attending to mental health and community criminal justice issues, but very few are effectively evaluating activities and services. For example, among 38 boards that reported having a contract for jail services, only 13 indicated having an evaluation measure for those services. Client satisfaction, rather than recidivism, was the most typical evaluation measure cited.
- There has been no change between 2002 and 2004 in the number of boards that are able to meet increased demand for services from Juvenile Justice and PCSAs. A few boards (N=5) currently are better prepared to meet increased demand for school-based services than two years ago.

Funding Trends

- More boards expect a decline in GRF and levy revenues in 2004 than did in 2002. Although fewer boards expect a Medicaid-match increase in the range of 5%, significantly more boards expect a 3% decline in level of resources for non-Medicaid services.
- Forty-five boards reported a total of 44 Medicaid-only agencies. Of all ODMH-certified agencies (N=404), the Medicaid-only group represents about 11% of the total.

- Half of all boards indicated that Medicaid-only agencies comprise 30% or less of all agencies in the service system. Nine boards report Medicaid-only agencies comprise 31 to 50% of all agencies. Only one board reported Medicaid-only agencies in excess of 91% of all agencies in its system of care.
- About one-third all boards (N=17) indicated that their non-Medicaid expenditures comprise between 51% and 60% of their total system expenditures. About 28% of all boards (N=14) reported their non-Medicaid expenditures in the range of 21% to 50% of the total. Nine boards reported non-Medicaid expenditures in excess of 61%, while five boards reported the range as less than 20%.
- About two-thirds of all boards (N=34) reported a deficit in the percent of total expenditures over total revenues. Half of all boards (N=26) reported their deficit in excess of 3%. About one-third of all boards (N=17) indicated that their deficits came from unexpected financial stressors.
- Boards ranked their greatest source of financial pressure as Medicaid match, particularly for out-of-county providers. Boards ranked pressure to provide services to other systems as their second greatest source of financial pressure.

Staffing

- Although two-thirds of all boards require agencies to have a cultural competency plan, only one third evaluate implementation or effectiveness of those plans.
- Boards reported fewer adult CSP staffing gaps in 2004, which is congruent with the *calculated* and *estimated* adult CSP caseload sizes[¶] since 2002.
- Boards reported little change in adult psychiatric staffing gaps in 2004, but both *estimated* and *calculated* psychiatric caseload sizes have increased since 2002.
- Boards reported more C&A psychiatric staffing gaps. Both *estimated* and *calculated* psychiatric caseload sizes have decreased since 2002.
- Fewer boards reported having advanced nurse practitioners in 2004 than in 2002. Urban boards reported significantly more advanced nurse practitioners than the other four demographic groups. There was no relationship between levy resources and the presence of advanced nurse practitioners.

[¶] Calculated caseload sizes are derived by dividing the total number of filled FTE positions reported by boards by the total number of consumers served during FY03. *Estimated* caseload sizes are those reported by boards in the survey instrument.

SURVEY PARTICIPANTS

ALLEN-AUGLAIZE-HARDIN
ASHLAND
ASHTABULA
ATHENS-HOCKING-VINTON
BELMONT-HARRISON-MONROE
BROWN
BUTLER
CLARK-GREENE-MADISON
CLERMONT
COLUMBIANA
CUYAHOGA
DELAWARE-MORROW
ERIE-OTTAWA
FAIRFIELD
FRANKLIN
GALLIA-JACKSON-MEIGS
GEAUGA
HAMILTON
HANCOCK
HURON
JEFFERSON
KNOX-LICKING
LOGAN-CHAMPAIGN
LORAIN
LUCAS
MAHONING
MIAMI-DARKE-SHELBY
MARION-CRAWFORD
MEDINA
MONTGOMERY
MUSKINGUM-GUERNSEY-MORGAN-COSHOCTON-NOBLE-PERRY
PORTAGE
PREBLE
PUTNAM
RICHLAND
ROSS-HIGHLAND-PICKAWAY-PIKE-FAYETTE
SCIOTO-ADAMS-LAWRENCE
SENECA-SANDUSKY-WYANDOT
STARK
SUMMIT
TRUMBULL
TUSCARAWAS-CARROLL
UNION
VAN WERT-MERCER-PAULDING
WARREN-CLINTON
WASHINGTON
WAYNE-HOLMES

