An Analysis of Recent Trends in Colorado's Public Mental Health System

Division of Mental Health
Office of Behavioral Health and Housing
Colorado Department of Human Services

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Executive Summary

Colorado's public mental health system has been impacted by the downturn in the state's economy since state fiscal year 2002. This downturn resulted in a number of impacts, not the least of which were reductions in the levels of funding for public mental health services. The Division of Mental Health (the Division) drafted this study as an initial attempt to measure the impacts of these recent state budget changes on the public mental health system. The Division also offers this study in response to questions posed by the Joint Budget Committee in November 2003. At that time, the Department stated:

> "As discussed earlier regarding the capitation program, due to the late timing and nature of the capitation budget reductions appropriated in FY 2002-03, FY 2003-04 data will more accurately examine and identify the impact of the reductions than comparing FY 2001-02 with FY 2002-03. This comprehensive study of the impact of the budget cuts will involve changes in the numbers of persons served, analysis of shifts in the services provided as captured through the encounter data system as well as looking at trend data regarding performance measures such as the mental health consumer and family member survey indicators, decreased problem severity ratings, children living in a family-like setting, adults living independently and penetration rates (for the Medicaid population). The Division of Mental Health will monitor the impact of the budget reductions using the data currently available and the existing performance measures, which allows for comparative trend analysis over time."

This study encompasses four areas:

1. Public mental health system funding, including state level appropriations and local level audited revenues;
2. Total numbers of reported persons served, including by age, severity categories and Medicaid status;
3. Total numbers of reported units of service, including by age and Medicaid status; and,
4. Performance measures.

The comprehensive study utilized various sources of data. These sources included data from: statutory appropriations, audited community mental health center revenues, the Colorado Client Assessment Record (CCAR), encounters (i.e., Units of Service), and surveys (Mental Health Statistics Improvement Program or MHSIP).

It is important to note that this study only measures the impacts as observed in the public mental health system and does not measure impacts to other systems. Simply reducing the number of persons with mental illness being served in the public mental health system did not result in a reduction in the number of persons with mental illness in the State seeking care. Moreover, Colorado's population also grew during this time period, thus increasing the number of persons likely to need services.

Organizations including the Mental Health Association of Colorado, the Colorado Behavioral Health Care Council, and the Legal Center for Persons with Disabilities have attempted to collect data and provide evidence that a percentage of persons with mental illness who were no longer

served in the public mental health system sought or received services in other systems such as primary care clinics, hospitals and jails. Some of these impacts have been felt also in other state funded systems, particularly the Department of Corrections, the Division of Youth Corrections and Medicaid.

Also, it is difficult to definitively correlate budget reductions to some of the changes—number of persons served, units and types of service, performance measures—in the public mental health system. Clearly, the Division has contracted with community providers for services for fewer non-Medicaid eligible persons with mental illness, which resulted in fewer non-Medicaid persons being served. However, other relationships between funding reductions and measured impacts are less definitive.

Key Findings
The Division notes the following key findings:

- **16,378 fewer persons were reported served from FY 2001 to FY 2004.** While 11,195 fewer non-Medicaid persons were reported served, there were also 5,183 fewer Medicaid individuals reported served in spite of increases in Medicaid caseload eligibility over that time.

- **The public mental health system no longer reports serving an equal number of non-Medicaid persons.** 10,461 fewer non-Medicaid than Medicaid persons were reported served in FY 2004 which is a reversal of FY 2001 when 878 more non-Medicaid persons were reported served. The percentage of all persons reported served that the non-Medicaid comprise dropped from 50.57 percent in FY 2001 to 41.76 percent in FY 2004.

- **Non-Medicaid federal and State General Funds shrunk as a percentage of total, reported revenue from 19.1 in FY 2002 to 16.8 percent in FY 2004 (aggregated from 17 community mental health center and two specialty clinic annual audits).** During the same time period, Medicaid funds (not including atypical antipsychotic medications) increased as a percentage of all revenue reported by community mental health centers from 62.3 percent in FY 2002 to 67.9 percent in FY 2004. Local government funding also declined over the three fiscal years from 6.3 to 5.1 percent, although there was an increase in Local government funding from FY 2003 to FY 2004 (4.2 to 5.1 percent).

- **The average funding per Medicaid eligible declined 24.73 percent from FY 2002 to FY 2004.** Medicaid funding per eligible (across eligibility categories and not including medications) declined from $526.25 in FY 2002 to $396.10 in FY 2004.

- **The level of severity of those reported served has generally increased from FY 2001 to FY 2004.** Youth (defined as all children and adolescents combined) with serious emotional disturbances (SED) increased as a percentage of all reported served from 64.76 percent in FY 2001 to 74.20 percent in FY 2004.

While the percentage served of adults without a serious mental illness (SMI) declined, the percentage of those served of adults with either a serious and persistent mental illness (SPMI) or a SMI increased by 6.68 percent.

- **Two-thirds of all units of service reported were delivered to Medicaid persons in FY 2004.** This compares to only 48 percent in FY 2001. The average number of units of service for non-Medicaid persons remained stable over this time period (31 per person to 30 per person), while the average number of units for Medicaid persons increased from 29 to 42. (See Page 10 for definitions of units of service.)

- **Responses to the MHSIP Consumer Survey have continued to indicate consumer satisfaction with care provided to those served in the mental health centers and clinics.**

- **Magnitude of improvement in problem severity in adults and children upon discharge stayed about the same.**

- **Measures of living situation indicated positive outcomes for adults on both their attainment and maintenance of independent living across all three years.** Youth showed positive outcomes in the maintenance of a family-like setting but not in gaining a family-like setting.

- **The number of Medicaid eligible persons receiving services (penetration rate) declined.** While it is not possible to calculate a penetration rate for the non-Medicaid population, the population in Colorado has increased over the years of interest while the number of persons served decreased. A similar pattern is reflected in the Medicaid penetration rates; the number served decreased from FY 2002 to FY 2004, while the number of Medicaid enrollees increased steadily by approximately 100,000 persons.

Public Mental Health System Funding

State Appropriations

The total State General Fund dollars appropriated to provide services to children and adults with serious emotional disturbances or serious mental illnesses were reduced from $18,777,197 in FY 2002, to $15,671,434 in FY 2003 (or a decrease of $3,105,763 or 16.54 percent). Between FY 2003 and FY 2004, State General Fund revenues further declined by $1,601,635 (an additional 10.22 percent). Overall, total State General Funds were reduced by $4,707,398 or 25.06 percent over the three fiscal years (Joint Budget Committee, Hearing on the Department of Human Services, December 2004).

During the same three-year period, State General Fund appropriations to the Medicaid Mental Health Capitation program also declined, despite increases in the number of eligibles. In FY 2002, the program was appropriated $148,906,860. This declined to $144,704,276 in FY 2003, or by $4,202,584 (2.82 percent). While the appropriations increased to $146,347,218 (or $1,642,942) in FY 2004, this still represented a decrease from FY 2002 of $2,559,642 or 1.72 percent. The number of eligibles (i.e., caseload) grew by 30.58 percent over that time period.

However, the average funding per eligible (averaged across all eligibility categories) declined from $526.25 in FY 2002 to $396.10 in FY 2004. This represents a 24.73 percent decline in funding per eligible.

Audited Revenue

The Division aggregated the data provided by the annual audit reports of the 17 community mental health centers and of two specialty clinics (Asian Pacific Development Center and Servicios de la Raza). These data are intended to show how various budget decisions—on the state and local levels—may have impacted the share of revenues available to the community mental health centers and clinics. It is important to note that the data do not reflect the net margins for these entities (i.e., net profit or loss), thus do not necessarily capture changes in the costs incurred to provide care.

Overall, total audited revenues declined from $217,070,055 in FY 2002 to $202,544,870 in FY 2004, which represents a decrease of 6.69 percent. However, there was also an increase between FY 2003 and FY 2004 of $2,953,375 or 1.48 percent.

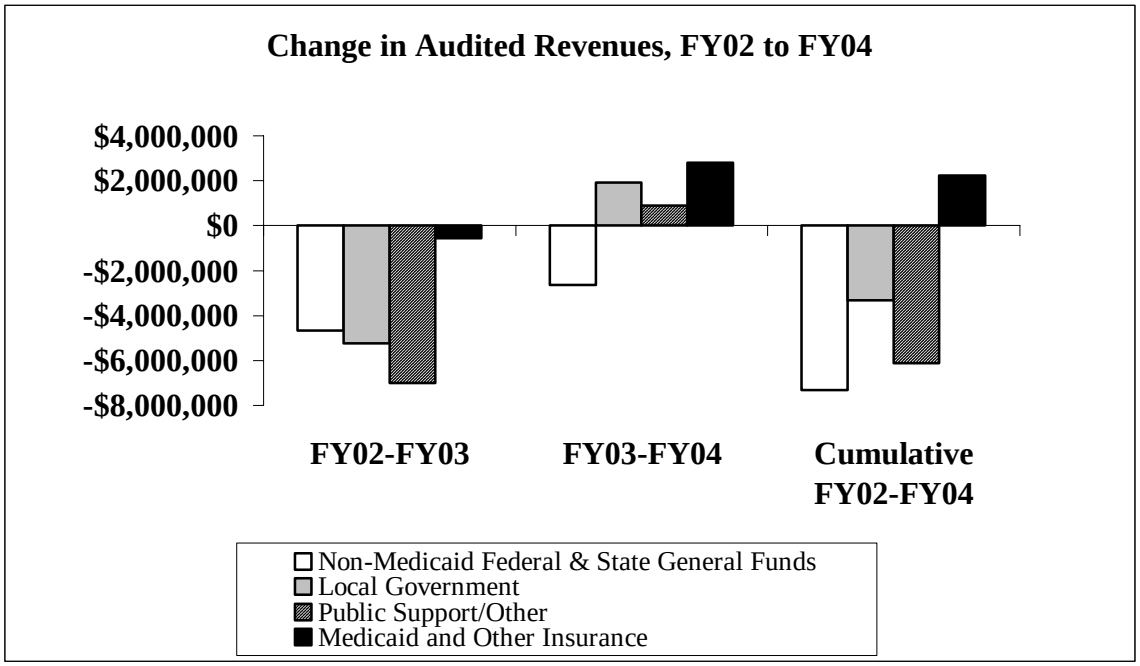
Table 1.

	2002	2003	2004
Non-Medicaid Federal & State General Funds	$41,415,281	$36,738,645	$34,094,103
Local Government	$13,701,883	$8,478,621	$10,383,939
Public Support/Other	$26,662,060	$19,649,224	$20,535,966
Medicaid and Other Insurance	$135,290,831	$134,725,005	$137,530,862
Total	$217,070,055	$199,591,495	$202,544,870

The audited data as presented in Table 1 were collapsed into four categories: Non-Medicaid Federal and State General Funds, Local Government, Public Support/Other and Medicaid and Other Insurance. Chart 1 below illustrates the percentage change in total revenue sources as reported in the audits from FY 2002 to FY 2004.

Notably, Medicaid and Other Insurance increased as a percentage of all revenue sources by 5.6 percent from FY 2002 to FY 2004. During this same period, Non-Medicaid Federal and State General funds decreased as a percentage of all revenues by 2.3 percent. Both Public Support/Other and Local Government decreased from FY 2002 to FY 2003 before rebounding slightly between FY 2003 and FY 2004. The total net reduction in revenue to community mental health centers for the three fiscal years is $14,525,185, or 6.69 percent.

Chart 1.



Total Persons Reported Served

The Division utilized data reported by providers on the CCAR to determine the unduplicated number of persons reported served in the public mental health system. The CCAR database contains information on all persons seen by providers in the public mental health system that are licensed and monitored by the Division regardless of funding source. All community mental health centers and clinics are required by the Division to report CCARs on every person served in the centers and clinics during the year. The *unduplicated* number reflects the total number of individuals who were served and does not reflect that a percentage of those persons' cases were closed and then re-opened during the fiscal year (i.e., 'duplicated'). Importantly, many consumers will access needed care more than once in a year.

The Division has documented numbers and characteristics of persons served for more than twenty years. As one of the first states to collect such data on each person, Colorado has been a leader in the development of a national reporting structure that presents each state's data. An ongoing consideration in the development of the information systems has been striving to refine and standardize data capture methods and definitions of data elements. Inherent in the dynamic approach to system design, process, and structure are temporary, minor variations from reporting guidelines. Such impacts are noted and incorporated into interpretation of the data.

The charts and tables below display the data by age and Medicaid status, as well comparing the numbers of persons served by Medicaid status. A person is counted as a Medicaid client if they received at least one Medicaid service during the year. Approximately seven percent of all clients seen received both a Medicaid and non-Medicaid service during the year. They are

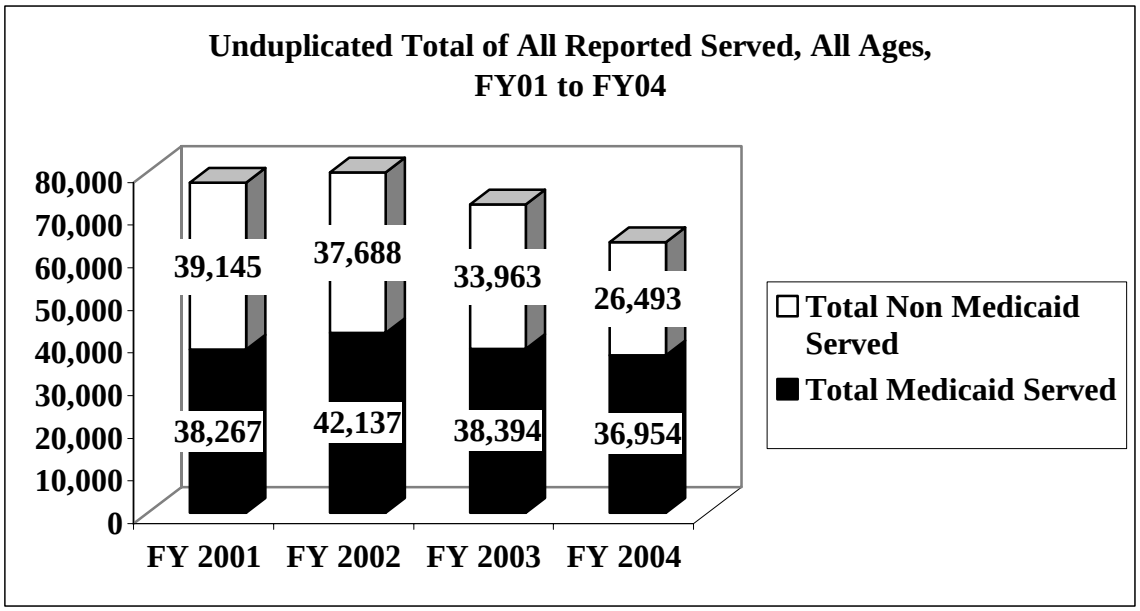
counted only in the Medicaid category. Again, in the interest of comparability across years, the Division needs to ensure equivalency in the populations. The Division has often assessed the populations served by Medicaid/non-Medicaid and determined that the populations do differ on key factors such as severity. For example, due to the entitlement nature of the Medicaid program, persons are served based on a determination of medical necessity regardless of the severity of the emotional disorder or mental illness. For non-Medicaid persons, it is more likely that the severity of their illness is a primary factor in their accessing services.

Numbers Served

77,412 persons were reported served in FY 2001. In FY 2002, 79,825 were served representing a 3.12 percent increase in persons reported served. This number declined to 72,357 in FY 2003 (9.36 percent). By FY 2004, the total number of persons reported served declined to 63,447, which was a decrease of 12.31 percent from FY 2003, and 18.04 percent from FY 2001.

As shown in Chart 2 below, fewer non-Medicaid persons have been served each fiscal year since FY 2002. These numbers declined in FY 2002 and FY 2003 by 3.72 and 9.88 percent, respectively. For FY 2004, there was another decrease of 21.99 percent. The cumulative total decrease of 11,195 in the numbers of non-Medicaid persons served represents a 29.70 percent decline from FY 2002 to FY 2004.

Chart 2.



After an increase of 3,870 Medicaid persons served in FY 2002, there have been subsequent declines in the total number reported served. This decline was 8.88 percent from FY 2002 to FY 2003, and 3.75 percent from FY 2003 to FY 2004. Overall, the decline of 5,183 Medicaid persons served from FY 2002 to FY 2004 equals 12.3 percent. This decline in persons served occurred at the same time as an increase in those eligible for Medicaid services.

Chart 3.

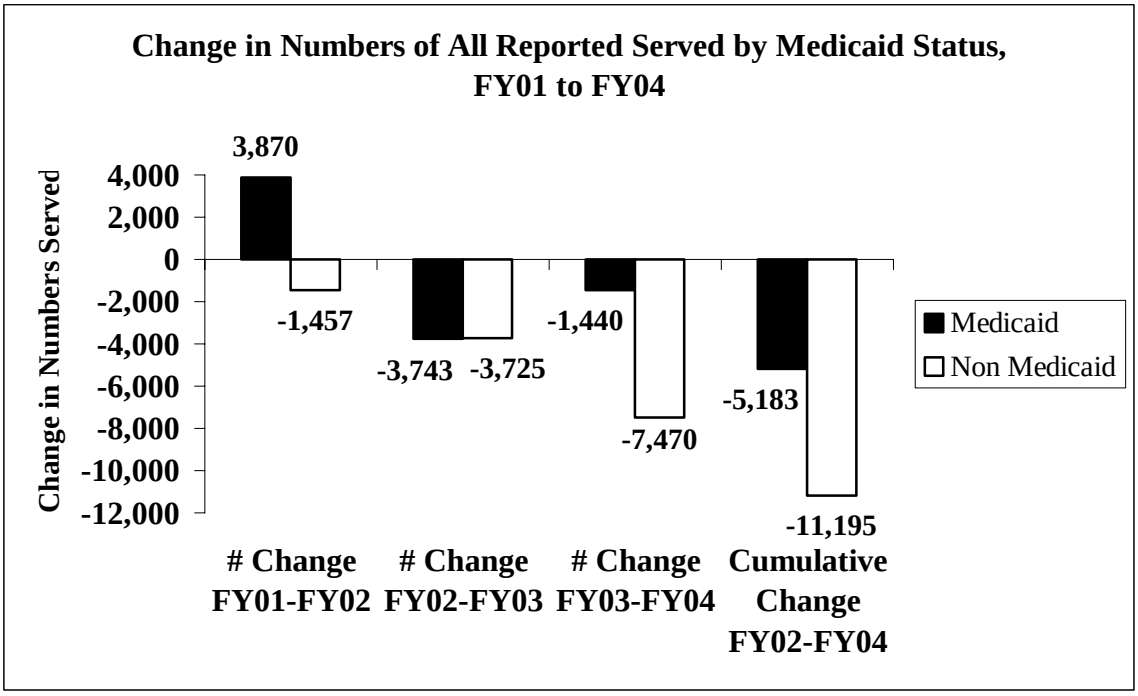


Table 2 depicts the percentage of all served by Medicaid status as well as the percentage change over time. Beginning with 50.57 percent in FY 2001, there has been a steady decline in the percentage of all served who are non-Medicaid.

Table 2.

All Served	FY 2001	Percentage of All Served	FY 2002	Percentage of All Served	FY 2003	Percentage of All Served	FY 2004	Percentage of All Served
Medicaid	38,267	49.43%	42,137	52.79%	38,394	53.06%	36,954	58.24%
Percent Change		*N/A*		*3.35%*		*0.28%*		*5.18%*
Non Medicaid	39,145	50.57%	37,688	47.21%	33,963	46.94%	26,493	41.76%
Percent Change		*N/A*		*-3.35%*		*-0.28%*		*-5.18%*
Total Served	77,412		79,825		72,357		63,447	

As indicated above, the Division officially reports the numbers of persons served from data collected on CCARs. While community mental health centers and specialty clinics are required to report these data, some data may be incomplete or missing. In an attempt to study other sources of data on persons served, the Division reviewed the data on the numbers served for the Medicaid population as it appears in the annual Mental Health Assessment and Service Agencies (MHASAs) audit reports for fiscal years 2001, 2002 and 2003. The Division no longer receives the annual audits from the MHASAs, currently known as Behavioral Health Organizations or BHOs, given the statutory transfer of the Medicaid Mental Health Capitation Program to the

Department of Health Care Policy and Financing (DCHPF) in April 2004. Although the audits were requested from DHCPF, the Division was not able obtain the FY 2004 audits in time for this study.

After reviewing the data, the Division found that the CCAR numbers served were higher than those in the audits. The Division also noted that there was an unexplained increase of approximately 25 percent in the numbers of Medicaid persons served from FY 2002 to FY 2003. The Division believes that more review of this audit data is necessary before any further analysis can be completed.

Severity
When comparing outcomes across time points or populations, it is vital to ensure the comparison is valid. One client factor necessary to consider is the severity of illness since it has been demonstrated to be related to outcome.

In 1981, the Colorado General Assembly expressed, in an advisory statement, the intent that the highest priority for state appropriated funds allocated to the mental health system be used "principally to contract for services for the seriously, critically or chronically [persistently] mentally ill." This legislative statement recognized that public programs do not meet all the mental health needs of Colorado's citizens and that the limited funding available for non-Medicaid eligible individuals should, therefore, be targeted toward priority populations. Since that time, this principle has guided the mental health system's use of State appropriated funds through the continuing development of comprehensive programs for persons who are considered to be "most in need" of mental health treatment. At present, individuals who are defined as "most in need" of services, and are thus the first priority for Colorado's public mental health system, include:

- Children and Adolescents with Serious Emotional Disturbances (SED): youth ages 0-17 who have emotional or mental health problems so serious that their ability to function is significantly impaired and, as a result, their ability to stay in their natural homes may be in jeopardy.

- Adults (ages 18-59) and Older Adults (ages 60 and older) with Serious and Persistent Mental Illness (SPMI): persons who have a mental illness which seriously impairs their ability to be self-sufficient, and who have been persistently ill for over a year or have been hospitalized for intensive mental health treatment.

- Adults and Older Adults with Serious Mental Illness (SMI): persons who are diagnosed with serious mental illness such as schizophrenia or severe affective disorders but who may not meet the definition of "persistent" because of the duration of their illness, the intensity of treatment they have received formerly, or the level of their dysfunction.

The data presented here are nearly complete, with missing information about the level of severity more prevalent in earlier years. In order to compare percentages across years, it is assumed that the population with missing data are representative of the population described in the data; such an assumption is warranted, given the relatively small amount of missing data overall.

Table 3.

	FY 2001				FY 2002				FY 2003				FY 2004			
Age Group by Severity	**Medicaid**	***Percent of Served***	**Non Medicaid**	***Percent of Served***	**Medicaid**	***Percent of Served***	**Non Medicaid**	***Percent of Served***	**Medicaid**	***Percent of Served***	**Non Medicaid**	***Percent of Served***	**Medicaid**	***Percent of Served***	**Non Medicaid**	***Percent of Served***
Youth with SED	13,094	*69.30%*	6,280	*63.92%*	14,475	*70.69%*	6,129	*68.09%*	14,017	*75.63%*	5,678	*66.08%*	13,653	*76.59%*	4,250	*67.44%*
Youth not SED	4,083	*21.61%*	3,545	*36.08%*	4,489	*21.92%*	2,871	*31.90%*	4,476	*24.15%*	2,881	*33.53%*	4,084	*22.91%*	1,922	*30.50%*
Unknown Severity	1,717	*9.09%*	0	*0.00%*	1,514	*7.39%*	1	*0.01%*	40	*0.22%*	33	*0.38%*	89	*0.50%*	130	*2.06%*
Total Served	18,894		9,825		20,478		9,001		18,533		8,592		17,826		6,302	
All Adults with SPMI	7,955	*41.06%*	6,251	*30.70%*	8,039	*37.12%*	6,180	*21.54%*	7,634	*38.44%*	5,789	*22.82%*	7,315	*38.24%*	5,004	*24.78%*
All Adults with SMI, not SPMI	6,072	*31.34%*	14,111	*69.30%*	7,384	*34.09%*	14,337	*49.98%*	7,916	*39.86%*	12,931	*50.97%*	7,972	*41.68%*	10,103	*50.04%*
All Adults not SMI	3,511	*18.12%*	0	*0.00%*	4,276	*19.74%*	8,167	*28.47%*	4,270	*21.50%*	6,618	*26.08%*	3,745	*19.58%*	4,927	*24.40%*
Unknown Severity	1,835	*9.47%*	0	*0.00%*	1,960	*9.05%*	3	*0.01%*	41	*0.21%*	33	*0.13%*	96	*0.50%*	157	*0.78%*
Total Served	19,373		20,362		21,659		28,687		19,861		25,371		19,128		20,191	

Table 3 indicates that the percentage of youth with SED served increased gradually from FY 2001 to FY 2004. While a perceptible increase in youth with more severe illness is seen in the non-Medicaid population; the change is most pronounced in non-Medicaid children served, with a 15% increase. For the Medicaid population, there was an increase of 8.87 percent in the numbers of adolescents with SED served. Percent of the population served with SED hovers around 75%, bouncing up and down slightly, from FY 2001 through FY 2004.

Adults and Older Adults overall showed slight upward change in the severity of the populations served across the years. However, Medicaid Adults showed a marked increase in the percent of SMI not SPMI in the service population, and the proportion of non-Medicaid Adults with SMI not SPMI stayed about the same. Equally noteworthy, the trends in percent served with SPMI are opposite, with non-Medicaid Adults inching upward 4% over four years and the share in Medicaid showing a steady decrease. The percent of Medicaid Adults without SMI decreased monotonically, from 31% to 24%.

Units of Service

Units of service are reported on all persons served in the public mental health system. The Division defines units of service as:

- Inpatient: A program of care in which the client remains for 24 hours a day in a facility licensed as a hospital by the State of Colorado. Inpatient care is provided by the center/clinic for clients in psychiatric hospitals, psychiatric units of general hospitals, etc. The Center admits the client to the hospital and is financially responsible.

- Acute Treatment Unit (ATU): The ATU is short-term care; intensive in nature; and has medical as well as clinical staff as service providers. Prior to the development of ATU's, these services were reported as residential units if provided by a community mental health center or possibly as an inpatient unit if provided by a hospital.
- Residential: Any type of 24-hour care (non-hospital setting) where the CMHC provides or is responsible for room; room and board; or room, board, and supervision. Examples are: nursing home, intensive and community residential facilities, boarding homes, HUD residences, and other types of independent or semi-independent living arrangements.
- Partial Long: Contact lasting more than four (4) hours, but less than 24 hours. Activities are programmatically linked.
- Partial Short: Contact lasting more than two (2) hours, but four (4) or less hours. Activities are programmatically linked.
- Group*:* Therapeutic contact with more than one client, up to and including two (2) hours.
- Individual*:* Therapeutic contact with one client of more than 30 minutes, up to and including two (2) hours.
- Individual Brief: Therapeutic contact with one client up to and including 30 minutes with one client.
- Case Management: Activities that are intended to ensure that clients receive the services they need, that services are coordinated, and that services are appropriate to the changing needs and stated desires of clients over time. Goals and objectives are developed collaboratively between case managers and clients. Case management activities are community-based, and are delivered either in the client's environment or in the organization by a designated person or team.
- Psychological Testing: Assessment including, but not limited to, cognitive, emotional, and psychosocial functioning including historical information, strengths, cultural factors and family issues. May also include specific tests and batteries such as the MMPI and the WAIS.
- Respite Care: Intervention or event that is a planned break from the care-giving role by the family to a client with chronic or persistent mental illness. These services can reduce the need for out of home placement and hospitalization by alleviating the stress of caring for a child with serious emotional disturbance or an adult with serious mental illness.
- Vocational Services: Services or contacts that assist clients to choose, obtain, and retain paid employment. A client contact related to vocational services may include many different vocational interventions, such as the following: job development, shadowing, coaching; on-the-job training; transitional employment in a sheltered workshop; and supported employment within the community
- HCBS-MI/Case Management: Home and Community Based Services—Mentally Ill/ Case management are activities performed by a case management agency that relate directly to the administration of the HCBS-MI program. These include all activities necessary for the certification of a person's eligibility for HCBS-MI services, the assessment of client need, the development and implementation of a case plan, the calculation of any client payment, the determination of individual cost-effectiveness, the coordination and monitoring of HCBS service delivery, the location and development of needed resources, the evaluation

of service effectiveness and the reassessment of service need. (This function was transferred to the Department of Health Care Policy and Financing effective July 2004.)

- Family Therapy: Family therapy is a therapeutic contact with client and one or more family members, up to and including two (2) hours.

Tables 4 and 5 show the total reported units of service for FY 2001 through FY 2004.

Table 4.

Medicaid Youth and All Adults	**FY 2001**	**FY 2002**	**FY 2003**	**FY 2004**	**Percent Change FY02-FY04**	**Percent Change FY01-FY04**
Inpatient	42,627	41,083	32,712	6,840	-83.35%	-83.95%
ATU	19,313	19,688	15,728	7,700	-60.89%	-60.13%
Residential	114,767	99,214	88,351	33,065	-66.67%	-71.19%
Inpatient Services	1,478	3,148	3,858	3,741	18.84%	153.11%
Partial – Long	90,392	66,715	57,537	31,557	-52.70%	-65.09%
Partial – Short	27,632	33,402	29,329	4,709	-85.90%	-82.96%
Group	140,545	148,969	136,643	113,599	-23.74%	-19.17%
Individual	150,774	178,213	208,437	217,614	22.11%	44.33%
Individual – Brief	152,421	169,160	153,561	152,882	-9.62%	0.30%
Case Management	319,291	471,713	551,617	493,008	4.51%	54.41%
Psychological Testing	846	704	549	1,018	44.60%	20.33%
Respite	6,685	11,985	11,881	7,253	-39.48%	8.50%
Vocational Services	11,979	13,189	14,344	22,604	71.39%	88.70%
HCBS	2,456	29,675	29,211	356	-98.80%	-85.50%
Family Therapy	28,390	32,250	42,165	55,040	70.67%	93.87%
Other	9,503	17,232	13,291	391,711	2173.16%	4021.97%
TOTAL	1,119,099	1,336,340	1,389,214	1,542,697	15.44%	37.85%

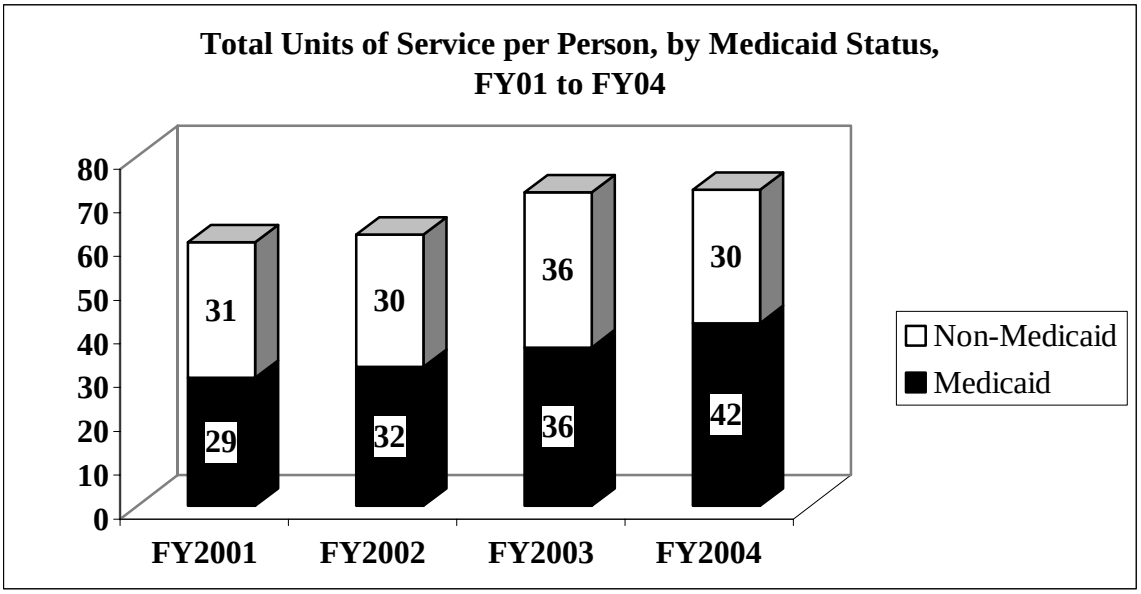
Table 5.

Non Medicaid Youth and All Adults	**FY 2001**	**FY 2002**	**FY 2003**	**FY 2004**	**Percent Change FY02-FY04**	**Percent Change FY01-FY04**
Inpatient	7,310	6,909	7,624	1,807	-73.85%	-75.28%
ATU	19,801	18,287	18,864	8,871	-51.49%	-55.20%
Residential	110,659	102,580	145,330	57,208	-44.23%	-48.30%
Inpatient Services	123	0	0	218	100.00%	77.24%
Partial – Long	23,019	15,907	17,773	13,191	-17.07%	-42.70%
Partial – Short	35,675	28,098	36,762	7,923	-71.80%	-77.79%
Group	209,454	196,873	166,148	125,696	-36.15%	-39.99%
Individual	167,570	148,039	139,078	130,286	-11.99%	-22.25%
Individual – Brief	257,040	256,868	273,757	178,941	-30.34%	-30.38%
Case Management	329,396	339,021	362,070	218,961	-35.41%	-33.53%
Psychological Testing	788	707	1,025	2,221	214.14%	181.85%
Respite	350	176	46	56	-68.18%	-84.00%
Vocational Services	17,306	17,769	18,873	12,686	-28.61%	-26.70%
HCBS	25,999	5,652	11,177	292	-94.83%	-98.88%
Family Therapy	8,844	3,816	6,085	13,399	251.13%	51.50%
Other	2,554	526	1,291	35,318	6614.45%	1282.85%
TOTAL	1,215,888	1,141,228	1,205,903	807,074	-29.28%	-33.62%

The 'Other' category indicates a significant increase in units of service from FY 2003 to FY 2004. This increase is primarily due to changes in how certain services are reported, notably 'non-traditional' services. These services—which the Division plans to add to individual categories in the future—include services such as specialized case management, drop-in centers, and supportive housing (an evidence-based practice).

The average number of units of service per person held stable for non-Medicaid persons between FY 2001 to FY 2004. However, this average increased by 20 percent from FY 2002 to FY 2003 (30 to 36), and then decreased similarly from FY 2003 to FY 2004. For Medicaid persons, the average units of service per person increased from 29 in FY 2002 to 42 in FY 2004. This represents an increase of 30.95 percent over the four years.

Chart 4.



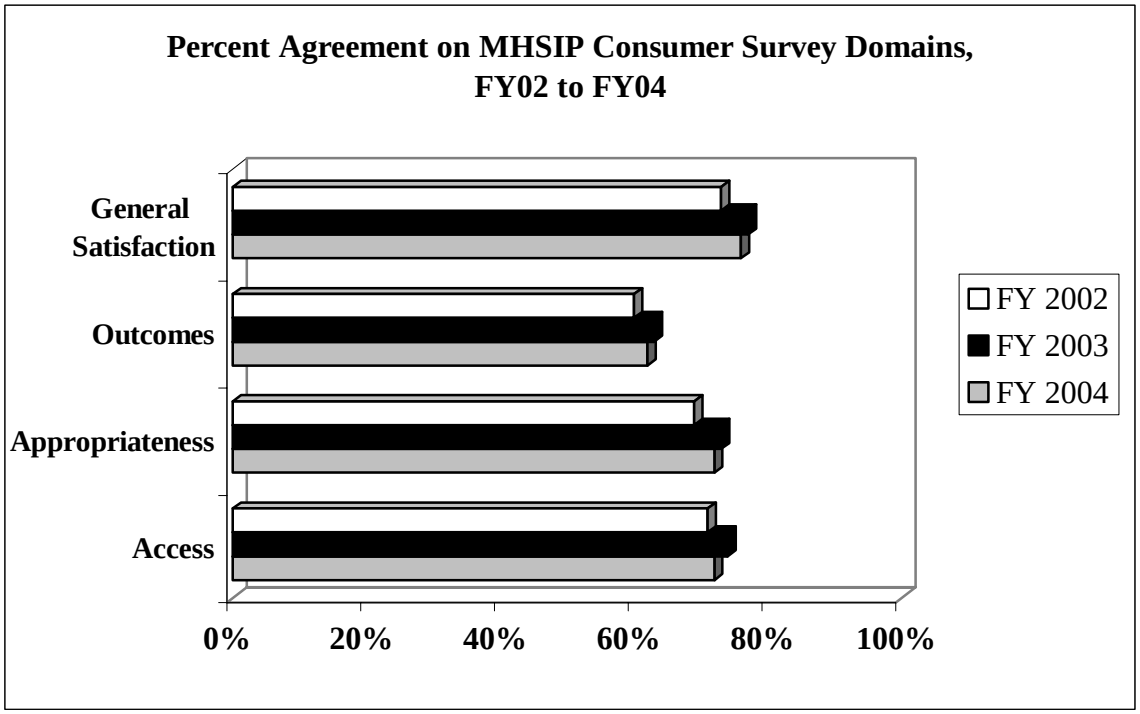
Performance Measures

Measures of the quality and outcomes of care across the three fiscal years are presented for the entire State. The indicators include results from the MHSIP Consumer Survey, measures derived from the Colorado Client Assessment Record (CCAR), and Medicaid penetration rates from Fiscal Years 2002 – 2004.

MHSIP Consumer Survey

The Mental Health Statistics Improvement Program (MHSIP)—a survey on perception of care—is conducted by the Division annually, with a sample of 8,000 consumers age 18 and older who received services during the fiscal year. Response rates to the survey have exceeded 30%, with almost 2,000 completed surveys. Questions on the survey comprise four domains. These are perception of Access to services (timeliness, ease of getting appointment when needed), Quality/Appropriateness (Were the services "right"?), Outcome (Are things better?), and a general measure of Satisfaction with services.

Chart 5.



The graph demonstrates little variation in statewide perception of care over the three years. These results indicate that consumers have continued to experience the quality of care they have always received. This survey domain measures perceptions of access for those consumers surveyed who have accessed, or are eligible to access, care. Therefore, the survey results do not address consumer perceptions about their initial access to care, i.e., actually being able to get in the door.

The following measures are captured via the CCAR, the standard tool required by the Division. The CCAR is a psychosocial assessment completed by a trained professional on every client seen under the auspices of the Division, regardless of payer. The Division has been collecting such data from providers for more than a decade. The instrument captures demographic, administrative, and clinical information and is completed upon admission and discharge to care, at a minimum. For the Division's purposes, from the CCAR data there are assessments of living situation, residence, employment, and problem severity.

Living Situation

Two measures are included to assess aspects of living, one for youth and one for adults. While the definition of the living situation differed for youth and adults, in both cases positive outcome was defined as either obtaining or maintaining the desired situation. The youth measure indicates whether the youth lived in a family-like setting, defined as living with any relative, in a foster home, or with a guardian. The adult measure indicates whether the adult is in an independent living situation.

Chart 6.

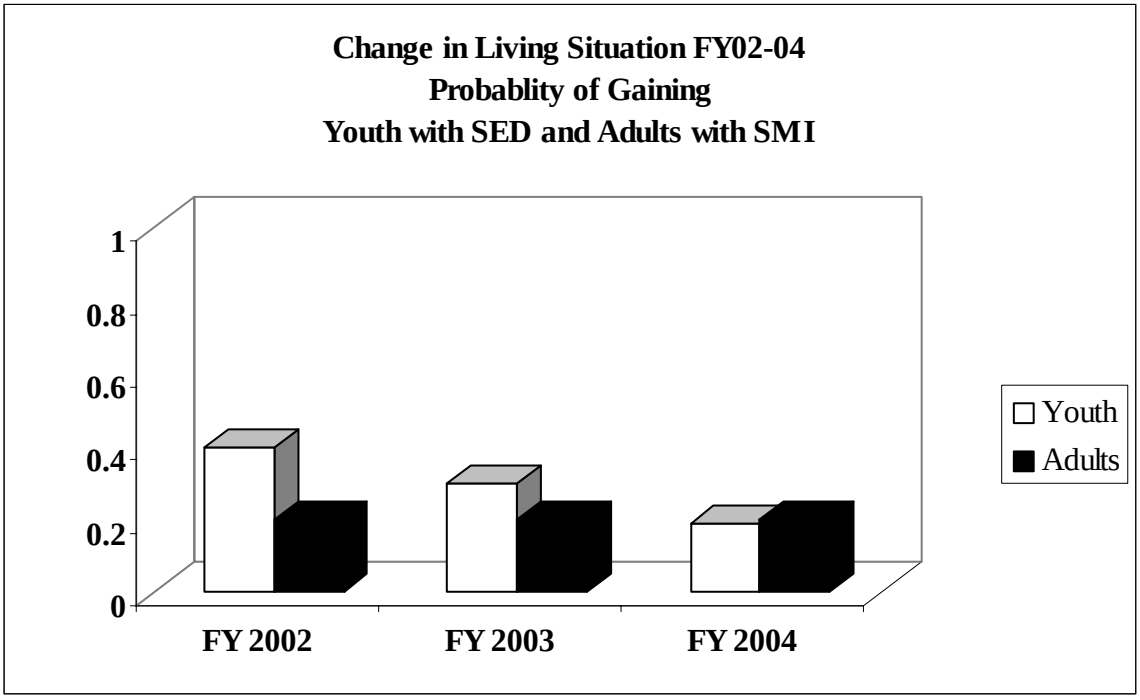
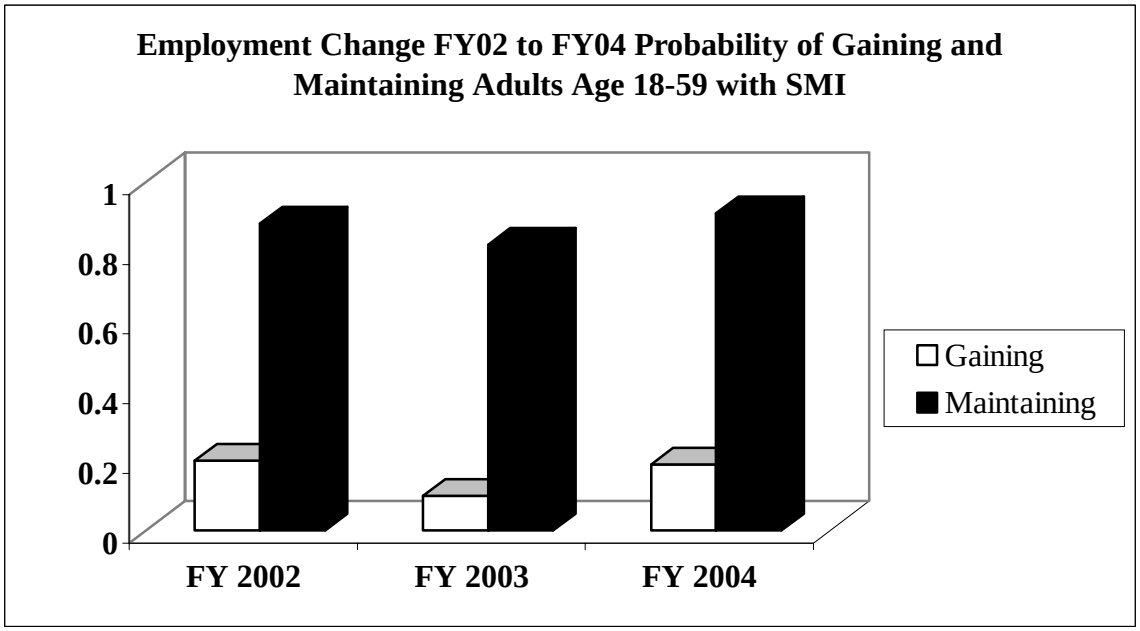


Chart 6 presents the probability of gaining the desired living outcome at two distinct points in time (not presented here). Of those youth out of home at Time 1, the percent who obtained a family-like setting by Time 2 decreased from FY 2002 to FY 2004. While the gaining measures showed steady decreases, the data on youth in family-like settings at Time 1 and adults living independently at Time 1 showed consistently high probabilities (.9 and higher) of maintaining those situations continued across the years.

Employment
An important outcome related to recovery is employment. The CCAR captures employment at each administration; admission, discharge, and annually--at a minimum. Details regarding being in the labor force, length of unemployment, student status, and supported employment are included.

The measure of Employment is similarly defined by combining the rate of maintaining and the rate of gaining employment.

Chart 7.



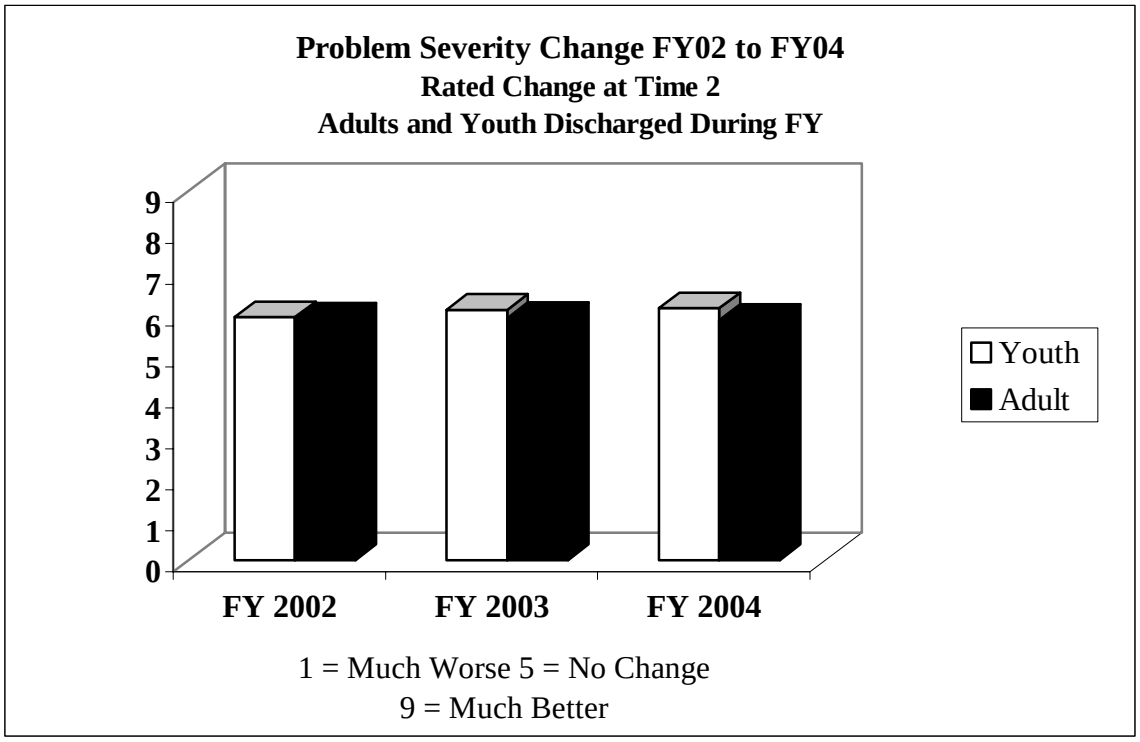
Interestingly, the percentage of adults with SMI maintaining employment over the years increased slightly. This may be due to dwindling job opportunities, resulting in more adults with SMI staying in an existing job. Gaining employment dropped by half from FY 2002 to FY 2003, then rose slightly in FY 2004. This trend mirrors Colorado's economic picture.

Problem Severity

The CCAR captures two metrics on problem severity. One is an overall assessment of problem severity at a point in time, and the other is a rated change in problem severity. This measure is calculated separately for youth and adults, and includes only those who have been discharged from care during the year.

The change in problem severity as measured by the difference in the two point-in-time assessments (not presented here) showed consistent improvement. Across the years, there was no change in the magnitude of improvement. Chart 8 displays the mean rated change in overall problem severity, with one representing "Much worse" and nine is "Much better." The chart indicates that rated improvement has remained relatively invariant over time.

Chart 8.

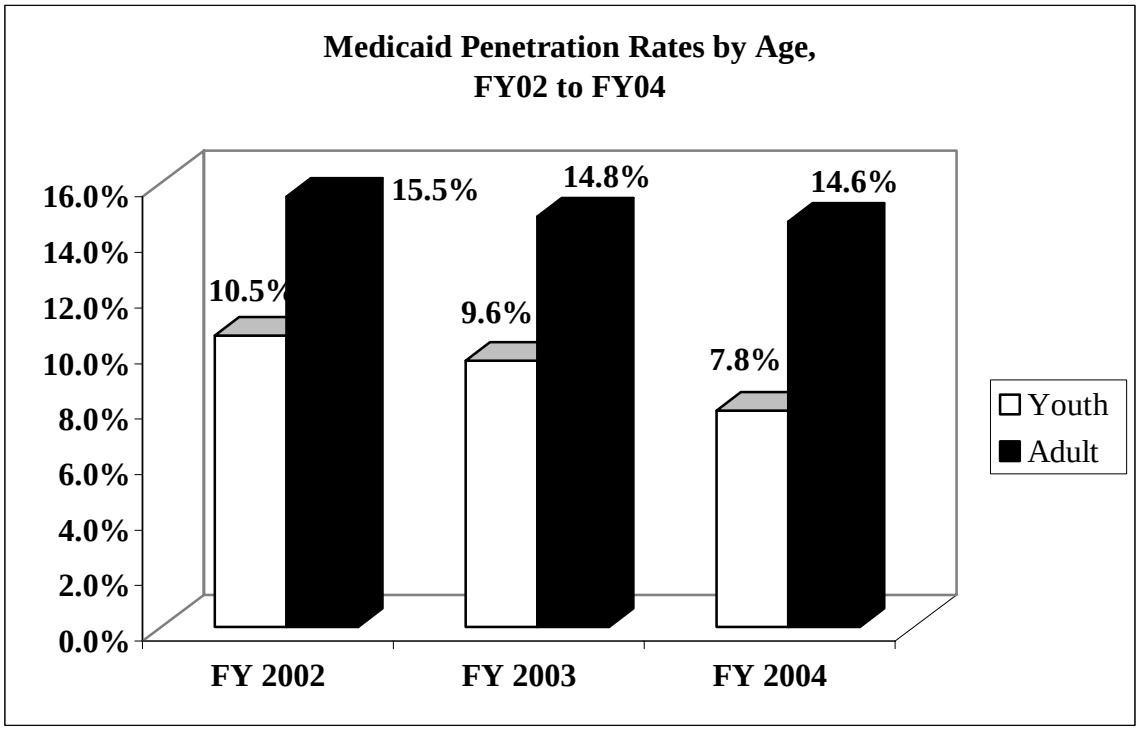


Penetration Rates

The calculation of penetration rates for persons on Medicaid receiving mental health services relies on the CCARs, encounters, and eligibility totals for the year. Number of Medicaid eligibles, required for the calculation of penetration rate, is determined from member months.

Penetration rates have declined steadily, with decreases for both Youth and Adults from FY 2002 to FY 2004. While the numbers served did decrease, the declines were not as pronounced as they seem. The other driver of penetration rate is the denominator; essentially the number of Medicaid enrollees during the year. The steady increase in enrollment numbers in Medicaid, all other things being equal, will drive down the calculated penetration rate. From FY 2002 to 2004, the number of eligibles increased by almost 100,000.

Chart 9.



Summary

Funding changes from FY 2001 to FY 2004 have dramatically reduced the number of non-Medicaid persons being served in the public mental health system. These reductions have resulted in an overall increase in the level of severity of those served, and have not decreased the average amount of services available to those persons able to access care. Nor have these reductions apparently negatively impacted the general quality or outcomes of those services.

Unexpectedly, the number of Medicaid persons reported served has also declined during this time period, despite an increase in caseload eligibility. However, the severity of the population served has also increased, in addition to a 44.83 percent increase in the average number of units of service reported delivered to each person. It is possible that this decrease in the numbers served is a product of the fact that budget reductions resulted in provider staff reductions, in addition to tighter assessment and 'triage' of all persons entering the system. It is also possible that the consistency in data reporting by the community was likewise impacted by these budget reductions.

The combined impact of these changes appears to show that Colorado's public mental health system increasingly is serving primarily those in crisis. This focus has, in turn, resulted in fewer prevention and early intervention efforts. For example, anecdotal evidence points to a reduction in outreach efforts in some schools. Of course, less prevention and early intervention will likely result in an increase in the number of persons needing crisis care. An effective and efficient public mental health system must balance these concerns in such a manner as to avoid foreseeable fiscal, economic and human costs.