

Review of the Orange County Central Receiving Center (CRC)

**Presented to Governing Board
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**Center for Community Partnerships
College of Health & Public Affairs
University of Central Florida**

Project Team

**Lawrence Martin, MBA, MSW, Ph.D., Director
Stephanie Myers, Ph.D., Faculty
Joan Nelson, MBA, MSW, Associate Director
Wende Phillips, MSW, LCSW, Coordinator
Hayden Smith, Graduate Research Assistant**

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PURPOSE

At the request of the Central Receiving Center (CRC) Governing Board, the UCF/CCP project team is pleased to provide this report analyzing the first six months of operation for the CRC. This report discusses thirteen findings and includes a capacity and equity analysis of state funding for services provided to persons with Severe and Persistent Mental Illness (SPMI). Recommendations are offered to assist the CRC in efficiently and effectively managing its human and financial resources.

The Project Team wishes to thank the management and staff of the CRC and its partner organizations that gave generously of their time for interviews and provided copies of reports and service data.

EXECUTIVE SUMMARY

Finding 1:

Management and staff of the Central Receiving Center (CRC) are doing an excellent job under challenging circumstances.

Recommendation:

Keep up the good work!

Finding 2:

A major goal of the CRC was to serve as a jail diversion program. This original goal has been replaced by other goals that now consume most of the CRC's resources.

Recommendation:

The mission and purpose of the CRC needs to be clarified. Is the CRC a jail diversion program or a community mental health receiving center or some combination? ***If*** a combination, ***then*** what proportion of the CRC activity should be directed toward jail diversion activities and what proportion to community mental health receiving center activities?

Finding 3:

A client processing "bottle neck" exists at the CRC.

Recommendation:

The CRC needs to have access to more community beds or decrease intake.

Finding 4:

Client length of stay at the CRC exceeds the 24 hour benchmark **47%** of the time.

Recommendation:

The CRC needs to take action to decrease client length of stay by: (1) clarifying its original purpose, (2) increasing access to more community beds, (3) decreasing intake, (4) revisiting the issue of remote placement, or (5) some combination thereof.

Finding 5:

Client average length of stay at the CRC is increasing.

Recommendation:

The CRC needs to take action to decrease client length of stay by: (1) clarifying its original purpose, (2) increasing access to more community beds, (3) decreasing intake, (4) revisiting the issue of remote placement, or (5) some combination thereof.

Finding 6:

The CRC facility is inadequate for its expanded role.

Recommendation:

The CRC needs to: (1) clarify its original purpose, (2) increase access to more community beds, (3) decrease intake, (4) revisit the issue of remote placement, (5) move to a larger facility, or (6) some combination thereof.

Finding 7:

Recidivism is not currently a problem at the CRC.

Recommendation:

Continue to track recidivism data.

Finding 8:

The number of community beds available to serve indigent clients is inadequate.

Recommendation:

The CRC needs to increase access to more community beds for indigent clients.

Finding 9:

The CRC is providing services to clients outside Orange County.

Recommendation:

The CRC needs to monitor this development and determine the impact on operations, costs, and community bed availability.

Finding 10:

The Public Defender is experiencing an increase in Baker Act activity as a result of the operations of the CRC.

Recommendation:

The CRC needs to continue to monitor the impact of workload on the Public Defender.

Finding 11:

Data collection lacks uniformity.

Recommendation:

The CRC needs to develop comprehensive data collection protocols across partner organizations.

Finding 12:

Orange County has a shortfall in state allocated funding for adults suffering from Severe and Persistent Mental Illness (SPMI) with a per person rate of \$483 compared to state's rate of \$797. Orange County has a short fall of 35 adult Crisis Stabilization Unit (CSU) "emergency" beds at a cost of \$3,718,278.

Recommendation:

The CRC and its partners need to bring this disparity to the attention of state officials and lawmakers.

Finding 13:

Priority areas for additional research and exploration include: (a) best practices for jail diversion/CRC programs, and (b) transitional services such as; client follow-up, case management services, medication management, step-down care, transportation, housing, and outpatient psychotherapy.

Recommendation:

This report has identified and documented several problems and issues confronting the CRC. The next step is to identify viable solutions.

PART I

FINDINGS & RECOMMENDATIONS

Finding 1:

Management and Staff of the Central Receiving Center (CRC) are doing an excellent job under challenging circumstances.

Discussion:

The increase in the number of clients being processed, the lack of available beds, transportation and transfer issues, limited space and limited resources make operation of the CRC a challenge for all involved. Nevertheless, the CRC management team has a long history of working collaboratively on community projects with mutual goals, while the CRC staff are experienced, resourceful, and also have well developed relationships with community agencies.

Recommendation:

Keep up the good work!

Finding 2:

A major goal of the CRC was to serve as a jail diversion program. This original goal has been replaced by other goals that now consume most of the CRC's resources.

Discussion:

As originally conceptualized, one of the major goals of the CRC was to serve as a jail diversion program. A primary target population for the CRC was originally intended to be: "persons with mental health and substance abuse problems ***who would otherwise have been arrested*** for misdemeanor offenses" (CRC Project Business Plan, Revision V dtd 09/01/02, page 1). During its first six months of operations, the actual number of clients brought to the CRC who would otherwise have been arrested represents only **7%** of the total clients served (see Table 1).

Table 1
Clients Diverted from Jail Compared to Non-Diverted Clients
Six Months: April 2003 to September 2003

	Apr	May	Jun	Jul	Aug	Sep	Totals	%
Diverted	15	19	13	20	20	17	104	7.4
Other	102	187	197	199	318	301	1304	92.6
Total	117	206	210	219	338	318	1408	100

Diverted = would have been arrested

Other = remainder of clients

Source: CRC Monthly Statistical Report

Other goals now consume a majority of the CRC's resources. The CRC now serves as a central receiving center for all clients with mental illness and substance abuse problems in Orange County. This change in focus has created the following issues:

- Increase in demand for services leading to the creation of a client processing "bottle neck" at the CRC.
- increase in client length of stay
- Inadequate CRC facilities
- Inadequate number of indigent beds
- provision of services to clients from outside Orange County

Recommendation:

The mission and purpose of the CRC needs to be clarified. Is the CRC a jail diversion program or a community mental health receiving center or some combination? ***If*** a combination, ***then*** what proportion of the CRC activity should be directed toward jail diversion activities and what proportion towards community mental health receiving center activities?

Finding 3:

A client processing "bottle neck" exists at the CRC.

Discussion:

The organization, facility and staffing for the CRC may be adequate for a "jail diversion program," but is inadequate for a community mental health receiving center designed to serve all clients with mental health and substance abuse problems in Orange County. The CRC began operations with a bed deficit. As part of its original plan, the CRC proposed the purchase of 20 hospital specialty beds at the Lakeside Alternatives, Princeton facility. The 20 beds never came on line. The lack of the original 20 beds combined with a shortage of short and long term substance abuse treatment beds,

crisis stabilization unit (CSU) beds, and step-down beds means that the CRC is forced to operate with a “chronic bed deficit.”

Additionally, law enforcement officers (LEO) now bring a variety of clients to the CRC, not just those who would otherwise have been arrested. This change in the practices of LEOs combined with the August 11 decision to accept hospital referrals has significantly increased intake at the CRC.

Entrance to the CRC is virtually unconstrained. Exit from the CRC is constrained by the “chronic bed deficit.” The front door of the CRC is wide open; the back door is not.

Recommendation:

The CRC needs to have access to more community beds or decrease intake.

Finding 4:

Client length of stay at the CRC exceeds the 24 hour benchmark 47% of the time.

Discussion:

Interviews with staff indicate that the original intent was for the CRC to place clients in a community treatment bed within 24 hours. During the month of September (see Table 2), The CRC met this benchmark only 53.5% of the time. Some 101 clients experienced a prolonged stay at the CRC of up to 4 days, while 38 clients experienced a prolonged stay of up to 10 days.

Recommendation:

The CRC needs to take action to decrease client length of stay by (1) clarifying its original purpose, (2) increasing access to more community beds, (3) decreasing intake, (4) revisiting the issue of remote placement, or (5) some combination thereof.

**Table 2
CRC Client Length of Stay
September 2003**

CRC LOS in Hours	Total Clients	% of Clients	Accumulative	
			Total	%
0 to 4 hours	70	23%		
5 to 12 hours	41	14%		
13 to 24 hours (1 day)	49	16%	160	53.51%
25 to 48 hours (2 days)	51	17%	51	17.06%
49 to 72 hours (3 days)	34	11%	85	28.43%
73 to 96 hours (4 days)	16	5%	101	33.78%
97 to 120 hours	14	5%		
121 to 144 hours	10	3%		
145 to 168 hours	3	1%		
169 to 192 hours	6	2%		
193 to 216 hours	3	1%		
217 to 240 hours (10 days)	2	1%	38	12.71%
Total Clients	299	100%	299	100.00%

Source: CRC Monthly Statistical Report

Finding 5:

Client average length of stay at the CRC is increasing.

Discussion:

As Table 3 illustrates, the average client length of stay has increased from 9 hours in May (the first month for which data are available) to 33.3 hours in September.

**Table 3
Total Client Average Length of Stay (LOS) in Hours & Minutes
Six Months: April 2003 to September 2003**

	APRIL 13-30	MAY 1-31	JUNE 1-30	JULY 1-31	AUG 1-31	SEPT 1-30
Average Total CRC Client Length Of Stay	N/A	9	14.02	14.24	28	33.33
Total Clients	117	206	210	219	338	318

Source: CRC Monthly Statistical Report

Recommendation:

The CRC needs to take action to decrease client length of stay by (1) clarifying its original purpose, (2) increasing access to more community beds, (3) decreasing intake, (4) revisiting the issue of remote placement, or (5) some combination of thereof.

Finding 6:

The CRC facility is inadequate for its expanded role.

Discussion:

The CRC facility was not designed for prolonged client length of stays. Few beds are available. The general purpose rooms are frequently crowded. Activities are limited. Additionally, the CRC was not intended to be a treatment facility. Increased client length of stay means that client treatment is delayed.

Recommendation:

The CRC needs to: (1) clarify its original purpose, (2) increase access to more community beds, (3) decrease intake, (4) revisit the issue of remote placement, (5) move to a larger facility, or (6) some combination thereof.

Finding 7:

Recidivism is not currently a problem at the CRC.

Discussion:

Interviews with staff indicated that a problem existed with repeat clients at the CRC. Staff consistently reported that 20% of the clients were responsible for 80% the CRC's business. Analysis of CRC data indicates that the percent of repeat consumers is low (under 10% over the last 30 days). While some clients revisit the CRC, the problem does not appear significant at this time. However, as system learning takes place, more clients may revisit the CRC.

Recommendation:

Continue to track recidivism data.

Finding 8:

The number of community beds available to serve indigent clients is inadequate.

Discussion:

Nearly **60%** of clients processed at the CRC are indigent. However, restrictions placed on CSU and other treatment beds make placing indigent clients a challenge for the CRC. Placement specialists are required to find an available bed that matches the payor source of the client (Medicaid, private insurance, indigent, etc.). Table 4 illustrates the steadily increasing number of indigent clients being processed at the CRC.

Recommendation:

The CRC needs to increase access to more community beds for indigent clients.

Table 4
CRC Clients by Payor Source

PAYOR SOURCE	APR 13-30	MAY 1-31	JUN 1-30	JUL 1-31	AUG 1-31	SEP 1-30	TOTALS	%
# INDIGENT	72	94	112	123	217	206	824	58.6
# MEDICAID	11	29	23	25	25	26	139	
# MEDICARE	4	16	10	19	20	15	84	
# MEDICAIRE/CAID	10	25	23	18	21	22	119	
# MANAGED CARE	20	40	42	18	35	28	183	
# MEDICAID MANAGE	N/A	N/A	N/A	16	14	18	48	
# VETERANS	N/A	N/A	N/A	N	6	3	9	
TOTALS	117	204	210	219	338	318	1406	100

Source: CRC Monthly Statistical Report

Finding 9:

The CRC is providing services to clients outside Orange County.

Discussion:

Objective 1 of the CRC Business Plan states: “Improve the centralized system of transportation, intake, comprehensive assessment, and provide immediate access to emergency behavioral healthcare services for **adult and elderly citizens of Orange County.**” Data indicates that some clients from surrounding counties are being served at the CRC (see Table 5).

**Table 5
CRC Clients by County of Residence**

COUNTY OF RESIDENCE	APRIL 13-30	MAY 1-31	JUNE 1-30	JULY 1-31	AUG 1-31	SEP 1-30	TOTAL YTD
ORANGE	96	167	157	173	261	252	1106
SEMINOLE	3	4	2	4	2	3	18
OSCEOLA	0	1	0	1	1	1	4
OTHER	4	3	4	1	2	4	18
OUT OF STATE	1	2	2	8	5	2	20
HOMELESS/ORANGE CO	13	29	45	32	66	56	241
HOMELESS/OTHER CO	0	0	0	0	2	0	2
TOTALS	117	206	210	219	339	318	1409

Source: CRC Monthly Statistical Report

Data provided by Center for Drug-Free Living (CFDFL) indicate that their Addictions Receiving Facility (ARF) is also being impacted by an increase in CRC clients from both Seminole and Osceola counties. As illustrated in Table 6, **35%** of CRC clients brought to the ARF are residents outside Orange County.

**Table 6
Number of CRC Marchman Act Clients by County**

	Orange	Seminole	Osceola	Totals
Mar 2003	8	11	3	22
May 2003	32	13	5	50
Aug 2003	68	20	3	91
Oct 2003	62	28	9	99
Totals	170 or 65%	72 or 27%	20 or 8%	262 or 100%

Source: CFDFL Monthly Data Report

Recommendation:

The CRC needs to monitor this development and determine the impact on operations, costs, and community bed availability.

Finding 10:

The Public Defender is experiencing an increase in Baker Act activity as a result of the operations of the CRC.

Discussion:

The Public Defender reports a significant increase in Baker Act activity following the August 11 decision of the CRC to accept all referrals from area hospitals. According to the Public Defender, the number of Baker Act cases closed per month ranged between 64 and 99 through August. In September, the number of closed cases increased to 120. This increase in case load translates into increased workload and associated costs for the Public Defender.

Recommendation:

The CRC needs to continue to monitor the impact of workload on the Public Defender.

Finding 11:

Data collection lacks uniformity.

Discussion:

Data collection across CRC partners is uneven and appears to have gaps. Individual partner management information systems (MIS) may be insufficient to track and report client data across all CRC partners. Interviews suggest that at least some partners are unsure of exactly what data are being collected and by whom. A comprehensive view of client flow through the CRC and its partners is difficult to establish.

Recommendation:

The CRC needs to continue to develop comprehensive data collection protocols across partner organizations.

Finding 12:

Orange County has a shortfall in state allocated funding for adults suffering from Severe and Persistent Mental Illness (SPMI) with a per person rate of \$483 compared to state's rate of \$797. Orange County has a short fall of 35 adult Crisis Stabilization Unit (CSU) "emergency" beds at a cost of \$3,718,278.

Discussion:

See Part II: Capacity and Equity Analyses.

Recommendation:

The CRC and its partners need to bring this disparity to the attention of state officials and lawmakers.

Finding 13:

Priority areas for additional research and exploration include: (a) best practices for jail diversion/CRC programs, and (b) transitional services such as; client follow-up, case management services, medication management, step-down care, transportation, housing, and outpatient psychotherapy.

Discussion:

A thread throughout interviews among CRC partners is that the mentally ill lack a variety of community-based services in Orange County. CRC partners suggest that community services for the mentally ill could prevent many of the crises that send individuals to the CRC. CRC partners suggest that services such as client follow up, medication and case management, housing, transportation, psycho-education and psychotherapy would not only resolve a majority of client needs, but would be more cost effective than adding more expensive program enhancements such as CSU beds.

Recommendation:

This report has identified and documented several problems and issues confronting the CRC. The next step is to identify viable solutions.

PART II

ORANGE COUNTY

**MENTAL HEALTH / SUBSTANCE
ABUSE**

TREATMENT

CAPACITY AND EQUITY ANALYSES

INTRODUCTION

This section presents findings on issues related to: (1) the status of mental health/substance abuse adult treatment demand and supply and (2) intra-state equity in the allocation of public (state) funds for mental health/substance abuse adult treatment in Orange County. The findings include information and data from the following sources:

- **National Institute of Mental Health**
Source: The Numbers Count, <http://www.nimh.nih.gov>. State mental health prevalence estimates.
- **US Department of Health and Human Services - Substance Abuse & Mental Health Services Administration (SAMHSA)**
Source: SAMHSA's National Mental Health Information Center, <http://www.mentalhealth.org>. State estimates of the numbers of persons with serious mental illness.
- **The Henry J. Kaiser Family Foundation State Health Facts**
Source: State Health Facts Online, <http://www.statehealthfacts.kff.org>. 2001 per capita mental health expenditure state rankings.
- **Medegy Health Information Management**
Source: "Orange County 2002 Comprehensive Assessment for Tracking Community Health (CATCH) report." Includes comparison rates for Baker Act, depressive disorders, psychoses, alcohol dependency and drug dependency hospital admissions for Orange County, peer counties and Florida.
- **Florida Department of Children & Families ADM Office – State and District 7**
Source: "Mental Health Program, Equity Analysis, Fiscal Year 2003 – 2004 report." State and sub-state estimates of the numbers of persons with serious mental illness, estimates for unmet Crisis Stabilization beds and estimates for substance abuse levels of need and funding for services.

National Institute of Mental Health

The National Institute of Mental Health prepared an annual report entitled “The Numbers Count.” These estimates place the issue of serious mental illness into a national context. According to the report, some **22%** of Americans age 18 and over (one in five adults) suffers from a diagnosable mental disorder in a given year. When applied to the 1998 US Census figures this translates into **44.3** million adults nationally.

U. S. Department of Health & Human Services – Substance Abuse & Mental Health Administration (SAMSHA)

SAMHSA estimates the total number of adults (age 18 and over) in Florida with serious mental illness at between 454,500 and 872,000. It should be noted that even the lower portion of this range is still considerably higher than the estimate of 312,234 used by the Florida Department of Children & Families in conducting their equity analyses (see below).

The Henry J. Kaiser Family Foundation

The Henry J. Kaiser Family Foundation ranks Florida:

- 6th** nationally in the number of state and county psychiatric hospital inpatient beds at 2,585;
- 7th** nationally in state and county psychiatric inpatient census at 2,451;
- 12th** nationally in total expenditures for the state mental health agency at \$578.3 million; and
- 47th** nationally in terms of per capita mental health expenditures at \$35.

Medegy Health Information Management

Reviewing the findings from the “2002 Orange County CATCH” study for comparison rates of Baker Act, Depressive Disorders and Psychoses hospital admissions for Orange County, the composite peer county, and the state presents interesting findings. According to the Medegy “2002 Orange County CATCH” study (see Table 7), Baker Act Hospital admission rates for Orange County in 2001 were 48.42 per 10,000. Comparable rates for the “peer” county were 60.71 per 10,000 and for the state, 55.95 per 10,000. In 1998 the rates were more comparable for Orange County and the “peer” county at 39.70 and 39.73 respectively. This may suggest that the rate of increase in psychiatric beds has not kept pace with the increase in need relative to the growth in population for Orange County as it has for the “peer” county and the state as a whole.

Table 7
Hospital Admission Crude per Capita Rates per 10,000 Total Population
(Baker Act, Depressive Disorders & Psychoses)

<i>Hospital Admissions</i>	Orange		Peer		State	
	1996/98	2001	1996/98	2001	1996/98	2001
Baker Act (*)	39.70	48.42	39.73	60.71	47.42	55.95
Depressive Disorders	1.45	2.32	1.83	2.78	1.22	3.18
Psychoses	43.78	38.81	42.41	65.49	38.58	56.73

(*) Baker Act information first year data for 1998, all other first year data 1996.

Source: Orange County 2002 Comprehensive Assessment for Tracking Community Health, Medegy Healthcare Information Management

The same pattern holds for hospitalizations for depressive disorders and most strikingly for hospitalization admission rates for psychoses. Of particular note is the increase in rates of admissions over time for both the state and “peer” county. The rate of increase for Orange County has not kept pace with the comparison rates, and in the case of hospitalization rates for psychoses the rate has dropped over time from 43.78 to 38.81 per 10,000 for Orange County.

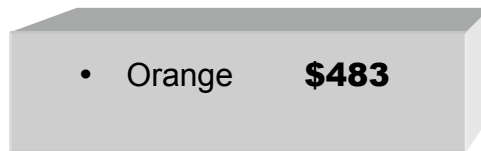
FLORIDA DEPARTMENT OF CHILDREN & FAMILIES (DCF)
MENTAL HEALTH PROGRAM
EQUITY ANALYSIS FISCAL YEAR 2003-2004

The Florida Department of Children and Families State and District 7 offices have prepared equity analyses of public funding levels for mental health services. The

methodology used applies percentage rates to general population statistics to determine the level of demand or need in numbers of clients requiring treatment services. This level is then divided into funding amounts to determine an annual per client expenditure level. These per capita levels are then compared to other districts in the statewide analysis and other counties in the county level analysis.

Estimates of the total number of clients with severe and persistent mental illness (SPMI) are based on a calculation of 3.3% of the general population between the ages of 18 and 54 combined with a calculation of .8% of the general population aged 55 and over. The result is then applied to state mental health adult appropriations for fiscal year 2003 – 2004. Based on the calculations, the following figures represent the current level of mental health public funding per person for Florida as a whole and for the four counties comprising District 7:

- Florida **\$797**
- Osceola **\$800**
- Brevard **\$748**
- Seminole **\$522**



As Table 8 illustrates:

District 7 receives less public mental health funding per person than other districts and Orange County receives less funding per person than other counties within District 7.

**Table 8
Per Capita Expenditure Estimates for Adults with SPMI**

	State	District 7	Orange	Osceola	Seminole	Brevard
SPMI population estimates	312,234	39,994	19,595	3,606	7,774	9,020
2003-04 appropriations	\$248,915,516	\$23,142,800*	\$9,458,753	\$2,883,689	\$4,056,973	\$6,743,385
Per person expenditures	\$797	\$579*	\$483	\$800	\$522	\$748
% of funds	----	9.297%	40.87%	12.46%	17.53%	29.12%
% of SPMI estimates	----	12.81%	48.99%	9.02%	19.44%	22.55%

* Adjusted from appropriation level in State Equity Analysis for District 7 actual allocations.

Source: Department of Children and Families State and District 7 Mental Health Equity Analysis.

The state equity analysis indicates that the annual treatment cost per person (including Baker Act funding) should be approximately \$1,225. Excluding Baker Act funding the amount is \$981. Using these numbers to estimate appropriate funding levels, District 7 has a revenue shortfall of between \$16,091,314 and \$25,899,850. Using these same numbers, the revenue shortfall for Orange County is between \$9,763,942 and \$14,545,122 (see Table 9).

Table 9
Funding Shortfalls Based On Florida DCF
Per Capita Costs Estimates for Adults with SPMI

	Total SPMI	Per person expenditures	Per person Shortfall excluding Baker Act funds	Per person Shortfall including Baker Act funds	Range of Funds needed
State	312,234	\$797	\$184	\$428	\$57,386,038 to \$133,571,134
District 7	39,994	\$579	\$402	\$646	\$16,091,314 to \$25,849,850
Orange County	19,595	\$483	\$498	\$742	\$9,763,942 to \$14,545,122

Source: DCF State and District 7 Mental Health Equity Analysis

ADULT CRISIS BEDS UNMET NEED

Florida Administrative Code, Chapter E-12.1C4 (8) establishes a ratio to estimate a community's need for crisis stabilization unit (CSU) beds at 10 beds per 100,000 adults. Using this ratio, the Florida Department of Children and Families estimates that District 7 needs **145.7** CSU beds.

Current funding levels through Baker Act and local matching funds support a level of **84.37** CSU beds (This figure is determined using a cost of \$292 per bed for 365 days, or a total cost of \$8,992,281). With the addition of 11 Medicaid beds, District 7 currently has support for 95.37 CSU beds.

The unmet need for CSU beds in District 7 is computed as

50.33

At rates of \$292 per day for 365 days the equivalent cost is \$5,364,064.

It is worth noting that:

District 7 has the greatest unmet (21.4%) need for CSU beds of all districts in Florida.

In order to determine Orange County's CSU unmet bed need, two approaches have been used. The first applies DCF's District 7 estimates for Orange County's percentage of the district's total SPMI population with serious and persistent mental illness at 48.99%. Applying that percentage rate to the District unmet need of 50.333 beds, the unmet need for beds in Orange County is 24.66. Using the same daily rate of \$292 for 365 days, the total funds needed to meet this need is \$2,627,855.

The second approach to estimate CSU unmet needs for Orange County follows the State Equity methodology using figures from District 7 office for number of currently funded beds. The ratio of 10 beds per 100,000 adult population indicates a need for 72.9 beds for Orange County's 728,872 adults. District 7 figures indicate 38 licensed CSU/SRT beds. Using the State's methodology, Orange County has an unmet need of 34.9 beds, with a cost estimate of \$3,718,278.

Estimates for Orange County's CSU unmet need range from 24.66 to 34.9 beds at cost estimates of \$2,628,382 to \$3,718,278.

ADULT SUBSTANCE ABUSE EQUITY ANALYSIS

Table 10 presents data for substance abuse treatment in Orange County. The Florida Department of Children and Families (DCF) estimates that some 58,887 persons are currently in need of substance abuse treatment services in the district (with 48.6% or a total of 28,620 persons residing in Orange County). The following table shows the funding allocations and per person estimates for Orange, Seminole, Osceola and Brevard counties.

Table 10
Per Capita Expenditure Estimates for Persons
Needing Substance Abuse Treatment

	District 7	Orange	Osceola	Seminole	Brevard
SA population estimates	58,887	28,620	5,302	10,971	13,994
2003-04 appropriations	\$12,176,299	\$6,133,615	\$998,325	\$1,361,694	\$3,682,665
Per person expenditures	\$207	\$214	\$188	\$124	\$263
% of funds	X	50.37%	8.20%	11.18%	30.24%
% of SA pop. Estimates	X	48.60%	9.00%	18.63%	23.70%

**Source: DCF State and District 7 Mental Health Equity Analysis

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Orange County 2002 CATCH data for Alcohol Dependency and Drug Dependency Hospital Admissions is presented in Table 10 below. Similar to the findings for mental illness hospital admissions, trends for rates for Orange County over time, when compared with the “peer” county and the state show a lack of growth for hospital admissions for both diagnoses. Orange County rates for hospital admissions for alcohol dependency dropped from 2.72 per 10,000 in 1996 to 1.39 in 2000. Rates for the “peer” county increased from 1.83 to 3.63 and for the state increased from 1.72 to 3.76 for the same period. Drug dependency admissions for Orange County dropped from .82 in 1996 to .42 in 2000. Rates from the “peer” county increased from 1.36 to 3.07 and the state from 1.08 to 2.42 for the same time period.

During this time period, the peak rate for Orange County occurred in 1998 with 1.60 per 10,000 drug dependency admissions. Similarly, 1998 had the highest rate of alcohol dependency admissions for Orange County over this time period at 3.01 per 10,000.

With these “spikes” in 1998, the data may be inconclusive with regards to admission rates for alcohol dependency and bed capacity. If there was capacity at the rate of 3.01 in 1998, it would seem that unless treatment beds were lost, there would be equivalent capacity but lower admissions for this condition in 2000.

However, there is a familiar pattern between drug dependency hospitalization rates in comparison with the “peer” county and state. While rates grew over time for both comparison groups, they did drop for Orange County. It could be argued that such differences between the “peer”, the state and Orange County may reflect lack of growth in service capacity compared to growing need, as well as possible other factors.

Table 11
Hospital Admission Crude per Capita Rates per 10,000 Total Population
(Alcohol & Drug Dependency)

<i>Hospital Admissions</i>	Orange		Peer		State	
	1996	2000	1996	2000	1996	2000
Alcohol Dependency	2.72	1.39	1.83	3.63	1.72	3.76
Drug Dependency	.82	.42	1.36	3.07	1.08	2.42

Source: Orange County 2002 Comprehensive Assessment for Tracking Community Health, Medegy Healthcare Information Management, Inc.