AN ANALYSIS OF MENTAL HEALTH CENTER COSTS in FY 1976-77

prepared for the

North Central Georgia
Health Systems Agency

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I. INTRODUCTION

A. Need to Understand CMHC Costs

The cost of Community Mental Health Center (CMHC) services is of considerable interest and concern to federal, state and county planners and decision makers. Georgia legislators, Department of Human Resources officials, and county commissioners must carefully weigh the costs and benefits of assuming a greater share of Center costs as the federal support continues to decline. What level and pattern of CMHC services should be maintained through state and county support?

The CMHC's are also concerned about their financial stability. Each center will have to take a hard look at its productivity, service patterns, staff, clients, and revenue mix in order to map a fiscally sound program strategy. Realistically, most of these centers facing the proposition of declining federal funds will have to find ways to trim costs and/or increase non-federal revenues.

At the same time, there is much concern among public and elected representatives over the soaring costs of health and mental health services. Many are looking toward the health systems agencies and planning process established under Public Law 93-641 to help contain these costs. Recently the Bureau of Health Planning and Resource Development issued a 'cost containment strategy' toward this end.[1]

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[1] Bureau of Health Planning and Resources Development, Cost Containment Strategy, Health Resources Administration, DHEW.

The Health Systems Agencies (HSA's) in Georgia have a responsibility to review community mental health center federal grant applications, and will likely have the authority to recommend the approval or denial of all federal funds to Centers in the not too distant future. Yet, until the HSA staff and review boards are able to obtain an accurate picture of Center costs and to understand the programmatic, administrative, and external factors underlying these costs, the reviews can have little substance. Without such information, HSA reviews can at best be superficial and at worst, arbitrary and capricious.

B. Study Purpose and Scope

Recognizing the critical need for such information, the North Central Georgia Health Systems Agency contracted with the Human Services Research Institute to:

1. Obtain and comparatively analyze the fiscal year 1976-77 operating costs of the community mental health centers in health service area III, and to identify the major factors contributing to cost variations.

2. To offer general and specific cost containment suggestions, and suggestions for improving the fiscal strength of the Centers. These suggestions stem from the analysis of Georgia CMHC costs, and from HSRI's general knowledge of cost containment tactics employed in other areas of the country.

3. To recommend practicable guidelines for the HSA's analysis of CMHC expenditure and revenue patterns as part of their center reviews. These guidelines are being prepared under separate cover, and are entitled: "Analyzing Mental Health Center Costs."

The study covers the 'out-patient' services of 14 of the 16 community mental health centers serving counties in the North Central Georgia health service area III:

North Georgia, Gainesville
North Cobb, Marietta
South Cobb-Douglass, Marietta
South Central Fulton, Atlanta
West Fulton, Atlanta
South Fulton, East Point
North Dekalb, Atlanta
Central Dekalb, Decatur
South Dekalb, Atlanta
Gwinnette-Rockdale, Lawrence
Clayton, Riverdale
Northeast Georgia, Athens
LaGrange, LaGrange
Griffin, Griffin

The Northside and Central Fulton community mental health centers in Atlanta were not included in this study as they are classified as 'in-patient' service providers; they're located at Northside Hospital and Grady Memorial Hospital respectively.

C. Organization of the Report

The remainder of the report is divided into four sections. Section II describes the process of data collection and analysis followed in the study. Section III presents a narrative summary of the study findings by Center. Section IV offers some cost containment suggestions for general consideration and for consideration by individual Centers. Section V proposes further work to increase the utility of the Mental Health Center cost analyses and analytic guide. The tabular analyses are included in the Appendix.

II. PROCEDURE

A. Data Base

1. Medicaid Reports

Georgia is one of only a few states allowing reimbursement for mental health center out-patient services as part of their state Medicaid plan. The FY 1976-77 Medicaid reports submitted by the Centers to the Community Services Support Section, Office of Mental Health, Department of Human Resources provided a reasonably comprehensive, economically obtainable, and readily available source of cost information upon which to frame the analysis. All direct and allowable indirect costs reported under Medicaid are categorized by program or disability group; in addition, the Medicaid-billable direct labor costs are classified by type of service; indirect service and administrative labor costs are identified as

- Program Administrative - Personnel time spent in the administration of a particular program.
- General Administrative - Personnel time spent in the planning, management, and administration of the Center in general.

Indirect expenses other than labor are identified as "unallocated" expenses, and are distributed among the direct service cost centers on the basis of direct service hours or other logical basis. The fundamental CMHC cost structure and procedures followed in the Medicaid reports can be found in the Community Mental Health Center Cost Finding Manual issued by the Community

Services Support Section, Office of Mental Health. (The manual has been revised as of July 1, 1978).

Of course, not all Centers offer a complete set of programs and services. Moreover, Centers report only those costs reimbursed under Medicaid; they generally do not report the cost of in-patient services (except as provided on an emergency basis through the supportive living program), or the cost of the training centers and other non-reimbursable services to the developmentally disabled. Except for relatively small expenditures for prolypsin and antibuse reported under the 'medication visit' service, the cost of drugs are not reflected in the outpatient Medicaid reports either.

As would be expected, having only begun the Medicaid Reporting Procedure in 1974, there were still a number of kinks in the system that affected the validity of the expenditure data. Be that as it may, the Medicaid reports offer some of the best cost information available in the nation on Mental Health Center outpatient operations. A few Centers claimed that the direct service staff, particularly the clinicians, were not reporting all of their direct service hours. Reportedly this reflected administrative breakdowns in a Center's service ticketing or time estimation procedures. One Center financial director indicated that the tendency was to under-estimate rather than over-estimate the number of service units delivered in order to effectively maintain the service unit Medicaid reimbursement allowance at a higher level. However, HSRI found instances where over-reporting

units-of-service was indicated as well. The distortion in unit or hourly service costs due to the under or over reporting of service units was most pronounced in the case of the low volume services, most commonly 'occupational' and 'recreational therapy'. Accordingly, the cost shown for these services should be considered unreliable. In any case, such mis-estimating should be reduced over time as Center review procedures continue to improve.

Another problem stems from variations in the ways Centers fit their services into the 1976-77 Medicaid direct service cost categories for reporting purposes. The biggest problem of this sort concerned the 'medical assessment' service cost center. Some CMHC's were including the lower-cost medication monitoring activities performed by nurses as well as the higher cost medication evaluations performed by physicians under the 'medical assessment' category thus leading to deceptively low unit of service costs. A separate 'medication visits' category has now been added in order to distinguish between these two activities. Other such problems reported by the Centers in 1976-77 were the over-use of the nursing assessment category to include activities other than monitoring, assessing, and treating of client physical problems, and the varying definition of what constitutes crisis intervention services in a given Center. However most such practices can be detected through a comparative analysis of Center costs and subsequently verified with the CMHC's. Realistically, such variations in reporting can be reduced over time but never

eliminated as the Centers will always have trouble force-fitting services into uniform categories. A final problem is that the reporting under the 'pharmacy' and 'residential' cost centers was too spotty and inconsistent to explain without further investigation.

By far, the greatest obstacle to picturing and comparing CMHC operations on the basis of the 1976-77 Medicaid reports alone, was the lack of information on time spent for staff activities subsumed under 'program' and 'general' administration. For each direct service contact, how much time do staff spend in charting, lab tests, co-therapy, transportation, case coordination, and other direct but non-billable services? Additionally, how much time is spent in research and evaluation, quality assurance, consultation and education, in-service training, reporting, and in other such program and general administration activities?

The importance of providing a balanced set of direct services and support activities is generally accepted. For this reason, a few of the Centers regularly collect this information for internal management purposes, and the Community Services Support Section in the State Office of Mental Health now captures the most important direct and indirect services in the Medicaid reports namely: charting, case management, transportation, child care, consultation and education, primary prevention, in-service training, and program and fiscal reporting.

Despite the Medicaid report limitations, the reports were very useful in deriving costs-per-units-of-service, and formulating administrative cost profiles and financial ratios in order to signal unusally high or low costs, or peculiar expenditure patterns for further investigation.

2. Center Surveys

In an attempt to obtain first-hand explanations for the unusually high or low Center costs or financial ratios, and to obtain supplementary programmatic, administrative, and epidemiologic information, HSRI mailed a survey to each of the fourteen (14) centers. The survey asked for:

(1) Catchment area demographic and epidemiologic data
(2) Service outlet location(s)
(3) Program staffing patterns
(4) Break-out of staff administrative time
(5) Break-out of direct, non-face-to-face service time
(6) Number of client episodes by program
(7) A characterization of the Center's financial management system

Most Centers could not produce items 3 through 6 without considerable staff effort. Center staff were already swamped with tasks such as revamping their accounting systems to accomodate the more elaborate Fiscal 1978-79 Medicaid reporting requirements, and preparing grant applications and budgets; as a result, few were able to submit complete survey responses. The survey

information provided by most Centers was incomplete. In order to obtain as much information as possible within the project time and cost limits, HSRI staff, accompanied by the HSA mental health planners, visited the following Centers: North Dekalb, Central Dekalb, Clayton, Griffin, North Cobb, South Cobb-Douglass, LaGrange, South Central Fulton, and South Fulton. The remaining Centers were contacted by phone with any questions pertaining to their fiscal profiles.

HSRI's ability to obtain the needed information during the Center visits was, in most cases, bounded by the knowledge of the financial directors and Center directors interviewed. Some of the Center directors and financial managers were new to their jobs and were not familiar with Center operations during the fiscal year in question, 1976-77. Few of the fiscal managers could offer much insight into the "why" (program implications) of the reported costs. Finally, unless the Centers had such information at hand at the time of our visit -- most did not -- they could not be expected to produce it within the time available for the interviews.

3. Other

The North Central Georgia Health Systems Agency also provided HSRI with the following information of help in interpreting the cost data, and in arriving at sensible cost containment and financial management suggestions.

- The 1976-77 state mental health/mental retardation reports. These reports profiled center admissions according to age, family income, disability, source of referral, and other personal characteristics of the target population. The reports also provided an indication of the relative numbers of Center clients. Reports were unavailable for the Fulton county Centers; they have only recently agreed to provide this information to the state. Two Center directors expressed the concern that the reports understated their client load in fiscal year 1976-77 due to Center under-reporting, and to the elimination of mis-formatted feeder reports that could not be processed by the computer; most Center directors accepted the reports as representative of their situations.
- National Institute of Mental Health (NIMH) 1975-78 grant applications, catchment area reports, and '75 inventories (profiles) of the federally funded centers. Much of this information was out-dated and could not be obtained for all Centers. Still, it served as good background information and as a check on other more current information obtained. Such information was not available for the non-federally-funded mental health Centers.
- The Mental Health Association of Metropolitan Atlanta, Inc. visited and prepared brief descriptions of the ten Centers in the Atlanta metropolitan area. These descriptions were of some use in understanding the programmatic objectives and service philosophies of the Atlanta Centers.

Though the inability to obtain uniform, documented program information from most of the Centers through the HSRI surveys and other sources limited the depth of HSRI's analysis, we are satisfied that enough information was made available to produce meaningful Center cost analyses and general cost containment suggestions.

B. Analysis

"Measurement without comparison is not sufficient to judge the value of the results" [1].

Unfortunately there is little available CMHC cost information or accepted cost norms against which to compare the costs of the community mental health centers in the North Central Georgia Health Service area. Fortunately, HSRI had benefit of the CMHC cost data compiled by Dr. Minnehan and Dr. Lauderbach in the course of their review of Center grant applications in DHEW Region III, as well as the ability to compare the fourteen North Central Georgia Centers. As noted in Section V, this base of comparison could be broadened considerably by compiling cost data on the remaining eighteen centers in Georgia, and by updating cost data for the North Central Georgia and other Georgia Centers in FY 1977-78, FY 1978-79, and future years. At the same time, additional cost data should be obtainable from Centers in other states, though inter-state comparisons would be more difficult to assess than intrastate comparisons due to significant differences in State Mental Health Systems characteristics.

HSRI employed two complementary approaches to the analysis of Center costs: the multiplicative or input/output approach, and the additive or component approach. Coupled with a cursory review

[1] R. Wideman and P. Horst, Design of an Evaluation System for the National Institute of Mental Health, Vol. I, Urban Institute, NTIS No. PB 2211-80, January 1973.

of program requirements and constraints HSRI was able to tentatively explain some of the differences in Center efficiency and expenditure patterns. These approaches are explained further in the HSRI's Guide entitled "Analyzing Mental Health Center Costs." (September, 1978).

1. Multiplicative Approach

The multiplicative model transforms the Center data into comparative input/output ratios indicative of relative Center efficiency - in other words, the relative ability of the Centers to provide a given level of direct service to clients in proportion to the resources expended.

Using these indices, HSRI could make a preliminary determination of the relative efficiency or productivity of each Center in terms of delivering direct face-to-face services to clients. As noted earlier, insufficient data was available in FY 1976-77 on the level of indirect services to include them in the analyses. Thus, the study examines relative Center 'efficiency' only insofar as the delivery of direct face-to-face services to clients are concerned and not with respect to the delivery of other services (e.g., consultation and education.)

The following chart shows the basic indices used in analyzing Center efficiency, and refers to the tables (in the Appendix) in which the indices are compiled.

Output		Input	Tables
unit or hour of service by program (disability group)	per	Cost	A1, and P1
units or hours of service	per	$1,000 total expenditure	A10, and P10
hours of face-to-face time	per	Staff	A7 and P7

2. Additive Approach

The additive approach examines the break-out of Center labor costs by service and administrative activity, and the break-out of other non-labor costs which make up the overall cost of operating each Center. The major of cost components are:

Direct face-to-face labor costs

+ Program administrative costs (labor):
  - Direct client non-face-to-face costs
  - Direct service labor costs (e.g. consultation and education)
  - Program-specific administrative costs

+ General administrative labor costs

+ Unallocated (non-labor) costs

= Total cost of the Center's operation

The series of tables showing these cost components and the relative size of these cost components are as follows:

Tables 2: Dollar components of total cost per hour

Tables 3: Percents of unallocated costs

Tables 4: Ratios of indirect costs to face-to-face costs

Tables 5: Ratios of indirect costs to direct costs

Tables 6: Cost component summary

By analyzing the proportionate size of these different categories of expenditure, and comparing expenditure patterns among the Centers, HSRI was able to identify areas of activity or operational expenses which appeared to be out-of-line and possibly out-of-balance. For instance:

- A disproportionately high ratio (proportion) of time (cost) spent for general administrative activities as opposed to direct service activities could indicate a top-heavy organization,
- A proportionately high amount of time (cost) for diagnosis and evaluation in the adult mental health program as compared to the amount of direct service time (cost) could indicate an ineffective case management system or treatment program.

a. Staff Costs

The cost of staff time spent on direct face-to-face outpatient services was available from the Medicaid Reports. The costs of staff time spent in different direct non-face-to-face service, indirect service, (e.g., consultation and education), and administrative activities generally accounts for about half of a Center's costs; consequently it is a most important area for possible cost containment measures. Yet, HSRI was unable to obtain the necessary break-out of these activities from the Medicaid Reports or Centers themselves and therefore could do little more than guess at the relative size of these activities, and suggest general cost containment options.

More specifically, the 1976-77 Medicaid Reports only broke down the costs into program, general administration, and consultation and education categories. Break-outs of direct non-face-to-face activities into charting, lab tests, co-therapy, transportation, case coordination, and the like were not available though a few Centers were able to provide estimated break-downs of these activities in response to HSRI's survey. Likewise, the 1976-77 reports did not break-out the staff time spent in different program and administrative activities such as research and evaluation, quality assurance, in-service training, and management reporting.

b. Non-staff Costs

The operational expenditures other than labor normally amount to less than 20% of the Center's costs. In and of themselves they have relatively little cost saving potential. Nonetheless, they can serve to affirm or discount different explanations of apparent inefficiencies. For instance, if a Center reports that its low utilization and corresponding high cost per client is a reflection of its pursuit of a Balanced Service System principle of "serving clients in their home environments", the travel expenditure should be relatively high. If not this explanation comes into question.

3. Program Requirements and Constraints

Finally, HSRI examined other organizational, programmatic, and epidemiologic information available on the Mental Health Center programs in order to better understand the Center's staff utilization, client mix, organization and staffing patterns, and catchment area characteristics (rural, urban), each of which influences Center costs. The table on the following page lists a number of these Center characteristics and related considerations.

Its important to remind the reader that these descriptors represent only a fraction of the total possible descriptors which could conceivably be examined. Moreover, these considerations do not necessarily apply in all situations. They are capsuled here to give the reader some insight into HSRI's interpretative judgements, and not as hard-and-fast rules.

Selected Mental Health Center Descriptors and Considerations

Descriptors	Some Considerations
Client Mix:	
Mental Health Treatment History • % former inpatients (mostly acute) • % former State Mental Hospital patients (mostly chronic) • % having no prior treatment (less seriously ill)	• c re of chronic patients is generally less costly than the c re of actue patients; the chronic patient is less likely to break appointments drop-out of service. • the acute clients usually attract more individual staff time, require proportionately more diagnostic work-ups and case management support. • the less seriously ill should be less costly to serve though this can be offset by a relatively high turnover, greater case start-up costs, and difficulty in collecting fees.
• no. of clients per 100,000 population	• Indicative of the Center's relative accessibility, acceptability, and catchment area penetration - the Center's actual and potential utilization.
Organization:	
• Decentralized operation (satellites)	• Higher general administrative costs • Higher facility and equipment costs • Higher potential utilization (accessibility)
• Centralized operation	• Lower general administrative costs • Lower facility and equipment costs • Lower potential utilization (accessibility)

Descriptors	Some Considerations
Staffing:	
• Higher proportion of donated (contracted) staff	• Lower fringe benefits
• Higher use of volunteer staff	• Lower cost per unit of service
• Proportionately greater no. of mental health clinicians than social workers	• Higher cost per staff
• No. of staff per 100,000 population	• Relative service capacity-potential utilization
Catchment Area:	
• Low population density (rural)	• Higher cost for travel and transportation; • Lower utilization potential
• High population density (urban)	• Higher resource costs (labor and non-labor); • Higher utilization potential
Treatment Philosophy:	
• Balanced Service System (out-of-Center Services)	• More staff travel required, less potential amount of face-to-face time per staff lower (productivity); higher proportion of individual and family counselling services entailed.
• Traditional, In-Center Services	• Less staff travel required, greater potential amount of face-to-face time per staff - higher productivity.

Descriptors	Some Considerations
Program/Service Mix:	
• Hours of service per 100,000 population by program	• Low volume programs and services are generally more costly than high volume programs and services.
• Relative hours of service (service mix)	• specialized programs such as those for children and adolescents are usually more costly than general programs; because these programs usually entail a more costly complement of specialized and less heavily utilized staff (e.g., child psychiatrist or psychologist).
	• Group modes of treatment are less costly to provide than individual modes of treatment.
	• Services requiring physician and nursing time (e.g., medical and 'nursing assessment') are generally more costly than other services.
Growth Pattern:	
• Center Age • Federal Grant year	• During the early years of a Center's growth or decline commonly coming at the beginning or end of a federal grant, the general administrative costs are likely to be relatively high as administrative staff are the first to be hired and the last to be let go;
	• Likewise, in the early years and late years, the program administrative costs will likely be relatively high reflecting the Center's case building process.
	• Equipment costs will be high in the early years.

Before presenting the findings, it's important to remind the reader that the time and cost constraints left HSRI little choice but to construct fiscal and program indicators from the data readily at hand. Certainly there are a number of efficiency, fiscal component, and programmatic indicators which would offer more insight into Center operations than those which we've been able to construct. Some such indicators are examined in HSRI's guide entitled "Analyzing Mental Health Center Costs." This guide is being prepared under separate cover. The guide will be much more helpful than this brief procedural description in terms of explaining how best to conduct general fiscal analyses, in presenting possible ways to interpret findings, and in introducing other considerations not noted here.

III. FINDINGS

A. General

This section attempts to highlight the more significant financial and programmatic implications of the data.

Interlaced with the findings regarding relative Center efficiency and expenditure patterns are explanations offered by the Center, or suppositions offered by HSRI regarding some of the chief factors or problems--controllable and uncontrollable--underlying differences in Center costs. There could well be explanations or overriding considerations other than those mentioned.

B. Specific

Findings for each of the following mental health centers are included in the remainder of this section:

1. North Georgia, Gainesville
2. North Cobb and South Cobb/Douglass, Marietta
3. South Central Fulton, Atlanta
4. West Fulton, Atlanta
5. South Fulton, East Point
6. North DeKalb, Atlanta
7. Central DeKalb, Decatur
8. South DeKalb, Atlanta
9. Gwinnette-Rockdale, Lawrenceville
10. Clayton, Riverdale
11. Northeast Georgia, Athens

12. LaGrange, LaGrange

13. Griffin, Griffin

Unless otherwise specified, the "average" against which each of the Center figures are compared means the average of these fourteen Mental Health Centers.

1. North Georgia Comprehensive Community Mental Health Center

Gainesville is one of the largest Centers in North Central Georgia. At the end of Fiscal Year 1976-77 the Center reported an active case load of 1,960. The catchment area covers 13 counties, 214,000 people, and 3,366 square miles. The Gainesville Center is a disciple of the Balanced Service System Principles and had been fully accredited by the Joint Commission on Accreditation of Hospitals in accordance with these principles.

The cost per labor hour of face-to-face service is generally lower than the average of the fourteen Centers; the group counselling cost is the lowest of all NCG Centers (Table P-1). Likewise, as shown in Table P-6, the overall cost per hour of direct personnel service (including direct non-face-to-face and indirect services) is the lowest of all the Centers in the study. This reflects the fact that the average salary of the service staff is lower than that of most of the other North Central Georgia Centers (Table P-7).

The savings attributed to lower staff salaries is mostly offset by the Center's adherence to the inherently inefficient

Balanced Service System mode of service delivery. The average caseload per staff member is less than 30% of the like average of the North Central Georgia Centers (Table P-7). The relatively high amount of staff time which must be spent in travel is indicated by the higher-than-average cost of travel--almost double that of the other NCG Centers (Table P-3). Still by keeping the average face-to-face time spent on each client contact above average (Table P-7), the Center seems able to keep costs in line with even those Centers providing the traditional, more inherently efficient in-center services. As would be expected under the Balanced Service System, the amount of individual and family counselling services provided per 100,000 population is higher than the average Mental Health Center in North Central Georgia. The day-care, activity therapy, medication visits and medical assessment services per 100,000 population are also higher than average as would be expected with the Center's relatively large chronic and acute population (Table U-2).

The higher-than-average ratio of program administrative to direct face-to-face personnel costs (Table P-6) may be explained in terms of the extra staff time spent in the client's natural envrionment and time spent in coordination with other community service providers.

The Center was able to keep its rent down as only the two main facilities in Toccoa and Gainesville demand rent. Services in the other 11 counties are provided in rent-free health

departments, schools, and other community-based facilities. The communication and travel expense are naturally high due to the large area which must be covered, the philosophy of providing service out in the community, and the considerable number of calls required to the regional hospital.

2. North Cobb and South Cobb/Douglass Mental Health Centers

The North Cobb catchment area takes in the cities of Marietta, Kennesaw and Acworth. The South Cobb/Douglass catchment area includes Powder Springs, Mableton, Austell, Smyrna, Lithia Springs and Vinings. The population in the North Cobb catchment area is 105,221; the population in the South Cobb/Douglass catchment area is 171,441. The combined area is approximately 545 square miles. The staffing for the North Cobb Center was approximately 115. The staffing for the South Cobb Center was less than 3.

Though the Cobb County mental health program had been divided into two separate area mental health and mental retardation programs, the administrative offices for both programs were located at the North Cobb Center until May of 1977. An NIMH operations grant was received in July, 1977.

Although the South Cobb/Douglass data is tabulated separately in the Appendices, its scale of operation is far too small and its administrative cost too inextricably tied to North Cobb to separate the cost analysis. The South Cobb/Douglass direct service staff consisted of one social worker plus a consulting physician to conduct the medical assessments and oversee medication visits at a

cost of $35.00 an hour. The extremely high case load per staff and correspondingly very low amount of face-to-face time which could be afforded each client raises strong doubts as to the quality of this service arrangement (Table P-7).

The cost per hour of face-to-face service was about average at the North Cobb program (Table P-1) as was the overall cost per hour of service including administrative and unallocated expenses Table P-10).

The service mix at North Cobb is also within a normal range with the exception of the 'diagnosis/assessment/evaluation' service; the units of this service per 100,000 population was the highest of any of the Centers (Table P-9). Most likely, this reflects the Center's efforts to increase its caseload in connection with the anticipated federal grant, but is also explained by the Center director as a possible accounting problem wherein many 'crisis intervention' services were reported as 'diagnosis and evaluation' services.

The program administrative, general administrative and unallocated expenses as a percent of face-to-face staff costs were all above average (Table P-6). In fact, in the mental health program the ratio of program administrative, unallocated, and overall indirect costs to direct costs were the highest of all the Centers studied (Table P-6). This again reflects in some part the amount of time spent by service staff in building the program. All of the programs showed a lower than average amount

of face-to-face service time per staff, and below average caseloads per staff as would be expected in an expanding program. The amount of face-to-face time per staff in the alcohol program was the lowest of any of the Centers indicating overstaffing and under utilization (Table P-7). The low utilization was explained by the Center as a function of the program's location in a high crime public housing project which discouraged the attendance of many potential program clients.

The high equipment expense was the most significant contributor to the above-average ratio of unallocated expenses to direct service costs. Equipment purchases are to be expected in the initial years of an expanding program, if for no other reason than as a ready means of spending public funds before they revert. Moreover, the full cost of the equipment must be reported in the year of purchase and cannot be amortized over the years according to Medicaid reporting requirements.

The Center's ratio of third party payment revenues to costs (less than 6%) was the lowest of any of the Centers likely reflecting their overriding interest in building the caseload, the readily available federal dollars, and the inclination of the therapists to grant high discounts (Table P-8).

3. South Central Fulton Mental Health Center[1]

The Center has been in operation since September of 1970.

[1]As the Fulton County Division of Mental Health has not provided data to the MHMRIS, there was no client information with which HSRI could derive utilization data. Similarly, no HSRI survey data was provided by the South Central and West Fulton Community Mental Health Centers and that provided by the South Fulton Center was limited. As a result, the level of analysis possible is not as great as with the other fourteen Centers.

It was in the seventh year of its staffing grant. Total staffing for the Center is 28. Of these only 8 are professional, in other words at masters level of above; six (6) are CETA employees. Until September of 1976, the Center's operation was housed at the Atlanta Southside Comprehensive Health Center. Currently the South Central Fulton Center has a contractual agreement with the Southside Center to provide partial hospitalization, drug abuse and alcoholism services for catchment area residents. The south central catchment area includes the "Model Cities" area of Atlanta, and is the most economically disadvantaged of any of the catchment areas. The catchment area population is estimated to be 90,000.

The cost per direct face-to-face hour of service in the South Central Fulton Center is about the average of the other North Central Georgia Centers (Table P-1). The level and mix of services is also about average with the exception of the medication visits and crisis intervention services, which are lower than average. There is a relatively high ratio of diagnostic and evaluation service units to counselling service units--39% (Table P-1). According to the Center staff this is due to a high number of client referrals from other agencies, and a high number of non-returns (in other words, high client turn over); the Center also was engaged in the process of building their caseload in the latter part of the year.

The overall cost per hour of service is also about average with the exception of the crisis intervention service which was

above average (Table P-6). The ratio of unallocated expenses to direct labor costs are average or below average except for the facility rental which may be higher due to their recent move to a relatively new social services center (Table P-3).

The administrative costs are generally higher than most of the Centers in North Central Georgia but lower than the other Fulton County Centers. The amount of face-to-face staff time to non-face-to-face staff time is below average particularly considering the relatively large day-care and activity therapy programs which typically entail proportionately less non-face-to-face service support (Table P-7). The lower staff productivity could be partially attributed to the disorganization and lower staff morale accompanying the declining budget from a high of $1,000,000 to the current level of about $400,000, it could be a function of the less-qualified service staff, or it could be a function of a strong inter-service coordination philosophy wherein considerable time is spent in referral and follow-up. It may also be a function of the non-billable time required to help multi-problem clients, and high rate of broken appointments common in more disadvantaged areas. Perhaps the staff also spends more time than other Centers in consultation and education services; they have implemented a life skills program for school age children.

4. West Fulton Mental Health Center

The Center has been in operation since July of 1971. The

population is approximately 137,000. The total staffing for the Center is 15 of which 11 are professional. All services are presently provided from the one Center location.

The cost of direct face-to-face services was generally above average, reflecting the higher level of training and salaries demanded by the staff. The cost of the ambulatory detoxification service was the highest of any of the Centers seemingly for the same reason that the South Fulton's ambulatory detoxification costs were high--the high cost of the medical staff time involved and relatively low service utilization.

The individual and group counselling costs were likewise among the highest of all the North Central Georgia Centers, undoubtedly a function of the relatively high level of training and commensurate salaries of the staff providing these services. The level of service provided per 100,000 population was generally lower than average with the exception of crisis intervention, individual and family counselling (Table P-9). Still, the overall costs per hour of direct service (including direct non-face-to-face services and indirect services) is generally lower than average (Table P-6). This is largely possibly due to the above-average amount of face-to-face time provided per staff (Table P-7). While the ratio of general administrative costs to direct service costs (face-to-face plus non-face-to-face time) was the highest of all of the Centers, this is largely offset by a reportedly small consultation and education program, and a lower than average ratio

of unallocated expenses to direct service costs. As is the case with the South Fulton Center, the high general administrative costs are likely due to the relatively high cost of the Center administrative staff.

The low ratio of diagnostic and evaluation service units to the counselling service units indicates a low client turnover (Table P-1). But in view of the lower than average service levels per 100,000 population (Table P-9), it may also reflect the under utilization of services and relatively poor accessibility, community visibility or acceptance.

5. South Fulton Mental Health Center

The South Fulton Mental Health Center is located on the grounds of the South Fulton Hospital; it has been in operation since July of 1971. The catchment area is approximately 133,700, and covers a 165 square mile area. The catchment area is urban in character with the exception of the more-rural southern most sector. The Center has approximately 21 staff. At present all services are being provided at the Center with the exception of a socialization program--the Friendship Club. The staff goes to Fairburn twice a month to work with the after-care groups at the Health Department.

The cost per hour of direct face-to-face service is higher than most of the Centers (Table P-1). This is a function of the higher-than-average salaries of the highly qualified staff which

includes a psychiatrist (80% time) who also serves as the Center director, and a child psychologist (80% time). Also included are a six-hour-per-week child psychiatrist and a pharmacist.

The level of services per 100,000 catchment population is lower than average with the exception of individual and family counselling. On the other hand, the crisis intervention service is the highest level of service provided per 100,000 population of any of the Centers. The reason is unknown, though it could reflect a relatively large 'acute' population.

The cost of the ambulatory detoxification face-to-face service is the highest of any of the Centers by far (Table P-1). According to the Center director this reflects the high quality of the clinical service staff; however, we would also suspect that the program was under utilized as it was in competition with the Alcoholism Treatment Center (ATC); the ATC eventually absorbed the program as part of the alcoholic treatment center's consolidation in which it lost 30 positions.

The Center is apparently able to offset its higher-than-average staff costs by providing a higher level of face-to-face services per staff (productivity). The average amount of face-to-face time spent per staff is among the highest of all the NCG Centers (Table P-7). The program administrative costs are sufficiently high to indicate that the high amount of staff face-to-face time is not at the expense of the essential indirect services such as charting, case management, etc. (Table P-6).

The general administrative time is among the highest of all

the Centers surveyed. One possible reason is that the director's salary as a psychiatrist is higher than most center directors, and 40 to 50 percent of his time and salary must be alloted for general administration.

The higher-than-average ratio of unallocated (non-staff) expenses to direct service costs reflects an extraordinarily high expenditure for supplies. The Center director explained that the Center had an over-supply of drugs going into the previous year and so they expended deceptively little for drugs in 1975-76; then despite the county's protests, the state cut their drug allocation in 1976-77 to reflect the 1975-76 expenditures. Consequently in 1976-77 the Center overran the state allotment and had to cover 10,000 to 20,000 in drug costs with county funds; this cost appeared under supplies.

The turnover among South Fulton clients appears relatively low as indicated by the low percent of diagnostic, evaluation and assessment units to counselling service units--16% (Table P-1).

6. North DeKalb Mental Health/Mental Retardation Center

The North DeKalb Center has been in operation since 1973. The population of the catchment area was estimated to be 158,000 in 1975. The catchment area includes the cities of Chamblee, Doraville, census track 201 of Atlanta, and unincorporated areas of Lynwood Park, Dunwoody, and Druid Hills. Like the Central DeKalb Center, the North DeKalb Center has a number of satellite

facilities. These facilities are the Lynwood Park Satellite Center, the DeKalb Addiction Center, the Doraville Family and Youth Center, and the Georgia Mental Health Institute housing the transitional and supportive living programs. The Center staffing totals 71 of which 27 are masters level or above. Fifty-five of the staff members are out-stationed from the Georgia Mental Health Institute.

Like the Central DeKalb Center the North DeKalb Center expanded its caseload by about two-thirds in 1976-77 (MHMRIS). The North DeKalb Center had one of the highest levels of overall hours of service per 100,000 population (Table P-9).

Most of North DeKalb's labor costs per face-to-face hour of service fall below the like costs of other Centers in the North Central Georgia area. The ambulatory detoxification, nursing assessment, medical assessment, family counselling, group counselling, and crisis intervention services are among the lowest in the North Central Georgia area (Table P-1).

Likewise the total cost per hour of service (including administration, consultation and education, and unallocated (non-staff) expenses) is among the lowest of all Centers for day-care and group counselling services, and is lower than average for individual and family counselling ambulatory detoxification and nursing assessment services (Table P-10). The overall average cost per direct hour of service is the lowest of any of the North Central Georgia Centers. Coincidentally, these same services are the relatively high volume services (Table P-9).

Factors possibly contributing to these lower costs are as follows:

(1) The sizable day-care and group counselling programs in particular contribute to the highest number of hours of face-to-face time per client of any Center even though the average number of face-to-face hours per staff is about average (Table P-7)

(2) The caseloads per staff are the lowest of any Center indicating that less case management time in outreach efforts are necessary than may be the case in understaffed Centers? (Table P-7)

In summary, the North DeKalb Center appears to have a productive staff, and an economic, highly utilized mix of traditional, in-center services.

7. Central DeKalb Mental Health/Mental Retardation Center

The Central DeKalb Center is located on the grounds of the DeKalb General Hospital. The Center has been in operation since January of 1973. The population of the Central DeKalb catchment area is approximately 200,000. It covers a large, generally urban area which includes the cities of Decatur, Avondale Estates, Tucker, Clarkston, Stone Mountain, Pine Lake and portions of Atlanta. The Center has a number of satellite facilities. One is the Kirkwood Mental Health Center, a second is the Dekalb Addiction Center, a third the Children's Program, and a fourth the Adolescent Program.

Toward the end of fiscal year 1976-77, the Center had 60 staff; half were masters level or above. Generally speaking, the Central DeKalb Center's direct labor costs per hour of service were about average and administrative costs were below average.

The relatively high number of medication visits and medical assessments per 100,000 population coupled with the relatively low average caseloads per staff member (Table P-9) would seem to indicate that the program has a relatively high number of chronically mentally ill clients though this is not indicated by the percent-4%-of clients having been referred from a state mental hospital (Table U-2). Possibly it indicates that the chronic patients recieve more frequent service than in most of the other NCG Centers or, perhaps it has more to do with the ready access to hospital physicians at Grady.

The Center programs provide their clients with an above-average amount of face-to-face service; the Child and Adolescent program shows an especially high rate of face-to-face service per client. The high cost (direct and indirect) of the adolescent program (Table P-6) is attributed largely to the fact that referrals from the participating school--a one third financial sponsor of the program--have declined purportedly for fear that the schools will eventually be obligated to pick up a larger share of the program cost under the recently passed Public Law 94-103.

The utilization (direct face-to-face service time) is lower than desired and the cost per unit of service and per client is higher than desired. And though the program's emphasis on individual counselling provides a more intensive individualized service than might otherwise be possible, it does little to bring the overall program costs within a reasonable range.

The impossibly low cost of $1.05 reported for each medical assessment is, according to the County Financial Manager, attributed to poor physician reporting (Table P-1). The comparatively high unit cost of the medication visits is attributed by the Center director to the high rate of no shows. The costs of the day treatment program are likewise higher than the typical mental health program. However, this is attributed by the Center director to inaccurate reporting. The facility rental costs are slightly higher than average due to the above average rent at the hospital facility and possibly due to the cost of the satellite facilities. The above average communication costs may possibly be due to concerted case management follow-up procedures as indicated by their ability to hold clients, i.e., relatively low client turnover (Table U-1). According to the MHMRIS reports, the Central DeKalb Center increased the size of its caseload by more than 2/3 during the year which would explain its slightly above average ratio of program administrative costs to direct face-to-face service costs (Table P-6).

8. South DeKalb Mental Health/Mental Retardation Center

The Center has been in operation since July of 1975. The population of the catchment area according to the 1970 census is approximately 121,000. Included in the catchment area are the towns of Lithonia, Redan, Avondale Estates, Wesley Chapel area, Lower Flat Shoals, Boulder Crest, Lower Stone Mountain, and portions of Atlanta. In addition to the principal Center location,

the Center is providing services at the Lithonia Health Department four days a week. The total number of Center staff in FY 1976-77 was 38. It is not a federally funded Center.

The South DeKalb Center's direct labor costs per hour of service are among the lowest of the fourteen Centers (Table P-6). In the case of the diagnostic assessment and evaluation service, the cost is the lowest of any of the NCG Centers (Table P-1). This is attributed largely to the high volume of testing and evaluation done for the juvenile court system as part of the adolescent program, and to the practice of conducting group intakes in order to screen out all but the most critical cases for admission into the children's program. The high volume of the diagnostic, evaluation and testing service is also likely due in part to case building as the Center was only in its second year of operation (Table U-1). The low cost of day-care and individual counselling (Table P-1) are attributed by the director primarily to the relatively low salaries and wages of the staff providing this service.

The average amount of face-to-face staff time per client is above average in all of the programs while the average number of clients (caseloads) per direct service staff member is consistently below average. Thus, the Center provides more units of service with a given level of staff than most Centers, thereby reducing the average labor cost per unit of service.

The general administrative costs of the Center as a percentage of direct labor costs are below average. The Center director

purposefully capped administrative activity in favor of direct service activity in order to meet budget, though he questions the advisability of this tact in the long run. The communications, travel, and supply costs are the lowest of any Center. The high volume of service units delivered coupled with the lower-than-average general administrative and unallocated expenses account for the ability of the South DeKalb Center to provide most services below the average cost of the other Centers in North Central Georgia.

The only possible reservation is that the level of non-face-to-face direct services and support services such as charting, case management, and coordination are possibly being sacrificed in order to keep the volume of direct face-to-face service high.

9. <u>Gwinnette-Rockdale Community Mental Health Center</u>

The Gwinnette-Rockdale Center is located in Lawrenceville, Georgia and its satellite operation in Conyers, Georgia. The Center has been in operation since 1973. The population of the Gwinnette area is approximately 110,000. The population of the Rockdale area is approximately 27,000. The total staff of the Center is 67.

As the Gwinnette-Rockdale Center failed to complete the HSRI survey, and was not visited during HSRI's follow-up, these interpretations are based entirely on the Medicaid reports, MHMRIS data, and visitation report of the Mental Health Association of Metropolitan Atlanta, Inc. in 1977.

The staff cost per hour of most of the Center's face-to-face services is equal to or lower than the average of the North Central Georgia Centers indicating a lower-than-average service staff salary level (Table P-1). Most of the staff at Gwinnette-Rockdale are donated by the Georgia Mental Health Institute. Medication visits and recreational therapy showed the lowest direct face-to-face labor costs of any of the Centers (Table P-1). The Center provides an above average level of services per 100,000 population, this is especially so with the medication visit, family counselling and crisis intervention services (Table P-9).

The same services are provided at the lowest overall cost-per-unit-of service of any of the Centers leading us to believe that the high demand for these services induces a greater percent of staff time to be spent in direct face-to-face service. The administrative cost to direct service costs ratio is about average as well.

In summary the Gwinnette-Rockdale costs are about average with few identifiable fiscal peculiarities.

10. Clayton Comprehensive Community Mental Health Center

The Clayton Center is located on the grounds of the Clayton General Hospital in Riverdale, Georgia. It has been in operation since May of 1971. Satellite facilities are located at the Clayton Developmental Center, Family Relations Clinic, Children's Center, and Forest Park Human Services Center. A new 'child and adolescent' building was being built during the year for operation next year.

The Center was seeking accreditation by the Joint Committee on the Accreditation of Hospitals. The staffing for the Center is approximately 130. Forty-five (45) percent of the Center staff are masters level or above. The Center had approximately 50 active volunteers in FY 1976-77. The Center was in its sixth year of an NIMH grant.

In the 1976-77 Medicaid reports, Clayton combined its direct non-face-to-face service time with the direct face-to-face service time. As a result the face-to-face service costs appear to be the highest reported of any of the North Central Georgia Centers; in fact, when the percentage of face-to-face and non-face-to-face times are broken out according to Clayton's study of therapist's time (conducted in June 1978), it shows that an average of 62% of the total direct service time is spent in non-face-to-face services. Assuming this same proportion of direct and non-direct service time held true in fiscal year 1976-77 as well, Clayton's direct service staff costs are about average.[1]

As indicated in Table U-2, the Center has a low percent of referrals from the Regional Mental Hospital (5%), and low percent of referrals having been one-time inpatients (16%). Clayton's target population seems to be the least seriously disabled of any of the Centers. Yet there is a surprisingly large day-care and activity therapy program which are designed to serve the chronically ill. According

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[1] Clayton's figures shown in the Appendix have been adjusted in this way.

to MHMRIS (Table U-1) client turnover at Clayton would appear to be the highest by far of the NCG Centers; i.e., there are many clients receiving relatively few units of service each. Considering the less serious nature of the target population's mental problems, this is to be expected.

Of all of the Centers, Clayton appears to have the highest level of service per 100,000 population. This is seemingly due in large part to its visibility and acceptance by the community, and to their efforts to improve accessibility such as providing transportation to and from the Center; approximately 400-450 clients are provided transportation to and from the Center each month.

11. Northeast Georgia Community Mental Health Center (Athens)

The Athens Center serves a population of 193,000 in a ten county area of 2,982 square miles. The Athens Center has a sizable administrative structure including a general administrative office, medical department, research unit, administrative services unit, indirect services administration, clinical services administration, mental retardation services office, drug program office, and child and adolescent program office. In addition to the main Center in Athens there are four training center satellites and one affiliate, one half-way house, and five full service satellites.

The labor costs per hour of face-to-face service are slightly above the average of the other 13 Centers in North Central Georgia indicating that the service staff salaries and wages are slightly

above average. The direct labor costs for the face-to-face day-care service, particularly in the child and adolescent program, is the highest of all Centers; this is explained by the Center director as primarily a function of service quality; the service model calls for a high staff-to-client ratio and high percent of staff time spent (80%) in face-to-face contact with the clients (Table P-1).

In general, the average amount of face-to-face time spent by each staff member is the lowest of the NCG Centers (Table P-7) rendering the overall cost per hour of service nearly triple the average of the other Centers, and the total hours of direct face-to-face service delivered per $1,000 the lowest of any of the Centers (Table P-10). The average amount of staff time spent per client was low as well. The program administrative costs per hour of face-to-face service is two and one-half times the average of the other Centers (Table P-6); the Center director claims that this reflects the relatively high ratio of non-face-to-face time necessary given the severely disabled character of the Center's clients. However, as indicated by the percent of referrals from the regional mental health center, 9.2% and the percent of clients having received services as an inpatient (32%), the population appears to be no more seriously ill than many of the NCG Centers- namely Griffin, LaGrange, Gainesville and North DeKalb (Table U-2). According to the MHMRIS the Athens Center increased its caseload by about two-thirds during the year which may account in part for the high program administrative costs (Table U-1).

The ratio of 'general administrative' to 'direct service' costs are nearly three times the 14 Center average. This is understandable in view of the large number of staff devoted to quality assurance, research, evaluation and administrative services.

The consultation and education (C&E) program is the largest identified in the state. While the C&E program may represent an effective preventive strategy, it does not appear to have led to an appreciable increase in service demand; the level of services provided by the Center per 100,000 population is below the average of most Centers (Table P-9).

The unallocated costs are also about three times the average of the other Centers in spite of the low rent. (Most of the programs operate out of county government buildings).

Travel was only high in the geriatrics program as it was described by the Center director as having more of an outreach orientation than most of the other programs.

Undoubtedly, the Athens Center has the strongest yet costliest administrative support program of any of the Centers under study. The question is balancing the benefits of the consultation and education, quality assurance, staff development, and other indirect services against their considerable costs. It is a question that could be best answered by taking a closer look at Athens service outcomes (which are documented). Unfortunately there is little comparative date obtainable from other Centers upon which to make a reasonable judgement regarding the relative contribution of these

indirect and support activities to service outcome.

12. LaGrange Community Mental Health Center

The LaGrange CMHC serves Troup, Carroll, Coweda and Merriweather counties, a rural area of approximately 161,000 people and 2,200 square miles. It apparently serves the largest percent of seriously mentally ill of any of the Centers as indicated by the high percent of admissions who have prior inpatient service--51%--and who come from the mental hospital--38% (Table U-2). In fact, in 1976-77 the size of the after-care caseload was reportedly equal to half of the active caseload at LaGrange.

In 1976-77, the LaGrange Center spent a higher-than-average number (of the NCG MHC's) of hours on medication visits, nursing assessments, recreational therapy, and crisis intervention per 100,000 population (Table P-9); this would be expected with an after-care population approaching 700. The Center had the highest caseload per staff ratios in its general mental health and drug programs of any of the Centers--329 to 1 and 167 to 1 respectively (Table P-7). Moreover, the Center reportedly spent a higher than average amount of face-to-face service time per staff. However, the number of face-to-face hours per staff are impossibly high; our hypothesis is that the number of face-to-face hours in the adult mental health program are likely overstated and the child and adolescent face-to-face figures are correspondingly understated; overall, the program has a realistic, but higher-than-average amount of face-to-face time reported per direct service staff

(Table P-7). It is also possible that these figures are inflated by the fact that a considerable amount of services are contributed by 30 to 40 volunteers, which may have inflated the amount of face-to-face service time actually spent by paid staff, and indeed lowers the Center's average cost per unit of service. Many of the volunteers provided diagnostic, evaluation, and counselling services at the outreach clinics. However, even with the use of the volunteers, the amount of face-to-face service time that could be afforded each client was below average (Table P-7). The Center also employed a higher-than-average number of contracted service and administrative staff which lowered the unallocated expense for staff pensions and benefits, and raised the 'contracted services' portion of the unallocated expenses (note: the 'contracted staff' expense was reported under the 'other' category - Table P-3).

On the other hand, the costs per unit of the face-to-face 'medication visit' service and the 'medical assessment' service were the highest of any of the Centers. This was due to the extraordinary high cost ($52,000 a year) of a full time psychiatrist. While the Center was able to recoup a sizable proportion of these costs through Medicaid, the psychiatrist's cost was simply hard to absorb.

The higher-than-average general administrative costs may be attributed to the Center's organizational and accounting scheme. One full-time staff member stationed in LaGrange was responsible for the administration of each of the outreach clinics. This

administrative time was charged to 'general administration' rather than to 'program administration'.

13. Griffin Mental Health Center

The Griffin Mental Health Center serves a population of 154,000 in the rural area of 1,661 square miles. The Center received a federal operations grant the following year (FY 1977-78). The program had satellite clinics in Henry and Bucks Counties, and a separate drug and alcohol unit in Spalding County. As indicated by the high percent of referrals from the regional mental hospital (27%), and high percentage of clients having prior inpatient service (47%), the Griffin Center serves one of the most seriously mentally ill populations of all the North Central Georgia Centers.

The Griffin Center was one of the most difficult to analyze as many of the unusually high or low cost figures are attributed to accounting discrepancies rather than to program and administrative factors. Moreover the Center's program and organization has changed markedly since 1976-77, and the financial manager was not present in 1976-77. A few general observations were possible.

As would be expected with a more seriously ill population, the Griffin Center has a higher-than-average level of medical assessment and medication visit services per 100,000 population; however it has a comparatively small day-care and activity program which is not to be expected (Table P-9).

The amount of face-to-face time afforded each client was consistently below most of the other 14 mental health Centers; in

the adult mental health program it was the lowest of any. Coupled with the low amount of face-to-face time per staff, the overall costs per hour of direct labor service (including administrative costs) was among the highest of all Centers (Table P-6). The particularly high face-to-face cost of the medical assessment and the medication visits was attributed by the Center to the relatively high cost of the 17 physician consultants providing these services on contract throughout the area. However, this high direct cost seems to be more than offset by the lower direct non-face-to-face (program administration), and indirect administrative costs associated with these contractual arrangements (Table P-6).

The low face-to-face unit costs of the nursing assessment and ambulatory detoxification services was attributed both to the use of a CETA nurse, and to the low cost of other service staff. It is also possible that the Center failed to record the "paper" costs of volunteers contributed as part of the Drug and Alcohol program. The high utilization (Table P-7) of the drug and alcohol program--it is the largest of any of the Centers--contributes to overall Center efficiency.

The relatively high program administrative costs are due to the classification of the administrative costs of each satellite as program administrative costs. The Center's general administrative staff was small and the programs were loosely coordinated. The cost of communication, travel, and rent were slightly higher than average, but not above what could be expected given the sizable area to be covered.

The costs of the direct personnel and program administration costs (Table P-6) are also inflated as pensions and benefits are included as part of these costs; in turn the unallocated expenses, pensions and benefits, are understated (Table P-3).

No explanation could be given for the fact that the overall cost of the alcohol day-care and recreation therapy services were the highest of all the Centers. However, the volume of these services is so low (Table A-1) that the reason could well stem from an accounting fault.

In summary, the overall cost of the drug and alcohol program services was generally less than the costs of the mental health program due to the comparatively lower average personnel costs, and higher service utilization (Table P-10). The overall costs of the other services is slightly higher than the average of the fourteen NCG Centers (Table P-6).

IV. COST CONTAINMENT

A. Definition

1. What Is It?

Ideally the goal of cost containment and cost effectiveness should be synonomous: the achievement of the maximum impact for any given level of expenditure. However, there isn't now and may never be an economically feasible, valid, and reliable way to measure and compare the impact of Mental Health Center services on clients. As a result, the objective of cost containment can only be defined in terms of achieving maximum service quality and accessibility as defined by certain indices assumed to represent relative service impact.

Simply stated, the objective of any cost containment measure should be to: *decrease or limit the cost of providing services to clients without sacrificing service quality and accessibility.*

2. What It Isn't

Cost reduction measures aimed at reducing the quality (assumed outcome) and/or accessibility (quantity, physical, economic) of Center services are not properly termed cost containment measures.

it could result in a critical decrease in the amount of third-party revenues coming to the Center as para-professional services are not presently covered by public and private insurers.

The level of understanding of Center operations possible through HSRI's "paper" analysis is sufficient to do little more than signal areas of potential cost savings. It would be presumptuous and far too risky to dictate how a particular Center should go about containing these costs.

3. Controllable vs. Uncontrollable Costs

In the planning stage, the client/service/revenue mix and corresponding staffing, facility, and major operational expenditures can be reasonably projected and largely controlled by design. With each succeeding year of operation, the degree of outright fiscal control declines; staff gain tenure and a hard-to-replace base of experience, the clientele becomes established and comes to expect service, facilities are purchased or leased, and investments in equipment are sunk. At this juncture, incremental and tactical rather than significant, strategic cost containment initiatives are the only administratively and politically feasible way to go.

Substantive cuts in staff and service can erode staff morale and energy - a critical commodity in this highly labor intensive service. A CMHC director is powerless to make substantive changes without Board, Federal, State and County approvals. In Georgia, the considerable out-stationing of state institutional staffs,

Considering the relative small size of the Mental Health Centers, a more practicable and potentially beneficial alternative may be to organize cost containment committee(s) and/or workshop(s) comprised of statewide or areawide Center representatives, mental health planners, and administrators to look into the feasibility of different cost containment strategies and/or to exchange cost containment ideas.

2. Cost Containment Strategies

There are three basic cost containment strategies:

- Increase the utilization of Mental Health Center services by improving the balance between service supply and demand;
- Increase the productivity of Center staff through work incentives, improved staffing structures, and more efficient use of staff; and
- Decrease the cost of Mental Health Center resources through economic procurement approaches.

These cost containment strategies are graphically portrayed in the schematic on the next page, and are introduced in the balance of this section.

a. Increase Service Utilization

In order to improve the balance between service supply and demand, a Center may opt to either alter the service supply or induce a change in service demand.

Mental Health Center
Cost Containment Strategies
- A Conceptual Framework -

a. Increase Service Utilization

- Bring Service Supply in Line with Demand
  - Increase or reduce personnel complement.
  - Increase or decrease personnel hours.
  - Alter the mix of intensive 1 staff-to-1 client services, and non-intensive 1 staff-to-1+clients services.
  - Refer clients to alternative service providers.
- Bring Demand in Line with Service Supply
  - Increase recognition and acceptability of Center services among consumers.
  - Increase accessibility of Center services to consumers.
  - Reduce number of broken client-therapist appointments.

b. Increase Staff Productivity

- Offer incentives or impose sanctions.
- Alter staffing patterns.
- Redeploy personnel.

c. Decrease Resource Costs

- Purchase/lease arrangements.
- Purchase-of-direct and indirect services
- Group purchasing arrangements

Bring Service Supply in Line with Demand

There are four basic ways to change the level of service commensurate with demand:

- Increase or decrease personnel
- Increase or decrease personnel hours
- Alter the mix of intensive (one-to-one) staff-to-client services such as individual counselling, and non-intensive services such as group counselling and day-care
- Refer clients to alternative providers of service

- Adding or Subtracting Staff -

The recruitment of competent psychiatrists and clinicians is particularly difficult for most Centers. The North Cobb Center has worked hard to find a psychiatrist for months; only recently have they been successful. The inability to compete with income potentials possible through private practice forces the Center to make other amends such as allowing moonlighting, expecting little service beyond the normal working hours, and/or knowingly permitting the psychiatrist to build a private practice through Center contacts. The North Dekalb Center and Fulton Centers appear to have been able to recruit competent clinicians through such tacit agreements. However, by definition this limits their ability to extend the psychiatrist's hours.

Cutting back the staff complement commensurate with low service demand is likewise difficult. While a few Centers might benefit by terminating the less productive employees, most Centers are forced to lay-off the less senior but valued employees. No

other cost containment measure has the same potential to undermine the long term effectiveness of a Center. Cuts in service and support staff should be made so that the work load remains balanced. Cutting the service staff too heavily can lead to a top heavy organization; converserly, cutting the administrative staff too heavily can lead to a bottom heavy organization. The bottom-heavy organization may show a high degree of productivity in the short run, but in the long run, the Center is likely to become disorganized and characterized by crisis management. Service staff in the top heavy organization are likely to become overworked and quickly dissatisfied with the bureaucratic tint of the Center; service staff turnover will increase and productivity will eventually decline.

Another problem with cutting and building staff to meet demand is that the associated quantum drop or gain in service capacity is often greater than necessary to meet demand. Too, such a decision may be too final and inflexible to suit inevitable demand fluctuations. A number of Centers, particularly Clayton and LaGrange, are increasingly contracting for services of an administrative as well as treatment nature in order to retain more flexibility. In this way they are in a better position to readily accomodate changing demand and/or unexpected declines in revenues.

- Staff Overtime -

As noted earlier, most Center directors can do little more than informally encourage staff to volunteer some extra hours on the job. The motivation of the staff has much to do with their willingness to allot their personal time to the job. The Center director's ability to motivate his or her staff is a critical factor and more a function of the director's leadership qualities than the few formal rewards or sanctions at his or her disposal. Though staff should not be expected to work overtime week-in and week-out, the demands upon the Centers are such that key staff must be willing to spend the extra hours necessary to get some jobs done.

- Altering the Mix of Intensive and Non-Intensive Services -

Some Centers such as LaGrange and South Fulton have organized group medication clinics in order to make the most of the psychiatrist's time. A day of group sessions is held periodically in each of the satellites. Individual sessions are stagger-started with the psychiatrist leading off each session and then retiring to a separate area to handle special individual client needs and concerns not appropriate to the group setting.

Similarly, many Centers will move to day care, activity therapy, and group counselling as opposed to individual counselling in order to accomodate increased service demand with a limited complement of staff; the North Dekalb and Clayton Centers appear to be two such examples. North Dekalb has the largest day care and

group counselling program of all the Centers. On the other hand, Centers will also move to increase the amount of individual counselling in the face of lower service demand. For instance, when school referrals to the adolescent program declined at Central Dekalb, Center staff were free to provide a higher amount of individual counselling. The Central Dekalb Center consequently has the highest level of individual counselling per 100,000 population of any of the Centers. The difficult issue is insuring that the service mode is suited to the needs of the client, and that the client is not being over-served or under-served in the interest of efficiency. This issue is elaborated in Section IV B.

- Referral of Clients to Non-Center Services -

A final way of satisfying client demand is by referral to other qualified service providers. A number of Centers, Gainesville in particular, reportedly try to take the most advantage of indigenous community services. The LaGrange Center for one has placed a strong emphasis on the use of the family physician as a primary care provider for many of the patients coming to the Center for services; the Center provides support to the physician as required. Likewise, the LaGrange Center has opted to use the services of the town pharmacist rather than providing pharmacutical services directly. The use of a private pharmacist by the Center and other human service providers in LaGrange -- public and private -- has not only contained Center costs, but has been useful in identifying and reducing the number of clients loading-up on drugs by placing themselves under the care of more than one physician.

Last year, Fulton County merged most of the alcoholism treatment services being provided by the individual Centers into the Alcoholism Treatment Center (ATC). The Centers now provide most alcoholism services by referral to the ATC. While the impact on service quality and accessibility is not known, the ATC should be able to provide these specialized services at a lower cost given the higher utilization possible by the combined Center referrals.

Bringing Service Demand in Line with Supply

Just as a Center can alter service supply it may also induce changes in service demand. As explained earlier, attempts to decrease service demand would come under the heading of service reduction not cost containment and thus are not addressed. Moreover, methods of increasing service demand are legitimately addressed under the cost containment banner only to the extent that the rise in demand does not exceed actual need. Conceptually, such a distinction is easy to make; practically speaking, it is a difficult judgement and depends largely on the Center's treatment goals. For instance, one Center may recognize and encourage 'marriage counselling' as a legitimate Center service, another may not.