THE NORTH CENTRAL GEORGIA HEALTH SYSTEMS AGENCY, INC.

ANALYZING COMMUNITY MENTAL HEALTH CENTER COSTS AND THEIR IMPLICATIONS

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PREFACE

The cost and quality of community mental health services is of considerable interest and concern to federal, state, regional and county planners and decision-makers. Georgia legislators, Department of Human Resource officials, and county commissioners must carefully weigh the costs and benefits of assuming a greater share of Community Mental Health Center costs as the federal support continues to decline.

The North Central Georgia Health Systems Agency, in its planning and review of local mental health programs, must have an accurate picture of their service costs and a clear understanding of the programmatic, administrative, and external factors underlying these costs. Without such information, Health Systems Agency reviews can at best be superficial; and at worst, arbitrary and capricious.

Recognizing the critical need for such information, the NCG-HSA initiated a cost analysis study in June, 1978, of fourteen public-supported Community Mental Health Centers serving counties in the North Central Georgia Health Service Area. The following guide is the result of this study. While no final conclusions are drawn, the report presents a methodology for analyzing community mental health center costs and offers additional considerations for cost containment. While this study is particularly directed to the community's public outpatient mental health services system, it does not suggest that the private system of mental health care is any less in need of scrutiny. However, data associated with costs of private sector mental health care is largely unavailable or inaccessible. Furthermore, comparisons of public and private sector costs are difficult, due to inherent differences in systems design and clientele. It is hoped that this initial study can form the framework for further study and improvement in the total mental health service system.

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I. INTRODUCTION

The purpose of this guide is to present a practical procedure for analyzing and comparing community mental health center costs and their implications as part of state and regional Health Systems Agency federal grant reviews and for Community Mental Health Center internal management and financial planning. The procedure was developed in the course of the North Central Georgia Health Systems Agency's study in June, July, and August, 1978, of fourteen community mental health centers serving counties in Health Service Area III. Accordingly, the guide may also be used to better understand the results of the Human Services Research Institute's computer-based analysis of Fiscal Year 1976-1977 mental health services costs in these centers as well as offer improvements for more complete analyses in the future. The subject of cost containment is addressed as a direct result of the study and offers some suggested strategies for Community Mental Health Centers (CMHC's) in this area.

While the concepts underlying the cost analytic procedure are generally applicable to the analysis of community mental health center costs anywhere, the procedure itself is tailored to fit the Georgia CMHC System. It is based on information contained in the Uniform Cost Reporting System (based on state Medicaid Reporting data), Mental Health/Mental Retardation Information System Reports (MH/MRIS), the Catchment Area Resource Summary Reports (CARS) prepared by the Division of Mental Health and Mental Retardation, Georgia Department of Human Resources, and other sources of information available in Georgia.

This study is in step with the increased concern among the public and elected officials over the soaring costs of health and mental health services. The CMHC's themselves 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 federal revenues. This guide outlines a means of using accounting and statistical data to aid in the careful analysis of costs so that CMHC administrators can determine areas needing closer study.

Many are looking toward the Health Systems Agencies and planning process established under Public Law 93-641 to help contain these rising health costs. Through this study, workshops and other expanded research in this area, the NCG-HSA hopes to answer some of the questions concerning mental health service cost concerns and cost containment possibilities without the loss of quality.

The guide identifies a set of selected vital signs (numerical indicators) indicative of Community Mental Health Center efficiency and productivity relative to cost, and describes a method for collecting, compiling, and deriving these indicators to form a center profile. An example of some of these indicators include: a) total cost per hour of service, b) direct face-to-face personnel costs by type of service, c) program-specific administrative and support personnel costs, d) consultation, education, and prevention service personnel costs, e) general administrative personnel costs, and f) unallocated (non-personnel) costs. By comparatively analyzing these center profiles, identification can be made of notable efficiencies and inefficiencies in center operations warrenting closer examination. Finally, the guide describes how one can identify probable reasons why particular centers are seemingly more or less efficient than average or than the norm between all CMHC's studies.

The study procedure does not, at present, examine relative center efficiency in delivering education or other non-direct services, or in delivering direct consultation services to non-CMHC clients. When future Uniform Cost Reports (Medicaid Reports), on which the study is based, are expanded to indicate levels of non-direct services and services to non-clients, as well as direct face-to-face services to clients (as planned), this guide will be expanded accordingly to reflect the full range of services - indirect and direct - in measuring relative center efficiency and productivity.

The guide describes a rudimentary fiscal analytic procedure. It intentionally centers on a limited set of procedures for the analysis of community mental health center costs. A variety of center performance dimensions are also considered in the analysis of service costs including: client mental health treatment history, population density and client concentration in service area, type of service organization, program and service size and mix, staffing patterns, treatment philosophy, and growth pattern of the center. Certainly, a more comprehensive analytic procedure would consider these as well as other factors in conjunction with center costs such as:

- Service target population - the estimated population of those individuals in need of mental health services

- Service need and demand - Based on the estimated target population, the volume and type of services probably needed and those actually requested

- Service quality - including measures of the outcome or inpact of center services or client behavior and functioning, "satisfaction" measures of client and community satisfaction with mental health center services, and other indicators of acceptable practice in terms of generally accepted standards

- Service accessibility and appropriateness - including measures of the degree to which mental health services are accessible and appropriate to those in need.

The material is presented in the form of an instructive manual with step by step explanations of a variety of cost formula approaches, including a case example. Where additional programmatic or other considerations appear important for follow-up analysis, these are discussed briefly. The guide addresses CMHC outpatient services allowed under the State Medicaid plan for Georgia; it does not cover mental health in-patient services. It focuses on the operational efficiency and productivity of the CMHC only in terms of delivering direct face-to-face services to clients.

This is not to say that the procedure is blind to these important dimensions of center performance. Service quality and accessibility are of paramount importance and should not be sacrificed for the sake of center productivity and efficiency. However, the procedure, alone, can do little more than raise service quality and accessibility problems as implied by the service cost and utilization data. These factors have been difficult to measure in the past and will require the careful development of complementary procedures to properly assess service quality and accessibility. Many states, including Georgia, are developing State Quality Assurance Standards which can assist in further assessing these dimensions. In the final analysis, the solution of such problems as those related to recovering costs, correcting service and management inefficiencies, and adopting new procedures, depends on well-considered decisions based on all cost and non-cost factors.

Productive use of the guide is heavily dependent upon a thorough understanding and appreciation of the dynamics of community mental health center operations. Such an understanding necessarily derives largely from experience. Without such experience, many service cost findings must be accepted as presented or through the advice of disinterested/unbiased parties having such background. Possible sources of such advise, beyond the HSA planning staff, might include outside consultants qualified to perform community mental health center reviews and knowledgeable staff from State Mental Health Administrative offices or from other unbiased CMHC's in the State. Each National Institute of Mental Health, U.S., DHEW., regional office has a cadre of such consultants willing and able to provide such advice on an "as-needed" basis who are often employed to conduct reviews of centers in connection with N.I.M.H. grant requirements.

The body of the cost analysis procedure is organized in three sections. Following a brief background of the CMHC study conducted by the NCG-HSA in Section II, the principal theoretical concepts underlying the analytic approach are capsuled in Section III. Section IV defines selected formulations (indicators) to be employed in the analysis of relative CMHC productivity - how they are derived, and how they might be interpreted and Section V defines a method for breaking down and analyzing center expenditure

patterns in order to narrow the numbers of explanations possible for above-or-below-average center efficiency. Section VI presents a case example of the step-by-step procedure by which each of the productivity formulas and cost component ratios are derived. Section VII, the final section, discusses the concept of cost containment and offers some suggested strategies for conserving CMHC resources. Appendix A cross references the explanations of key Community Mental Health Center fiscal indices presented in this Guide, and the derivation of these indices in FY 1976-77 as presented in the NCG-HSA's report entitled - An Analysis of Mental Health Center Costs in FY 1976-77. Appendix B includes the latest definitions of the different face-to-face outpatient services which may be provided by the Centers as found in the Manual of Accounting and Reporting Specifications for Community Mental Health Centers, Department of Human Resources, Division of Mental Health and Mental Retardation (July 1, 1978). The Manual provides a comprehensive explanation of the cost accounting and reporting procedures employed by the Community Mental Health Centers in Georgia, and must be fully understood by the reviewers in order to better appreciate what the cost figures represent.

II. THE COMMUNITY MENTAL HEALTH CENTER COST ANALYSIS STUDY

In June, 1978, the NCG-HSA contracted with the Human Services Research Institute to conduct a comparative cost analysis study within fourteen Community Mental Health Centers serving counties in Health Service Area III:

North Georgia, Gainesville
North Cobb, Marietta
South Cobb-Douglas, Marietta
South Central Fulton, Atlanta
West Fulton, Atlanta
South Fulton, East Point
North DeKalb, Atlanta
Central DeKalb, Decatur
South DeKalb, Atlanta
Gwinnett-Rockdale-Newton, Lawrenceville
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 due to lack of comparable cost data for these facilities. Northside and Central Fulton CMHCs are hospital-based and did not participate in the Division of Mental Health and Mental Retardation (DMH/MR) uniform cost accounting system during Fiscal Year 1977.

The purpose of the study was 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 NCG-HSA's analysis of CMHC expenditure and revenue patterns as part of their center reviews.

A. DATA COLLECTION

1. Data Base - Uniform Cost Reports

Georgia is one of only a few states allowing reimbursement for mental health center out-patient services as part of its state Medicaid plan. The FY 1976-77 Uniform Cost Reports submitted by the CMHCs to the Community Services Support Section, Division of Mental Health and Mental Retardation, Georgia 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, Division of Mental Health and Mental Retardation. (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 uniform cost reports either.

As would be expected, having only begun the uniform cost reporting procedures in 1974, there were still a number of kinks in the system that affected the reliability 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 CMHC 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, instances were found 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 costs shown for these services should be considered unreliable. In any case, such errors in estimating should be reduced over time as CMHC's service unit accounting procedures continue to improve.

Another problem stems from variations in the ways CMHCs 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 units 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 CMHC. However, most such practices can be detected through a comparative analysis of CMHC costs and subsequently verified with the CMHCs. 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 uniform cost 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 Division of Mental Health and Mental Retardation now captures the most important direct and indirect services in the uniform cost reports, namely: charting, case management, transportation, child care, consultation and education, primary prevention, in-service training, and program and fiscal reporting.

Despite the uniform cost 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 unusually high or low costs, or peculiar expenditure patterns for further investigation.

2. Community Mental Health 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 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 year 1978-79 uniform cost 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 CMHCs was incomplete. In order to obtain as much information as possible within the project time and cost limits, HSRI staff, accompanied by the NCG-HSA mental health planners, visited the following CMHCs: North DeKalb, Central DeKalb, Clayton, Griffin, North Cobb, South Cobb-Douglas, LaGrange, South Central Fulton, and South Fulton. The remaining Centers were contacted by phone to clarify questions pertaining to their fiscal profiles.

Obtainment of the needed information during the CMHC visits was, in most cases, bounded by the knowledge of the financial directors and CMHC 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 CMHCs 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 allotted for the interviews.

3. Other Study Data

The following information was also 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 Information System 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 CMHC clients. Reports were unavailable for the Fulton county CMHCs; they have only recently agreed to provide this information to the state. Two CMHC directors expressed the concern that the reports understated their client load in fiscal year 1976-77 due to under-reporting, and to the elimination of misformated 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) 1976-78 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 CMHCs. 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 visited and prepared brief descriptions of the ten CMHCs in the Atlanta metropolitan area. These descriptions were of some use in understanding the programmatic objectives and service philosophies of the Atlanta CMHCs.

Though the inability to obtain uniform, documented program information from most of the CMHCs 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 CMHC cost analyses and general cost containment suggestions.

B. Analysis

"Measurement without comparison is not sufficient to judge the value of the results."*

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 Health Service Area III. Fortunately, HSRI had benefit of the CMHC cost data compiled by Dr. Minnehan and Dr. Lauderbach in the course of their review of CMHC grant applications in DHEW Region III, as well as the ability to compare the fourteen north central Georgia CMHCs. 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 CMHCs in FY 1977-78, FY 1978-79, and future years. At the same time, additional cost data could be obtainable from CMHCs in other states, though inter-state comparisons would be more difficult to assess than intra-state comparisons due to significant differences in State Mental Health System characteristics.

Two complementary approaches to the analysis of CMHC costs were employed: the multiplicative or input/output approach, and the additive or component approach. Coupled with a cursory review of program requirements and constraints, tentative explanations of some of the differences in CMHC efficiency and expenditure patterns were drawn.

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*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.

III. THEORETICAL FRAMEWORK FOR COST ANALYSIS

The theoretical base upon which the procedure for cost analysis is founded is "production function theory" whereby the community mental health center is considered a service producing system using a set of inputs or resources, and producing a set of outputs or services. Inputs include such resources as professional staff, facilities, medication, etc.; the outputs include units or hours of different services delivered to center clients.

By calculating the amount of resources expended in delivering a particular service or set of services to a group of clients, we arrive at an indicator of the center's efficiency, and by comparing like resource (input)/service (output) ratios among centers, we arrive at an indicator of the center's efficiency relative to that of other centers. Theoretically speaking, the possible combinations of resources and services which could be analyzed is enormous. Practically speaking, it is limited to those resource and service categories for which reasonably uniform cost and service measurements are available for the centers under review.

In Georgia, the Uniform cost reports of the mental health out-patient service system or the CMHC service system and the Mental Health/Mental Retardation Information System reports offer a base of such information unmatched in most other states. Still, there are a number of data gaps that restrict the number of calculable input/output ratios.

The analysis of the CMHC's service producing system (production function) is along two dimensions.

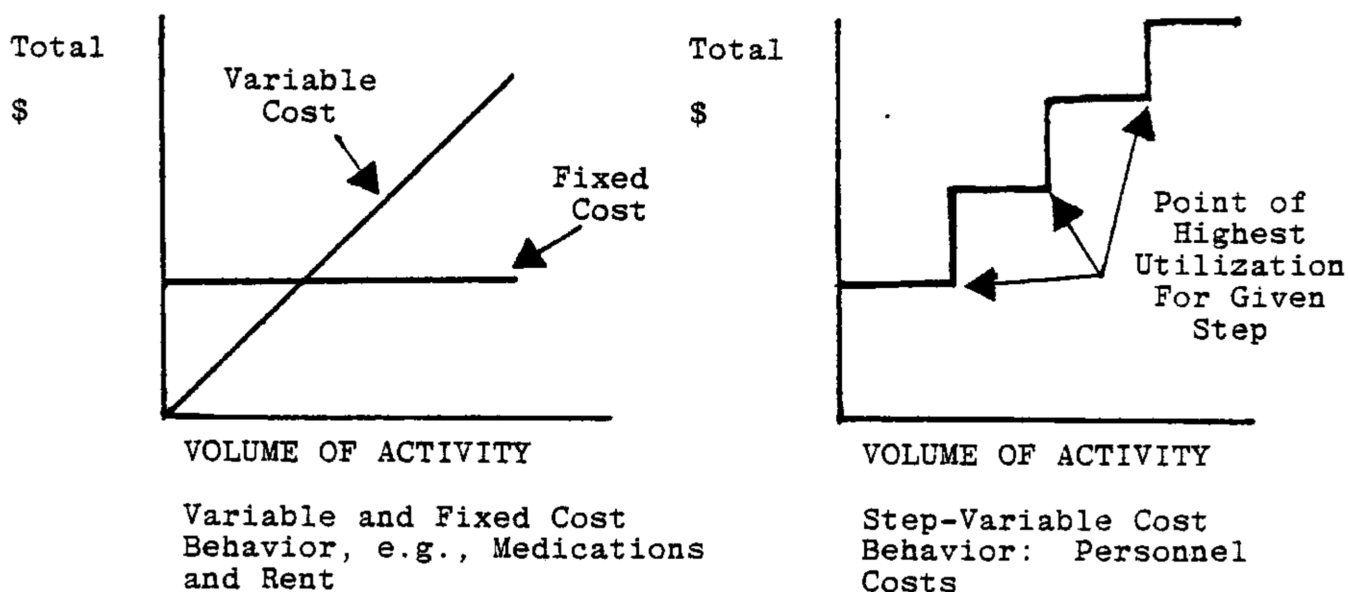
The first dimension involves the development of indicators of the center's relative productivity - i.e., relative ability to produce services (outputs) for a given level of resources (inputs). This is labeled the 'multiplicative' approach as it involves the calculation and inter-center comparison of input/output ratios or 'multipliers.' The basic input/output formula is:

$$\text{COST PER HOUR OF SERVICE (CPHS)} = \frac{\text{CENTER COSTS (INPUTS)}}{\text{HOURS OF SERVICE (OUTPUTS)}}$$

Usually, one would expect that the total cost of a center would vary with the volume of activity (hours of service delivered), and thus the cost per hour of service would remain relatively constant over time. However, this is

not always the case. To understand why, it is first necessary to understand the concepts of variable, semi-variable, and fixed costs.*

Variable costs are those which are expected to fluctuate, in total, directly in proportion to some measure of activity such as the number of patients in beds or number of patient visits. For example, costs such as food or medications in inpatient or partial hospitalization facilities may vary directly with the daily census. Some costs may be step-variable, that is, they vary over a wide range of activity but not in direct proportionality. Professional labor costs, for example, behave in this step-fashion; generally there is some practical limit to the number of patients that the psychiatric social worker can serve before another individual has to be added to the staff. Fixed costs, on the other hand, remain constant in total amount regardless of the level of fluctuation in the volume of activity. Examples of a fixed cost are salaries of administrators, rent, and depreciation costs. The relationships of variable, step-variable, and fixed costs are graphed below.



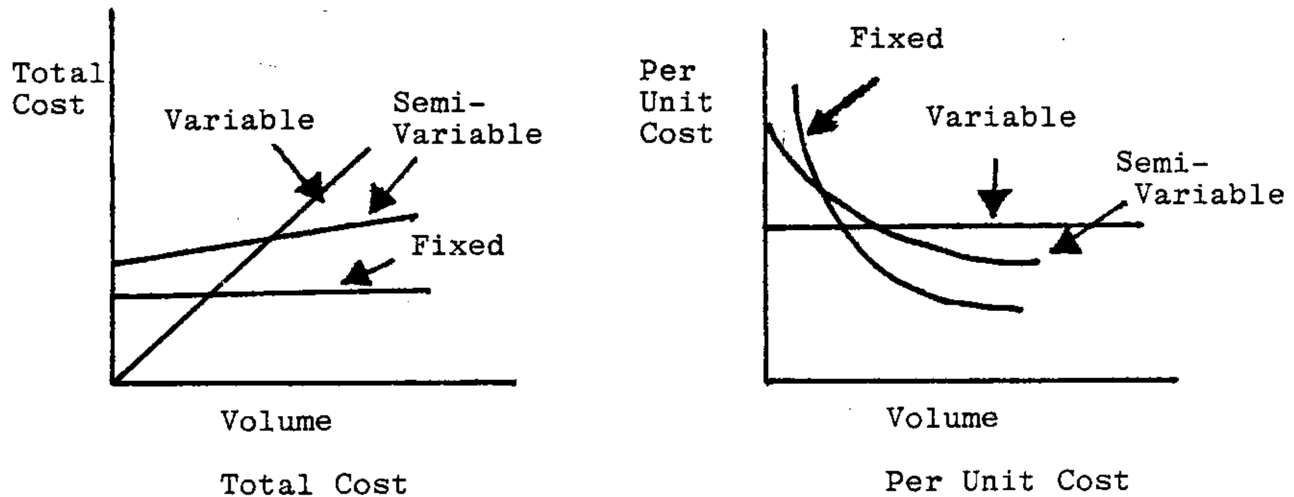
Variable and Fixed Cost Behavior, e.g., Medications and Rent

Step-Variable Cost Behavior: Personnel Costs

GRAPHICAL ANALYSIS OF COST BEHAVIOR

*This discussion of cost behavior has been extracted from a paper delivered by James E. Sorensen, Ph.D., C.P.A., "Assessing the Costs of Community Service Programs," at the National Institute of Mental Health's, Community Support Program, Learning Community Conference, Washington, D.C., November, 1978.

Note on the graph below that the behavior of per unit cost is different from the behavior of the total cost. Variable per unit costs are constant on a per unit basis but variable in total, while fixed costs are variable on a per unit basis (depending on the volume of activity), but they remain constant in total. Semi-variable costs change both as to per unit and total as volume fluctuates. These relationships are graphed below.



GRAPHICAL BEHAVIOR OF TOTAL AND PER UNIT COST

The observations about cost behavior are extremely helpful in analyzing and reviewing the financial desirability of specific services, programs, or cost containment ideas. If a center director is considering the addition or deletion of a specific service, he or she must carefully distinguish between average, variable, and fixed costs. By dropping a service, the director may reduce some variable costs and, perhaps, some fixed costs, but many of the fixed costs cannot be avoided in the short run; by eliminating a service, the director may find that he has increased the average cost of the remaining services since the fixed cost previously allocated to the deleted service is now allocated to the remaining services. (The reverse effect could occur by adding a service; that is, the original services show a lower cost since some of their fixed cost may be allocated to the newly formed service.)

The analysis and understanding of center cost behavior (fixed, variable, and semi-variable costs) is an essential forerunner of the cost containment strategies (explained in Section VII) in order to better assure that the cost containment tact will have the intended impact on center costs.

The second dimension entails the analysis of the mix of resources (inputs) employed by the center in producing services as evidenced through the center's pattern of expenditures. The procedure describes a basic expenditure classification scheme consistent with the Uniform Cost Report categories, and useful in drawing attention to fundamental areas of center operations. We call this the "additive" approach as added together the five categories of expenditure account for all mental health center inputs (costs). In other words, it involves a closer look at the input side of the formula as illustrated below.

$$\text{COST PER HOUR OF SERVICE} = \frac{\text{DIRECT FACE-TO-FACE SERVICE COSTS} + \text{PROGRAM ADMINISTRATIVE COSTS} + \text{GENERAL ADMINISTRATIVE COSTS} + \text{CONSULTATION \& EDUCATION COSTS} + \text{UNALLOCATED COSTS}}{\text{HOURS OF SERVICE}}$$

Three input/output formulas central to the analysis of relative center productivity, and five input/input ratios central to the analysis of how the center chooses to employ resources in delivering service, are defined in Section IV and V, respectively. In addition, the summary table at the end of Section V attempts to highlight some of the important factors to be considered in understanding center costs and cost behavior such as service volume (hours of service), client mix, organization and staffing patterns, center size, treatment philosophy, program/service mix, and stage of center growth.

IV. CMHC PRODUCTIVITY (INPUT/OUTPUT) ANALYSIS

The <u>total</u> cost per hour of service is the first order indicator of the center's productivity in providing direct services to clients as it encompasses all center inputs (costs) and all center outputs (hours of service).* However, in-and-of-itself, it sheds little light on <u>why</u> one center shows a lower cost-per-hour-of-service than another. Such factors as level of qualified staff, thus salary involved and amount of travel included in service provision are two examples of other considerations to be made.

The total costs per hour of service may be calculated using two formulations:

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*Except direct non-face-to-face services and indirect consultation, education, and prevention services.

- Formula B: TOTAL COST PER HOUR OF FACE-TO-FACE SERVICE = (1) TOTAL COST PER PROGRAM STAFF DIVIDED BY (2) CASELOAD PER PROGRAM STAFF MULTIPLIED BY (3) HOURS OF FACE-TO-FACE SERVICES PER CLIENT. This formula permits an examination of the center's total cost per hour of direct face-to-face service in light of the average number of hours of service rendered each client.

- Formula C: TOTAL COST PER HOUR OF FACE-TO-FACE SERVICE = (1) TOTAL CENTER COST PER PROGRAM STAFF DIVIDED BY (2) HOURS OF FACE-TO-FACE SERVICE PER STAFF. This formula permits an examination of the center's total cost per hour of face-to-face service in light of the average number of hours of service demanded of each staff member delivering face-to-face services to clients.

A third formula - Formula A: DIRECT COST PER HOUR OF FACE-TO-FACE SERVICE = FACE-TO-FACE STAFF COSTS DIVIDED BY HOURS OF FACE-TO-FACE SERVICE. This formula permits an examination of the direct costs by individual service. Formula A should be derived before Formulas B and C, as the formula identifies unusually high or low personnel costs associated with individual face-to-face services, and thus indicates the services' relative contribution to total direct face-to-face service costs employed in Formulas A and B.

In other words, it may identify individual face-to-face service abberations which largely account for differences in the Center's Total Cost Per Hour of Service.

A. FORMULA A: DIRECT COSTS PER HOUR OF FACE-TO-FACE SERVICE

This ratio represents the direct cost of personnel time spent in face-to-face service to clients (as obtained from schedule IV-a of the Uniform Cost Reports) divided by the total number of hours of face-to-face service provided by the center (as obtained from schedule IV-c of the Uniform Cost Reports).

Abnormally high costs may indicate:

- the involvement of higher paid, more qualified staff,

- the use of overly qualified staff because of low demands on their time for other services more commensurate with their abilities, or

- the underutilization of the service and staff assigned to provide the service.

Abnormally low costs may indicate:

- the involvement of lower paid, less qualified staff,
- the use of underqualified staff because of demands on the use of qualified staff in higher priority service areas, or
- the overutilization of the service and staff assigned to provide the service.

In any case, it is a useful and necessary step to identify possible service-specific problem areas before beginning the overall service analyses.

B. FORMULA B: TOTAL COST PER HOUR OF FACE-TO-FACE SERVICE

The total cost per hour of face-to-face service = (1) the total cost per program staff divided by (2) the caseload per program staff multiplied by (3) the hours of direct face-to-face services per client.

1. TOTAL COST PER PROGRAM STAFF

This figure is derived by dividing the total center costs for a given program (as obtained from Schedule III, of the Uniform Cost Reports) by the estimated number of full-time equivalent staff working in that program. The number of full-time equivalent staff in the program is estimated by dividing the estimated number of staff hours spent in the program by the number of regular work hours per staff each year, 2080 (52 weeks x 40 hours per week). The number of staff hours spent in the program is estimated by dividing the total program costs (face-to-face service cost + program administrative costs as obtained from Schedule III) by the direct cost for hour of face-to-face service -- the derivation of which is explained under formula A.

2. CASELOAD PER PROGRAM STAFF

The average number of clients per program staff is calculated by dividing the total number of clients seen by the center in a given year (as reported in the MH/MRIS Reports) by the number of full-time equivalent program staff (the derivation of which is described in sub-section B.1).

3. HOURS OF DIRECT FACE-TO-FACE SERVICE PER CLIENT

The hours of direct face-to-face service per client are calculated by dividing the hours of face-to-face service (obtained from schedule IV-c of the Uniform Cost Reports by the number of clients seen (as reported in the MH/MRIS Reports).

4. GENERAL ANALYTIC CONSIDERATIONS

A look at the formula tells us that a relatively high cost per program staff (numerator) may be offset by the ability of that staff to deliver a relatively high number of hours of service (denominator). However, if the relatively high number of service hours reflects an abnormally high caseload per staff and abnormally low number of hours of service per client, the 'quality' of care may be jeopardized. Conversely, if the relatively high number of service hours reflects an abnormally low caseload per staff and a relatively high number of service hours per client, questions may be raised about the 'appropriateness' of such intensive individual treatment.

C. FORMULA C: TOTAL COST PER HOUR OF DIRECT FACE-TO-FACE SERVICE

The total cost per hour of direct face-to-face service equals (1) the total cost per program staff divided by (2) hours of face-to-face service per staff. This formulation is identical to formula B except that it does not include the client (caseload) dimension in the computation of the hours of face-to-face service per program staff.

1. TOTAL COST PER PROGRAM STAFF

The derivation of this figure is explained in sub-section B.1.

2. HOURS OF FACE-TO-FACE SERVICE PER PROGRAM STAFF

The average number of hours of face-to-face service per staff is calculated by dividing the hours of face-to-face service (reported in schedule IV-c of the Uniform Cost Reports) by the number of full-time equivalent staff working in that program (the derivation of which is described in sub-section B.1.).

3. ANALYTIC CONSIDERATIONS

The formulation shows that relatively high costs per program staff (numerator) may be offset by the ability and willingness of staff to provide a high number of hours of face-to-face services (denominator). However, an inordinate amount of staff time spent in face-to-face service may be leaving too little time for the direct non-face-to-face support services such as charting and case management, generally accepted as essential components of effective service delivery. If the staff are not slighting non-face-to-face support services, then their workloads may be extreme; overtime can contribute to staff burn-out and turnover.

Conversely, abnormally low staff costs and/or hours of face-to-face service provided per staff may be an indication of low staff motivation and productivity or limited program accessibility.

COMMUNITY MENTAL HEALTH CENTERS PRODUCTIVITY (INPUT/OUTPUT) ANALYSIS - ANALYTIC CONSIDERATIONS

PRODUCTIVITY FORMULAS	INPUTS	OUTPUTS	SOME CONSIDERATIONS
Formula A: Direct cost per hour of face-to-face service = $\dfrac{\text{Cost of Face-to-face Service Staff}}{\text{Hours of Face-to-face Service}}$	Abnormally High Face-to-Face Service Staff Costs Abnormally Low Face-to-Face Service Staff Costs	High hours of face-to-face service Low hours of face-to-face service	Over utilization? Over qualified staff? Underutilization? Under qualified staff?
Formula B: Total cost per hour of face-to-face service = $\dfrac{\text{Total Cost Per Face-to-face Service Staff}}{\left(\text{Caseload per Face-to-face Service Staff}\right)\left(\text{Hours of Service Per Client}\right)}$	High Cost Per Face-to-face Staff High Cost Per Face-to-face Service Staff	High hours of service per client & low caseload Low hours of service per client & high caseload	Service appropriateness? Center accessibility? Service quality?
Formula C: Total cost per hour of face-to-face service = $\dfrac{\text{Total Cost Per Face-to-face Service}}{\text{Hours of Face-to-face Service Per Staff}}$	High Cost Per Face-to-face Service Staff Low Cost per Face-to-face Service Staff	High hours of face-to-face service per staff Low hours of face-to-face service per staff	Staff burn-out, morale, & turnover? Staff motivation and training?

SUMMARY

The table on the following page attempts to summarize some of the more important considerations discussed. The table illustrates how abnormally high or low center costs (inputs) may be offset by high or low face-to-face service levels (outputs) thus keeping costs per hour of service within an expected range. The table also identifies possible questions concerning service quality and accessibility suggested by abnormally high or low input and output levels. If the total cost per hour of face-to-face service is abnormally high or low, reviewers should take a closer look (as explained in Section IV) at those areas of the center's operation accounting for the center's seemingly high or low productivity: e.g., administration of the drug and alcohol program, unallocated costs of the adolescent program, etc.

V. CMHC COST COMPONENT (INPUT/INPUT) ANALYSIS

The productivity analysis indicates the overall efficiency if the center in terms of relative "cost per hour of face-to-face service." It also presents a picture of the production function or mode of service delivery employed by the center in terms of service mix (hours of service per 100,000 population by program, relative hours of service by programs), staff costs and workloads, and client service patterns. In so doing, it gives rise to important questions concerning service quality and accessibility and need, as well as questions concerning those center operations that are most directly related to the centers' relative efficiency. The analysis of the inputs (cost components), described in this section, addresses the latter questions.

The total CMHC costs (inputs) are broken down into five basic areas of expenditure:

- Direct face-to-face personnel costs by type of service,
- Program-specific administrative and support personnel costs including the cost of direct non-face-to-face services to clients,
- General administrative personnel costs,
- Consultation, education, and prevention service personnel costs, and
- Unallocated (non-personnel) costs.

These areas of expenditure, as defined in the Manual of Accounting and Reporting Specifications for Community Mental Health Centers,* are:

- Face-to-face service costs - the cost of staff time spent in face-to-face service to clients. This cost includes that portion of the service staff salaries, wages, and fringe benefits spent in face-to-face service to center clients. Staff are broadly defined to include persons whose time is purchased by the center as well as the time of persons employed by the Center. This cost center includes the following services: diagnostic assessment, day care, methadone maintenance, medication monitoring, ambulatory detoxification, nursing assessment and care, psychiatric/medical assessment and care, physical therapy, speech and hearing therapy, occupational therapy, activity therapy, medication administration, individual counseling, family counseling, group counseling, crises stabilization, pharmacy, and residential.

- Program administration costs - this category largely includes the cost of staff time spent in direct non-face-to-face, case-related services such as charting, lab tests, co-therapy, transportation, and case coordination. It also includes other administrative, consultative, and educational activities relating to a specific program function and not included elsewhere.

- General administrative costs - included are the costs of personnel time spent in general research and evaluation, quality assurance, accounting, facilities maintenance and operation, in-service training, reporting, and in other such administrative and support activities not devoted to a particular client disability group (program).

- Consultation, education, and prevention costs - this category includes the cost of staff time spent consulting with representatives of other agencies, educating the public, and other activities aimed at reducing the incidence of mental problems requiring eventual treatment. Unless a center has separately organized and budgeted consultation and education activity, the consultation and education costs are reported under the 'program administration' category. At present, only a few centers in Georgia have distinct consultation and education programs.

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*Department of Human Resources, Division of Mental Health and Mental Retardation (Effective Date: July 1, 1978). These definitions are included in Appendix B of the Guide.

Accordingly, it is not possible to distinguish the cost of staff time spent in direct case-related support services from the cost of staff time spent in consultation, education, and preventive activities, let alone time spent in program administrative activities. Clearly, this greatly limits the reviewer's ability to determine whether exceptionally high or low program administrative costs actually reflect high or low staff productivity, or simply the proportion of time spent by the staff in activities other than face-to-face service, e.g., in non-direct face-to-face service, consultation and education services or in other program activities.*

- Unallocated costs - this category includes non-personnel expenses incurred in the provision of direct services, and allocated to the various programs/services on some rational basis. These costs and their basis for allocation are shown below:

COSTS	ALLOCATION BASIS
Pensions and Benefits	Limit $
Travel	Direct Service Hours
Equipment	Direct Service Hours
Supplies and Materials	No. of Contacts
Communication Services	Direct Service Hours
Utilities	Estimated Square Footage
Printing and Publicity	Direct Service Hours
Property and Equipment Maintenance	Direct Service Hours
Rent	Estimated Square Footage
Drugs	Pharmacy
Contract Services	Direct Service Hours
Miscellaneous	Direct Service Hours

By calculating the proportion of center expenditures (inputs) in each of these categories, and comparing these proportions to the norm (center average), it is possible to identify areas of the center's operation, the cost of which appear to be disproportionately high or low. Areas of the center's operation where the costs appear low may indicate inadequate resources, or may suggest problems in terms of the center's viability and service capability or others. Above average levels of resources in general administration or direct service (program administration and face-to-face service) may suggest a top heavy or bottom heavy program respectively. Five input/output ratios are described in this procedure. These ratios, their derivation, and some factors to be considered in their interpretation, are presented in the following Sections A-E. The final section attempts to summarize these and other important analytic considerations.

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*The latest Cost Accounting and Report Manual (July 1, 1978) provides for the separate accounting and reporting of these activities, and will offer a much more telling picture of the staff time and costs associated with such activities.

A. RATIO A: DIRECT FACE-TO-FACE SERVICE COSTS TO TOTAL PROGRAM COSTS

The face-to-face service costs may be derived by subtracting the 4.3% charge for DHR overhead (schedule III, item 8) from the total face-to-face service costs (schedule III, item 2). The total program costs may be derived by adding the program administrative costs to the direct face-to-face service costs. The program administrative costs are calculated by subtracting the 4.3% charge for DHR overhead (schedule III, item () from the Total Program Administrative Costs (schedule III, item 3). The ratio is then calculated by dividing the direct face-to-face service costs by the total direct (program-specific) costs.

The ratio provides some indication of the relative level of effort and related costs put into direct face-to-face services as opposed to other direct non-face-to-face services: general consultation, education, and prevention services; and general program support and administrative activities.

Normally, the ratio of direct face-to-face service costs to total direct (program) costs should not fall below .25 or exceed .5. Programs having large consultation, education, and prevention service components, the costs of which are included under program administration, and new and expanding centers in the process of building their caseloads, may have legitimately low ratios not indicative of program inefficiency.

Programs having unusually high ratios of face-to-face service costs to total program costs may not be providing an adequate level of direct non-face-to-face service such as charting, laboratory testing, and case management, or may be providing a proportionately high level of non-clinical services such as recreation and socialization that generally require relatively little non-face-to-face service support. Other considerations are included in sub-section F.

B. RATIO B: GENERAL ADMINISTRATIVE COSTS TO DIRECT (PROGRAM-SPECIFIC) COSTS

The general administrative costs are reported in Schedule III, Item 4 of the Uniform Cost Reports. Derivation of the direct service (program-specific) costs is explained under Ratio A. Dividing the administrative costs by the program-specific costs provides an indication of the relative amount of effort being spent in general administration and support as opposed to direct services and program-specific support.

Normally, general administrative costs should be one-third or less of direct (program-specific) costs. However, much depends on what portion of the total administrative costs the center chooses or is able to directly assign to a given program.

In order to indicate the extent to which unusually high or low ratios of general administrative costs to direct costs may be a function of such cost allocation decisions rather than a function of actual differences in administrative cost levels, a third ratio, Ratio C, should be calculated.

C. RATIO C: DIRECT FACE-TO-FACE SERVICE COSTS TO GENERAL ADMINISTRATIVE AND PROGRAM ADMINISTRATIVE COSTS

This ratio is derived by dividing the face-to-face service costs (the derivation of which is explained under Ratio A) by the sum of the general administrative costs and program administrative costs (the derivation of which is explained under Ratio B).

If the ratio of face-to-face service costs to general and program administrative costs is within the normal range of .18 - .37 then the problem is likely one of accounting procedure. Overall administrative costs (direct labor overhead) is probably not out of line.

D. RATIO D: NON-PERSONNEL (UNALLOCATED) COSTS TO PERSONNEL COSTS

The total unallocated costs (shown in Schedule III, item 6 of the Uniform Cost Reports) are generally defined to include only non-personnel expenses. However, in the NCG-HSA's study of 1976-1977 costs, some centers were found to have included the cost of purchased services, fringe benefits, and inpatient services in this cost category. Accordingly, before calculating this ratio, it is best to identify and exclude such personnel costs from the unallocated cost total. These costs are itemized in Schedule III, of the Uniform Cost Reports.

The adjusted unallocated cost is then divided by the personnel costs (direct face-to-face service costs and program administrative costs + general administrative costs as reported in Schedule III of the Uniform Cost Reports). Normally, the ratio of non-personnel costs to personnel costs should run between 20-50%. These costs may be higher in the case of new programs purchasing facilities and equipment; this is especially so in Georgia as centers cannot amortize capital costs over a number of years; the full cost of facilities and equipment must be recorded in the year purchased.

As a rule, in hospital-based programs and in urban areas, rents are higher; and in rural programs, travel and communication costs are higher.

E. RATIO E: DIRECT FACE-TO-FACE SERVICE COSTS TO TOTAL CENTER COSTS

Total center costs are reported in Schedule III, Item 7 of the Uniform Cost Reports. They include face-to-face service costs; program administrative costs; consultation, education and prevention

costs; Georgia Department of Human Resources (DHR) overhead charge of 4.3%; general administrative costs; and unallocated expenses. The derivation of direct face-to-face service costs is explained under Ratio A.

The ratio of direct face-to-face service costs to total center costs should normally run between 15 and 30%. Many of the factors which may underlie an abnormally high or low ratio of direct face-to-face service costs to total center costs have already been mentioned.

ANALYTIC CONSIDERATIONS

These and other factors which may serve to explain unusual or abnormal center expenditure patterns are outlined in the table on the next page. The table also identifies factors which touch on accessibility, utilization, and treatment questions raised in the productivity analysis.

Before referring to the table, please remember that none of these interrelated factors can be considered in isolation. They much be weighted as part of a comprehensive analysis which accounts as best possible for their interplay. It should be noted that the component analysis procedure does not discuss the analysis of the costs of consultation, education and preventive services, as only the Athens CMHC provided details on these costs on the Uniform Cost Reports in Fiscal Year 1977. However, as additional centers organize and report on separate and distinct consultation and education services, this will become an important dimension of the cost analysis. A general rule of thumb is that the consultation and education costs should run between $1 and $2 per capita.

SELECTED FACTORS TO BE CONSIDERED IN ANALYZING COMMUNITY MENTAL HEALTH CENTER COSTS AND THEIR IMPLICATIONS

FACTORS	SOURCES	CONSIDERATIONS
Client Mix:		
-Mental Health Treatment History		• Care of chronic patients is generally less costly than the care of acute patients; the chronic patient is less likely to break appointments and drop-out of service.
• % former inpatients in short term facilities (mostly acute)	MH/MRIS Reports	• The acute clients' needs usually change more rapidly than the needs of chronic clients; more individual staff time is spent on diagnostic workups and case management.
• % former State Psychiatric Hospital patients (mostly chronic)	MH/MRIS Reports	
• % having no prior treatment (less seriously ill)	MH/MRIS Reports	• The less seriously ill should be less costly to serve though this can be offset by a relatively high turnover, greater case startup costs, and difficulty in collecting fees.
Client Concentration:		
• Number of clients per 100,000 population	MH/MRIS Reports & Georgia Office of Planning & Budget	• Indicative of the Center's relative accessibility, program acceptability, and catchment area penetration - the Center's actual and potential utilization and need.
Organization:		
• Decentralized operation (satellites)	Grant Application or Center Survey	• Higher overall administrative costs • Higher facility and equipment costs • Higher potential utilization (accessible to more people)
• Centralized operation	Grant Application or Center Survey	• Lower overall administrative costs • Lower facility & Equipment Costs • Lower potential utilization (accessible to fewer people)
• Size: Small operation	Schedule III Uniform Cost Reports	• Larger centers tend to have a relatively high ratio of administrative costs to direct service costs. As a rule, the larger the center, and the greater the number of services the center must develop, administer, and coordinate, the greater the adminis-

FACTORS	SOURCES	CONSIDERATIONS
		trative complexity, and corresponding inefficiency (i.e., the higher the proportion of administrative to direct service costs).
• Size: Large operation	Schedule IV-C Uniform Cost Reports	• Smaller centers, particularly multiple service centers, tend to have a relatively high ratio of administrative costs to direct service costs. There is a fixed set of administrative requirements and related costs attending the operation of a center regardless of its size. Seldom, are small centers able to find staff capable and flexible enough to efficiently meet their requirements; rare is the therapist who can keep the books! In other words, smaller centers, too, face inherent inefficiencies relating to their size.
Staffing Patterns:		
• Higher proportion of donated (contracted) staff	Schedule III Uniform Cost Reports	• Lower fringe benefits
• Higher use of volunteer staff	Grant Application or Center Survey	• Lower cost per hour of service
• Proportionately greater number of highly specialized mental health clinicians	Grant Application or Center Survey	• Higher cost per staff
Staffing:		
• Number of staff per 100,000 population	Ga. Office of Planning & Budget	• Indicative of the center's relative service capacity and potential utilization.
Catchment Area Population Density:		
• Rural: population per square mile	Ga. Office of Planning & Budget	• Higher cost for travel and transportation; and hence lower utilization potential
• Urban: population per square mile		• Higher resource costs (labor and non-labor) for staff, but higher utilization potential.

FACTORS	SOURCES	CONSIDERATIONS
Treatment Philosophy:		
• Emphasis on generic service utilization (out-of-center services)	Grant Application or Center Survey	• Higher program administrative costs allowing for case and program coordination with other service providers less potential amount of face-to-face service time per staff (lower productivity)*
• Emphasis on traditional, in-center services	Grant Application or Center Survey	• Less staff travel required; greater potential amount of face-to-face time per staff (higher productivity). **
Program/Service Mix:		
• Hours of service per 100,000 population by program • Relative hours of service (service mix)	Schedule IV-C Uniform Cost Reports Ga. Office of Planning & Budget	• Low volume programs and services are generally more costly than high volume programs and services • Specialized programs such as those for children and adolescents are usually more costly than generalized programs because these programs usually entail a more costly complement of specialized and less heavily utilized staff (e.g., child psychiatric or psychologist) • Group modes of treatment (e.g., counseling) are less costly to provide than individual modes of treatment (e.g., individual counseling) • Services requiring physician and nursing time (e.g., medical and 'nursing assessment') are generally more costly than other services.

* & ** Productivity for the purpose of this analysis is defined in terms of hours of direct face-to-face service in relation to cost. It does not look at 'changes in client functioning' or other higher level outcomes in relation to cost.

FACTORS	SOURCES	CONSIDERATIONS
Growth Pattern:		
• Center Age	Grant Application or Center Survey	• During the early years of the Center's growth or decline, commonly coming at the beginning or end of a federal grant, the administrative costs are likely to be relatively high as administrative staff are the first to be hired and the last to be let go.
• Federal Grant Year	Grant Application or Center Survey	• Likewise, in the early years and late years of a federal grant, the program administrative costs will likely be relatively high reflecting the increased emphasis on case building. • Capital costs will likely be high in the early years.

VI. CASE EXAMPLE

The purpose of this case example is to illustrate the step-by-step procedure by which the complement of productivity formulas and cost component ratios may be derived for a given center program. Most of the information needed to derive the productivity formulas and cost component ratios can be found in Schedule III and Schedule IV-C of the Uniform Cost Reports. These schedules are prepared as part of a larger set of schedules and details submitted for each Community Mental Health Center program by those Community Mental Health Centers seeking reimbursement under the mental health outpatient option of the state Medicaid plan. These reports are submitted to the Community Support Unit, Mental Health Services, Division of Mental Health/Mental Retardation, Georgia Department of Human Resources. Illustrative copies of these schedules for the adolescent program center X are shown on pages 33 and 34.

Information pertaining to numbers of center clients and client characteristics is available in the Mental Health/Mental Retardation Information System (MH/MRIS) reports. An illustrative copy of the MH/MRIS client movement data as reported by center X is shown on page 35. It is important to note that the number of program (disability group) categories reported by a given center in the Uniform Cost Reports (UCR) is sometimes greater than the number of categories reported center in the MH/MRIS reports. In order to assure comparable cost/client movement (utilization) figures for analysis, some of the program categories in the UCR may have to be collapsed. This is commonly the case with the child and adolesent programs which are reported separately in the Uniform Cost Reports and as one in the MH/MRIS Reports. The step-by-step computations of the formulas and ratios are described below.

FORMULA A
DIRECT COST PER HOUR OF FACE-TO-FACE SERVICE

STEP 1

Compute the face-to-face service costs
by subtracting the Department of Human Resources (DHR) overhead charge (Schedule III, Item 8): 269
from the total face-to-face service costs (Schedule III, Item 2): 8199

$$8199 - 269 = \underline{7930}$$

STEP 2

Compute the direct cost per hour of face-to-face service
by dividing the face-to-face service costs: 7930
by the hours of face-to-face service (Schedule IV-C): 1604

$$7930 \div 1604 = \underline{4.94}$$

FORMULA B
TOTAL COST PER HOUR OF FACE-TO-FACE SERVICE

STEP 1
Compute the program administrative costs
by subtracting the DHR overhead charge (Schedule III, item 9): 1626
from total program administrative costs (Schedule III, item 3):
39,435
39,435 - 1,626 = 37,809

STEP 2
Compute the total program (direct personnel) costs
by adding the direct face-to-face service costs (Formula A, Step 1): 7,930
to the program administrative costs (Step 1): 37,809
37,809 + 7,930 = 45,739

STEP 3
Estimate the number of staff hours spent in this program
by dividing the total program (direct personnel) costs (Step 2):
45,739
by the direct costs per hour of face-to-face service (Formula A, Step 2): 4.94
45,739 ÷ 4.94 = 9,445

STEP 4
Estimate the number of staff working in this program
by dividing the number of staff hours spent in this program (Step 3) 9,445
by the number of regular work hours per staff each year (52 weeks x 40 hours per week): 2,080
9,445 ÷ 2,080 = 4.44

STEP 5
Compute the total program cost
by subtracting the DHR overhead charge (Schedule III, Item 12):
2,308
from the total program costs (Schedule III, Item 7): 72,612
72,612 - 2,308 = 70,304

STEP 6
Estimate the total cost per program staff
by dividing the total program costs (Step 5): 7,304
by the estimated number of staff working in this program (Step 4): 4.44
70,304 ÷ 4.44 = 15,834

STEP 7
Compute the total number of clients seen in the program during the year
by adding the beginning year caseload (MH/MRIS): 4
to the unduplicated additions (MH/MRIS): 234
234 + 4 = 238

STEP 8
Compute the number of clients (caseload) per program staff
by dividing the total number of clients seen in the program during the year (Step 7): 238
by the number of full-time equivalent staff working in the program (Step 4): 4.44

238 ÷ 4.44 = 53.6

STEP 9
Compute the hours of face-to-face service per client
by dividing the total hours of service delivered during the year (Schedule IV-C): 1,604
by the total number of clients seen in the program during the year (Step 7): 238

1,604 ÷ 238 = 6.74

STEP 10
Compute the hours of face-to-face service per staff
by multiplying the number of clients (caseload) per program staff (Step 8): 53.6
by the hours of face-to-face service per client (Step 9): 6.74

53.6 x 6.74 = 361

STEP 11
Compute the total cost per hour of face-to-face service
by dividing the total cost per program staff (Step 6): 15,834
by the hours of face-to-face service per staff (Step 10): 361

15,834 ÷ 361 = 43.80

FORMULA C
TOTAL COST PER HOUR OF FACE-TO-FACE SERVICE

STEP 1
Compute the hours of face-to-face service per staff
by dividing the total hours of face-to-face service delivered during the year (Schedule IV-C): 1,604
by the number of full-time equivalent staff working in the program (Formula B Step 4): 4.44

1,604 ÷ 4.44 = 361

STEP 2
Compute the total cost per hour of face-to-face service
by dividing the total cost per program staff (Formula B, Steps 1-6): 15,834
by the hours of face-to-face service per staff (Step 1, above): 2,083

15,834 ÷ 361 = 43.86

RATIO A
DIRECT FACE-TO-FACE SERVICE COSTS TO TOTAL PROGRAM COSTS

STEP 1
Compute the face-to-face service costs
by subtracting the DHR overhead charge (Schedule III, Item 8): 269

from the total face-to-face service costs (Schedule III, Item 2): 8,199

8,199 - 269 = <u>7,930</u>

STEP 2

Compute the program administrative costs
by subtracting the DHR overhead charge (Schedule III, Item 9): 1,626
from the total program administrative costs (Schedule III, Item 3): 39,435

39,435 - 1,626 = <u>37,809</u>

STEP 3

Compute the total program (direct) costs
by adding the direct face-to-face service costs (Step 1): 7,930
to the program administrative costs (Step 2): 37,809

7,930 + 37,809 = <u>45,739</u>

STEP 4

Compute the ratio of direct face-to-face costs to total program costs
by dividing the direct face-to-face service costs (Step 1): 7,930
by the total program (direct) costs (Step 3): 45,739

7,930 ÷ 45,739 = <u>.17</u>

RATIO B
GENERAL ADMINISTRATIVE COSTS TO TOTAL PROGRAM COSTS

STEP 1

Compute the general administrative costs
by subtracting the DHR overhead charge (Schedule III, Item 10): 413
from the total general administrative costs (Schedule III, Item 4): 10,019

10,019 - 413 = <u>9,606</u>

STEP 2

Compute the ratio of general administrative costs to total program costs
by dividing the general administrative costs (Step 1): 9,606
by the total program costs (Ratio A, Step 3): 45,739

9,606 ÷ 45,739 = <u>.21</u>

RATIO C
DIRECT FACE-TO-FACE SERVICE COSTS TO TOTAL ADMINISTRATIVE COSTS

STEP 1

Compute the total administrative costs
by adding the program administrative costs (Ratio A, Step 2): 37,809
to the general administrative costs (Ratio B, Step 1): 9,606

9,606 + 37,809 = <u>47,415</u>

STEP 2

Compute the ratio of direct face-to-face service costs to total administrative costs
by dividing the direct face-to-face service costs (Ratio A, Step 1): 7,930
by the total administrative costs (Step 1): 47,415

7,930 ÷ 47,415 = .17

RATIO D
NON-PERSONNEL (UNALLOCATED) COSTS TO PERSONNEL COSTS

STEP 1

Compute the total personnel costs
by adding the total administrative costs (Ratio C, Step 1): 47,415
to the direct face-to-face service costs (Ratio A, Step 1): 7,930

7,930 + 47,415 = 55,345

STEP 2

Compute the ratio of non-personnel (unallocated) costs to total personnel costs
by dividing the unallocated costs (Schedule III, Item 6): 14,959
by the total personnel costs (Step 1): 55,345

14,959 ÷ 55,345 = .27

RATIO E
DIRECT FACE-TO-FACE SERVICE COSTS TO TOTAL PROGRAM COSTS

STEP 1

Compute the total program costs
by subtracting the DHR overhead charge (Schedule III, Item 12): 2,308
from the total program costs (Schedule III, Item 7): 72,612

72,612 - 2,308 = 70,304

STEP 2

Compute the ratio of direct face-to-face service costs to total program costs
by dividing the direct face-to-face service costs (Ratio A, Step 1): 7,930
by the total program costs (Step 1): 70,304

7,930 ÷ 70,304 = .11

PROGRAM TYPE: (ADOLESCENT) ADULT, DRUG, OR ALCOHOL

COST CENTER ANALYSIS

DESCRIPTION	A Recorded Cost (Expenses from Trial Balance)	B Cost Paid By Related Organizations (Sch. III-b)	C DHR OVERHEAD 4.3% (Sch. III-d)	D TOTAL (A+B+C)
DIRECT SERVICE				
Diagnosis/Evaluation	1,607		69	1,676
Medication Visits	5			5
Occupational Therapy	101		4	105
Individual Counseling	2,212		95	2,307
Family Counseling	1,727		74	1,801
Group Counseling	380		16	396
Crisis Intervention	254		11	265
Non Medicaid	1,644			1,644
TOTAL DIRECT	7,930 (1)		269 (8)	8,199 (2)
IND. & ADMIN.				
Adm. - Pro.	18,464	19,345	1,626 (9)	39,435 (3)
Adm. - General	9,606		413 (10)	10,019 (4)
C & E	0			0 (5)
TOTAL INDIRECT & ADMINISTRATIVE	28,070	19,345	2,039 (11)	49,454
UNALLOCATED EXPENSE				
Renchet @ 14.9%	5,364	2,883		8,247
Travel	191			191
Rent	5,249			5,249
Telephone	376			376
Misc.	896			896
TOTAL UNALLOCATED	12,076	2,883		14,959 (6)
TOTAL COST	48,076	22,228	2,308 (12)	72,612 (7)

ADOLESCENT PROGRAM

DIRECT SERVICE HOUR ANALYSIS

FOR PERIOD ENDED 6/30/77

DIRECT SERVICE COST CENTERS	HOURS OF DIRECT SERVICE SCHEDULE II & II-a	PERCENT OF DIRECT TOTAL HOURS
Diagnosis/Assessment and/or Evaluation	287.9	17.9%
Day Care - Partial Hosp.		
Methadone Maintenance		
Medication Visit		
Ambulatory Detoxification		
Nursing Assessment and Care		
Medical Assessment and Care		
Physical Therapy		
Speech and Hearing Therapy		
Occupational Therapy	10.3	.6%
Activity Therapy	8.	.5%
Recreational Therapy		
Individual Counseling	538.6	33.6%
Family Counseling	337.0	21.1%
Group Counseling	74.3	4.6%
Crisis Intervention	34.2	2.1%
Pharmacy	314.2	19.6%
TOTAL	1,604.5	100.0%

TERMINAL NO. : 01
REPORT NO. : MI5731R1
FACILITY NO. :
RUN DATE : 07/31/77

STATE OF GEORGIA - MENTAL HEALTH AND MENTAL RETARDATION INFORMATION SYSTEM

M O V E M E N T B Y P R I M A R Y D I S A B I L I T Y

COMMUNITY
MENTAL HEALTH CENTER
FOR JULY 1, 1976 - JUNE 30, 1977

MOVEMENT	PRIMARY DISABILITY: MENTAL-EMOTIONAL PROB. CHILD	MENTAL-EMOTIONAL PROB. ADULT	MENTAL RETARDATION	ALCOHOL ABUSE	DRUG ABUSE	TOTAL
UNDUPLICATED COUNT OF ACTIVE CLIENTS ON FILE (BOP)	4	159	34	95	7	299
ADDITIONS DURING PERIOD						
FIRST ADMISSION TO SERVICE IN GEORGIA	135	213	23	1	2	374
FIRST ADMISSION TO SERVICE IN THIS FACILITY	84	648	123	280	39	1,174
READMISSIONS TO THIS FACILITY	27	72	10	66	6	181
MOVEMENT WITHIN THIS FACILITY	1	8	3	0	0	12
TOTAL ADDITIONS DURING PERIOD	247	941	159	347	47	1,742
TOTAL UNDUPLICATED COUNT OF ADDITION CLIENTS	234	889	152	314	42	1,631
RELEASES DURING PERIOD						
TOTAL RELEASES DURING PERIOD	128	463	33	279	33	936
TOTAL UNDUPLICATED COUNT OF RELEASE CLIENTS	121	434	28	249	28	860
UNDUPLICATED COUNT OF ACTIVE CLIENTS ON FILE (EOP)	171	614	158	160	21	1,070

VI. COST CONTAINMENT: DEFINITION AND STRATEGIES

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.*

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

Given our definition of cost containment, there are three important precautions in devising and initiating worthwhile Mental Health Center cost containment strategies or tactics.

1. Service quality and access ("end") objectives should override service efficiency ("means") objectives tendered under cost containment.

2. The risk of unintentionally sacrificing service quality and accessibility is inversely related to the level of understanding of the target center's operation, and directly related to the size of the planned cost reduction.

3. Far fewer costs are controllable in the operational stage than in the planning stage of a Center's life.

SERVICE QUALITY, ACCESS, AND EFFICIENCY

"The preamble to Public Law 93-641, The National Health Planning and Resource Development Act, states: "the achievement of equal access to quality health care at a reasonable cost is a priority of the federal government.* The stated purpose of Public Law 93-641, Section 1122 of the Social Security Act, and other such federal laws is to improve the balance between the access, quality, and cost through the

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*10 p.7.

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

re-allocation of our mental and physical health resources. It's important that cost containment measures not disrupt this balance in the name of efficiency and cost containment. We mustn't lose sight of the fact that the provision of effective services is paramount. Successful cost containment measures should increase CMHC productivity or reduce the cost of Center resources without jeopardizing the quality of, or access to needed services.

The Utilization Review process is intended to deal with just this issue. It is designed to judge through the periodic review of selected cases, whether the level, type, and length of service being provided to Center clients is appropriate to their needs. The difficulty of second guessing the mental health therapist is easy to see. Its just as difficult to judge, through an examination of overall center utilization figures, whether clients are being overserved or underserved in the interest of efficiency. What is the maximum effective level of a given service for a chronic or acute patient? What is the minimum or maximum effective ratio of direct non-face-to-face hours of charting, lab-tests, case therapy ... to direct face-to-face service hours.

The issue of maintaining the proper balance of service quality, access, and efficiency is brought to the fore in Georgia by the adherence of many of the Centers in Georgia to the 'Balanced Service System' model of service delivery. The Balanced Service System (BSS) rests on the theory that mental disability is primarily a matter of an individual's inability to function in his community. The Center's rehabilitative focus then, is less on in-center, psycho-therapeutic treatment and more on helping the individual cope in his or her natural environments. The Balanced Service System encourages working with an individual at home rather than in the Center itself, and encourages the securement of, and coordination with, a broad range of service options outside the realm of the Center.

The pursuit of the BSS principles inherently entails considerable staff travel, lower utilization of Center services, and more time spent in service coordination and other such non revenue-producing support activities. It is <u>not</u> a cost/efficient mode of service delivery from the individual Center's perspective, but its advocates ardently maintain that it is a cost/effective mode of care from the public's perspective. Only a careful evaluation will tell. Until then, a decision to force Centers back to the traditional treatment modes in the name of efficiency would seem to be unfounded.

A similar "effectiveness" or "quality" issue which has yet to be resolved concerns prevention. Many centers devote a high percentage of their time to the provision of consultation and education. (C & E) services in the interest of prevention and

caseload building.* Although some Centers report a high consultation and education cost recovery rate, the vast majority are able to recover only a small share of the actual cost; consequently the cost must be apportioned to the direct services effectively raising their cost.**

Though federal officials and most practitioners strongly favor the provision of consultation and education services, many state and local officials still question their relative cost effectiveness.

RISK

Most of the federally-funded CMHC's are currently in a squeeze. Just as the availability of federal grant monies fostered the expansion of Center operations, declining federal resources are forcing cut-backs in Center operations. Generally speaking, there is little "fat" in most Center budgets to absorb miscalculated cost containment measures. As the size and complexity of the cost containment measure grows so does the risk of incidentally affecting service quality and accessibility.

Cost containment measures should not be considered in isolation; most every measure of any consequence will have a multi-dimensional impact on a Center's operations. The combination of cost containment measures (strategy) to be employed in any given Center should be sensitive to the Center's situation.

The risk of initiating impractical and disserving cost containment measures is inversely related to the initiator's understanding of the dynamics of the Center's operations. For instance, while a measure to increase the responsibilities of para-professionals may work quite well in a Center adhering to the "psycho-social" model of service, it may not work at all in a Center adhering more to the "medical model" of service; further, 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.

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*NIMH estimated in 1975 that 4% of the total staff effort in the 286 federally funded centers sampled was devoted to consultation and education services. Source: Mental Health Statistical Note #147, Rosalyn D. Bass and Marilyn Rosenstein, March 1978 Title: The Indirect Services: Consultation and Education and Public Information and Public Education, Federally Funded Community Mental Health Centers, 1975. DHEW-NIMH Division of Biometry and Epidemiology, Survey and Reports Branch.

**Cal Gough, "Money Matters", No. 2, February 25, 1978, Community Services Support Unit, Division of Mental Health & Mental Retardation, Georgia Department of Human Resources, p. 15

The level of understanding of Center operations possible through the NCG-HSA'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.

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, and the cumbersome civil service regulations often restrict the ability of some Center directors to re-allocate CMHC manpower. Federally mandated services, program standards, and third party reimbursement provisions likewise prohibit many changes in program service patterns, and render still other changes economically unfeasible.

COST CONTAINMENT SUGGESTIONS

Having introduced the cost containment objectives and melange of cost containment constraints, let's examine some general cost containment possibilities in North Central Georgia.

The cost containment suggestions are defined in capsule form. It is beyond the scope of this project to elaborate on these cost containment measures. Further, the hypothetical effects of alternative CMHC funding schemes aimed at indirectly inducing the containment of Center costs are not discussed. Excellent discussions of alternative funding arrangements can be found in articles by Pauli,* and Dowling.** It's also important

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*Mark V. Pauli, "Efficiency, Incentives, and Reimbursement for Health Care," Inquiry, Vol. VII, No. 1, p. 114-131.

**William J. Dowling, "Prospective Reimbursement in Hospitals," Inquiry, Vol. XI, September 1974, p. 163-180.

the quantify of services provided, reduce service quality, or reduce accessibility are defined as 'cost reduction' not 'cost containment' measures, and are not addressed.

FINANCIAL MANAGEMENT

Worthwhile cost containment measures are generally predicted on a sound financial management system of planning and control.

FINANCIAL PLANNING

Financial management begins with a fiscal plan and budget projecting program revenues and expenditures over the long and short term. It is at this point that the Center, Health Systems Agency, and other reviewers and prospective sponsors should carefully evaluate the cost and revenue implications of alternative organizational and operational strategies and policies.

MANAGEMENT INFORMATION

The success of any cost management program lies in the ability to identify costs, to analyze their potential for control, and to produce information to enable management to exercise that control. It's fair to say that few of the Center representatives with whom we spoke had any idea of the Center's efficiency relative to that of other Centers. In other words, few had reason to question the efficiency of their operation or the potential for improvement.

The Centers' implementation of the cost accounting systems necessary to meet the FY 78-79 Uniform Cost Report requirements, should provide them with the essential fiscal data to find and control the costs of direct and indirect services. If, in addition, the Center's review and planning and financing agencies can be provided with timely feedback from the State's Mental Health and Mental Retardation (MHMRIS) data bank, there could be a reasonably sufficient base of program and fiscal information for sound financial and program management. The repeated and justifiable complaint of the North Central Georgia Center directors was that they should be fed back essential information from the MHMRIS (as promised). As it stands, only the larger federally-funded Centers have been able to afford to compile such information for their own purposes. It is recommended that up-to-date, comparative fiscal information (such as that produced in this study), and comparative program information (such as is available from the MHMRIS), be fed back to the Centers, and Mental Health Planners and reviewers in the interest of improving the fiscal management of the Community Mental Health Centers.

It is further suggested that the state compile the Uniform Cost Report and MHMRIS information (feedback) in a meaningful and readily useable form. The indicators presented in HSRI's analytic guide are good examples of telling ways to present such information. Section V elaborates on this recommendation.

COST CONTAINMENT IMPETUS

The financial management system notwithstanding, unless there is some outside impetus for cost containment, Centers are unlikely to act. The prospective decline in federal revenues is certainly a driving force for cost containment, as are the periodic reviews of State and County planners and officials.

A less direct, but more positive way to promote the containment of Mental Health Center costs could be through the organization of cost containment committees or workshops. The American Hospital Association and others have come out in favor or organizing standing cost containment committees in hospitals. 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.

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 protrayed in the schematic on the next page, and are introduced in the balance of this section.

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.

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 SUBSTRACTING STAFF

The recruitment of competent psychiatrists and clinicians is difficult for many Centers. Rural Centers in particular find it difficult to recruit psychiatrists. 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, etc.

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; conversely, 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 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 a 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 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. On the other hand, Centers will also move to increase the amount of individual counselling and other labor intensive service modes in the face of lower service demand. 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.

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 try to take the most advantage of indigenous community services. Some Centers have placed a strong emphasis on the use of the family physician as a primary care provider for many patients coming to the Center for services; the Center provides support to the physician as required. Other Centers have opted to use the services of the town pharmacist rather than providing pharmaceutical services directly. The use of a private pharmacist by the Center and other human service providers -- 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.

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.

There are three basic means of increasing services:

- Increasing the recognition and acceptance of three of the Center's services by prospective clients or advocates, and by other sources of referral.
- Increasing the physical accessibility of Center services.
- Decreasing the proportion of missed therapist-client appointments.

BUILDING RECOGNITION AND APPRECIATION OF CENTER SERVICES

An aggressive consultation and education program is not only a means of preventing unnecessary out-patient and in-patient admissions, but is also a means of building caseloads through increased public recognition and a sense of confidence on the part of other care givers with respect to the staff's capabilities.

Few Centers appear to be able to afford to mount a sizeable consultation and education program for lack of staff time, and the ability to develop reimburseable consultation agreements. Many Centers are known to use volunteers to augment their public information program and thereby increase the demand for services.

Federal grants may be obtained for the specific purpose of building and maintaining consultation and education programs. As with the other Center grants, the amount of federal support gradually declines but unlike the other grants, levels off at roughly 25 to 50% for the life of the program depending on whether the Center is located in a "poverty" area.

Increasing the CMHC's physical visibility is another means of building recognition. Increased awareness of the centers services often results from their new visibility, raising the demand for services.

INCREASE PHYSICAL ACCESSIBILITY

Physical accessibility to Center services may be increased in one of three ways:

- By increasing the number of service outlets (affiliates, out-reach units, or satellites) in the catchment area where clients might avail themselves of service. Most of the Centers have established multiple service outlets, and others are planning to relocate or establish more accessible service outlets. Still, it must be remembered that the gain in demand must be sufficient to offset the added administrative costs of decentralization if it is to be truly a cost containment measure. The extent to which this will reduce demand remains to be seen.

- By taking the services to the client pursuant to the Balanced Service System philosophy.

- By providing transportation services to clients unable to practically use either public or private means of getting to and from the Center.

Increasing client discounts would be another possible way to increase demand; however, it is questionable whether the increased demand would be sufficient to offset the revenues lost. It not, the end effect could be to reduce the overall level of service which the Center is able to afford its clients. Practically speaking, in the face of limited federal, state, and county funds, and rising demand, most Centers are presently inclined to maintain or reduce the client discounts - not increase them - in order to support current service levels.

REDUCING THE NUMBER OF BROKEN CLIENT-THERAPIST APPOINTMENTS

Missed appointments can reduce effective demand and staff productivity significantly. Broken appointments are usually higher among acutely disturbed clients, and troubled youth. The practice of calling and reminding clients of appointments has been reported to help considerably. Where the broken appointment rate is found to be unusually high with respect to one or a few therapists, the problem can often be traced to the therapists' casual attitude in setting the appointments; or to other correctable factors. It may also be necessary to enroll habitual "no-shows" in group rather than individual services in order to minimize the amount of therapist time-wasted.

INCREASE STAFF PRODUCTIVITY

The productivity of Center staff is a function of the positive and negative incentives associated with good or poor

performance, the inherent service potentials and limitations of different staffing patterns, and how efficiently the staff are deployed. Before beginning to suggest possible ways to increase staff productivity, the complexity and challenge of managing and motivating Center personnel must first be acknowledged. While there are no pat answers, a number of lessons have been learned over the past years. First, the traditional, industrial-oriented management technologies of centralized decision making, task specialization, and hierarchical relationships are seldom appropriate. As Maloof explains:

> "Human service organizations must ordinarily place much greater emphasis on the professionalization of personnel rather than specialization. This plays havoc with the bureaucratic principle of a strict hierarchy of authority. Personnel in human service agencies are likely to feel as competent as those at higher levels of authority because they share in their awareness of the total organization. Management in these organizations, then, must often be more decentralized. Decentralization is nurtured further by intangible goals, uncertain technology, and professional discretion which reduce the degree of accountability...
>
> The administrator of a human service organization is faced with less autonomy, greater uncertainty, and more difficulty in the operationalization of processes and outcomes. He must: 1) allow for greater staff and consumer participation in the policy and decision making process, 2) cooperate with other agencies to coordinate a system of service delivery, 3) adjust the resources of the organization to meet existing goals rather than holding resources constant adjusting goals, and 4) rely on professional standards rather than hierarchical relationships to ensure the conformity of his staff."*

POSITIVE AND NEGATIVE INCENTIVES

Centers are restricted to the use of salary as the sole form of reimbursement for Center staff. Ruled out are the use of monetary rewards associated with increased productivity such as might be possible with private service providers.

The State Merit System and restricted Center budgets largely prohibit the use of monetary rewards for staff performance.

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*Bruce A. Maloof, "Peculiarities in Human Service Bureaucracies," Administration in Mental Health, State University of New York, Stony Brook, New York, Fall, 1975, page 25.

Generally, low salary levels lead staff to expect, and Center directors to award step and grade increases as a matter of course rather than in accordance with performance. The value of monetary rewards is questionable in any case as many staff accepting positions with the Centers likely did so for other than monetary reasons. The promise of personal and professional job satisfaction "doing good", would seem to be one reason. Psychiatrists and psychologists opting for public service may also accept the monetary limitations in exchange for the promise for free personal time, and the potential of building a practice.

Non-monetary rewards seem to be the only realistic option open to the Centers. A good in-service training and staff development program can do much to retain staff, and to keep staff morale and motivation high. Trips to professional conferences and workshops, citations, and other such non-monetary perks can be used to encourage professional staff productivity and reduce staff turnover. Shortened work weeks, and compensatory time may also be granted if an employee is able to meet a service quota or job requirement in less than the time alloted, or to induce service staff to work on Saturdays and in the evenings when there is a greater potential demand for services.

The State Merit System also restricts the director's prerogatives to select, discipline, and discharge employees. The time consuming procedures and red tape required to demote and fire employees whose performance is unsatisfactory is enough to discourage most Center directors from such a tact. Many Centers prefer contracting for services because they are able to incorporate and enforce performance rewards and sanctions much more easily. Similarly, fee-for-service contracts are favored though not always attainable from private clinicians whose services are in great demand.

STAFFING PATTERNS

Some Centers are making use of CETA employees to augment the administrative and service staffs. However, the temporary nature of the CETA funds, can eventually interrupt Center operations, and can drain the time of the staff assigned to train the CETA employees; the value of the CETA employees is particularly questionnable if the Center is not able to add them to the Center's budget at the end of the year.

Other Centers make heavy use of volunteers. In many Centers, non-practicing social workers, psychologists, and other such persons, are provided a designated number of hours of training, and in exchange agree to volunteer a set number of hours per week in direct service. In most Centers, volunteers are trained and used in more general activities.

Volunteers are used to make home visits, strengthen the Center's public information efforts, provide beautician services, help tutor the mentally retarded, provide client transportation services, and offer instruction in arts and crafts.

The extent to which the Centers utilize para-professionals in unknown. A number of studies have shown that with proper training para-professionals can effectively be used as recreational and occupational therapists and out-reach workers.*

STAFF DEPLOYMENT

In order to minimize the amount of time that the higher paid professional staff must spend on non-face-to-face service functions, lower-paid administrative staff are increasingly relieving service staff of tasks such as completing the intake forms, scheduling and confirming appointments, and coordinating with other service providers. At many Centers, group medication clinics are employed to screen out all but the exceptional problems requiring the psychiatrist's individual attention.

While a number of Center directors would like to relocate staff among Center satellites, outreach units, and affiliates in order to increase administrative efficiency and reduce costs, one barrier mentioned which inhibits such action was that local associations for retarded citizens, particularly in the rural areas, have a strong interest in, and the political clout necessary to prevent the movement of staff - under-utilized though they may be - from facilities serving the mentally retarded.

DECREASE THE COST OF CENTER RESOURCES

There are three tacts for reducing the cost of Center goods and services:

- The Economic Decision of Buy/Lease Facilities and Equipment

  The possible range of equipment and facility purchase/ lease options is too extensive to cover in any detail. Suffice it to say that such consideration should be given to each major facility and equipment acquisition by the Center.

- Contracting for Services

  A number of Centers have found that the cost of contracting for services such as physicians, nurses, emergency,

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*John D. Tyler, and Brian D. Burtells, "Para-Professionals in the CMHC", Professional Psychology, Volume 6, Number 4, pp. 442-452, November 1975.

janitorial, accounting, and transportation can be appreciably less than the cost of hiring staff to perform these functions. Even more, the ability of the Center to adjust service levels to meet demand requirements or budget constraints is much greater than in the case of hired staff.

- Group purchasing

  Though hospitals in many urban areas have formed cooperatives for the purpose of the economic large-scale purchasing of supplies and services, its hard to imagine any large-scale need for such goods and services by the community mental health centers with the exception of drugs. In Georgia, the state already acts as the purchasing and distribution agent for drugs, thus providing this economic advantage to the Centers.

VIII. CONCLUSION

The community mental health philosophy of care has reached wide acceptance over its almost twenty year span. It has now, however, reached a critical point of economic survival in which hard questions of cost equity and service quality and efficiency are at issue. State governments are being forced to set firm political priorities in which they must either replace the declining federal dollars or loose the vital community services that have been developed. Proposed national legislation would allocate money through a system of performance contracts in which states would be required to prepare specific plans that include CMHC's financial constraints and assets. On all sides then is the CMHC being forced to assess its financial feasibility and reconcile its existence. Without doubt, the systematic analysis of CMHC costs through studies such as this can be an effective way to group the critical program, as well as fiscal, dimensions of a center's operation, both indemically and as viewed in comparison to other centers.

The NCG-HSA community mental health service cost analysis approach is at the beginning stage of what appears to be an exciting and fruitful examination of service costs and economy. With the assistance of CMHC administrators, State personnel and others, it is hoped that proper refinement of the study technique can be made to allow a fair and constructive examination of the major aspects of service costs and quality.

Beginning in September 1979, the NCG-HSA will conduct the community mental health services cost analysis study on an annual basis, predicated on the initial study design with improvements. Yearly cost figures will be obtained from the Division of Mental Health and Mental Retardation Uniform Cost Accounting System Reports, submitted in August of each year. Accompanying programmatic data will be gathered from the Division of Mental Health and Mental Retardation and Area III CMHC's. It will be of prime interest to the NCG-HSA to assess the data not only for project review and planning, but for improvement by the CMHC administrators of overall fiscal management and program planning. Furthermore, it is hoped that this approach can be useful as a model to other states attempting to assess CMHC services through a sound and tested methodology which considers service characteristics in respect to costs.

APPENDICES

A. Cross Reference Table: Mental Health Center Cost Analysis Guide/FY 1976-77 Cost Analysis Report

B. Definition of Services by Cost Center / Service Subaccounts

(extracted from the Manual of Accounting and Reporting Specifications for Community Mental Health Centers, Division of Mental Health and Mental Retardation, Georgia Department of Human Resources, July 1, 1978

CROSS-REFERENCE TABLE

ANALYTIC GUIDE		FY 1976-77 COST REPORT (APPENDIX) Indiv. Center Data A-Tables	Comparative Center Data P-Tables	Summary F-Tables
III. Productivity (Input/Output) Analysis				F-2
Formula A:	Direct Cost per Hour of Face-to-Face Service =	A-1	P-1	
	Direct Face-to-Face Service Costs			
	÷			
	Total Direct (Program Specific) Costs			
Formula B:	Total Cost per Hour of Face-to-Face Service =	A-7	P-1	
	Total Center Cost per Face-to-Face Service Staff	A-7	P-7	
	÷			
	Caseload per Face-to-Face Service Staff	A-7	P-7	
	x			
	Hours of Face-to-Face Service per Client	A-7	P-7	
Formula C:	Total Cost per Hour of Face-to-Face Service =	A-7	P-7	
	Total Center Cost per Face-to-Face Service Staff	A-7	P-7	
	÷			
	Hours of Face-to-Face Service per Staff	A-7	P-7	
IV. Component (Input/Input) Analysis				
Ratio A: =		A-5,6	P-5,6	
	Direct Face-to-Face Service Costs	A-2	P-2	
	÷			
	Total Program Costs	A-2	P-2	

		Indiv. Center Data A-Tables	Comparative Center Data P-Tables	Summary F-Tables
Ratio B: =		A-5,6	P-5,6	
	General Admin. Costs	A-2	P-2	
	÷			
	Direct (Program-Specific) Costs	A-2	P-2	
Ratio C: =		A-4	P-4	
	General Admin. Costs & Program Admin. Costs	A-2	P-2	
	÷			
	Direct Face-to-Face Service Costs	A-2	P-2	
Ratio D: =		A-5,6	P-5,6	
	Unallocated (Non-personal) Costs	A-2,3	P-2,3	
	÷			
	Direct (Program-Specific) Costs	A-2	P-2	
Ratio E: =		A-4*	P-4*	
	Direct Face-to-Face Service Costs	A-2	P-2	
	÷			
	Total Center Costs	A-2	P-2	

*In the Report Table, the inverse ratio was computed (i.e., Total Center Costs/Direct Face-to-Face Service Costs). In order to arrive at the straight ratio divide by the figure shown in the table.

EXHIBIT III-1

DEFINITION OF SERVICES BY COST CENTER/SERVICE SUBACCOUNTS

UNIT = ONE UNIT OF SERVICE	COST CENTER SUBACCOUNT NUMBER	DIRECT SERVICES - FACE TO FACE CONTACT
15 Minutes	01	Diagnostic Assessment - The primary purpose of this service is to screen and assess the consumer's problems, develop or determine a diagnosis, or perform an evaluation. This code is usually used when an Individualized Service Plan is being developed or revised. Therefore, diagnostic assessment is not limited to the early contacts with a consumer, but may be conducted at any time necessary for developing or revising the Individualized Service Plan.
1 Hour Two Hours Minimum	02	Day Care - Partial Hospitalization - The primary purpose of this service is to provide psychosocial supports through a structured program (with a minumum of 2 consecutive hours) designed for stabilization, sustenance, or growth. The core services provided in the program must be described in writing by each local program and make a part of the Policy and Procedures of the Program.
One Contact	03	Methadone Maintenance - The primary purpose of this service is to administer methadone as part of a structured program.
One Contact	04	Medication Monitoring - The primary purpose of this service is to monitor a consumer who is receiving medication. This service may include the writing of a prescription or medication order by a physician, and no more than brief therapy.
15 Minutes	05	Ambulatory Detoxification - The primary purpose of this service is to offer a structured, time-limited series of services necessary to evaluate and treat the physical processes involved in the withdrawal of a client from a substance. The core services provided in the program must be described in writing by each local program.

EXHIBIT III-1 (Continued)

UNIT = ONE UNIT OF SERVICE	COST CENTER SUBACCOUNT NUMBER	DIRECT SERVICES - FACE TO FACE CONTACT
15 Minutes	06	Nursing Assessment and Care - The primary purpose of this service is to monitor, assess, and/or treat the physical problems of a consumer. Only a nurse can provide this service. (Excluded from this service is the administering of drugs as included in medication administration and methadone maintenance.) Other services provided by a nurse should be included in other service codes.
15 Minutes	07	Psychiatric/Medical Assessment and Care - The primary purpose of this service is to provide appropriate medical/psychiatric services. This may include assessment of related physiological status, psychiatric diagnostic evaluation, and psychiatric therapeutic services. This service can only be provided by a physician. Not included is the monitoring medication covered by service number 4.
15 Minutes	08	Physical Therapy - The primary purpose of this service is to treat physical defects with natural force, heat, exercised and for physically disabled consumers, certain mechanical devices. These services can only be performed by, or under the supervision of, a licensed physical therapist, and each service must be specifically authorized by a written physician's order.
15 Minutes	09	Speech and Hearing Therapy - The primary purpose of this service is to improve speech and/or hearing defects. These services can only by performed by, or under the direction of, a speech and/or hearing specialist, and must be authorized by a physician's order.
15 Minutes	10	Occupational Therapy - The primary purpose of this service is to treat a mental or developmental disability by using therapeutic activity (work related) appropriate to the particular consumer and/or the service plan. These services must be performed under the direction of an occupational therapist.

EXHIBIT III-1 (Continued)

UNIT = ONE UNIT OF SERVICE	COST CENTER SUBACCOUNT NUMBER	DIRECT SERVICES - FACE TO FACE CONTACT
15 Minutes	11	Activity Therapy - The primary purpose of this service is to use activities such as arts, crafts, and activities requiring physical exercise (such as bowling, swimming, etc.) to help stabilize, maintain or improve a consumer ability to function better, personally and socially. The goal of the therapy must be described in the consumer's treatment plan and the amount of duration of the therapy must be justified in writing.
Contact	12	Medication Administration - The primary purpose of this service is to administer an oral or injectable medication except for methadone. Only a physician or licensed nurse may perform this service.
15 Minutes	13*	Individual Counseling - Includes any verbal therapy (including rehabilitation counseling) between a single consumer and an approproate member of the center's staff. (For discharge planning, individual counseling may take place in a protective environment, otherwise, the therapy must take place in either the consumer's natural environment or the supportive environment.
15 Minutes	14*	Family Counseling - The primary purpose of this service is to provide therapy for the consumer and his family as a unit. The therapy may be conducted in the natural or supportive environment. (In discharge planning, this therapy may take place in a protective environment.) When conducting family therapy, several members of the consumer's family may be present, but at least one family member must be present.
15 Minutes	15*	Group Counseling - The primary purpose of this service is to use verbal therapy with a group of consumers in order to improve or maintain these consumer ability to function personally and socially. The therapy may be conducted in the natural or supportive environment; in discharge planning, group counseling may be conducted in a protective environment.

EXHIBIT III-1 (Continued)

UNIT = ONE UNIT OF SERVICE	COST CENTER SUBACCOUNT NUMBER	DIRECT SERVICES - FACE TO FACE CONTACT
		*Although counseling for discharge may take place in a protective environment, the medical outpatient clinic option will not pay for services delivered to clients who have not been discharged from local hospitals or state regional hospitals.
15 Minutes	16	Crisis Stabilization - The primary purpose of this service is to provide a time-limited stabilization service to a consumer in crisis. The therapy may be conducted in the natural or supportive environment.
Prescription	17	Pharmacy - The purpose of this service is to fill a prescription and dispense pharmaceuticals to a consumer. This service may only be performed by a pharmacist.
1 Day	18	Residential - The purpose of this service is to account for all services provided to a consumer who is enrolled in a facility, or institution, where services are provided on a 24 hour basis, including food service, lodging, and general supervision. This protective environment includes in-patient units of local hospitals; and the State regional psychiatric hospitals (if clients remain enrolled at CMHC and not included in Hospital enrollment) as well as other facilities, nursing homes, group homes, which provide around the clock, supervised care. This code will be used for all services provided by any CMHC staff to residents to Psychiatric Units.
	(19-29)	Open for Future Use
		Other Direct Services - (Direct contact with client not required)
15 Minutes	30	Other Direct Services (non-billable to Medicaid) - Those treatment related services which directly affect or result from those services delivered face to face, examples: charting, staffing of consumers, transportation,

EXHIBIT III-1 (Continued)

UNIT = ONE UNIT OF SERVICE	COST CENTER SUBACCOUNT NUMBER	DIRECT SERVICES - FACE TO FACE CONTACT
(Continued)		phone crisis, case management, and person and agency conferences relating to Mental Health/Mental Retardation consumers. This code also includes supervision directly related to a single consumer's case. This category may be used separately or in conjunction with any other service/activity code(s) in the 30 series.
15 Minutes (Optional)	31	Charting - This category may be used for the entering of written information in a consumer's case record.
15 Minutes	32	Case Management - This category may be used for the coordination of activities aimed at linking consumers to the service system or systems in order to achieve a successful outcome also includes monitoring and advocacy.
15 Minutes (Optional)	33	Transportation for Direct Service - This category may be used for going to or from a consumer's site of service in order to provide a direct service. It may also be used to record the round trip transporting of a consumer to a direct service.
15 Minutes (Optional)	34	Child Care - This category may be used for those services provided to the child(ren) of a consumer while the consumer is receiving a service.
15 Minutes	(35-39)	Open for Future Use
1 Hour	40	Consultation & Education - (Indirect Service) - This category will be used to indicate those services delivered which do not directly relate to the treatment of particular consumers, but which affect or result from the service delivery capability of the community at large, examples: consultation with representatives of other agencies, public education; excluding inservice training and program or general administration. This code may be used separately or in conjunction with service/activity code 41-primary prevention and 43-travel.

EXHIBIT III-1 (Continued)

UNIT = ONE UNIT OF SERVICE	COST CENTER SUBACCOUNT NUMBER	DIRECT SERVICES - FACE TO FACE CONTACT
1 Hour (Optional)	41	Primary Prevention - This category may be used to indicate those activities which reduce the incidence of Mental disabilities. This code may be used for activities which have a goal of reducing the incidence of a specific problem and are directed at a target population not exhibiting symptoms of that specific problem.
1 Hour	42	In Service Training - This category will be used to indicate any activity where the primary purpose is the skill building or personal growth of a staff member(s). Its purpose is to upgrade the understanding and performance of the staff. Staff time spent in training and education of students, as well as of other staff should be included here.
1 Hour (Optional)	43	Travel for indirect service.
1 Hour	(44-49)	Open for Future Use
		Administration and Support Services
1 Hour	50	Program Administration - This service/ activity code is to be used for those activities relating to a specific program function (budget/sub-budget) which are not subsumed under any other code. This category also includes general programmatic supervision not related to a specific consumer's case.
1 Hour	51	General Administration - This service/ activity code will be used for those activities relating to the general administration of all program functions. Will be charged to program enter budget 040 exclusively.