IX. Access

Initial Access to Behavioral Health Services

The impact analyses revealed that stakeholders in nearly all states studied felt that initial access to behavioral health services was easier as a result of managed care implementation, regardless of design, though some questions about potentially compromised initial access were raised in relation to managed care systems with integrated designs.

An assessment of the effect of managed care systems on initial access to behavioral health services in the 2000 and 2003 State Surveys found that, overall, initial access is considered to be improved by managed care systems in comparison with pre-managed care. Improved access was reported for 85% of the systems, up 15% from 70% in 2000 (**Table 82**). While 2000 results suggested that initial access is likely to be better in systems with carve out designs, in 2003 better initial access was reported equally by carve outs and integrated systems. Further, whereas initial access to behavioral health services reportedly had worsened in one-third of the integrated systems in 2000, this was not the case in 2003; initial access reportedly has worsened in only 7% of the integrated systems. This improvement in initial access to behavioral health care, and particularly the improvement in initial access over time reported for integrated systems, is significant given that improving access to behavioral health services is a goal reported for most managed care systems.

Table 82

Impact of Managed Care Systems on Initial Access to Behavioral Health Services in Comparison to Pre-Managed Care

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Initial access to behavioral health services is better	70%	86%	85%	85%	15%
Initial access to behavioral health services is worse	15%	5%	7%	6%	-9%
No change	15%	9%	8%	9%	-6%

Access to Extended Care

Though improvement in initial access to behavioral health services is evident in the 2003 State Survey results, over time the Tracking Project has identified more problems associated with access to extended care. In both impact analyses, there was a widespread perception that it was more difficult to obtain care beyond a certain basic level and that accessing extended care services was more difficult post-managed care implementation. These reported difficulties stemmed from factors including authorization processes and tighter controls on admission and length of stay in hospitals, residential treatment centers, and other services. In addition, the typical emphasis in managed care systems on short-term treatment was identified by many stakeholders as a major problem; some asserted that managed care systems often do not sufficiently consider or serve children needing more than brief treatment.

Over time, the Tracking Project has found some improvement in access to extended care within managed care systems. As shown on **Table 83**, the 2003 State Survey found that access to extended care services reportedly has improved in nearly two-thirds of the managed care systems, a 26% increase from 2000. Carve outs were more likely to report improved access to extended care — improved access was reported for most carve outs (71%) but fewer than half of the integrated systems (46%). In 2003, few systems of either type reported that access to extended care is worse in comparison with pre-managed care. In about a third of the systems (32% overall and nearly half of the integrated systems), managed care has had no impact on access to extended care services, either positive or negative, according to respondents.

Table 83

Impact of Managed Care Systems on Access to Extended Care Behavioral Health Services in Comparison to Pre-Managed Care

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Access to extended behavioral health services is better	36%	71%	46%	62%	26%
Access to extended behavioral health services is worse	14%	5%	8%	6%	-8%
No change	50%	24%	46%	32%	-18%

Consistent with findings suggesting improved initial access, the 2003 State Survey found shorter wait lists for children's behavioral health services in more than half of the carve outs (57%) and about a third of the systems with integrated designs (38%) — half of the total sample of systems (**Table 84**). Only 9% of the systems across the entire sample reported longer wait lists for services, an 11% decline in reports of longer wait lists since 2000. Longer wait lists were more likely to be reported for integrated systems, 15% as compared with only 5% of the carve outs.

Table 84

Impact of Managed Care Systems on Waiting Lists for Children's Behavioral Health Services in Comparison to Pre-Managed Care

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Waiting lists are shorter	48%	57%	38%	50%	2%
Waiting lists are longer	20%	5%	16%	9%	-11%
No change	32%	38%	46%	41%	9%

Access to Inpatient Services

The impact analyses found that stakeholders in most states perceived inpatient services to be more difficult to access as a result of managed care systems. More stringent admission and continuing stay authorization processes were seen as severely curtailing access and length of stay in inpatient settings. Concerns were pervasive among stakeholders about discharging youngsters prematurely from inpatient settings in an effort to reduce lengths of stay and cost. Some respondents regarded the decreased use of hospitals (both admissions and length of stay) to be a positive change in service systems which, in their opinion, used inpatient services too routinely and where lengths of stay were regarded as excessive. However, many stakeholders felt that the shift away from inpatient care had become too dramatic, that inpatient services had become far too difficult to access, and that stays had become dangerously brief.

The 2000 and 2003 State Survey explored this area, which was not examined in the previous all-state surveys. The surveys found that initial access to inpatient care is not considered to be more difficult in most cases as a result of managed care systems; only 11% of the systems reported this to be the case in 2003, and, in fact, nearly two-thirds of the systems in 2003 characterized initial access to inpatient treatment as easier than in the pre-managed care environment (**Table 85**). Much more significant, however, is the observation that inpatient lengths of stay are shorter — reported for most of the carve outs (71%) and nearly all of the integrated systems (93%) in 2003. No system reported longer lengths of hospital stays in 2003.

Table 85

Impact of Managed Care Systems on Access to Behavioral Health Inpatient Services in Comparison to Pre-Managed Care

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Initial access is easier	Not asked	67%	57%	63%	NA
Initial access is more difficult	20%	10%	14%	11%	-9%
Average lengths of stay are shorter	63%	71%	93%	80%	17%
Average lengths of stay are longer	Not asked	0%	0%	0%	NA
No change	Not asked	10%	0%	6%	NA

NA=Not Applicable

Both impact analyses found a host of problems associated with reduced length of stays in inpatient settings, such as discharging children prior to stabilization and returning them to the community in highly vulnerable conditions, discharging children without linking them with needed community services and supports, placement of children in community services that are ill-equipped to serve youth at a high level of acuity, and inappropriate use of residential treatment centers and child welfare and juvenile justice facilities.

The 2000 and 2003 State Surveys were used to explore these areas more fully and to obtain a better sense of the extent to which these problems are occurring. Most notable on **Table 86** is that most of the problems associated with changes in access and length of stay in inpatient care are more pronounced in systems with integrated designs than in carve outs. For example, premature discharge before stabilization, children discharged without needed services, and placement in community programs without the clinical capacity to serve them all reportedly occur more frequently in integrated systems. Only the use of residential treatment as a substitute for inpatient services was reported to a greater extent among carve outs — this practice reportedly occurs in 35% of the carve outs and 27% of the integrated systems.

Table 86

Problems Associated with Changes in Access to Behavioral Health Inpatient Services

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Premature discharge before stabilization from inpatient settings	29%	12%	27%	19%	-10%
Children discharged without needed services	33%	18%	27%	22%	-11%
Placement in community-based services lacking appropriate clinical capacity to serve them	29%	24%	40%	31%	2%
Increased use of residential treatment services as a substitute for inpatient	29%	35%	27%	31%	2%
Inappropriate use of child welfare emergency shelters	21%	6%	7%	6%	-15%
Inappropriate use of juvenile justice facilities	21%	12%	13%	13%	-9%
Discharge without a safe placement for children in child welfare	8%	0%	7%	3%	-5%
No negative effects have occurred	Not Asked	18%	13%	16%	NA
N/A (Access is not more difficult and lengths of stay are not shorter)	Not Asked	24%	20%	22%	NA
Other, Specify	Not Asked	35%	13%	25%	NA

NA=Not Applicable

Declines in a number of these negative effects were found from 2000 to 2003. In particular, problems such as children discharged without needed services, inappropriate use of child welfare emergency shelters and juvenile justice facilities, and premature discharge from inpatient settings without stabilization were reported by 9 to 21% fewer managed care systems in 2003 than in 2000. Still, serious negative effects resulting from the shorter inpatient length of stay reportedly are experienced by most systems; only 16% reported no negative effects from reduced access to and/or length of stay in inpatient settings.

A major concern with respect to reduced length of stay in inpatient services is the lack of sufficient capacity to provide home and community-based services as alternatives. Although the availability of home and community-based services reportedly is increasing somewhat, in a number of states, stakeholders interviewed for the impact analyses observed that alternatives to inpatient care were not sufficiently developed prior to reducing admissions and/or length of stay.

The 2000 and 2003 State Surveys were used as a vehicle to explore the extent to which alternatives to hospitalization are being developed. Again, carve outs are more likely to do so, 81% as compared with 62% of the integrated systems in 2003 (**Table 87**). However, both carve outs and integrated systems indicated efforts to develop alternatives to hospitalization — nearly three-quarters (73%) overall have done so, an 11% increase from 2000. A concern is that 27% of the systems overall reportedly are not developing alternatives to hospitalization, this despite the finding that reduced length of stay in inpatient settings, and the associated problems, are widespread.

Table 87

Percent of Managed Care Systems Leading to the Development of Treatment Alternatives to Inpatient Hospitalization

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Treatment alternatives to hospitalization have been developed	62%	81%	62%	73%	11%
Treatment alternatives to hospitalization have not been developed	38%	19%	38%	27%	-11%

In states where alternatives are being developed, respondents specified a wide range of alternatives to hospitalizations, including:

- Crisis respite services
- Walk-in urgent care centers
- Mobile crisis teams
- Emergency psychiatric visits
- Home-based services
- Wraparound process for stabilization and support
- Intensive outpatient services
- Therapeutic foster care
- Crisis stabilization units
- Partial hospitalization/day treatment
- Short-term, sub-acute residential services
- Intensive care management
- Non-hospital detoxification
- Mentoring