The Crisis in Ohio's Acute Mental Health Care: A Mental Health and Overall Health Problem

A Call to Educate, Collaborate and Advocate

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A report from the Ohio Department of Mental Health

The Acute Mental Health Crisis: An Overall Health Problem

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Introduction

In recent years availability and access to inpatient mental health services has been steadily decreasing. This is true nationally and in Ohio. The changes have occurred over a number of years, but at a slow and insidious rate. Taken together the changes have been a series of quiet storms rather than occurring all at once like a major hurricane. The cumulative effect, however, is a crisis of significant proportions. This report, *The Crisis in Ohio's Acute Mental Health Care: A Mental Health and Overall Health Problem* reviews the problem, the causes and impacts.

What is Acute Care?

This report refers to acute mental health care as defined by The President's New Freedom Commission on Mental Health Subcommittee on Acute Care. The Subcommittee defines acute care as:

• Short-term (with a median length of stay of approximately 30 days or fewer), 24-hour, inpatient care and emergency services provided in hospitals;
• Short-term, 24-hour care provided in residential treatment facilities for children; and
• Treatment in other crisis and urgent care service settings.

The Subcommittee report states, "appropriately managing acute care needs requires a comprehensive community mental health system with a full range of effectively coordinated components and a wide range of other services in a community appropriate for people with mental illnesses across the life span….In some communities, the shortage of acute care beds has risen to crisis proportions. Too often budget shortfalls have reduced funding for other essential community mental health services, consequently increasing the demand for already limited inpatient care as an alternative."[1]

The decreased availability of acute care services impacts other community resources and services. If acute care beds are difficult to access, the effect may be experienced not only in the mental health community, but also in other systems such as the criminal justice system or the general health care system. This report focuses attention on the crisis in acute mental health care in Ohio and its impact on other parts of the mental health and general health care systems. It includes the private and public systems as well as adult and child and adolescent services.

The topics of inquiry in this report include access, capacity, length of stay, funding, staffing, and integration with the mental health and general health systems. In addition to providing information on acute mental health care issues in Ohio, the report calls for those who should be concerned with this shortage situation to work collaboratively to address the concerns described.

Accessing the Acute Care System

ACCESS/CAPACITY

Decreasing Inpatient Bed Capacity

Many publications, journal articles, reports, and private correspondences have documented the decrease in both public and private inpatient psychiatric beds nationwide. The National Association of Psychiatric Health Systems (NAPHS) estimates that state mental hospital beds decreased 32 percent from 1992 to 2000 and private psychiatric hospital beds declined 23 percent.[2]

The American Hospital Association (in a letter to the Centers for Medicare and Medicaid Services) documented a loss of 98,666 beds which represents a 42 percent decrease in inpatient capacity. Estimates show that public beds have decreased from 650,000 to 57,000 for the years 1960 through 2000.[3] Additional national data collected by the Illinois Hospital Association in 2001 showed that 50 percent of responding hospitals were planning to cut the number of available psychiatric beds.[4]

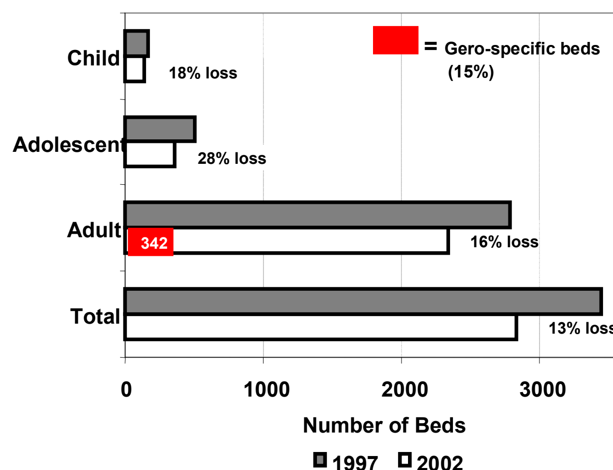
The November/December 2001 issue of the APA newsletter, *Psychiatric Practice and Managed Care,* offered accounts of psychiatric bed shortages reported by 16 states. The newsletter reports that Hawaii can only admit patients that have been court ordered and Maryland has to assign "sitters" to psychiatric patients waiting on a medical unit to be admitted to psychiatric units.[5]

Based on comprehensive claims data collected from Minnesota's 140 acute care hospitals, the Minnesota Hospital and Healthcare Partnership (MHHP) reports that inpatient behavioral utilization rose by 16 percent from 1997 to 2001 while emergency department usage for behavioral disorders rose 39 percent during that same period of time. For the age group 15 to 20, these rates were even greater.[6]

According to the California Healthcare Association's Center for Behavioral Health, the number of freestanding acute psychiatric hospitals in that state has been cut in half, from 85 in 1992 to 42 in 2002. Additionally, the number of licensed acute psychiatric beds in California has been reduced by greater than 30 percent since 1992. The Association believes the primary reason for the loss of acute psychiatric beds is the extraordinary penetration of managed care across both sectors, private and public (85 percent and 100 percent respectively). Since the institution of managed care in the early 1990s, reimbursement rates for hospitals have significantly decreased.[7]

Like the states mentioned above, Ohio has also witnessed a steady decline not only in the number of available private and public hospital beds, but also in the actual number of psychiatric hospitals or hospital psychiatric units. Thirteen private psychiatric units closed between 1997 and 2002 representing an 13 percent decrease in beds from 3,456 to 2,842 (Figure 1).The decline in availability of private beds was a trend seen across all age categories: adults (16 percent), adolescents (28 percent) and children (18 percent).

Figure 1
Changes in Ohio's private psychiatric inpatient capacity 1997-2002



Between 1991 and 1996, Ohio closed its two public children's hospitals and three adult facilities. Public beds for Ohio, between 1997 and 2002, were reduced by 21 percent from 1444 to 1146. While all regions have experienced declines, or a best case scenario of zero change, specific areas have encountered losses in licensed beds in excess of 70 percent. Thirty per-

cent of mental health boards said use of state hospital beds was changing as a consequence of diminished access to community hospital beds. More than half of these boards reported increased use of a state hospital for acute care.

Persistently high bed occupancy rates in both private and public inpatient mental health settings impact timely access to needed services. The Greater Cincinnati Health Council (GCHC) released the results of a survey that focused primarily on the quality of care and patient safety issues encountered by southwestern Ohio and northern Kentucky public and private inpatient psychiatric service providers.[8] The data was gathered from 24 of the 30 hospitals in the region (80 percent), spanning a one-year time frame (April 1, 2002 and March 31, 2003). On average, occupancy rates were reported to occur 86 percent of the time for adult beds, 60 percent for geriatric beds, and 87 percent for pediatric/adolescent inpatient beds.

One of the survey questions asked how frequently each facility had no (0) inpatient beds available? Each cell in the following table represents the number of responding hospitals (see Table 1).

Table 1	Times per Month				
	0	1-10	11-20	22-30	> 30
Inpatient Adult	2	4	3		
Inpatient Geriatric (dedicated only)	2	2			
Inpatient Pediatric		1	2		
Inpatient Adolescent	1	2	2		
Substance Abuse/Detox (dedicated only)		1			

A follow-up measure of inpatient capacity that the report surveyed was how often each facility had to place psychiatric patients temporarily in non-psychiatric units? Nine of the 15 responding hospitals indicated that at least once a month, and up to 10 times per month, they had to place a patient in a medical unit due to the unavailability of inpatient psychiatric beds. Two hospitals, one serving adolescents and the other children, reported that they were placing patients on non-psychiatric units more than 30 times per month (see Table 2).

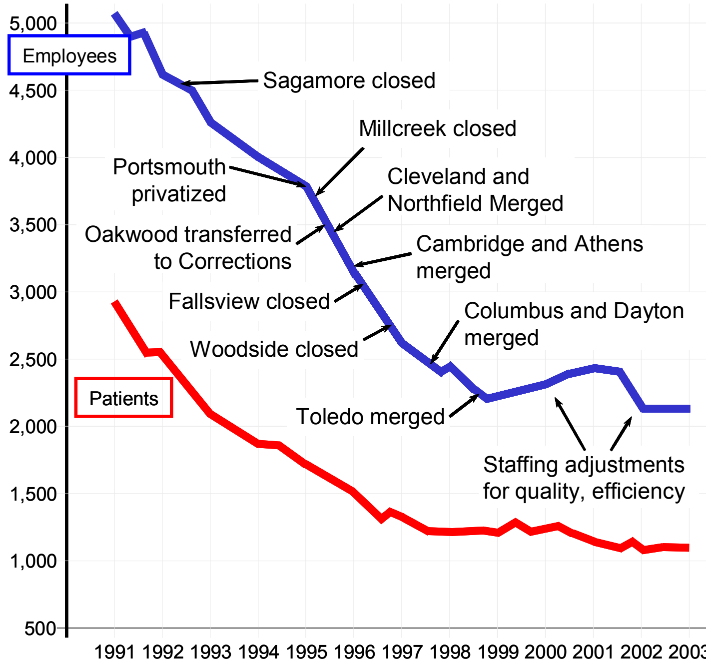
Table 2	Times per Month				
	0	1-10	11-20	22-30	> 30
Inpatient Adult	3	4	1		
Inpatient Geriatric (dedicated only)	3	1			
Inpatient Pediatric					1
Inpatient Adolescent		1			1
Substance Abuse/Detox (dedicated only)					

High occupancy rates have also affected Ohio's state hospitals in recent years. On average, the daily occupancy rate was 91 percent across all nine state hospital sites during the second quarter of 2004 (April through June). Peak occupancy rates were reported to occur 36 percent of the time within that same quarter. The table below summarizes the results for the state hospitals receiving direct acute care admissions (Table 3).

Table 3	Times per Month at 95 Percent or Greater Occupancy				
	0	1-10	11-20	22-30	> 30
Athens		X			
Cambridge		X			
Cleveland			X		
Columbus				X	
Dayton		X			
Massillon		X			
Northfield (Akron/Cleveland area)		X			
Toledo				X	

April to June 2004. Average occupancy rate is 91 percent. Percentage of days at 95 percent or greater occupancy is 36 percent.

ODMH State Hospital Trends 1991-2003

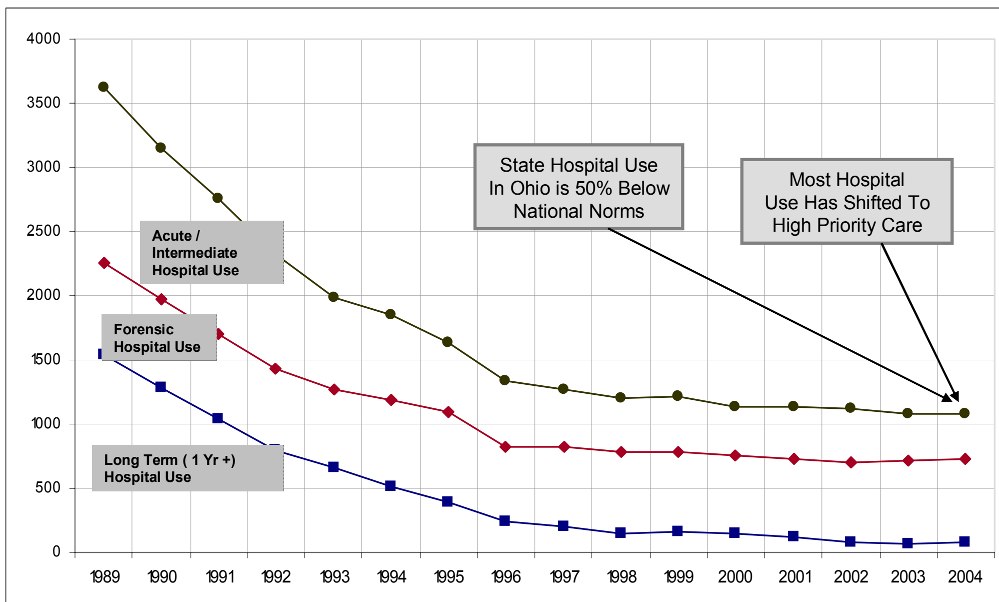


Jan '91 – Jan '95
Period of downsizing related to the MH Act of 1988. Community preferences led to a reformed state hospital system and the transfer of funds to other community care providers.

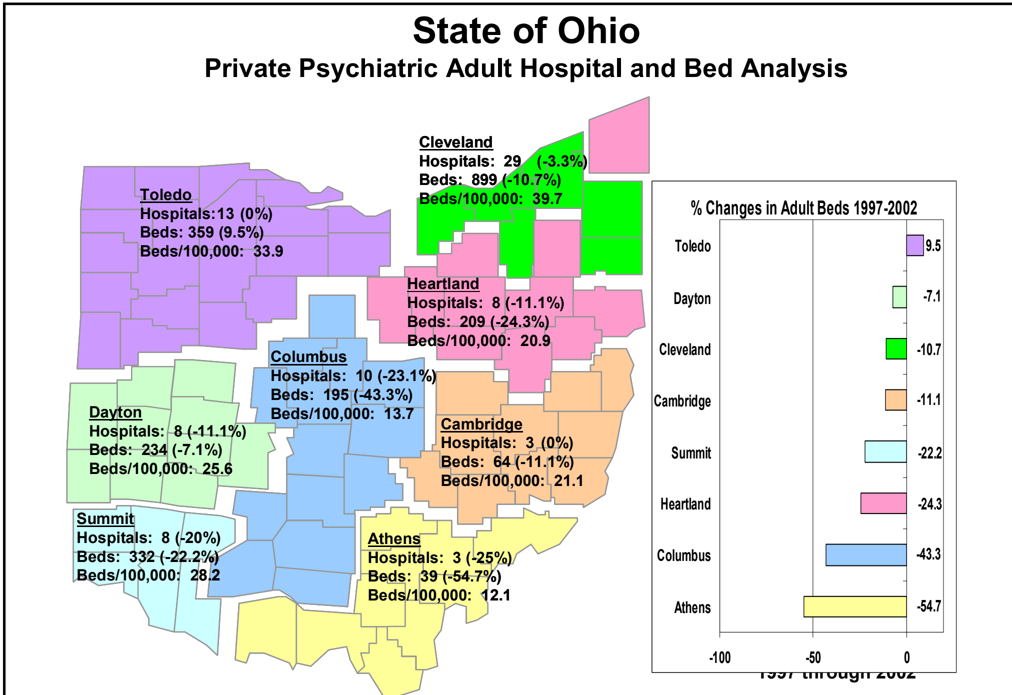
Jan '95 – Jan '97
Period of closures / consolidations. State system pursues administrative efficiencies, reengineering activities. Continued shift of funds to local community care.

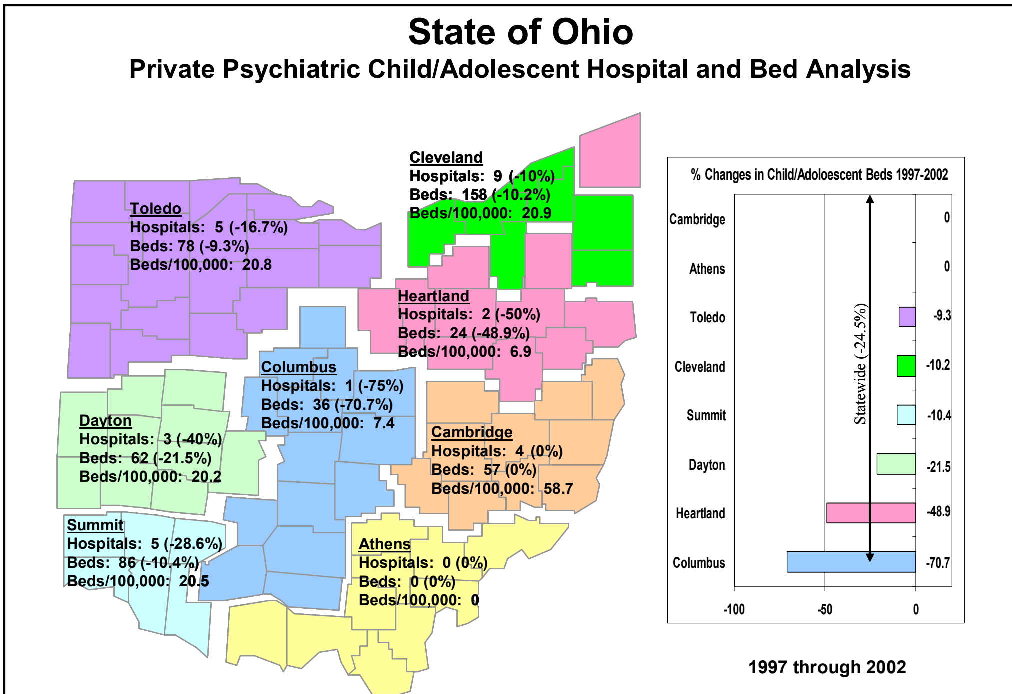
Jan '97 – Jan '03
Period of state funding erosion for public MH. Led to reduced staff, adjustments for quality and efficiency. More acute patients with fewer state hospital beds.

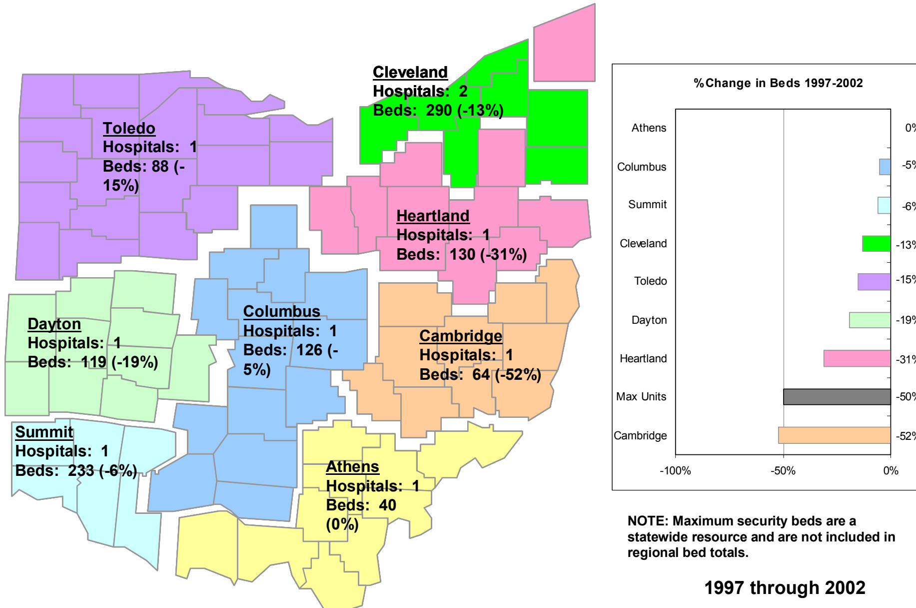
Ohio's State Hospital Utilization from 1989 - 2004



Graph shows the number of patients onrolls at the end of State fiscal year.


State of Ohio
Private Psychiatric Adult Hospital and Bed Analysis
Cleveland
Hospitals: 29 (-3.3%)
Beds: 899 (-10.7%)
Beds/100,000: 39.7
Toledo
Hospitals:13 (0%)
Beds: 359 (9.5%)
Beds/100,000: 33.9
Heartland
Hospitals: 8 (-11.1%)
Beds: 209 (-24.3%)
Beds/100,000: 20.9
Columbus
Hospitals: 10 (-23.1%)
Beds: 195 (-43.3%)
Beds/100,000: 13.7
Dayton
Hospitals: 8 (-11.1%)
Beds: 234 (-7.1%)
Beds/100,000: 25.6
Cambridge
Hospitals: 3 (0%)
Beds: 64 (-11.1%)
Beds/100,000: 21.1
Summit
Hospitals: 8 (-20%)
Beds: 332 (-22.2%)
Beds/100,000: 28.2
Athens
Hospitals: 3 (-25%)
Beds: 39 (-54.7%)
Beds/100,000: 12.1
% Changes in Adult Beds 1997-2002
Toledo 9.5
Dayton -7.1
Cleveland -10.7
Cambridge -11.1
Summit -22.2
Heartland -24.3
Columbus -43.3
Athens -54.7
-100
-50
0


State of Ohio
Private Psychiatric Child/Adolescent Hospital and Bed Analysis
Cleveland
Hospitals: 9 (-10%)
Beds: 158 (-10.2%)
Beds/100,000: 20.9
Toledo
Hospitals: 5 (-16.7%)
Beds: 78 (-9.3%)
Beds/100,000: 20.8
Heartland
Hospitals: 2 (-50%)
Beds: 24 (-48.9%)
Beds/100,000: 6.9
Columbus
Hospitals: 1 (-75%)
Beds: 36 (-70.7%)
Beds/100,000: 7.4
Dayton
Hospitals: 3 (-40%)
Beds: 62 (-21.5%)
Beds/100,000: 20.2
Cambridge
Hospitals: 4 (0%)
Beds: 57 (0%)
Beds/100,000: 58.7
Summit
Hospitals: 5 (-28.6%)
Beds: 86 (-10.4%)
Beds/100,000: 20.5
Athens
Hospitals: 0 (0%)
Beds: 0 (0%)
Beds/100,000: 0
% Changes in Child/Adoloescent Beds 1997-2002
Cambridge 0
Athens 0
Toledo -9.3
Cleveland -10.2
Summit -10.4
Dayton -21.5
Heartland -48.9
Columbus -70.7
Statewide (-24.5%)
-100
-50
0
1997 through 2002


State of Ohio
State Hospital Adult Bed Analysis
Cleveland
Hospitals: 2
Beds: 290 (-13%)
Toledo
Hospitals: 1
Beds: 88 (-15%)
Heartland
Hospitals: 1
Beds: 130 (-31%)
Columbus
Hospitals: 1
Beds: 126 (-5%)
Dayton
Hospitals: 1
Beds: 119 (-19%)
Cambridge
Hospitals: 1
Beds: 64 (-52%)
Summit
Hospitals: 1
Beds: 233 (-6%)
Athens
Hospitals: 1
Beds: 40 (0%)
% Change in Beds 1997-2002
Athens 0%
Columbus -5%
Summit -6%
Cleveland -13%
Toledo -15%
Dayton -19%
Heartland -31%
Max Units -50%
Cambridge -52%
-100%
-50%
0%
NOTE: Maximum security beds are a statewide resource and are not included in regional bed totals.
1997 through 2002

Increased Admissions and Reduced Lengths of Stay

According to the National Association of Psychiatric Health Systems, admissions to private psychiatric hospitals and psychiatric units in general hospitals have increased by 3 to 4 percent annually. For the nine-year period, 1993 through 2001, data from the Agency for Healthcare Research and Quality's National Inpatient Database, the largest all-payer inpatient care database in the United States containing information from approximately seven million hospital stays, documented an increase of 29 percent in the number of patients being discharged with a primary mental health diagnosis from 1,096,929 to 1,403,161.[9]

Nationally, the average length of stay for all mental health major diagnostic categories (MDCs) has declined 37 percent from 12.8 days (1993) to 8.1 days (2001). In comparison, all other general medicine MDCs decreased at nearly half of that rate (23 percent) from 6.2 to 4.8 days.

Ohio has also experienced similar increases in the numbers of admissions and discharges across both its private and public sectors. Patients discharged from all private Ohio hospitals with a major diagnostic category of mental illness increased 3.5 percent between 2000 and 2002 from 75,310 (529,953 bed/days) to 77,912 (528,584 bed/days). Ohio Medicaid admissions grew nearly 30 percent over the five-year period from 17,339 in 1999 to 22,500 in 2003. Although state averages tell one type of story, individual counties vary widely in their profiles. Montgomery County, which includes the Dayton metropolitan area, experienced a 36 percent increase in mental health discharges from 2000 to 2001.[10]

Pressures to reduce length of stay in Ohio have followed similar patterns exhibited by other states. Between 1999 and 2003, the average length of stay for Ohio Medicaid patients admitted primarily to inpatient psychiatric units of private general hospitals, decreased from 8.1 to 7.3 days (9.9 percent). Data supplied by the Ohio Hospital Association indicates that inpatient lengths of stay for all Ohio patients discharged with a primary mental health diagnosis fell 3 from 7.0 to 6.8 days between 2001 and 2003.[11]

In Ohio's state hospitals, length of stay has also been decreasing (Figure 2). Approximately, three-fourths of the patients served tend to be acute with a median length of stay of nine days. While the number of acute care patients has increased prominently in recent years, there has been a marked reduction in the number of long-term patients, defined as patients with a length of stay greater than 45 days. Since 1998 the long term bed days have fallen by over 60 percent. The table below looks at discharged patients and their median length of stay for fiscal year 2003 (July 2002 through June 2003) for acute, forensic and long-term patients.

Figure 2

State Hospitals
Increased Acute Care Presence

Patient Category	Patient Discharges	Percent of Total	Median Length of Stay
Acute (<=45days)	4678	74 percent	9
Long Term (>46 days)	748	12 percent	80
Forensic	862	14 percent	70

Data from Fiscal Year 2003 for ODMH's state hospital system. Patient separations include forensic patients on conditional release.

MENTAL HEALTH FUNDING

The evolving fiscal environment has transformed the way that inpatient and emergency psychiatric care, both public and private, is being managed and delivered. These changes are being experienced internally, from within the mental health system, as well as externally, by health care in general.

What are some of the financial changes that have molded this picture in states that are uniformly experiencing a crisis in acute mental health care?

- Reduced mental health budgets forcing the closure or downsizing of state hospitals and decreasing the capacity of community mental health systems;
- The growth of Medicaid as a payer and the influence of Medicaid design on the delivery of services
- Cost reduction practices implemented by managed care
- Inadequate coordination among and between payers and providers;
- Lack of insurance parity with physical health care;
- Increased public awareness and demand for services.

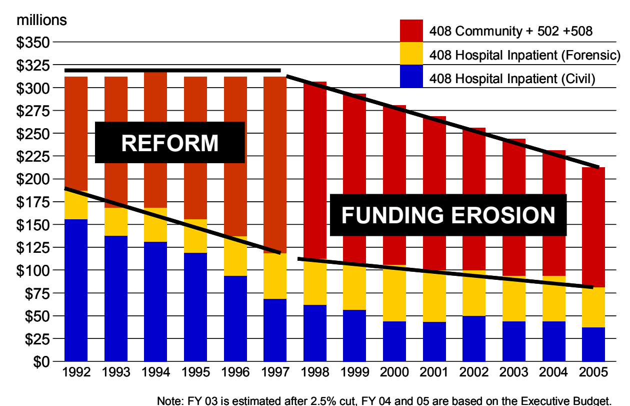
Public Mental Health Funding

In 1997, national health care costs totaled more than $1 trillion dollars of which nearly $71 billion is attributable to mental health service provision. A majority (57 percent) of mental health care costs are publicly funded, compared to 46 percent of overall health care expenditures.[12]

Medicare and Medicaid and other federal payers account for 37 percent while state and local funding make up 20 percent of overall mental health spending. State funding for mental health services is decreasing in a majority of states. The National Mental Health Association reports 29 states made cuts in 2002 and 35 in 2003.[13]

During the early 1990s, the Ohio Department of Mental Health's (ODMH) general revenue funding increased roughly at the same pace as inflation but hospital closures and consolidations and cost containment during that time allowed for transfer of funds to community care within a level budget. The expansions in community care were financed largely by savings realized in state hospitals, not new revenues. Since 1997, however, ODMH funding has declined against inflation (Figure 3). At the same time private inpatient capacity was decreasing making state hospital acute care beds more vital, so no downsizing could be considered. The decline in state funding has eroded the community's capacity to provide quality care.
A second major funding issue in the public mental health system concerns the growing importance of Medicaid. The U.S. Surgeon General's report describes this development in the following excerpt. "Where the role of direct state funding of mental health care has been reduced, Medicaid funding of mental health care has grown in relative importance. One consequence of this shift is that Medicaid program design has become very influential in shaping the delivery of mental health care."[14]

Figure 3



A troubling example of this in Ohio occurs in some communities where Medicaid caseloads have become very large. Because local mental health boards are required to provide approximately 40 percent of Med-

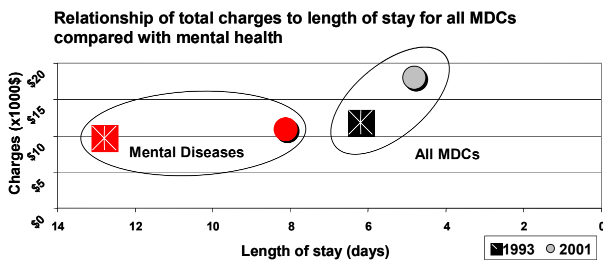
icaid costs, funds are less available for non-Medicaid reimbursed services. In order to remain solvent some local providers have restricted access to non-Medicaid eligible consumers. The impact of these Medicaid-related dynamics can be extensive. When access to community services is reduced, the burden may shift to inpatient care and to others such as emergency departments, general health care, the criminal justice system, families and other resources.

Increased Costs & Charges, Decreased Reimbursements

The percentage of health care dollars devoted to psychiatric care has dropped significantly. There is a lack of parity in mental health reimbursement. As a proportion of total health costs, behavioral health care benefits decreased from 6.1 percent in 1988 to 3.2 percent in 1998. This contrasts with an increase of 7.4 percent in general health expenses during the same time. Claims from private insurance plans of large U.S. employers between 1992 and 1999 showed total health expenses grew 23 percent or 3 percent annually. However, mental health and substance abuse expenditures fell by 20 percent, or 3.1 percent annually. This decrease occurred despite the cost of psychotropic drugs increasing by 9.9 percent annually during those years.[15]

The cost of psychiatric inpatient care did not increase compared to the rate of inflation (3 percent) during the 1990s, and is well below the rising cost of inpatient care for general health care. Between 1993 and 2001 the cost for an inpatient stay increased 11 percent from $10,888 to 12,086. In contrast the cost for an inpatient stay for general healthcare increased 57 percent from $11,800 to $18,800[16] (Figure 4).

Figure 4



Despite modest increases in cost between 1993 and 2001, the length of stay for psychiatric illnesses declined by 40 percent, from 13 to 8 days. (Figure 3). This is in contrast to the 18 percent reduction in inpatient days for general health care (from 6.1 days to 4.9 days). Despite dramatic reductions in length of stay the cost of inpatient psychiatric care lagged behind inflation and well behind the increased costs in the rest of health care.

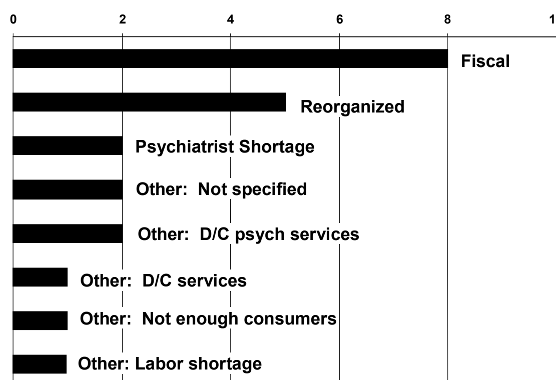
Despite very modest increases in the cost of psychiatric inpatient care, reimbursement for care has been inadequate. One example was described in the Minnesota Psychiatric Society Task Force Report, *The Shortage of Psychiatrists and of Inpatient Psychiatry Bed Capacity* citing the average cost of a psychiatric hospitalization in 2000 was $1388, but health plans paid an average of only $678.[17]

The effect of inadequate reimbursement is suggested in a 2001 ODMH survey of recently closed general hospital psychiatric units (Figure 5). As reasons for closing, 36 percent (8 of 22) indicated fiscal pressures, 23 percent (5) cited reorganization and mergers, and 9 percent stated they discontinued psychiatric services.[19] Thus 68 percent of those psychiatric units that closed indicated that funding and related reorganization issues were the primary reason for closure.[18]

Currently, there is also concern that proposed rule

Figure 5

Reasons cited for closing private psychiatric units in Ohio

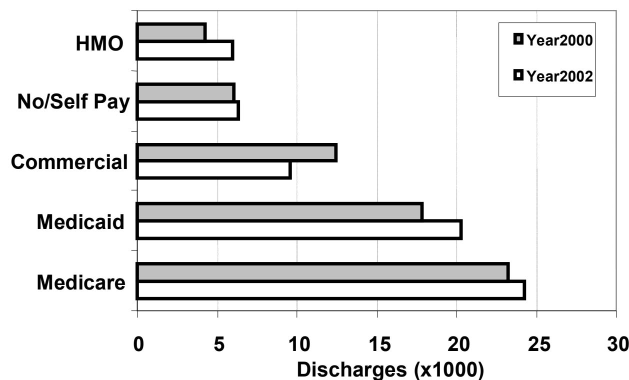


changes regarding the prospective payment system (PPS), by the Centers for Medicare and Medicaid Services, will "decrease the reimbursement for non-governmental psychiatric facilities and could result in the closures of psychiatric units and hospitals," as noted in a February 2004 letter to CMS from the National Association of State Mental Health Program Directors (NASMHPD).[19]

Payer Source

Based on data provided by the Ohio Hospital Association, Medicare and Medicaid programs were the largest payer source for mental health discharges in Ohio from private psychiatric inpatient settings during both 2000 and 2002.[20] When comparing year 2000 and 2002, the number of discharges for commercial payers fell, while all other categories experienced increases in the number of discharges. The increase in no/self pay discharges represents a substantial. This may be due to the declining access and quality of community care. The self-pay category represents a substantial amount of uncompensated care which further burdens inpatient hospitals (Figure 6).

Figure 6



STAFFING

Psychiatrists

Inpatient medical care today is often provided by "hospitalists," hospital employed physicians who essentially limit their practices to hospital-based inpatient care. This trend is now becoming evident in the psychiatric inpatient setting. Many psychiatrists today are choosing not to do inpatient acute care because of difficult inpatient working conditions. Examples include EMTALA laws that prevent diversion of admissions when the unit is crowded, more burdensome seclusion/restraint regulations, relentless pressure to discharge patients, difficulty finding community placements and services, poor reimbursement, dealing with managed care companies, and rising malpractice insurance costs.

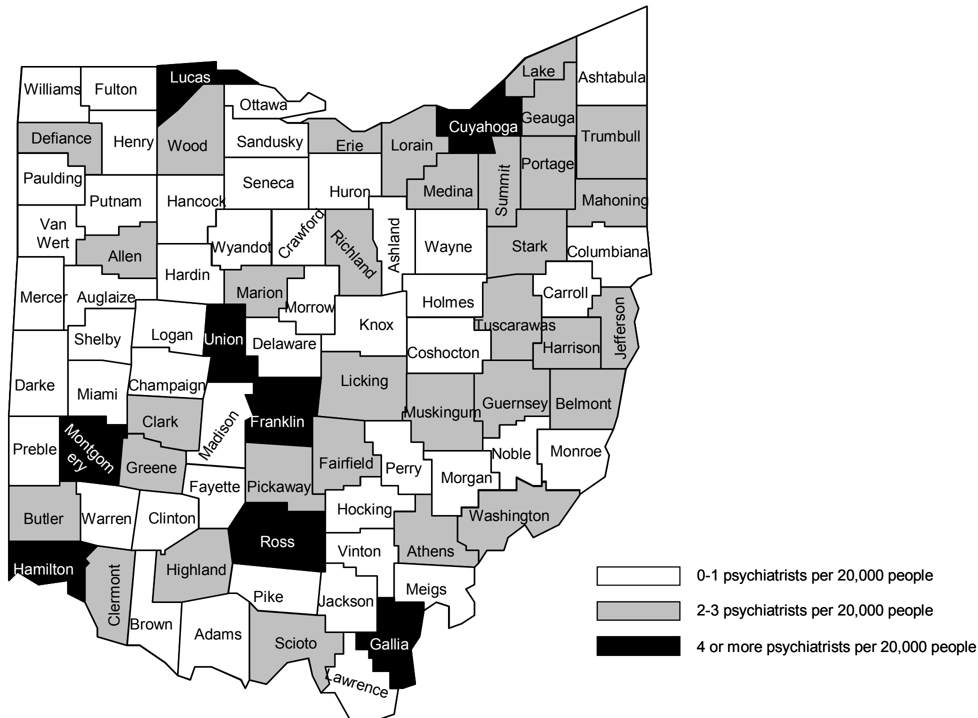
Most psychiatrists practice in urban settings, and not in rural areas. In a 2004 survey of mental health boards, eight counties report four or more psychiatrists per 20,000 residents, 33 counties report two to three psychiatrists per 20,000 residents, and 47 counties report zero to one per 20,000 residents.[21] Thus in many areas of Ohio access to psychiatric care is limited (Figure 7).

Psychiatric Nurses

Nationwide, as well as in Ohio, there is a nursing shortage in all practice areas, including, psychiatric nursing. An adequate number of trained, competent nurses is a vital component to the successful operation of any inpatient psychiatric unit. The Ohio Department of Mental Health (ODMH) mandates nursing staff-to-patient ratios in rules to licensed inpatient psychiatric units. If a licensed facility has difficulty recruiting and/or retaining qualified professional staff, the number of beds that can be operated may need to be reduced as a result.

Psychiatric nurses are competent in assessing and treating both the behavioral health and physical health

Figure 7
Psychiatrists distribution in Ohio by counties



of patients. This combination of qualities is what nurse managers at one of the state's university hospitals look for when considering candidates for potential employment on their inpatient psychiatric units.

Retention is key to having a stable and capable psychiatric nursing staff. Management's flexibility in scheduling, attention to staff needs, and being proactive when staffing a unit, contribute to increased satisfaction of staff, both new and old. Promoting a learning atmosphere and encouraging experienced staff to mentor new staff and incorporate the fresh perspective that they bring to the team is an important step toward improving retention. State hospitals have also experienced difficulty in retaining psychiatric nursing staff. One ODMH nursing supervisor indicated that new staff needs to be nurtured and supported in their jobs by other more experienced staff.

Other Mental Health Providers

While the shortage of psychiatrists and psychiatric nurses have directly impacted the availability of acute inpatient care in Ohio, other professionals providing mental health care can also impact the need for acute care services. The role of primary care in providing mental health services is one component sometimes overlooked by the mental health community. This report highlights primary care as only one of many examples of involvement of healthcare professionals in the mental health arena and particularly because primary care's role in providing mental health services continues to grow and impact not only acute care, but prevention and continuity of care. This segment of the mental health provider system has been termed the "DeFacto Mental Health System." Improved coordination between the different components of care for persons with mental disorders would likely result in better efficiencies and better outcomes.

The 2004 American Medical Association Textbook, Psychiatry for Primary Care Physicians, offers this description:

"Primary care physicians play a key role in the identification and management of mental health disorders. More patients with mental health disorders will seek help from their primary care physicians than from a mental health specialist. As a result, almost 40 percent of patients seen in the primary care setting will experience a significant mental health problem. It is therefore critically important that primary care physicians be able to recognize and diagnose common mental health disorders and activate patients to seek and adhere to treatment for these problems. As the literature continues to document the impact of mental health problems on the development and outcomes of a variety of medical diseases, such as coronary artery disease, diabetes mellitus, and asthma, medical subspecialists will also need to develop and apply these skills.

In recent years, primary care physicians have become increasingly involved in the management of mental health disorders. Both the number of primary care visits for mental health disorders and the number of psychotropic prescriptions written by primary care physicians have increased dramatically over the past 10 years. Currently, primary care physicians write more than 70 percent of the selective serotonin reuptake inhibitor prescriptions in the United States.

There is still tremendous pressure on primary care physicians to assess and manage psychiatric disorders themselves rather than to refer to specialists. Some of the pressure comes from patients, who want help from someone they know and trust; at times, they may also wish to avoid the stigmatization they associate with receiving psychiatric care. Other pressures come from the health care system itself, which may place logistical or financial barriers in the way of psychiatric care. Timely, competent psychiatric consultations and treatment services are far from uniformly available for many primary care physicians' use. Although managed care organizations in some parts of the country have reduced disincentives to make specialty referrals, the psychiatric care may itself be tightly managed; the patient may have mental health benefits that are limited in scope, duration or monetary total; or the care may be "carved out" to a mental health entity unconnected to the patient's primary health care system."[23]

Sustaining a Viable System of Care

INTEGRATION WITH THE MENTAL HEALTH SYSTEM

Continuity of Care

"Accessing mental health services has become difficult in many communities around Ohio and the nation," Dale Svendsen, M.D., ODMH Medical Director, wrote in the May 2004 edition of Quality Matters. "I frequently hear comments like it takes six weeks or longer for a psychiatric appointment at a mental health center. For the most part, the problem seems to stem from fiscal constraints. Government, the private mental health system and all stakeholders need to be aware and take action."[24]

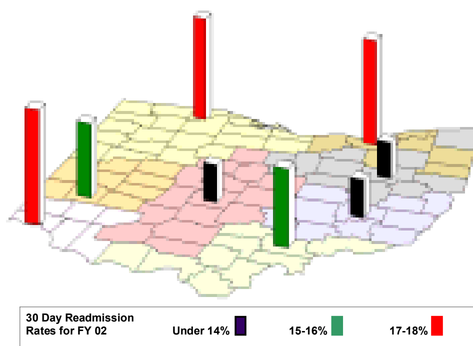
According to rules used to license private psychiatric hospitals, inpatient psychiatric service providers in Ohio must provide for appropriate aftercare for patients for up to two weeks post discharge, unless the outpatient aftercare provider assumes responsibility for service provision prior to that time.[25] Over half of Ohio mental health boards report that consumers can wait up to 45 working days to access outpatient psychiatric services. An additional nine boards reported consumers must wait up to 60 working days for services, while eight boards reported wait times of up to 90 days or more.[26]

Conversely, many inpatient providers are having difficulty meeting their two week post-discharge aftercare requirement and are logging their discharge concerns. Most are working with their local mental health boards to resolve this dilemma and create a sound safety net for patients after discharge from an inpatient stay.

Figure 8

Continuity of Care: 30-Day Readmission Rates

Adult Private Medicaid and State Inpatient Care



Ambulatory Care Services

Logically, a decrease in inpatient capacity could result in an increase in the use of ambulatory care. According to a survey conducted by the Ohio Ambulatory Behavioral Healthcare Association, marketplace forces have negatively impacted ambulatory mental health programs. The Association's data suggests a pattern of declining use of ambulatory programs, rising inpatient admissions, high inpatient re-admission rates and mushrooming emergency department visits.

Underutilization of ambulatory services for mental health care represents a serious access problem for Ohio consumers. Partial hospitalization admissions decreased 22.3 percent and intensive outpatient admissions have decreased 18 percent since 2000. The average partial hospitalization census has declined to perilously low levels threatening the viability of programs. Survey respondents reported that partial hospitalization is rarely approved by insurance companies and the number of sessions per client have been cut by the managed care companies.[27]

Only modest changes in ambulatory care staffing have occurred between 2000 and 2003. Respondents to the Association's survey reported the average time clinical staff spent in direct treatment as 65.

Children/Adolescent Acute Care Services

There currently are 134 child and 348 adolescent psychiatric inpatient beds available in Ohio. Half of the state's 50 mental health boards have contracts to access these beds. Some boards report that the 134 inpatient beds available to children are not sufficient to meet their needs.

Thirty-four boards report they do not have a crisis care facility for children and adolescents but four report having a contract for crisis observation beds at a local hospital. This means 30 boards have no access to crisis beds in the community. All of these boards are rural or suburban.[28]

Decreased private inpatient capacity for children and adolescents, combined with the absence of other acute care settings in many communities, has increased the reliance on crisis and/or acute care beds in residential treatment facilities. They are often some distance away, usually in urban areas, and in comparison to inpatient settings often lack the clinical expertise to address both the acute mental health and physical health needs for these youth. Twenty-nine board areas report there are not sufficient residential treatment center beds to meet demands. Sixteen of these board areas send all their children and adolescents to out-of-county facilities.

Due to inadequate resources for the spectrum of care for children and adolescents in Ohio, residential treatment centers today appear to be serving three populations of children and adolescents:

- Children and adolescents who need an acute level of care but inpatient psychiatric care is not available.
- Children and adolescents who might be safely maintained at home if intensive home and community based services were available. Lack of these services has been identified by the President's New Freedom Commission on Mental Health and the federal Child and Family Service Review conducted in Ohio.
- Children and adolescents who cannot be safely maintained at home and benefit from a structured 24-hour treatment environment.

The State of Ohio is already taking steps to increase the availability of Intensive Home and Community Based Services by developing a named Medicaid service and by increasing the availability of community-based services through its Access to Better Care Initiative. However, the lack of acute care capacity has not been addressed.

Coordination of Care

Sustaining a viable healthcare system involves the components of the system working together to achieve better client care. Some of the major components in this system include private and state hospitals, emergency room services, community mental health crisis service providers, law enforcement, courts, and the county mental health boards. Improving coordination across the continuum and achieving better client outcomes is complex and challenging, especially for acute patients with formidable clinical care issues.

One measure to help view the viability of a regional healthcare system is through the readmission rate of clients returning back to a hospital level of care soon after discharge to a community setting. Aggregated on a regional basis, readmission rates within 30 days of discharge provide a measure of the system's ability to provide a continuum of care. As regional systems strengthen and improve care across the continuum, we should expect to see 30-day readmission rates decrease.

INTEGRATION WITH THE PHYSICAL HEALTH SYSTEM

EMERGENCY SERVICES

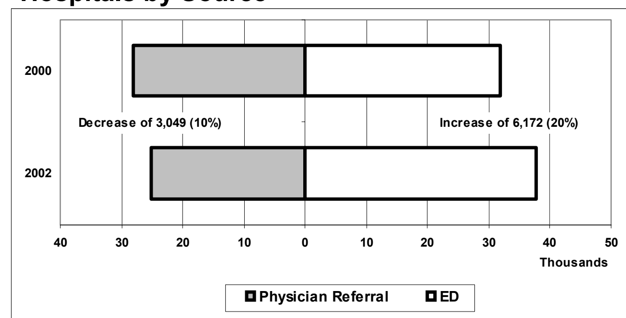
In a March 2004 online survey of members of the American College of Emergency Physicians, 70 percent of the 340 respondents cited an increase in people being admitted to the hospital and forced to wait in the emergency room until inpatient psychiatric beds are available. This is called "boarding." Sixty percent reported that the increase in psychiatric patients being served in emergency rooms is negatively affecting access to emergency medical care for all patients. Sixty-six percent also blamed state health care budget cutbacks and the decreasing number of psychiatric beds for the trend. One in ten emergency physicians said that there is nowhere else in their community where the mentally ill can get treated.[29]

According to the Minnesota Psychiatric Society Task Force, the demand for emergency or inpatient psychiatric services has risen 16-39 percent between 1997 and 2001.[30] The acute psychiatric bed shortage in California is exacerbated by the backlog hospitals are experiencing in their emergency rooms. Serious financial problems resulted in the closure of 23 hospitals in that state between 1995 and 2000. In San Diego, patients in need of emergency care are re-routed to an alternative location approximately 30 percent of the time. In response to high occupancy rates in psychiatric units, hospital emergency departments are being forced to hold patients and occupy an emergency room bed while providing one-on-one supervision. Rhode Island has had to use reclining chairs as beds for patients waiting in emergency departments.[31]

As in other states, Ohio's general hospital emergency departments continue to gain prominence as the first point of access for many persons in psychiatric crisis. While direct admissions by referring physicians to private psychiatric inpatient beds have decreased by 10 percent from 2000 to 2002, admissions to these beds from emergency departments have increased by 20 percent in the same period. For example, the six general hospital emergency rooms in Montgomery, Greene and Miami counties saw 58 percent more psychiatric patients in 2001 than in 1999. Their total psychiatric volume, including patients admitted for at least one night, rose by 66 percent to 17,171.[32] Similar patterns are seen in emergency care for children. Cincinnati Children's Hospital has seen an increase from 1,379 in 1999-2000 to 3,871 in 2003, making the hospital the nation's busiest pediatric emergency room for child psychiatry services.[33]

Figure 9

Number of MDC 19 Admissions to Private Hospitals by Source



In addition, psychiatric care provided in emergency departments is less than optimal. A survey, conducted by the Greater Cincinnati Health Council, found that the overall average length of stay in emergency departments (triage to admission) of persons with a psychiatric condition as the primary diagnosis was five hours.[34] Factors limiting the ability to provide adequate emergency service to psychiatric patients include (in order of most to least significant): physical space in the emergency department, on-call psychiatric availability, nursing staff in the emergency department, physician staff in the emergency department, reimbursement, administrative and mental health support services, and security issues.

Of Ohio and Kentucky providers of inpatient psychiatric services surveyed, only two of seven responding hospitals replied that psychiatric patients are held longer than 23 hours in the emergency department zero (0) times per month. One hospital reported holding psychiatric patients for greater than 23 hours over 30 times per month (Table 4).

Table 4	Times per Month				
	0	1-10	11-20	22-30	> 30
# of Responses	2	3	1		1

And, as psychiatric inpatient bed capacity continues to evaporate, treatment traditionally provided in inpatient settings now occurs in either community mental health outpatient or residential care environments. For example, from 2000 to 2003, the number of persons receiving outpatient crisis intervention services increased by 62 percent from 29,000 to 46,500.[35]

Increased Demand on Emergency Departments: Two Hospitals' Stories

Mercy Hospital Clermont

Two years ago, Mercy Hospital Clermont saw an influx of adult behavioral health patients. At the time, the hospital had a 20-bed adult unit and a separated 10-bed adolescent unit. Due to the diminishing number of psychiatric beds in the region, hospitals that have specialized units were increasingly stressed to meet demand.

It was at this time that Mercy Hospital Clermont had to start keeping psychiatric patients in the emergency department or in medical beds with sitters to wait for psychiatric beds to become available. Some of the most agitated patients in the emergency department were on hold for many hours, creating an access problem and the increased likelihood of the patient leaving the hospital without treatment.

Social workers in the emergency department were strapped trying to disposition patients to other facilities when possible. They often found that other units were also full. There was a noticeable tendency that patients without a payor source didn't move out of the emergency department. This situation is not unique to Mercy Hospital Clermont, as other hospitals have reported the same scenario.

The hospital decided to close its adolescent unit to make an expanded 30 bed unit for adults. The adolescent unit had been open for 23 years so this was not an easy decision, but the community need in the region was for adult beds. At the same time, Mercy Clermont's sister hospital, Mercy Franciscan, enlarged its adolescent unit creating additional beds for Mercy Clermont to send adolescents. Unfortunately, this creates a greater travel distance for families to visit their relative and participate in family therapy.

St. Rita's Medical Center, Lima

Due to the increasing volume of clientele and extensive waiting periods for triage and services, community physicians, behavioral health leaders and professionals developed a shared psychiatric emergency service to provide a unified community approach to best practices and activities that would demonstrate clinical and fiscal effectiveness. In the summer of 2003, a project team was organized to implement a collaborative service model with eight essential components in conjunction with St. Rita's Medical Center, Lutheran Social Services and the Mental Health and REcovery Board of Allen, Auglaize and Hardin Counties.

This centralized service will be located at St. Rita's Medical Center and will serve as a point of contact to provide rapid access to mental health/addiction services. The service components will include telephone crisis intervention, information and referral services; initial evaluation and emergency triage; 24/7 mental health and addiction assessment services; social service/case-management services; after care/bridge services; onsite pre-screening in the community; community outreach education/prevention services; and observation/placement services will be established in 2005.

Both the Mental Health and Recovery Service Board and St. Rita's Medical Center will financially support the service and Lutheran Social Services will implement the Center. Contracts will be completed and the Advisory Committee established by June 2004. A Director, coordinators, professional and support staff will be hired by August 2004. The expected implementation date for services is September 2004.

Overall Health System

"Mind and body are inseparable," stated U.S. Surgeon General David Satcher in his 1999 monumental report of Mental Health. If one views this starting from the medical side the co-occurrence of illnesses such as depression with common medical disorders is high and impairs recovery. Co-occurring mental illness may impair a person's ability to care for oneself and may even increase the risk of death. For example, people with diabetes who develop depression have impaired ability to self-care and to adhere to treatment and develop more complications. For people who have a heart attack or stroke there is a 20 to 50 percent chance of developing depression and the risk of death in the next several years is greatly increased.[36]

For persons with severe mental disorders the co-occurrence of medical disorders has alarming consequences. Patients with serious mental illnesses have been found to die10 years earlier than persons without serious mental illness. In a sample of 20,000 former state hospital patients in Ohio between 1996 and 2002, the risk of death from medical illness was double compared to the general Ohio population. The most common cause of death was heart disease. Factors such as smoking, obesity, heredity, lower socioeconomic status and accessing less medical care are all possible factors.[37]

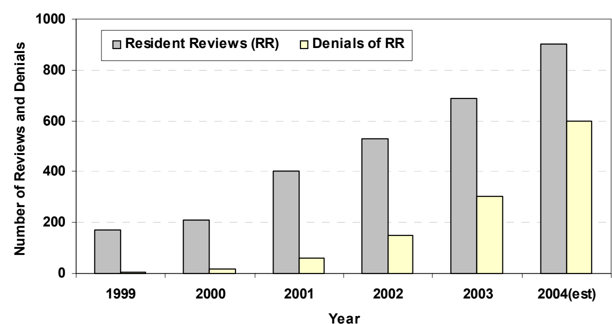
"Mental health is essential to overall health," states the 2003 President's New Freedom Commission on Mental Health as it called for improved collaboration between the mental health and general health care systems.[38] The changes in the mental health care system and its impact on emergency department use, the changes occurring in primary care and the increased awareness of the common co-occurrence of psychiatric and medical disorders and their impact on outcomes, are examples that call for improved collaboration between the mental health and the general health care systems. Acute care is one setting where this collaboration often begins and in the continuum of care can be increased.

Nursing Facilities

Data from the Ohio Department of Mental Health indicate a clear trend of patients residing in nursing facilities and who require a review of their status, as experiencing a greater need for acute psychiatric inpatient services. During the late 1990s and early 2000, very few patients were determined to require such intensive services; however, by 2003 that number had increased nearly five-fold from the previous year.[39]

Nursing home patients who were once able to receive inpatient care are now finding it more difficult to do so. As the availability of inpatient psychiatric beds becomes fewer and fewer, and the pressures to shorten lengths of stay become greater and greater, coupled with a scarcity of adequate acute care community resources, many hospitals are utilizing nursing facilities as temporary "step-down" units for their discharged patients. In all likelihood, these individuals could have been discharged directly from the hospital, or even maintained in a community setting, if greater acute care treatment options had originally been available.

Figure 10



Conclusions

A CALL TO EDUCATE, COLLABORATE AND ADVOCATE

Inadequate mental health services affect individuals, the mental health system and overall public health. Addressing the crisis in acute mental health care requires:

EDUCATION

An improved understanding of the relationship between mental health and physical health on the quality of life of consumers served

An increase understanding of the link between mental health and physical health is vital. As this report demonstrates, stress on the acute mental health care system permeates other systems in Ohio. The strain on consumers, families, public/private psychiatric care facilities, and alternative services is undeniable.

COLLABORATION

Collaboration between public and private mental health systems to ensure quality and appropriateness of mental health services

A broader, system-of-care approach is necessary to address the issues that are affecting acute care capacity in both the public and private mental health delivery systems.

Establishment of local/regional planning groups whose mission is to aid in the understanding of the interrelatedness of public and private inpatient mental health care in Ohio is essential. Such groups should, at minimum, be comprised of individuals representing state, private, inpatient, residential and ambulatory acute psychiatric service providers, as well as mental health boards. It is also necessary to continue to collect and share data on acute care in Ohio through this collaborative approach.

ADVOCACY

Advocacy of mental health transformation driven by stakeholders in the mental health community using their individual and organizational strengths

The final report of the President's New Freedom Commission recommends "fundamentally transforming how mental health care is delivered in America."[41] The Ohio Department of Mental Health encourages all stakeholders to use their individual and organizational strengths to advocate for enactment of this change.

To address these issues the Ohio Department of Mental Health calls for a plan to educate, collaborate and advocate.

Educate
- Distribute this report widely
- Discuss with shareholders
- Assimilate
- Share with others

Collaborate
- Work with natural partners and with others who are affected to address the acute mental health care crisis
- Identify strategies for improving and transforming the system

Advocate
- Bring awareness and recommendations to decisions makers to improve the acute care crisis
- Advocate on individual factors that are impacting acute care

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The Acute Mental Health Crisis: An Overall Health Problem

Regional Viewpoints

PRIVATE PSYCHIATRIC HOSPITALS

Eighty-seven private hospitals in 37 of Ohio's 88 counties provide inpatient behavioral health services.

TOLEDO COLLABORATIVE *

12 private psychiatric hospitals in Allen, Defiance, Erie, Fulton, Hancock, Lucas and Sandusky counties

CLEVELAND COLLABORATIVE

28 private psychiatric hospitals in Cuyahoga, Geauga, Lake, Lorain, Mahoning, Summit, and Trumbull counties

HEARTLAND COLLABORATIVE

Nine private psychiatric hospitals in Ashtabula, Columbiana, Richland, and Stark counties

COLUMBUS COLLABORATIVE

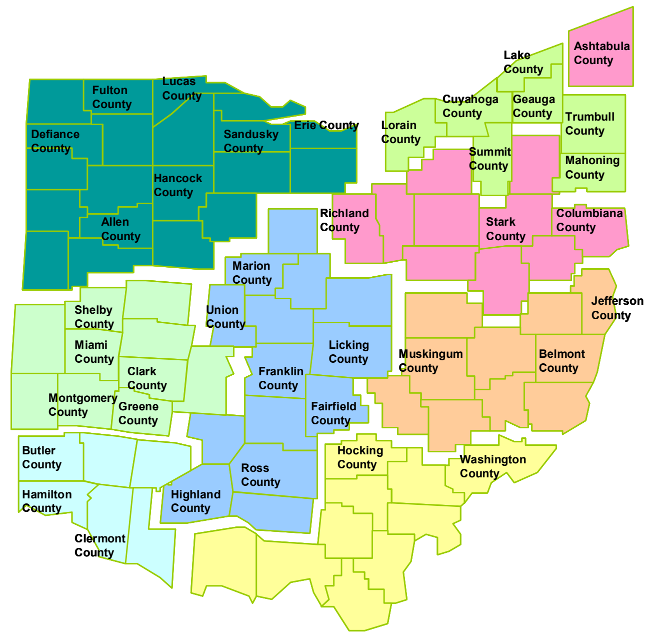
11 private psychiatric hospitals in Fairfield, Franklin, Highland, Licking, Marion, Ross, and Union counties

DAYTON COLLABORATIVE *

Nine private psychiatric hospitals in Clark, Greene, Miami, Montgomery and Shelby counties

SUMMIT COLLABORATIVE

Nine private psychiatric hospitals in Butler, Clermont, and Hamilton counties



ATHENS COLLABORATIVE

Two private psychiatric hospitals in Hocking and Washington counties

CAMBRIDGE COLLABORATIVE

Four private psychiatric hospitals in Belmont, Jefferson, and Muskingum counties

STATE BEHAVIORAL HEALTH ORGANIZATIONS

The Ohio Department of Mental Health's five Behavioral Healthcare Organizations (BHOs) provide intensive inpatient treatment at nine campuses across the state.

TOLEDO COLLABORATIVE *

Northcoast Behavioral Healthcare - Toledo

CLEVELAND COLLABORATIVE

Northcoast Behavioral Healthcare - Cleveland and Northfield

HEARTLAND COLLABORATIVE

Heartland Behavioral Healthcare - Massillon

COLUMBUS COLLABORATIVE

Twin Valley Behavioral Healthcare - Columbus

DAYTON COLLABORATIVE *

Twin Valley Behavioral Healthcare - Dayton

SUMMIT COLLABORATIVE

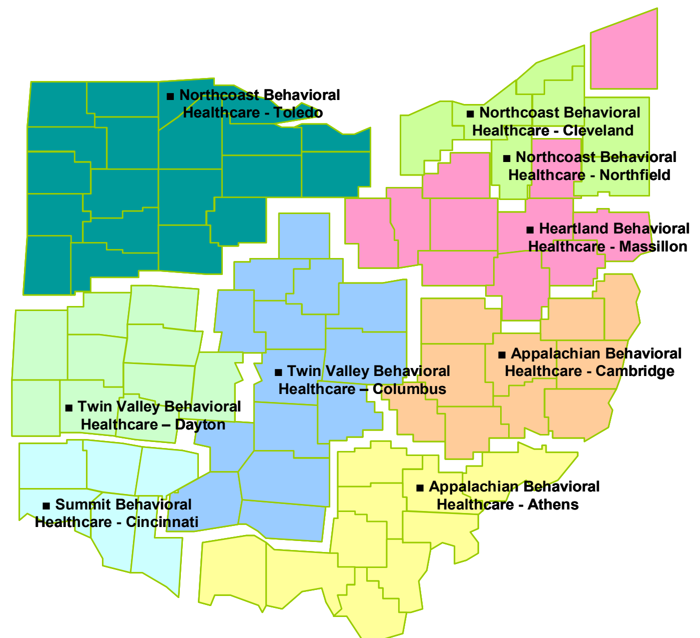
Summit Behavioral Healthcare - Cincinnati

ATHENS COLLABORATIVE

Appalachian Behavioral Healthcare - Athens

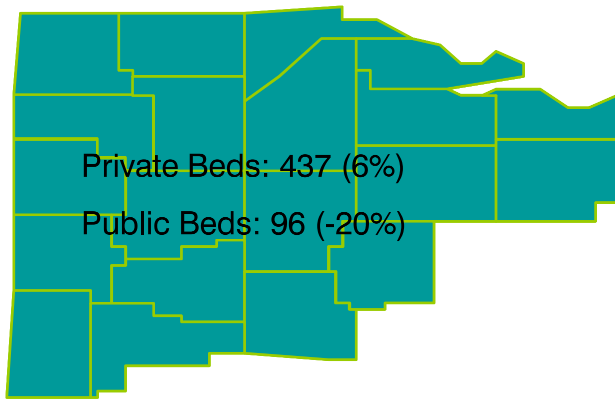
CAMBRIDGE COLLABORATIVE

Appalachian Behavioral Healthcare - Cambridge



* Please note: Allen, Auglaize and Hardin counties have recently been moved from the Toledo Collaborative to the Dayton Collaborative. The data in this publication does not reflect this change.

TOLEDO COLLABORATIVE*



COUNTIES
Allen, Auglaize, Defiance, Erie, Fulton, Hancock, Hardin, Henry, Huron, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Van Wert, Williams, Wood, Wyandot

TOTAL POPULATION
1,433,433

STATE BEHAVIORAL HEALTHCARE ORGANIZATION
Northcoast Behavioral Healthcare, Toledo Campus

PRIVATE PSYCHIATRIC HOSPITALS
Allen County
St. Rita's Medical Center – 38 adult (18 gero specific)

Defiance County
Defiance Hospital, Inc. – 13 adult

Erie County
Firelands Community Hospital – 26 adult, 4 adolescent

Fulton County
Fulton County Health Center – 20 adult

Hancock County
Blanchard Valley Regional Health Center – 11 adult

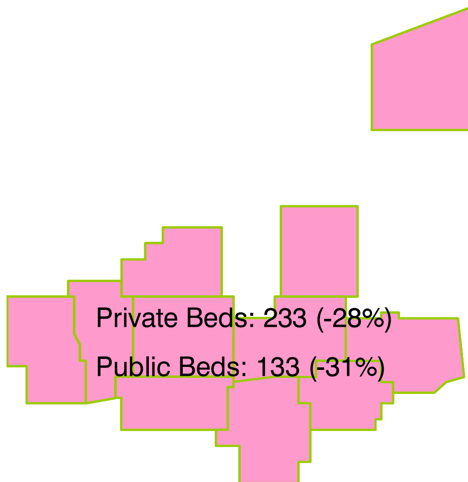
Lucas County
Focus Healthcare of Toledo – 30 adult
St. Charles Mercy Hospital – 65 adult, 15 adolescent
Flower Hospital – 55 adult
St. Vincent Mercy Medical Center – 31 adult
Promedica Health Systems/The Toledo Hospital – 10 adolescent
Medical College of Ohio – 12 adult (8 gero specific), 15 adolescent, 10 child

Sandusky County
Memorial Hospital – 13 adult

CLOSURES SINCE 1997
Charter Hospital, Lucas County
Mercy Hospital, Lucas County
Riverside Mercy Hospital, Lucas County
Lima Memorial, Allen County
Henry County Hospital, Henry County

* Please note: Allen, Auglaize and Hardin counties have recently been moved from the Toledo Collaborative to the Dayton Collaborative. The data in this publication does not reflect this change.

HEARTLAND COLLABORATIVE



COUNTIES
Ashland, Ashtabula, Carroll, Columbiana, Holmes, Medina, Portage, Richland, Stark, Tuscarawas, Wayne

TOTAL POPULATION
1,347,689

STATE BEHAVIORAL HEALTHCARE ORGANIZATION
Served by Heartland Behavioral Healthcare

PRIVATE PSYCHIATRIC HOSPTIALS
Ashtabula County
Ashtabula County Medical Center – 17 adult

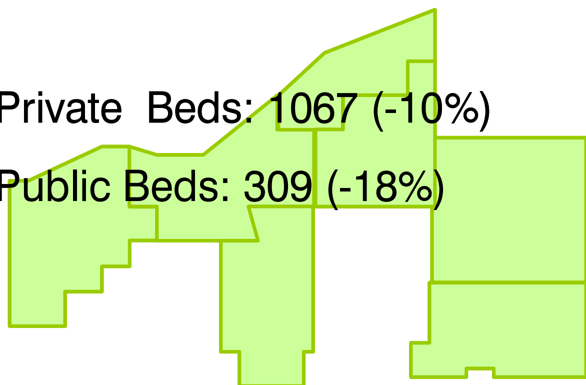
Columbiana County
East Liverpool City Hospital – 20 adult, 10 adolescent

Richland County
Samaritan Regional BHU at Peoples Hospital – 10 adult
MedCentral Health System, Mansfield Hospital – 32 adult (10 gero specific), 8 adolescent

Stark County
Massillon Community Hospital – 14 adult (gero specific)
Alliance Community Hospital – 10 adult (gero specific)
Doctors Hospital of Stark County – 14 adult (gero specific)
Mercy Medical Center – 66 adult, 16 adolescent
Aultman Hospital – 41 adult

CLOSURES SINCE 1997
Brown Memorial Hospital, Ashtabula County
Robinson Memorial Hospital, Portage County
Richland Hospital, Richland County

CLEVELAND COLLABORATIVE



Counties
Cuyahoga, Geauga, Lake, Lorain, Mahoning, Summit, Trumbull

Total Population
3,022,618

State Behavioral Healthcare Organization
Served by Northcoast Behavioral Healthcare, Cleveland Campus and Northfield Campus

Private Psychiatric Hospitals
Cuyahoga County
University Hospitals of Cleveland – 80 adult (18 gero specific)
Deaconess Hospital of Cleveland – 31 adult
Windsor Hospital – 36 adult beds, 9 adolescent, 2 child
Meridia Euclid Hospital – 15 adult (gero specific)
Parma Community General Hospital – 12 adult (gero specific)
St. Vincents Charity – 50 adult
Marymount Hospital – 32 adult, 8 adolescent
Southwest General Health Center – 10 adult, 4 adolescent
MetroHealth Medical Center – 20 adult
South Pointe/Cleveland Clinic Health System – 20 adult
Meridia Huron Hospital – 32 adult
UHHS Saint Michael Hospital – 20 adult (gero specific)
Lakewood Hospital – 32 adult
Lutheran Hospital – 54 adult (20 gero specific)
Cleveland Clinic Foundation – 22 adult, 12 adolescent, 6 child

Geauga County
UHHS Geauga Regional – 20 adult

Lake County
Lake West Hospital – 10 adult (gero specific)
UHHS Laurelwood Hospital – 96 adult, 20 adolescent, 12 child

Lorain County
EMH Regional Medical Center – 14 adult
Community Health Partners – 21 adult, 3 adolescent

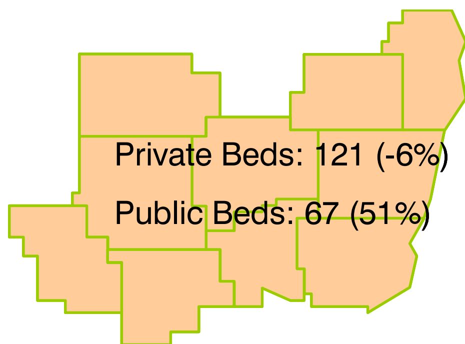
Mahoning County
St. Elizabeth Health Center – 32 adult

Summit County
Barberton Citizens Hospital – 20 adult
Children's Hospital Medical Center of Akron – 14 adolescent, 10 child
Akron General Medical Center – 55 adult
Summa Health System – St. Thomas Hospital – 36 adult

Trumbull County
BHC Belmont Pines Hospital, Inc. – 10 adult, 22 adolescent, 10 child
Forum Health – Trumbull Memorial Hospital – 36 adult (16 gero specific)
St. Joseph Health Center – 24 adult
Western Reserve Care System – 25 adult, 16 adolescent, 6 child

Closures since 1997
Davenport, Cuyahoga County
Fairview, Cuyahoga County
Mt. Sinai, Cuyahoga County
St. Luke's Medical Center, Cuyahoga County
St. John West Shore Hospital, Cuyahoga County
Youngstown Osteopathic Hospital, Mahoning County

CAMBRIDGE COLLABORATIVE



Counties
Belmont, Coshocton, Guernsey, Harrison, Jefferson, Morgan, Monroe, Muskingum, Noble, Perry

Total Population
400,211

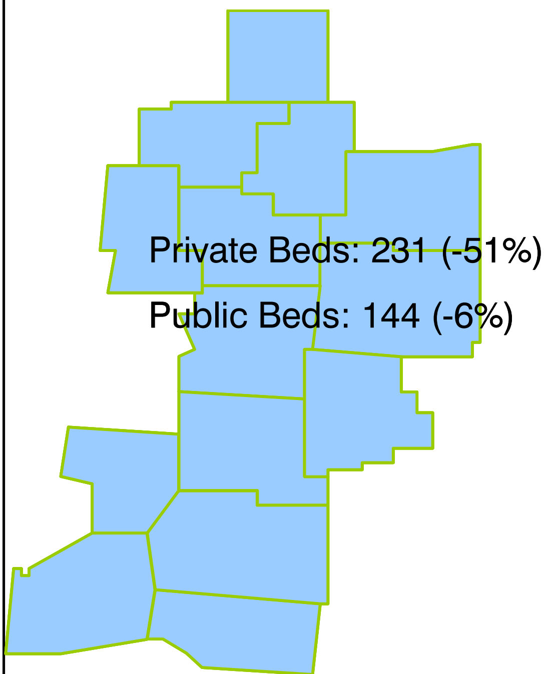
State Behavioral Healthcare Organization
Served by Appalachian Behavioral Healthcare, Cambridge Campus

Private Psychiatric Hospitals
Belmont County
BHC Fox Run Hospital – 16 adolescent, 15 child
Belmont Community Hospital – 10 adult, 4 adolescent

Jefferson County
Trinity Medical Center East – 12 adult, 8 adolescent

Muskingum County
Genesis HealthCare System – 42 adult, 10 adolescent, 4 child

COLUMBUS COLLABORATIVE



Counties
Crawford, Delaware, Fairfield, Fayette, Franklin, Highland, Knox, Licking, Marion, Morrow, Pickaway, Pike, Ross, Union

Total population
1,910,512

State Behavioral Healthcare Organization

Served by Twin Valley Behavioral Healthcare, Columbus Campus

Private Psychiatric Hospitals

Fairfield County
Fairfield Medical Center – 6 adult

Franklin County
Doctors Hospital, Ohio Health – 20 adult
Riverside Methodist, Ohio Health – 19 adult
Ohio Hospital for Child/Adolescent Psychiatry - 10 adolescent, 4 child
Ohio State University Medical Center – 58 adult (18 gero specific), 20 adolescent, 16 child
Mt. Carmel Medical Center – 24 adult

Highland County
Highland District Hospital – 10 adult (gero specific)

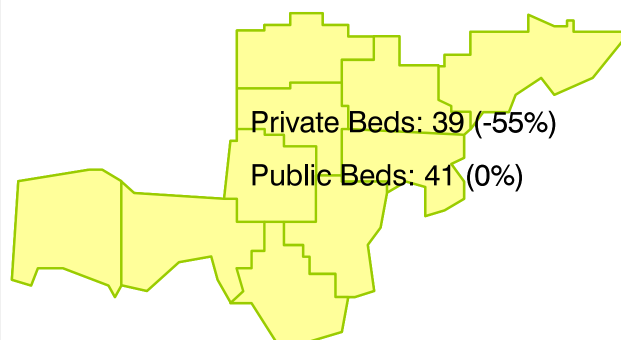
Licking County
Licking Memorial Hospital, Shepherd Hill – 9 adult

Marion County
Marion General Hospital – 24 adult

Ross County
Adena Regional Medical Hospital – 15 adult

Union County
Memorial Hospital – 10 adult

Closures since 1997
Columbus Community Hospital, Franklin County
Knox Community Hospital, Knox County
Grant Hospital, Franklin County
Harding Hospital, Franklin County



ATHENS COLLABORATIVE

Counties
Adams, Athens, Gallia, Hocking, Jackson, Lawrence, Meigs, Scioto, Vinton, Washington

Total population
422,147

State Behavioral Healthcare Organization
Served by Appalachian Behavioral Healthcare, Athens Campus

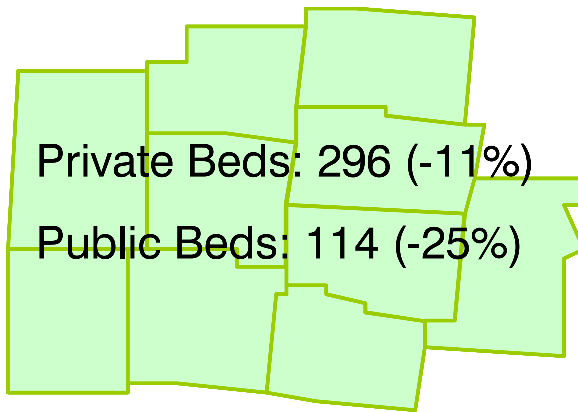
Private Psychiatric Hospitals

Hocking County
Hocking Valley Community Hospital – 10 adult (gero specific)

Washington County
Marietta Memorial Hospital – 13 adult

Closures since 1997
River Valley Health Systems, Scioto County
Veteran's Memorial Hospital, Meigs County
Oak Hill Community Medical Center, Jackson County
Selby General Hospital, Washington County

DAYTON COLLABORATIVE*



COUNTIES
Champaign, Clark, Darke, Greene, Logan, Madison, Miami, Montgomery, Preble, Shelby

TOTAL POPULATION
1,219,222

STATE BEHAVIORAL HEALTHCARE ORGANIZATION
Served by Twin Valley Behavioral Healthcare, Dayton Campus

PRIVATE PSYCHIATRIC HOSPITALS

Clark County
Mental Health Services for Clark County, Inc. – 16 adult

Greene County
Greene Memorial Hospital, Inc. - 18 adult

Miami County
Upper Valley Medical Center/Dettmer Hospital – 17 adult, 16 adolescent, 10 child

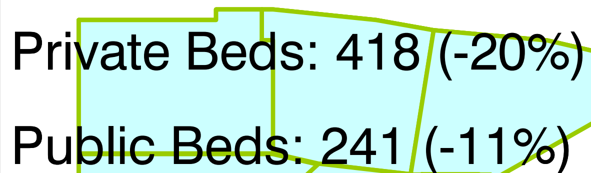
Montgomery County
Good Samaritan Hospital – 29 adult
Grandview Hospital and Medical Center – 60 adult
Kettering Youth Services – 22 adolescent, 8 child
Kettering Memorial Hospital – 30 adult
Miami Valley Hospital – 47 adult

Shelby County
Wilson Memorial Hospital – 10 adult (gero specific)

CLOSURES SINCE 1997
Madison County Hospital, Madison County
Franciscan Medical Center, Montgomery County
Dartmouth Hospital, Montgomery County

* Please note: Allen, Auglaize and Hardin counties have recently been moved from the Toledo Collaborative to the Dayton Collaborative. The data in this publication does not reflect this change.

SUMMIT COLLABORATIVE



COUNTIES
Brown, Butler, Clermont, Clinton, Hamilton, Warren

TOTAL POPULATION
1,597,298

STATE BEHAVIORAL HEALTHCARE ORGANIZATION
Served by Summit Behavioral Healthcare

PRIVATE PSYCHIATRIC HOSPITALS

Butler County
Fort Hamilton Hospital – 21 adult
Middletown Regional Hospital - 19 adult, 6 adolescent

Clermont County
Clermont Mercy Hospital – 20 adult, 10 adolescent

Hamilton County
Good Samaritan Hospital – 54 adult (27 gero specific), 5 adolescent
Christ Hospital – 90 adult (24 gero specific)
University Hospital, Inc. – 70 adult
Deaconess Hospital – 28 adult (18 gero specific)
Mercy Franciscan Hospital, Western Hills Campus – 30 adult (gero specific)
Mercy Franciscan Hospital, Mt. Airy Campus – 16 adolescent, 6 child
Children's Hospital Medical Center - 28 adolescent, 15 child

CLOSURES SINCE 1997
Jewish Hospital, Hamilton County
Bethesda, Hamilton County

For more information or additional copies of this publication, contact the ODMH Office of the Medical Director at 614-466-6890.

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