REPORT OF THE DEPARTMENT OF MENTAL HEALTH

AND MENTAL RETARDATION TASK FORCE

ON

FUNDS FOLLOWING THE CLIENTS

TO

THE GOVERNOR

AND

THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 20

COMMONWEALTH OF VIRGINIA
RICHMOND
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STATE MENTAL HEALTH AND MENTAL RETARDATION BOARD

1981

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SENATE JOINT RESOLUTION NO. 8

Requesting that the State Mental Health and Mental Retardation Board and the Department of Mental Health and Mental Retardation make studies concerning the funding of services for the handicapped, liability insurance for community services boards and the double diagnosis client.

Agreed to by the Senate, March 5, 1980
Agreed to by the House of Delegates, March 3, 1980

WHEREAS, during a series of public hearings in nineteen hundred seventy-eight and in subsequent deliberations, the Commission on Mental Health and Mental Retardation was introduced to an innovative concept of financing services provided mentally handicapped persons whose appropriate treatment, training or care may be provided by a State institution, by community services or both; and

WHEREAS, the Commission learned that the cost of treatment or training received by citizens in State institutions is currently funded by State and federal funds but includes no local monies, while community-based services for the mentally handicapped are financed by State and local funds, and these current funding practices provide financial incentives for localities to place individuals in State institutions, thereby relieving the locality of any financial responsibility for the individual; and

WHEREAS, the Commonwealth is dedicated to the policy of providing treatment, training and care for mentally handicapped individuals in the least restrictive environment which, in most instances, is the community rather than an institution; and

WHEREAS, under the concept of funds following the client the local community services board would be charged a unit cost for services rendered to an individual by a State institution, thus, providing financial incentives to retain the individual in community care except where institutionalization is imperative; and

WHEREAS, during its study the Commission on Mental Health and Mental Retardation also heard testimony concerning legal liability for the decisions and actions of the members and staff of community services boards which provide services for the mentally handicapped in localities throughout Virginia; and

WHEREAS, grave concern was expressed about the lack of State policy governing liability insurance for the boards, and such a lack of State policy has resulted in a variety of practices among the community services boards which, in some regions, have purchased liability insurance for the members and staff and, in other regions, have not arranged such coverage; and

WHEREAS, the provision of liability insurance for the members and staff of the community services boards requires further study to determine the need, the cost and the most appropriate method of providing liability insurance coverage for these individuals; and

WHEREAS, during its study the Commission on Mental Health and Mental Retardation also learned that individuals diagnosed as both emotionally disturbed and mentally retarded are not receiving services to appropriately address their multiple needs; and

WHEREAS, the double diagnosis individual frequently has physical disabilities which complicate the problems of emotional disturbance and mental retardation, and the complexity of this individual's handicaps increases the difficulty of developing an effective program for his appropriate treatment and care; and

WHEREAS, designing appropriate programs and services for the double diagnosis client is a perplexing problem in Virginia and throughout the Nation; and

WHEREAS, the Developmental Disabilities Planning Council has studied the needs of children with multiple disabilities in the State, and Central State Hospital, the Southside Virginia Training Center and the Southside Community Services Board are cooperating to better serve multiply-handicapped citizens in Southside Virginia; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That it is requested that the following studies be undertaken by the State Mental Health and Mental Retardation Board or the Department of Mental Health and Mental Retardation as designated:

1. That the State Mental Health and Mental Retardation Board is requested to study the concept of funds following the client. The goal of the Board's research shall be to recommend several pilot projects in various regions of Virginia to implement this concept. The recommendations of the Board shall be submitted to the Governor and the General Assembly by September one, nineteen hundred eighty-one with accompanying plans to include the proposed pilot projects in the biennial budget for nineteen hundred eighty-two through nineteen hundred eighty-four.

2. That the State Mental Health and Mental Retardation Board is requested to study the feasibility of providing liability insurance for community services boards' members and staff. The study shall determine the actual need for liability insurance for the boards, the cost of providing the insurance if it is needed and whether the insurance should be provided by the State, the localities or both. The recommendations of the State Board shall be submitted to the Governor and General Assembly prior to the nineteen hundred eighty-one session.

3. That the Department of Mental Health and Mental Retardation is requested to study the double diagnosis client. The Department shall identify the approximate number of citizens with multiple disabilities and recommend an effective method of assuring that these citizens receive the services they need. The experience and study of the Developmental Disabilities Planning Council and the State and community services in Southside Virginia should be utilized by the Department in the conduct of this study. The Department is requested to present an interim report to the Governor and the General Assembly in the nineteen hundred eighty-one session and a final report to the nineteen hundred eighty-two session.

EXECUTIVE SUMMARY

Senate Joint Resolution No. 8 describes funds following the client as a system whereby local community services boards are charged a unit cost for services rendered to an individual by a state institution and are given another unit cost for services rendered in the community to a former or potential hospitalized individual. A funds following the client system is needed because at present it is financially advantageous for community programs to refer clients to state institutions rather than treat them in the community.

Appropriate funding systems in four states were studied -- California, Colorado, Massachusetts and Tennessee. While no single state system seemed appropriate, elements from the four other state systems were combined in designing a proposal for Virginia. The recommended pilot sites were Hampton-Newport News Community Services Board and Eastern State Hospital.

The Virginia proposal consists of three phases: preparation; initial implementation and final implementation. In the preparation phase the community will assess the service needs of the prospective clients at Eastern State Hospital. In addition, Eastern State Hospital will assess current staffing levels at the Bayside Building to determine whether or not current staffing levels are appropriate. At the initial implementation stage, the community will move 25 patients from Eastern State Hospital into the Hampton-Newport News area. Eastern State Hospital will eliminate 25 beds from its rated bed capacity. In the third phase, the community will move another 25 patients from Eastern State Hospital into the community. The community will also use this time to make program adjustments to fine tune the entire project. The hospital will eliminate an additional 25 beds from its rated bed capacity.

The final task force recommendations were as follows:

1. Hampton-Newport News Community Services Board should proceed with the preliminary steps necessary to implement this project.

2. Hampton-Newport News Community Services Board should identify by November 1, 1981, the dollar amount that will be needed to start this project.

3. Appropriate staffing levels should be identified by November 1, 1981 for the Bayside Building at Eastern State Hospital and the department should decide on the appropriate remedy if necessary.

4. The department believes that the principle of a funds following the client proposal must be fully incorporated into the department's long-range plan for providing equitable, balanced and appropriate mental health and mental retardation services to patients, residents and clients. However after considering the Hampton-Newport News Community Services Board proposal and the efforts of other states, the department recommends that it not proceed with the development of a funds following the client system.

5. The department shall carefully study and utilize, whenever possible, the information and procedures used by Hampton-Newport News Community Services Board and Eastern State Hospital staff in developing the funds following the client proposal. Other department proposals for discharging patients/residents from the state hospitals and training centers should follow many of the same steps as the Hampton-Newport News Community Services Board and Eastern State Hospital staff did in formulating their service recommendations.

FUNDS FOLLOWING THE CLIENT TASK FORCE REPORT FOR SENATE JOINT RESOLUTION NO. 8

Introduction

Senate Joint Resolution No. 8 describes funds following the client as a system whereby local community services boards are charged a unit cost for services rendered to an individual by a state institution and are given another unit cost for services rendered in the community to a former or potential hospitalized individual. Two task forces were convened to study funds following the client and to recommend a pilot project to implement this concept.

The members of the two task forces were selected so that they represented the community, different geographic areas in Virginia and the fields of mental health and mental retardation. Task Force I was comprised exclusively of Central Office staff and its responsibilities consisted of: problem specification, information gathering, definition of alternatives, and choice-making. Task Force II was comprised of Task Force I members plus representatives from the institutions, community programs, and community services boards. The responsibility for Task Force II consisted of: review and comment, and analysis of the alternatives (see Appendix A for complete listing of task force members).

Issues Involved in SJR8

Over the last 20 years states have discharged thousands of chronic patients from their institutions. Initially, it had been thought that a massive reallocation of resources would accompany decreased state hospital utilization. This did not occur for a number of reasons. In fact, there was a net increase rather than decrease of institutional staff. For many patients, who had been discharged into the community in the expectation that resources and services would follow them from the institution, the results have been tragic.

Mental health funds following the client is an idea for achieving a significant reallocation of mental health dollars. Unfortunately, few have demonstrated how to operationalize and implement this concept. On the other hand, the literature is replete with criticisms of the mental health system for implicitly encouraging the institutionalization of people who should be served by community alternatives. The Task Panel on Cost and Financing of Mental Health reported that the current financing system for mental health services actually prevents the receipt of adequate and appropriate services that many need to help them lead fully productive lives. This view is echoed in many other reports.

Two major federal programs, Medicaid and Medicare, present formidable barriers to people needing mental health services that are consistent with current preferred modes of treatment. Most existing means of financing health services focus on the provision of care in institutions. Private health insurance plans, Medicare, and all but a very few state Medicaid plans provide little or no funding for nonmedical home care services. This situation actually discourages families and communities from

maintaining individuals within the family, home, or community and sends many of the aged and chronically ill to institutions and to less appropriate services.

Title XVIII of the Social Security Act, the Medicare Program, consists of 2 programs: Part A, Hospital Insurance, and Part B, Supplemental Medical Insurance. Anyone 65 years or older and some disabled people under age 65 are eligible. Inpatient psychiatric services under Part A are limited to 190 days during a person's lifetime in addition to the restrictions applicable to all hospital care under the Medicare Program.

Anyone eligible for Part A coverage can enroll in Part B by paying a monthly premium. Part B coverage includes a variety of medical services and supplies that are furnished in connection with physicians' services, outpatient hospital services and home health services after a deductible has been met. Part B reimbursement is 80% of reasonable charges although reimbursement for medical care of a patient with mental illness on an outpatient basis cannot exceed the lesser amount of either 50% of the charges or $250 in each calendar year. This provision does not account for the fact that mental illness is often acute and that a patient benefits from prompt treatment. If the intervention is not prompt, the episode is likely to become chronic or more difficult as well as expensive to treat.

The reimbursement limitation does not apply when a physician provides medical or psychiatric care to a mentally ill beneficiary who is an inpatient of a hospital. This provision is, in fact, an incentive for an individual, his family, or a community to seek hospitalization and to use general physician's services which are not designed for the treatment of mental disorders. Current Medicare restrictions often reward inappropriate services for mental and emotional distress. The limitation not only affords inadequate coverage but promotes hospitalization rather than care in the community, often contrary to sound psychiatric practice.

Title XIX, the Medicaid Program, was established to provide federal financial resources to the state's programs of medical assistance for certain low-income populations. Consequently, the Medicaid program has made sizeable financial contributions toward the support of mental health services for the poor. Although Medicaid, along with certain other state programs, provides the most significant sources of funding for mental health services for the low-income population, the program focuses on institutional services. Many mental health services such as outreach and support services are not reimbursed under Medicaid. Nearly 66% of Medicaid expenditures are for hospitals and intermediate care facilities.

Although the major thrust of the national mental policy, by law, is outpatient services through community mental health centers and deinstitutionalization, the de facto policy is institutionalization. To a considerable extent, the de facto public policy on mental health is a function of where the funds for treatment of mental health are available. The Task Panel on Deinstitutional, Rehabilitation, and Long-Term Care similarly concludes that the need and type of care given to the chronically mentally disabled is frequently based on what services are fundable and not what services are needed or appropriate.

At least in terms of financing, federal and Virginia mental health policy for the treatment of mental illness is hospitalization or other institutionalization. The cost of institutional treatment in Virginia is borne by state and some federal funds but

includes no local monies. Community-based services are funded by state and local funds. Clearly it is financially advantageous for localities to place clients in state facilities as the institutionalized patients' treatment costs are paid by the state. Community programs can use the money that would have been spent on the institutionalized patients for other services and clients. The Bagley Commission in recognizing this situation requested that the Virginia Department of Mental Health and Mental Retardation study the concept of funds following the client. Under this concept, institutional as well as community programs would be funded jointly by the state and local governments. The concept is intended to provide financial incentives to localities for retaining clients in community programs and to provide financial disincentives for using the inpatient services from state institutions.

Issues from the Community Perspective

In establishing a funds following the client model a number of issues have to be addressed. The start-up costs of such a project have to be considered. Experiences in other states have shown that simply switching or adding to a funding formula is not sufficient to implement an innovative program.

Hospital budgets must be maintained at a certain funding level so as to insure that an adequate level of the quality of care is provided to patients or residents. An adequate level of quality of care is easily determined at mental retardation and geriatric facilities which are currently Title XVIII (Medicare) and Title XIX (Medicaid) certified or accredited by the Accreditation Council for Services for the Mentally Retarded and Other Developmentally Disabled Persons (AC MRDD) or the Joint Commission on Accreditation of Hospitals (JCAH). For facilities that are neither certified or accredited it is not clear how easily it will be to ascertain, not to mention establish, a quality level of care.

The communities must have start-up money to add or supplement services for the discharged hospital patients. Once established the services should be supportable through the funds following the client mechanism.

A funds following the client system seems to be appropriate for a psychiatric population only. A large amount of the money in mental retardation and geriatric facilities is from federal sources. If patients were transferred from these facilities to the community, there could be a considerable loss of federal funds. The federal funds would not follow the clients unless the clients were discharged to intermediate care facilities.

Issues from the Central Office Perspective

If a funds following the client project is to be successful, the innovation must be consistent with departmental policies. A radical alternative would not succeed as legislative, department and community resistance would be substantial. A project that is consistent with departmental policy and the long range goals of the department would be more easily accepted and consequently have a higher probability of success.

Another issue is the department's perception that communities seem to be slowing down in their efforts to provide and maintain alternatives to institutionalization. In the past few years the growth or expansion of community placements has declined or ceased. This is due to variety of causes e.g. less funds

available, community resistance, etc. As a result communities are looking to the state to provide inpatient services rather than starting up or seeking out alternative treatment services. In addition, as the state facility censuses declines, patients who remain in the hospitals are more difficult to treat. Consequently, the length of treatment increases and community placement for these patients becomes more difficult.

Method for Addressing the Resolution

Task Force I made a site visit to Tennessee to learn more about that state's funds following the client model. The model was prompted by Tennessee House Joint Resolution 400 which mandated that the Tennessee Department of Mental Health develop an evenhanded, non-discriminatory method of allocating funds to community programs throughout Tennessee. Under this mandate the Tennessee Department of Mental Health developed a funding formula which provided a disincentive for sending clients to state institutions and an incentive for getting clients out of institutions and keeping them out.

The formula calls for each community mental health center to be assigned a utilization standard equal to the actual average daily census (ADC) of the chronic care population in the state institutions from the center's catchment area during FY 79-80. The ADC is monitored periodically during the year and marginal cost adjustments are made. Community mental health centers which reduce their ADC relative to their standard receive additional funds equal to the marginal cost rate per day ($3.97 for FY 1979-80) multiplied by the number of days in the period for which actual utilization is available. Community mental health centers which experience an increased ADC relative to their standard will have their funding reduced in a similar manner.

As a result of these reductions in the ADC, there will be a fixed cost savings at the institutions. The fixed cost savings (which are mostly personnel costs and represent greater dollar amounts) are distributed to the centers in the following manner:

1. If the savings are administrative fixed costs, 100% of the savings are transferred to the community based programs,

2. If the savings are clinical fixed costs, 50% of savings are transferred to community based programs, 25% are kept by the institution for correcting clinical staffing difficulities and 25% is pooled and allocated through the budget process according to priorities established by the commissioner.

The task force's main criticism of the Tennessee model is the small amount of money with which the locality is supposed to start new programs for those clients who were formerly institutionalized. Currently the community centers in Tennessee are finding that the marginal cost transfers are not enough to keep pace with inflation. Even if there were inflationary adjustments for the marginal costs, there would still not be enough front-end money for providing the needed new services. During the last quarter for FY 80, there was only $7000 in marginal cost transfers for the entire state of Tennessee. For all of FY 80 there was only $100,000 in marginal cost transfers for the entire state.

Task Force II met to discuss the Tennessee funds following the client model as well as other issues on this topic. The meeting was held in Bristol, Virginia as the community mental health center there serves Virginia and Tennessee clients and is funded accordingly by both states. Center director, Ron Harrington, said the Tennessee system had little effect on the Bristol Community Mental Health Center as there was no inflation provision in the funding allocation. As a result the new money transferred from Tennessee state hospitals had little effect because the increase was about the same as the inflation rate.

There was a consensus among the group on the problems and needs for a funds following the client system. First, there must be up-front money for communities to start-up new programs and inflationary adjustments must be included. Second, the hospitals must be maintained as a funds following the client system is not intended to close the hospitals. While there should be an incentive to the hospital for discharging patients, the quality of care in the institutions must not be reduced. As the census declines, the level of care required for patients remaining in the hospital increases and the need for specialized training likewise increases. This result is an increase in staff time and treatment time. Third, the hospitals do not have to provide an entire range of services. Many of the services can be provided by the community programs, e.g. community preparation, vocational training, outreach, etc. If the hospital can identify a special area of need for its patients or residents, those services should be provided. However, many of the services currently provided at the hospital can and should be provided in the community. Fourth, new and additional community services for the functionally disabled population must be provided.

The group rejected the Tennessee model as it did meet problems described above. The group came up with its own funds following the client system proposal. The first part of the proposal requires a change in perspective. Instead of thinking of one service system for hospital patients and another for community clients, there should only be one system. All services (even hospitalization) should be considered as services for community clients. Institutionalization is only one of the services that is available to a community service system for its clients. This change in thinking necessitates an establishment of an inter-dependency between the hospital and the community. The system should not be separate and independent but rather inter-dependent and mutually beneficial. One way of achieving this is by directing all the dollars to the community centers. The community centers could then purchase inpatient services on a quarterly or annual basis from an institution. This would require the state institutions to start planning and budgeting in order to deal with a more variable source of funding. Although initially difficult, planning and budgeting would not be impossible. Such activity would be similar to the planning and budgeting that already occurs at private hospitals. There must still be some sort of disincentive to discourage communities from continuing the status quo by purchasing the same amount of inpatient services as are currently provided to catchment area residents. In order to do this, there must be a ceiling put on the number of admissions from a center's catchment area.

This could be similiar to the Tennessee system in which the average daily census for the previous year is the ceiling and the center must not exceed that ceiling. There could also be a requirement for a match of these state dollars with local dollars. This would discourage centers from passing on their clients to the institutions. If a community simply passed on the patients and purchased the inpatient services from the

institutions, some of their local dollars would be transferred to the institution along with the state dollars.

There also would be a need to keep centers from using the dollars for other services. Initially, there would probably have to be a definition of the services that must be provided.

In establishing this system there will need to be a method for determining the amount of money that would go to the community for each patient. Tennessee uses a simple per capita formula. This would be inequitable for many of the centers throughout Virginia. Such a formula does not reward previous performance, i.e. how well a center gets and keeps its clients out of the institutions. A simple per capita formula does not take into account that there are certain places to which patients are likely to be discharged. There needs to be an adjustment for the centers in these particular areas.

Such a system requires an adjustment for inflationary costs as well as up-front money for the communities and the hospitals. The hospital will need a certain budgetary amount in order to maintain a sufficient quality level at the institution. The community will need the up-front money so that it will be able to start new services.

Literature Review

The task force, having raised a number of problems and needs, requested that the task force chairman review the literature to learn about other state's attempts to design funds following the client models. In addition to Tennessee, the states of California, Colorado and Massachusetts have developed innovative programs.

California Model. California's efforts at establishing a community mental health service were formalized in the Short-Doyle Acts of 1957, 1963 and 1968. The California legislature realized that it had to provide incentives to counteract the convenience of commiting mental patients to state hospitals in order to develop community programs for the care and treatment of the mentally disabled. The Short-Doyle Act provided for a 50/50 state and county match for the funding of mental health services, established a conference of local mental health directors and mandated mental health advisory boards for each local program.

Under the Short-Doyle Act a county must annually develop and adopt a mental health plan which specifies the service to be provided in county facilities, in state hospitals and through private agencies. The plan provides the basis for reimbursement of the counties' mental health programs. Specific requirements (e.g. an inventory of resources, a description of persons to be served, a 3 year projection, etc.) must be addressed in the plan in order for the county to avail itself of the 90/10 matching funds. The Director of the California Department of Mental Health allocates the funds available to the counties on the basis of approved Short-Doyle plans.

The legislature gradually increased the share of state monies in the original Short-Doyle Act formula to 75/25 for new programs in 1963, to 75/25 for all programs in 1968, and finally, as part of the Lanterman-Petris Act of 1968, to 90/10. The ratio of state-to-county funding is currently 90/10. In addition, there is another cost sharing

formula of 85% state, 5% county and 10% contracting organization which is designed to encourage counties to contract with non profit community organizations for innovative treatment programs.

The Lanterman-Petris-Short Systems Act of 1968 represented a legal overhaul of California's mental health system. The act created a single mental health system based on local responsibility for the treatment and care of the mentally disabled. The single system was a community system with community mental health programs controlling state hospital utilization. The law established one appropriation for mental health that included both state hospitals and local programs rather than separate appropriations.

By state law, funds were allocated to the county according to the requirements of its mental health programs. Included in the money allocated to the county (to which the county contributes 10%) is a charge to each county for each of the state hospital residents who are from that county. The charge is set at the estimated number of patient days (based on the utilization rates from the previous fiscal year) times the average daily cost per patient day.

Quotas are set for the number of state hospital patient days for each county. If a county exceeds the "projections of usage", there is a transfer from the county budget to the state budget for the full cost of the excess of patient days beyond the "projection of usage".

The money saved by reducing the number of patients in the state hospital is kept by the counties to fund new community programs. The California Department of Mental Health stipulates that money returned to the counties is to be used for programs to prevent state hospitalization and to prevent patients from returning to state hospitals.

During the first 15 years of Short-Doyle funding the effect on service delivery was dramatic. By 1972 with increased community efforts and the movement of patients into board-and-care homes, local programs had exceeded state programs in total budgetary allocation and state hospital days had fallen sharply. Currently the state hospital population is 5000 (3000 mental health and 2000 forensic) from a total population of 22 million state residents.

The Lanterman-Petris-Short Act, which was part of community mental health reform, made long-term, involuntary detention in a mental institution extremely difficult and placed legal responsibility for the care of the mentally disabled with the county. The use of inpatient care at state institutions was reduced through financial inducement to the counties to provide alternatives.

California has moved from a state-operated hospital-based, centralized system to an almost entirely locally operated, community-based, decentralized system still largely financed by state money. Most importantly the power responsibility, money and services being delivered to California's mentally disabled are almost all located at the local level.

Colorado Model. Colorado took a different approach which is called redeployment. Redeployment involved a significant shift in service responsibility and funding. In 1974 the Colorado General Assembly appropriated $1.5 million to the Division of Mental Health to purchase all the necessary adult psychiatric services for 4 of the state hospital's catchment areas. The funding for the program was taken from the state hospital budget.

The communities were responsible for providing most adult psychiatric services. The services included: inpatient hospital care, any type of 24 hour non hospital care or supervision, partial care (i.e. more than 3 hours but less than 24 hours of care per day), outpatient care, halfway house care (i.e., 24-hour supportive services in a progressive care facility), family care (i.e., therapeutic program in which a client lives with foster family in community and receives supervised daily support) and treatment in which the client receives therapy while he/she lives at home.

The state hospital was responsible for providing services to clients who are severely disabled and must be maintained for an indefinite period of time in a clinically supervised setting. The need for hospital care had to be determined in each case. For a client to be eligible for hospital care 2 of the following conditions had to be present:

1. The mental health center made a reasonable and determined, but unsuccessful effort to treat the person.
2. The client required more intensive and extensive treatment than the center was able to offer.
3. The client could be expected to improve with extended care.
4. The person required a supervised/protected setting for an indefinite period of time.

With a sweep of the pen, the governor created the Colorado model. It is not clear how the figure of $1.5 million was derived. Since the dollars came out of the hospital budget, there was considerable hue and cry over the demise of the hospital and the significant personnel reductions that followed.

Such a system could work but an accurate and reasonable method for arriving at a figure to transfer from the hospital to the community must be developed. In addition, the system only worked because there were no reprieves for the state hospital. The cuts were made and the hospital and community had to find ways to make the program work i.e. laying off or transferring staff and providing services in the community.

Massachusetts Model. The 1965 Comprehensive Community Mental Health Plan for Massachusetts envisioned state mental hospitals becoming centers which serve the local geographic area and provide backup services for patients in neighboring catchment areas. By the early 1970's many citizens and professionals became convinced that the Massachusetts facilities could not assume community mental health functions. This led to a policy of deinstitutionalization and expansion of comprehensive community based services.

The policy called for all state hospitals to be phased down over a 5 year time period and that the funds be redeployed to community services so as to improve clinical care at the local level. A series of public forums sponsored by the Massachusetts Department of Mental Health revealed that this policy was supported by most citizens and professionals. The apprehensions expressed were in relation to the job security of hospital personnel and the assurance of adequate mental health services for the discharged hospital patients.

The Massachusetts Department of Mental Health designated community residences as a basic service that community mental health programs must provide. In addition the community centers must provide inpatient and outpatient services, partial hospitalization, emergency services, and consultation and education. While this does not guarantee successful continuity of care for clients treated in the community, it clearly places administrative responsibility for community adjustment with mental health professionals in the community.

When institutional services are replaced by community-based services, the fear of job loss and personal economic disaster is not unfounded. Massachusetts planners and administrators grappled with this problem in scheduling the phase down of state hospitals and concluded that the principal methods to be used in transferring resources to community programs would be relocation, attrition and retraining of present hospital staff. Continuity of employment was maximized for hospital staff who were motivated to participate in community programs. Hospital positions that were not neccessary for community programs (e.g. maintenance, food service, laundry personnel) were managed through natural attrition plus a hiring freeze. Early retirement incentives were also used for this group.

The success of this model in the long term has yet to be proven. There has been some discussion in the literature of the effects this policy has had on general hospitals, which must now admit involuntary psychiatric patients who may present management problems. Even supporters of the system are cautious in their assessments of the program thus far. They believe that if psychiatric services are broadened in a thoughtful, deliberate way, with a firm committment to tailor programs carefully to meet patients' clinical needs, without loss of control over admissions and discharges then the overall quality of psychiatric care under the Massachusetts model can be enhanced.

The task force library search was a thorough review of the literature for models of funds following the client. The California model serendipitously approximates the model drafted by the Funds Following the Client Task Force at their meeting in Bristol last September. The Massachusetts Model is not a viable one for the Commonwealth of Virginia at this time. There are elements, however, in the implementation of this model which should prove helpful in the implementation of a Virginia Model (e.g. displacement of hospital employees). An amalgamation and modification of the Tennessee and the Colorado models could be implemented in Virginia. Task Force I developed a funds following the client model based on the elements in the Tennessee and Colorado models.

Introduction to Proposal

The Funds Following the Client Task Force prepared a proposal for a pilot project at Hampton-Newport News (HNN) Community Services Board and Eastern State Hospital (ESH). This section is an overview of the proposal. The proposal consists of three parts: community implementation, hospital implementation and evaluation. The following 3 sections lay out the details of implementing the proposal.

Implementation of the project will occur in 3 phases. Phase I of the project will be an assessment of the service needs of the ESH patients being considered for discharge. In addition, adequate staffing levels for ESH will be determined.

In the second phase, HNN and ESH will make the necessary preparations to respectively receive and discharge 25 patients. The preparation is necessary to insure that the transfer of the 25 patients occurs at about the same time. If HNN does not take the 25 patients at once, the 25 services slots planned for these clients would probably be used by other clients who also need the services set up for this transfer. HNN will need to add some types of service; mostly, HNN will need to increase the capacity of existing services.

There are some constraints which must be addressed before a funds following the client project can be put into place. ESH seeks assurance from the department that reductions in patient population that are a result of this project will not affect ESH's staffing levels. However, unless ESH's target is reduced when patients are transferred, there will be no funds to transfer to HNN. In addition, if the staffing at ESH is determined by the DASH project to be inadequate, ESH requests that the department take steps to improve staffing levels before funds follow the client to HNN.

The third phase would involve the development of a second array of services for an additional 25 patients at ESH. In addition, the third phase would involve the fine tuning of the system. Once the building at ESH were closed, those beds would no longer be available to HNN. HNN would be discouraged from hospitalizing clients as the actual number of beds available would be reduced from 115 to 65.

Once the services were added on or supplemented, patients from the HNN catchment area were discharged from ESH and the 50 beds at ESH were eliminated, there would be a dollar amount transferred. This transfer would be phased in over a period of months. The actual dollar amount of transfer would be a percentage of the hospital savings. The Task Force proposed that 65% of the actual savings would be transferred to the community and 35% of the savings would remain in the hospital. The hospital and the community would have an incentive to move patients out of the hospital and into the community. The hospital money could be used to improve services for the more disabled patients who would not leave the hospital as quickly as the less disabled patients.

Proposed Plan for Funds Following the Client

Presented By
Hampton-Newport News Community Services Board and
Bayside Unit of Eastern State Hospital

From the local perspective, the purpose of developing a method to allow for institutional funds following the client into the community and community funds returning to the institution with the client is: 1) to further de-emphasize the institutional services system; 2) to create incentives for the communities to develop service options for more individuals with chronic mental health problems; and 3) to further humanize the service delivery system by reducing the necessity for hospitalizations and the trauma inherent in such hospitalizations. To demonstrate the feasibility of this approach, the Services Board of Hampton and Newport News proposes to reduce its average daily census of adult psychiatric clients at Eastern State Hospital by fifty individuals per day below the FY 81 average daily census.

Present hospital and community data is inadequate to develop a plan to accomplish this. While the number of admissions to Eastern State Hospital is routinely reported, the number of individuals these admissions represent is not. Detailed information on the services required to substantially reduce the likelihood of future hospitalizations of individuals presently residing at or recently discharged from Eastern State Hospital is also not available. In the absence of this information, any proposal which would reflect amounts and types of services to be offered would be based in largest part upon assumptions concerning the needs of our clients, which may or may not prove to be valid.

Eastern State Hospital and Community Services Board staff have agreed that a system of supportive services, which could include closely supervised living, supervised apartment programs, outreach support services to individuals living in independent residences, day services emphasizing pre-vocational and independent living skills, vocational opportunities, and expanded crisis services will probably be necessary to reduce the average daily utilization of the Bayside Unit by fifty beds. Locally, modification of existing service sites and the addition of another service site may be necessary.

The volume of each of these services that will be required in this endeavor cannot be determined until the needs of the target population for this activity are more clearly identified. Recognizing this, this Services Board proposes the following process to: 1) assess the real need for services to substantially reduce the likelihood that these individuals will require further hospitalization in a state facility; and 2) fund and implement these services.

Proposed Action Plan

By August 17, 1981, a working group of Eastern State Hospital and Community Services Board staff will be established.

By September 1, this group will have completed an assessment instrument for identifying the services needed by present and future Bayside Unit clients. This instrument will be compatible with the Department's management information system.

From September 1 to October 1, Community Services Board and Bayside Unit staff will assess the needs of individuals who have been in the unit since September 1980, using this instrument. Level of care data for

Bayside clients will also be reviewed.

October 1: The needs assessment instrument will start to be used in conjunction with the pre-screening form for all individuals pre-screened in the Hampton-Newport News catchment area.

October 9: The initial array of new services (see choice list) needed to move twenty-five clients from Eastern State Hospital to the Hampton-Newport News area and eliminate the need for twenty-five hospital beds will be proposed to the Executive Director of the Services Board and the Director of Eastern State Hospital.

October 20: A plan for these services and their implementation will be acted on by the Hampton-Newport News Community Services Board.

October 23: The plan adopted by the Board will be presented to the Department.

October 23 to February 1: The working group will develop and implement plans to prepare the clients for relocation from Eastern State Hospital to community services. Development of the first group of new services will be initiated, along with refinement of existing local services.

November 2 to December 31: Further information concerning the needs of clients pre-screened in the community or residing at Eastern State Hospital will be gathered, using the assessment instrument.

January 5, 1982: The second array of services needed to reduce the average daily census of the Bayside Unit by an additional twenty-five beds will be proposed to the Executive Director of the Services Board and the Director of Eastern State Hospital.

January 19: The plan for the development and implementation of the second array of services will be acted on by the Hampton-Newport News Community Services Board.

January 22: This plan will be presented to the Department.

February 1: The first array of services proposed will be ready to receive clients.

February 2 to 15: Clients from Eastern State Hospital will be integrated into new services.

February 16: Twenty-five beds at the Bayside Unit will be closed.

February 18 to May 18: Involvement of the initial clients leaving Eastern State Hospital in the first array of services will be routinized. The Eastern State Hospital/Community Services Board working group will develop and implement plans for the integration of clients into the full array of existing and planned services. The impact of the newly-developed services on requests for admissions to Eastern State Hospital following prescreening will be assessed by the working group. The development of the second array of new services and further refinement of the existing services system will proceed.

By May 1: The Services Board Executive Director and the Director of Eastern State Hospital will be apprised by the working group of progress to date, and revisions of existing and proposed services will be recommended.

May 18: The Services Board will act on FY83 mental health program budgets, to include activities specific to the closing of the additional twenty-five beds at the Bayside Unit.

August 2: The second array of new services will be ready to receive clients.

August 2 to September 1: An additional twenty-five residents of Eastern State Hospital will be involved in community services.

September 2: An additional twenty-five beds at the Bayside Unit will be closed.

September 15 to December 1: The Eastern State Hospital/Community Services Board working group will assess the impact of services on the number of admissions to Eastern State Hospital and the length of stay of Hampton-Newport News clients at the Hospital.

December 21: Upon recommendation of the Executive Director of the Services Board, in consultation with the Director of Eastern State Hospital, final program modifications will be proposed to the Hampton-Newport News Community Services Board.

Choice List of Possible New Services Required to Reduce the Average Daily Census of the Bayside Unit By Fifty Individuals

Residential Services Closely-Supervised Living

This type of living arrangement would provide an on-site staff (4-5 FTE) during prime programming hours and would be contained within a block of apartments or a group home. Each program would serve twelve individuals, providing them active assistance in acquiring the full array of independent living skills, community orientation, assistance in acquiring employment or day activities, medication assessment and monitoring, group and individual counseling, help in accessing other mental health and generic services, food and lodging, and substantial supervision.

Estimated number of service slots: 12

Supervised Apartment Living

This program would be operated in apartments under the control of the Services Board or its vendor but not contained in a single facility. Individuals involved in this service would receive daily contact, either directly or by telephone, assistance in budgeting and apartment management, medication monitoring, community orientation, support through informal groups, and assistance in acquiring generic services. Food and lodging costs would be paid by the clients within sixty days of entering the program. Most clients involved in this type of service would also be involved in actual employment or in the Services Board-sponsored day and vocational programs.

Estimated number of service slots: 24 beds

Outreach Support Services

Outreach support services would be provided by mobile staff located in areas with high concentrations of individuals who have or are about to be returned from Eastern State Hospital or are in danger of being hospitalized at a State facility. Activities will include case management, assistance in budgeting, support through informal and formal groups, medication monitoring, assistance in accessing generic services, and assistance in problem-solving. Staff contact could be as frequently as daily or as infrequently as weekly, depending on the needs of the client. Twenty-four-hour telephone support will be available to these individuals through our existing emergency services. Involvement in day services will often be required.

Estimated number of service slots: 30 clients per employee

Day Services Sheltered Employment and Workers' Cooperatives

Through the addition of a specialist for vocational development to its staff, this Services Board, in cooperation with its vendors, would develop sheltered enclaves in industry and small (10-20 clients) workers' cooperatives which would be manned by clients who have a history of involvement with State facilities. While the types of goods or services produced in these enclaves or cooperatives will be determined based on the abilities and needs of the clients and the marketplace, an example is available in our pending bid for the operation of the cafeteria at the new Hampton Social Services site. This would serve as a dining facility for Social Services staff and a site for the hot lunch program of our local Agency on Aging. It is our intent that this facility would start as a training site for disabled individuals, with clients assuming incrementally greater responsibility for its complete operation. Our present plans include employment of eighteen to twenty-two clients on a part-time basis. The annual staff cost to this Services Board to employ and maintain an individual whose full-time responsibility would be the development of such sites is $30,000. Operationalizing each site will require $6,000 to $18,000 of one-time money for equipment and operating expenses for two to three months. These requirements are virtually the same for a program as they would be for any individual starting a small business.

Estimated number of new starts a year: 3 to 4

Day Services

All of the individuals who must be served if we are to meet our goal will not be ready for sheltered employment upon discharge from Eastern State Hospital or referral directly from prescreening. For individuals who cannot tolerate the demands of sheltered employment, we propose a modification of our existing day services program and the addition of a similar service in the Denbigh area of Newport News. The services of this program will include pre-vocational training for two to three hours daily, development of independent living skills, active group therapy, medication assessment and monitoring, the development of social skills, expansion of the awareness of recreational alternatives, and orientation to the two communities.

Estimated number of service slots: 40

Additional Crisis Intervention Services

At present, twenty-four-hour face-to-face contact is available only in the Emergency Room of Riverside Hospital, located in Newport News. Given the expanded powers of magistrates, as specified in Section 37.1-67.1 of the Code of Virginia, it is clear that this Services Board will need to lend active assistance to the Hampton Judiciary after hours to assure that individuals are referred to Eastern State Hospital only as a last resort. This could be accomplished through adding three crisis workers to our present Hampton staff. In addition to providing services to the Courts and police, these individuals could be available for off-hour contact with individuals in our living programs based in Hampton.

Task Force Recommendations

The HNN-ESH project is similar to the shift of alcohol services from Western State Hospital (WSH) to the community that is currently taking place. WSH is phasing out its alcoholism treatment unit and replacing the hospital services with services in the community. The General Assembly appropriated $304,000 to facilitate WSH's phasing out efforts. In addition, $100,000 of indirect costs was transferred from the WSH budget.

At the end of a 1 year WSH will only offer medical detoxification services to alcoholics and all other alcohol treatment will be provided by the community. The $304,000, which represents the cost of 23 direct care positions, will be taken from the WSH budget and allocated to the community after the 1 year phase-in.

Accordingly, the Funds Following the Client Task Force suggests that a similar process take place at HNN and ESH to implement the proposal presented in this report. Accordingly, the task force recommends the following:

1. HHN should proceed with the preliminary steps necessary to implement this project.

2. HNN should identify by November 1, 1981, the dollar figure that will be needed to start up this project.

3. Appropriate staffing levels should be identified by November 1, 1981 for the Bayside Building at Eastern State Hospital and the department should decide on the appropriate remedy if necessary

4. The department believes that the principle of a funds following the client proposal must be fully incorporated into the department's long-range plan for providing equitable, balanced and appropriate mental retardation services to patients, residents and clients. However, after considering the HNN proposal and the efforts of other states, the department recommends that it not proceed with the development of a funds following the client system.

5. The department shall carefully study and utilize, whenever possible, the information and procedures used by HNN and ESH staff in developing the funds following the client proposal. Other department proposals for discharging patients/residents from state hospitals and training centers should follow many of the same steps as HNN and ESH staff did in formulating their service recommendations.

Funds Following the Client Evaluation Proposal

This proposal is a description of the evaluation of the funds following the client project. Of course the major question will be the success of the project in decreasing the use of 50 beds at Eastern State Hospital and the cost to HNN, to ESH, and to other

service agencies (e.g., police, courts, housing authority, etc.) for accomplishing it.

If this project is to be implemented statewide other questions must be studied. The characteristics of the clients, the characteristics of the mental health system, and the interaction of clients, systems and successful placement or diversion into the community. The proposed evaluation would examine the following program goals.

Scope

The evaluation will focus on the four areas identified below:

1. Clients: This level of evaluation will focus on describing the mentally ill served by HNN. What are their significant characteristics? What are their needs? How do their characteristics, such as demographics, clinical history and functioning, interact to define these needs?

2. Systems and Programs: This component of the evaluation will attempt not only to identify which services exist and how frequently they are utilized by clients but also to evaluate the interagency linkages and variables related to least restrictive and normalizing community environments, and availability of or accessibility to a more enhanced set of opportunities and programs.

3. Outcome: The follow-up of clients will focus on assessing changes in functioning, adjustment, severity of illness, employment, living situation, life satisfaction, quality of environment, symptomatology, readmission and community tenure.

4. Interaction of Clients and Systems: All of the variables listed immediately above will also be studied in terms of their interactions with client characteristics and patterns of service delivery and utilization.

The various levels of evaluation are not mutually exclusive. In fact, they fit together into a comprehensive strategy designed to sequentially answer questions relevant to the functioning and success of the funds following the client project.

Methodology and Instruments

An evaluation will be conducted at ESH and HNN. During the first year an attempt will be made to follow-up all clients discharged from ESH who participate in the program. Data on clients will be collected at four points in time (baseline and three follow-up surveys at 6 month intervals.) A comparison group of clients discharged from ESH but not participating in the funds following the client project will also be selected in a non-biased fasion and followed using the same instruments and time intervals.

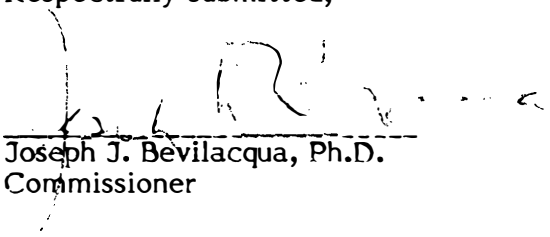
The instrument used will be the CSS 100 designed by the National Institute of Mental Health and currently utilized by New York State in evaluating their Community Support Program. The purpose of administering this instrument is to identify client characteristics, client functioning and service utilization and to follow clients over time to assess changes in functioning. The comprehensive design of the instrument allows analysis of client characteristics, system characteristics, and the interaction of the client and the system.

Approximately six months after the initiation of the funds following the client a study will be conducted to study the patterns of interorganizational linkages. Key respondents will be asked to answer questions concerning their relationships with other agencies with which they have had the most frequent contact over the previous six months. Variables studied will include describing the reasons for contact among agencies, such as information sharing, referral of clients, joint planning between agencies, dependence, types of agreements, number of contacts, etc.

The purpose of this component of the evaluation is to define the human services system and the interaction among the parts of these systems and to understand the benefits and costs of linkage building. In addition, the study will try to determine the patterns of linkages and the extent to which the constituent programs are coordinated/integrated and whether or not programs for the mentally ill are comprehensive, continuous and adequate.

This information should also have implications for designing consultation and education strategies to implement funds following the client projects statewide and for evaluating the success of those strategies over time.

Respectfully submitted,



Joseph J. Bevilacqua, Ph.D.
Commissioner

Appendix A

FUNDS FOLLOWING THE CLIENT TASK FORCE MEMBERSHIP LIST

Task Force I

John Barrett, Budget Planner, Central Office
Donald S. Biskin, Ph.D., Assistant Commissioner, Technical Services, Central Office
Suzanne Biskin, Director, Community Support Unit, Central Office
C. W. Brett, Ph.D., Deputy Commissioner, Central Office
Frankie Denton, Capital Outlay Planner, Central Office
Mike Fehl, Hospital Administrative Assistant, Central Office
Raymond F. Holmes, Ph.D., Assistant Commissioner, Institutional Services, Central Office
Jim Martinez, Assistant Director, Community Support Unit, Central Office
Caren Phelan, Ph.D., Assistant Commissioner, Community Services, Central Office
Robert H. Shackelford, Administrative Services Director, Central Office

Task Force II

Members of Task Force I and
Ben Allen, Ph.D., Director, Southwestern Training Center
Steve Capo', Executive Director, Hampton-Newport News Community Services Board
Tom Geib, Director, Arlington Community Mental Health Center
Ron Harrington, Director, Bristol Community Mental Health Center
Dave Pribble, Director, Eastern State Hospital
Lynda Warner, Aftercare Coordinator, Southwestern State Hospital

Task Force Chairman: Joseph W. Avellar, Ph.D., Director, Office of Program Standards and Evaluation, Central Office

REVIEW OF
AGENCY STUDIES FOR GOVERNOR AND
GENERAL ASSEMBLY

Study Names: Funds Following the Client

Resolution No.: SJR 8 Year: 1980 Reporting Date: 12/81

Agency: Department of Mental Health and Mental Retardation

DPB Review and Comments:

Senate Joint Resolution No. 8 assigns to the Department of Mental Health and Mental Retardation the responsibility of studying a funding scheme which incorporates a "funds following the client" concept. Community funds would follow a client to an institution from a community program and state funds would follow a client to a community from a state institution. This concept is designed to institute a financial advantage for communities to treat clients in the community. The report recommends a pilot project to operate between Eastern State Hospital and the Hampton-Newport News Community Service Boards. The proposal submitted by the two Service Boards totals one million dollars; however, Departmental personnel feel the project could be operated between two and three hundred thousand dollars. This amount could more appropriately be absorbed by the Department of Mental Health and Mental Retardation rather than by General Assembly appropriation of additional funds as recommended in the report.

December 29, 1981
Date

Ray T. Sorrell
Signature RC

Secretarial Comments:

Date

Signature

S.C/DPB.Q/vp

COMMONWEALTH of VIRGINIA

Department of Planning and Budget

POST OFFICE BOX 1422
RICHMOND 23211
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January 7, 1982

The Honorable Jean L. Harris
Secretary of Human Resources
9th Street Office Building
Richmond, Virginia 23219

Dear Dr. Harris:

I am transmitting our analysis of the SJR 8 report, which involves the study of "funds following the client" concept. The study was conducted by the Department of Mental Health and Mental Retardation.

You may wish to have Dr. Bevilaqua reassess the study recommendations. In a recent presentation before the Joint Subcommittee on Mental Health and Mental Retardation, Dr. Bevilaqua stated that the "funds following the client" concept would not work in Virginia and, therefore, should be rejected.

Sincerely,

Ray T. Sorrell

Attachment

RTS/#1253/rt