REPORT OF THE
DEPARTMENT OF MENTAL HEALTH,
MENTAL RETARDATION AND
SUBSTANCE ABUSE SERVICES
AND THE DEPARTMENT OF
SOCIAL SERVICES ON

Aftercare Needs of Mentally Disabled Clients in Adult Homes

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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EXECUTIVE SUMMARY

Homes for Adults, (HFAs) licensed by the Department of Social Services, were originally conceptualized as domiciliary care settings designed to serve primarily elderly individuals who were not able to live independently or could not be maintained at home. However, the return of mentally disabled citizens to their home communities has provided Homes for Adults with another clientele whose needs are often greater than the setting was designed to accomodate. As a result of limited Community Services Board (CSB) housing programs, many mentally disabled clients live in Homes for Adults where their SSI and auxiliary grant payments often provide the necessary package of otherwise unavailable financial supports. Thus HFAs, although not necessarily designed for this purpose, frequently offer the only residential option for many of these individuals and are being used to fill the gap in the State's system of residential services.

The 1986 General Assembly, through House Joint Resolution 70, directed the Departments of Social Services and Mental Health, Mental Retardation and Substance Abuse Services to collaborate on the study and development of a model to improve the delivery of services to mentally disabled residents of Homes for Adults in the Commonwealth of Virginia. In response, the goal of the study is to enhance the quality of services provided to mentally disabled HFA residents by:

- ensuring more adequate resources for needed specialized services;
- improving the service linkages between HFAs and mental health, mental retardation, and substance service providers; and
- assuring the quality of care through improved oversight and technical assistance for providers.

Given the specific focus of HJR 70, several major related issues, although significant, fall outside the mandated scope of the study. The areas thus not addressed include: (1) overall HFA rate structure and rate adequacy; (2) implications of the increasing physical/medical care needs of HFA residents; (3) adequacy/effectiveness of general HFA regulatory structure; and (4) overall availability/accessibility of appropriate housing and related support services for mentally disabled persons.

Resident and Facility Survey

To provide in-depth data on issues judged to be essential to the study, a major survey was conducted in a sample of 89 Homes for Adults during summer 1987.

The resident survey data indicate that there are an estimated 5,190 mentally disabled residents of Homes for Adults statewide. The majority of these residents (over 78%) have a primary disability of mental illness, with the remainder having a primary disability of mental retardation or substance abuse. Of the mentally disabled HFA resident sample, 68% also receive Auxiliary Grant benefits, which indicates that approximately 3,529 persons residing in HFAs statewide are likely to be mentally disabled Auxiliary Grant recipients.

Mentally disabled residents of Homes for Adults are generally older individuals whose ability to function independently (e.g., to manage their lives in their own home) is impaired by a combination of conditions which require structure, support, assistance, training, and/or supervision. Few of these individuals are seen as needing more intensive care (such as might be provided by a nursing home or hospital) on an ongoing basis.

The majority of these individuals are also currently receiving supportive services from agencies and organizations other than the Home for Adults. For the most part, these service providers are the local Community Services Boards, private providers, and other public agencies such as the local Departments of Social Services. However, many mentally disabled residents are not receiving the supportive services which HFA staff believe they need. The greatest disparity between the proportion of residents needing a service and those who do not receive them are found in those service areas such as day support, vocational rehabilitation, and outpatient therapy services, which are the most difficult for HFAs to make available through their own program resources (staff, space, funds, etc.).

The licensed capacity of the facilities are found to be related to several characteristics of the HFAs. Smaller HFAs tended to have a much larger percentage of mentally disabled residents than did larger HFAs. Furthermore, while the average percentage of mentally disabled residents in the smallest HFAs was 58.5%, the average percentage of mentally disabled residents in HFAs with more than 100 beds was 22.3%. In general, as the size of the HFAs increased they were found to have a smaller percentage of mentally disabled residents.

A breakdown of staff by position type indicates that the largest category of staff within an HFA were typically administrative staff, closely followed by other medical/direct care staff shich included registered nurses, licensed practical nurses, and aides. In contrast, the HFAs typically had a small percentage of ancillary staff and an even smaller percentage of physicians and psychiatrists.

The issue of written service agreements between the HFAs and CSBs was also addressed. It should be noted that HFAs are required by licensing requirements to have an agreement with the local CSBs if they serve residents who have been discharged from DMHMRSAS facilities. Only 39.3% of the HFA operators reported that there was a written service agreement between their HFA and the local CSB. However, of those operators who reported an ongoing relationship with the local CSB, 56.5% reported that they have a written service agreement. For those HFAs which have agreements, 51.4% reported that the agreement is updated annually, while 34.3% reported that it had not been updated in more than two years. Nearly all of the operators with service agreements reported that they were satisfied with the agreement (88.6%).

Issues Analysis

The major issues emerging from the study data and the analysis of other background information are described in more detail in the attached report, and are summarized as follows:

1. HFAs play a major role in serving the mentally disabled population, and improvements in rate structures, service planning mechanisms, and staff/service resources are needed.
2. The patterns of similarity among the mentally disabled HFA resident population suggest that differential levels of care may not be necessary to meet service needs.
3. The administrative orientation of HFA staff unfavorably influences the ability of HFAs to meet the needs of mentally disabled residents.
4. Many mentally disabled individuals are screened out or discharged from HFAs due to a lack of specialized services.
5. HFAs could expand the availability of services to mentally disabled residents with additional funding.
6. Smaller homes for adults would be most greatly impacted by changes in financing, regulation, or services for the mentally disabled.
7. There is a need for incentives to induce closer cooperation between CSBs and HFAs with respect to the mentally disabled population.

Proposed Model

Using the above information, the two Departments have developed and recommended a model to enhance the quantity, quality, and coordination of supportive services available to mentally disabled HFA residents. The proposed approach also would result

in closer linkages between CSBs and HFAs, allowing for more effective service coordination. The proposed model, described in the attached report, would make available to qualified HFAs a supplemental payment of approximately $1,800 per year for each eligible mentally disabled resident within the home. These funds would be used by HFA operators to access or provide additional rehabilitative and supportive services which are needed by mentally disabled residents and which are currently not available to the extent needed to ensure an appropriate level of care and support for these residents. For homes with a significant number of mentally disabled auxiliary grant recipients the aggregate level of funding would be sufficient to allow for hiring of additional staff to increase on-site service provision. For homes with fewer eligible residents, funds can be used for transportation to off-site services or limited contracts for supplemental services provision.

HFAs would continue to be licensed by the Department of Social Services. However, those serving mentally disabled residents could also apply to be certified by DMHMRSAS. This voluntary certification would qualify the home to receive supplemental funding for services to eligible individuals. The intent of the certification would be to provide basic, initial assurances that the home is willing and able to make effective use of these funds for better services to mentally disabled residents.

HFAs could then propose selected residents for the supplemental funding program. These residents would be both (a) eligible for/already receiving auxiliary grants, and (b) mentally disabled. The determination that a given resident is mentally disabled will be made on the basis of CSB assessment, at the request of the HFA operator. Those persons deemed to need long-term mental health, mental retardation, and substance abuse services will be defined as mentally disabled for the purposes of this program.

Services for each eligible client would be outlined in individual supplemental service plans to be jointly developed by the HFA and a CSB coordinator. Appropriate services might include:

- Transportation to specialized day support, vocational rehabilitation, or outpatient services.
- Contractual arrangements for on-site special services.
- Off-site special services requiring fees.
- Supplemental part- or full-time qualified staffing for enhancing behavior management, resident skill training and special supervision.
- Salary incentives for staff who obtain special training or credentialing for work with this population.

As access to information on client functioning improves, fewer people should "fall through the cracks" within the case management system. CSBs will be more aware of HFA operators' needs for support, training and consultation and will have some resources to be more responsive. Case planning and consultation can occur more regularly, so that service goals can be better coordinated.

This proposal represents a significant first step in addressing the needs of clients served in Homes for Adults. By design, it focuses on a specified mentally disabled population. It does not attempt to resolve related current concerns with general rate structures or the demands for enhanced medical care for frail or physically disabled elderly residents. These issues will continue to be addressed by the Department of Social Services as part of its licensure and service delivery processes.

I. Introduction

Background:

Homes for Adults (HFAs) are social model residential care facilities charged to provide basic care, protection, maintenance, and supervision in activities of daily living for aged, infirm, or disabled individuals. In Section 63.1-172 of the Code of Virginia, a facility subject to licensure as a home for adults is defined as follows:

> "any place, establishment, or institution, public or private, including any day-care center for adults, operated or maintained for the maintenance or care of four or more adults who are aged, infirm or disabled, ... maintenance or care means the protection, general supervision and oversight of the physical and mental well-being of the aged, infirm or disabled individual".

Homes for Adults have been licensed by the Virginia Department of Social Services, or its organizational antecedents, since 1954. Financing of these placements is through both private and public payments. Approximately 29% of the beds in homes for adults (HFA) are occupied by individuals who receive public assistance from the Auxiliary Grants Program (AG). This payment, an average of $202.90 per month in April 1987, when added to other income such as SSI allows an individual to pay for care in an HFA.

Since the inception of the basic regulatory and financing models for HFAs, major changes have occurred in the scope of the system and the roles and resident populations of most homes. A steady growth in the number of homes and residents and the auxiliary grant budget has been paralleled by increasing diversity in the types of residents and the demands placed on HFA operators and staff to meet their needs.

Homes for Adults were originally conceptualized as domiciliary care settings designed to serve primarily elderly individuals who were not able to live independently or could not be maintained at home. However, the return of mentally disabled citizens to their home communities has provided Homes for Adults with another clientele whose needs are often greater than the setting was designed to accomodate. As a result of limited Community Services Board (CSB) housing programs, many mentally disabled clients live in Homes for Adults where their SSI and auxiliary grant payments often provide the

necessary package of otherwise unavailable financial supports. Thus HFAs, although not necessarily designed for this purpose, frequently offer the only residential option for many of these individuals and are being used to fill a gap in the State's system of residential services. Although not a focus of this study, it should be noted that HFAs also serve a second unanticipated clientele: the frail and/or seriously health-impaired adults who are not now served in nursing home settings. The placement process as it currently operates with respect to such special need individuals may therefore be driven largely by the accessibility of HFA beds. HFA operators have attempted to meet the greater needs of these special groups. Their efforts have been constrained, however, by the existing financing and regulatory systems designed for the original domiciliary role of HFAs.

Recent Studies

The pressures of serving residents with increasing care needs have, in many instances, created problems for both operators and residents which the original regulations and financing system were not designed to address. These problems have been documented in recent studies of the HFA system (e.g., Ernst and Whinney, 1985), the deinstitutionalization process (e.g., JLARC, 1986), and long-term care needs in Virginia (Report of the Joint Subcommittee Studying Long-Term Care, 1987).

JLARC, for example, concluded from their review of adult homes that HFAs, as now constituted, are "a generally unsatisfactory alternative for State-provided housing for the mentally disabled" (p. 91). Their report also indicated that, "Homes for Adults exist as a housing alternative largely outside of the community mental health continuum of care", and "existing regulations do not guarantee the appropriateness of a given home" (p.92). Their report recommended that standards for staff qualifications and levels of staffing be developed and used for homes that serve mentally disabled residents. The 1985 Ernst and Whinney study of the DSS Auxiliary Grant Program noted similar problems and identified needs for (1) increased involvement of local DSS agencies and CSBs in the assessment, placement, and monitoring of mentally disabled HFA residents, (2) more effective methods of delivering services to these residents, and (3) a rate determination process which could more accurately reflect the costs of providing these services for the mentally disabled.

In responding to the issues raised over the years by homes for adults operators and others concerning increasing resident needs, a task force to study levels of care in

homes for adults was appointed by the General Assembly in 1985. The task force met in 1986 to study the feasibility of compensating homes for adults for services provided to the residents based on individual needs. They reported in House Document 30 that:

> "Providers claim that the rates of payment to home-for-adults residents are insufficient. They have proposed a system which provides payment to clients in homes for adults based on the level of care provided to a client. Such a system requires subjective decisions regarding services needed and an enforcement process to verify service needs and the provision of services. The proponents hope to find a method of caring for individuals in homes for adults in a manner which guarantees an acceptable quality of life and paying on that basis, without creating a system so complex that it forces smaller homes out of business.
>
> In the course of its study, the Task Force determined that there is considerable variation in the service requirements of residents in homes for adults that is not recognized by current regulations or payment processes. There seems to be no consistent manner of evaluating residents to determine what their needs are, how best to fill those needs, what future needs may be, and how to pay for the provision of services."

They also recommended that DMHMRSAS and DSS explore further the concept of "aftercare grants" to mentally disabled HFA residents, including issues related to client-based payment systems, pre-placement assessment and periodic case monitoring, quality assurance, and the development of standards to enhance the delivery of services to this group.

Purpose of this Study

The general issues on HFA financing/regulation and the specific concerns regarding the needs of mentally disabled persons living in adult homes provided the impetus for the passage by the 1986 General Assembly of HJR 70. This resolution (Appendix 1) requested the Department of Social Services (DSS) and the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to conduct a joint study of the service needs of mentally disabled HFA residents. The resolution directed the Departments to develop a model for better addressing those needs through acknowledgment of differential levels of care, with appropriate regulatory and financing mechanisms.

It should be noted that the resolution requested study of these issues as they affected mentally disabled HFA residents, and did not direct action related to the broader issues of general rate structures, changing medical/physical care requirements of residents in adult homes or of community services needs for mentally disabled persons. The study

and recommendations to be presented here are thus more focused in scope than any of the three major reports (JLARC, Ernst and Whinney, House Document 30) cited earlier. HJR 70 essentially directs attention to the specific issues at the points of overlap among those reports, e.g., how the needs of a specific subpopulation in the HFA system can best be met. With this focus, the goal of the study is to enhance the quality of services provided to mentally disabled HFA residents by:

- o ensuring more adequate resources for needed specialized services;
- o improving the service linkages between HFAs and mental health, mental retardation, and substance abuse service providers; and
- o assuring the quality of care through improved oversight and technical assistance for providers.

Specifically, the objectives/approach for the study will be:

1. Provide more extensive and relevant descriptive data on the Virginia HFA system and the needs of mentally disabled residents served in that system. With that data base, identify major issues and unmet needs (services, funding, regulation, coordination) in serving mentally disabled residents;
2. On the basis of this assessment, develop and review major policy options for enhancing services; and
3. Recommend the most feasible option and provide preliminary implementation plans, including costs and services/provider impact.

Given the specific focus of HJR 70, several major related issues although significant fall outside the mandated scope of the study. The areas thus not addressed include: (1) overall HFA rate structure and rate adequacy; (2) implications of increasing physical/medical care needs of HFA residents; (3) adequacy/effectiveness of general HFA regulatory structure; and (4) overall availability/accessibility of appropriate housing and related support services for mentally disabled persons.

Approach Used

Preliminary review of studies to date and available data indicated an inadequate base of descriptive information in three key areas: (1) mentally disabled HFA residents, (2) the capacities/characteristics of the homes which serve them, and (3) the existing services linkages among provider sectors (e.g., CSBs, HFAs, DSS, private providers). To expand

this data base, the two Departments cooperated to conduct an extensive survey of a sample of 89 adult homes. The survey focused on the three areas described above and generated more complete information on prevalence of mental disability, service use patterns, facility size and staffing, and other key variables.

To ensure a broad and comprehensive perspective, the two Department also solicited additional comments on the study's policy questions from both HFA and CSB providers. HFA operators were invited to meet with study staff in five locations around the state, and CSB staff submitted their comments in writing.

The collection of these provider comments, along with more detailed survey data, was directed by a steering committee composed of four key management staff from the two Departments, with additional participation by the Deputy Secretary of Human Resources. The steering committee met over a period of seven months to design the study and to review policy options in light of the data before making final recommendations.

II. Virginia HFA System and Needs of Mentally Disabled Persons: Background Information

General Background: HFA System

As indicated in the statute cited earlier, HFAs were originally established with a mission to serve as long-term domiciliary care facilities for aged, infirm and disabled individuals. The regulations that govern the facilities, promulgated under the authority of the State Board of Social Services, address such areas as: staffing, staff qualifications and required areas of staff in-service training; admissions and required areas of staff in-service nutrition; building and grounds; housekeeping and maintenance; activities and services, including services related to necessary assistance with medications and medical care; resident rights; record keeping; fire and emergency planning.

Within the scope of these minimum standards, however, the facilities are marked by extreme diversity in their essential characteristics. They include for-profit and non-profit operations which may be proprietorships, partnerships, corporations, associations,

as well as governmentally operated facilities. Some are free-standing, while others are components of multi-service operations, or life-care contract operations that may include nursing homes and/or independent-living apartments. The size range is from four beds to 635 beds. The residents in care at any given facility may be fairly homogeneous or heterogeneous in their needs.

All homes are required to provide such basic services as meals, laundry, housekeeping, and a program of supervision and activities necessary both to conform to licensure standards and to the needs of the particular group in care. For example, homes are not specifically required to provide transportation, although many do so, but they are required to see that residents are able to secure needed medical or other services that may require transportation; whether that transportation is the responsibility of the family, the resident, or the home is addressed in required resident agreements. Similarly, homes are not required to have medically trained personnel on staff, but many choose to hire nursing staff, to contract with physicians or podiatrists to make rounds periodically, or contract with home health care agencies to enable residents to remain in care who otherwise might be considered inappropriately retained.

The regulations permit the facilities to care for all such persons under the following general proscriptions: (1) they may not admit or retain any resident unless a physician certifies that the resident is not in need of nursing or convalescent (nursing home) care; (2) they may not admit or retain any resident whose exceptional needs cannot be met within the services and staffing available; (3) they may not admit or retain a non-ambulatory or semi-mobile resident unless the home meets the appropriate building code and other regulatory requirements necessary to meet the additional fire safety risks posed; (4) they may not admit any resident who is already bedfast, even if nursing home care is not indicated, but, under all the foregoing strictures, may retain a resident who becomes bedfast if the physician continues to certify, at no less than ninety-day intervals, that the care is acceptable; (5) they may not admit or retain a resident who presents a clear danger to himself or other residents or staff.

Aside from the laws and regulations pertinent to the Department of Social Services' licensure authority, homes are required to meet the relevant building codes, zoning ordinances, and any local business licenses or fees. They must pass annual inspections by other state and/or local regulatory agencies related to the following: maintenance of the structure in accordance with the certificate of occupancy, fire hazards, the Virginia Health Department's regulations for restaurant service, and water/sewage.

The Department's last comprehensive revision of the regulations for homes for adults was performed during 1978-79, with the resulting regulations adopted by the State Board of Social Services to become effective in 1980. Since then, a number of partial revisions have occurred, primarily in response to new legislation. These have included expanded regulations addressing the rights of residents, legislative reductions in fire safety requirements for a sub-category of residents defined as "semi-mobile", and assorted minor revisions. The resident rights regulations adopted in 1985 are currently undergoing the mandatory post-adoption review specified in the Administrative Process Act, during which the Department will also propose revisions responsive to recommendations from the 1985 Ernst-Whinney report.

Other studies have examined more fully the licensing, enforcement, and sanction systems used with HFAs. It should be clear from the brief background presented here however, that special issues relevant to the needs of mentally disabled residents are not fully addressed through the current licensure process.

Within the diversity of the HFA system, services are funded both through private and public funds. While public pay rates are capped, private pay rates vary greatly. As earlier indicated, approximately 29% of HFA occupied beds are used by individuals receiving assistance from the auxiliary grants (AG) program. This payment, averaging $202.90 in 1987, combines with other income as a payment to the individual to cover the HFA rate. This public pay rate is capped at $542/month (slightly higher in P.D. 8). Eligibility criteria for AG payments are both nonfinancial and financial. A home must have applied for a rate to be set in order for AG payments to be used. Such rates are cost-based, not services-based. Since not all homes have established rates, a subset of homes does not serve public-pay residents.

General Background: Mental Health, Mental Retardation and Substance Abuse Services System

Services to mentally disabled persons in Virginia are provided through both the public and private sector. Within the public sector, services are managed at the local level by 40 community services boards (CSBs) which provide or contract for mental health, mental retardation and substance abuse services in a given catchment area.

CSBs retain responsibility for the management of client services in the community and when clients are in State facilities. They are responsible for preadmission screening

and discharge planning for clients seeking entry to or discharge from State facilities. They are also responsible for assuring the following "core" services: inpatient; outpatient and case management; residential; day support (including psychosocial rehabilitation); prevention and early intervention. Funding for CSB services is provided by State funds (allocated through DMHMRSAS), local funds, fees, and other third-party payments. Localities are required to provide at least a 10% match to State funds for mental health, mental retardation and substance abuse services. CSBs are also responsible for the development of cooperative agreements with other community service providers, including HFAs. HFAs which take residents with mental disabilities are required by licensing standards to have a service agreement with CSBs. CSBs also coordinate multi-provider services through the mechanism of local prescription teams, which are mandated by statute.

As in the HFA system, CSBs vary greatly in size and service capacity, ranging from Boards serving low population rural areas to large metropolitan service areas. They are linked to 15 State facilities serving mental health, mental retardation and substance abuse patients/residents. They include four large psychiatric hospitals, two children's mental health facilities, two geriatric mental health facilities, two small acute care psychiatric institutions, and five mental retardation training centers. As indicated above, these facilities are accessed through CSBs, and discharge planning takes place jointly with CSBs. The policies and guidelines which articulate the CSBs' central role in the discharge and placement process, particularly for mental health and substance abuse patients, were promulgated in 1985 and 1986. Though the guidelines are currently undergoing revision, they will continue to emphasize the CSB role in service planning and the linkage between CSBs and facilities to provide continuity of care.

As regards the specific service issues involved in placement of patients in HFAs, DMHMRSAS policy (see Appendix 2) has emphasized the general principles of appropriate client placement into adult homes based on individual need. It has also been Departmental policy to encourage CSBs and facilities to provide consultation to HFA operators to enhance care for mentally disabled residents.

Regulation of the CSB system is now undergoing a major revision which will substitute a a combination of licensure and in-depth service evaluation for the current certification review process. Certification standards to date have required an HFA-CSB service agreement. The new evaluation procedure, as currently being planned, will likely include a broader review of CSB-HFA service linkages.

III. Survey and Provider Perspectives: New Data

Survey Data: HFA Facilities and Mentally Disabled Residents

The general information described above, although a useful background, leaves significant questions unanswered as to mentally disabled residents in adult homes, their use of current HFA services, and their unmet needs. These questions can be grouped as follows:

1. Facility data: staffing patterns; services provided; types of residents admitted/discharged.
2. Resident data: reported prevalence and distribution of mental disability by types of homes, demographics of residents reported to be mentally disabled; service needs and level of functioning; service use patterns.
3. Service linkages data: referral/placement sources; outside service sources; admission and discharge procedures and criteria; relationships between HFAs and CSBs.

To provide a more in-depth data base on these issues judged to be essential to the study, a major survey was conducted in a sample of 89 adult homes during summer 1987.

The survey collected facility-level data on all 89 HFAs. A second objective of the survey was to collect additional data about mentally disabled residents of home for adults. To accomplish this task, surveyors first selected a sample of current residents of the 89 HFAs included in the survey. Surveyors then determined which of these residents were mentally disabled (e.g., mentally ill, mentally retarded, or substance abusing). Lastly, for each mentally disabled resident in the sample, surveyors interviewed HFA staff to complete a questionnaire which included items related to demographics, service needs, utilization patterns, and behavioral functioning.

Staff from DMHMRSAS facilities, DSS regional offices and from both central offices were used to conduct the surveys. Staff used in conducting interviews received a one-day training session. Assistance in data collection, entry and analysis was provided under contract by the Virginia Center on Aging. A copy of the survey is included in Appendix 3.

This sample of HFAs was randomly selected from the total population of 402 licensed HFAs, with the sample stratified by HFA licensed capacity (i.e., less than 16, 16 to 43,

44 to 100, and more than 100 licensed beds). It should be noted that because of the small number of HFAs with more than 100 beds, HFAs in this category were over-sampled. The descriptive statistics presented in this section have been appropriately weighted to account for this.

The Homes for Adults

In this section, a description will be presented of the licensed homes for adults (HFAs) in Virginia. The HFAs will be described in terms of their occupancy rate, staffing, types of services provided, types of residents, and their relationships with the local community services boards (CSBs) and the Department of Social Services (DSS).

Occupancy

The licensed bed capacity of all HFAs (N = 402) ranged from 4 to 635 beds. There were 137 (34%) of the HFAs in the smallest size category (less than 16 beds), while there were 164 (41%) with a capacity of 16 to 43 beds, 63 (16%) with a capacity of 44 to 100 beds, and 38 (9%) with a capacity of more than 100 beds. The licensed capacity of each HFA was determined through administrative records obtained from the Department of Social Services.

The occupancy rate of HFAs in the sample was assessed at the time of the interview with the operator. Occupancy rate was calculated as the number of current residents divided by the licensed capacity of the HFA. The occupancy rate for the sample of HFAs ranged from 32% to 100%, with the average HFA having an occupancy rate of 89.5%. Approximately 47% of the HFAs had occupancy rates of 90% or greater, while only 8% had an occupancy rate of less than 50%.

Staffing

A variety of information was collected on the staffing of each HFA. This included the total number of full time equivalent (FTE) staff and a breakdown of staff by position type (i.e., medical/direct care, ancillary, and administrative) and employment status (i.e., contract, salary, and volunteer).

Information on the total number of FTEs was used to determine the staffing ratio for each HFA. This was calculated as the number of FTEs divided by the licensed capacity.

The overall staffing ratio of the HFAs ranged from .005 to 1.59, with an average staffing ratio of .39 staff per resident. A summary of the staffing ratios for each type of position is presented in Table 1. **All tables from this section are included in Appendix 4.**

A breakdown of staff by position type indicates that the largest category of staff within an HFA were typically administrative staff, closely followed by other medical/direct care staff which included registered nurses, licensed practical nurses, and aides. In contrast, the HFAs typically had a small percentage of ancillary staff and an even smaller percentage of physicians and psychiatrists.

As one would expect, most operators of HFAs reported that the vast majority of their staff were salaried employees (91.2%). In contrast, there was limited reliance on contractual staff with the majority of HFAs (64.0%) having no contractual staff at all. Volunteers were also not extensively used by the HFAs.

Services Provided

The HFAs typically provided a broad range of services for their residents. Some of the more commonly provided services were transportation and recreation, and special diets. Some of the less commonly provided services were occupational therapy, employment opportunities, and physical therapy. A complete summary of the services provided by the HFAs is presented in Table 2.

The special services provided to HFA residents were primarily provided directly by HFA staff (e.g. 94.0% directly provided transportation, 95.8% provided recreation services.) Other special services provided through contractual arrangements included physical therapy and occupational therapy (34.1%). While volunteers were not used extensively, those services that were provided by volunteers more frequently included recreation services, transportation, and employment opportunities. A complete summary of this data is provided in Table 3. It should also be noted that 69.2% of the operators indicated that their HFA received services from their local community services board for clients in need of such services.

Despite the broad range of services provided by the HFAs, it was not at all uncommon for admission to be denied to specific people because the HFA could not meet certain critical needs of the applicant. The operators of 59.1% of the HFAs reported that

admission had been denied to at least one applicant during the past year. The most frequently stated reason for the denial was that the HFA could not meet the special physical care needs of the applicants. Other cited reasons for denial included non-ambulation (24%), aggressive behavior by the applicant (21%), history of wandering (5%), and active substance abuse (5%).

It was also found that 67% of HFAs had discharged one or more resident within the past year because the facility was unable to meet the resident's needs. The most common reason cited for this was that the physical/medical needs of the resident could not be met (39%). Other reasons given for discharge included aggressive/disruptive behavior by the resident (33%), a need for mental health services (16%), and wandering (6%).

Resident Composition of the HFAs

A large majority of the operators of HFAs (81.6%) indicated that they accepted people who had been discharged from a facility operated by DMHMRSAS. Consistent with this information is the finding that 81.9% of the HFAs included in the study currently had residents who were "mentally disabled" (see Table 4). Finally, it was determined that 27.4% did not have any residents on the day of the survey who were auxiliary grant recipients. However, for those HFAs that did have auxiliary grant recipients among their residents, the percentage of residents receiving auxiliary grants ranged from 2.2% to 100.0% (see Table 5).

Relationship with the Local CSB and DSS*

The operators of most HFAs reported a generally positive relationship with both their local CSB and DSS. Of the 27 HFA operators who reported that they have an ongoing relationship with their local CSB, 75.8% reported that the relationship was positive in nature. Similarly, of the 74 HFA operators who reported that they have regular contact with their local DSS office, 79.7% reported that the relationship was positive. Very few of the operators reported a poor relationship with either the CSB or DSS (8.1% and 6.8%, respectively). It was also found that those HFAs that accepted people who had been discharged from a state facility were much more likely to use CSB services. In fact, while 84.1% of those HFAs that accepted state facility discharges also used CSB services, none of those that did not accept state facility discharges used CSB services.

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* The data presented in this section were the result of a content analysis of a set of open-ended questions and were, therefore, not weighted.

The issue of written service agreements between the HFAs and CSBs was also addressed. It should be noted that HFAs are required by licensing requirements to have an agreement with the local CSBs if they serve residents who have been discharged from DMHMRSAS facilities. Only 39.3% of the HFA operators reported that there was a written service agreement between their HFA and the local CSB. However, of those operators who reported an ongoing relationship with the local CSB, 56.5% reported that they have a written service agreement. For those HFAs who have agreements, 51.4% reported that the agreement is updated annually, while 34.3% reported that it had not been updated in more than two years. Nearly all of the operators with service agreements reported that they were satisfied with the agreement (88.6%).

HFA Size

The relationship between HFA size and several other dimensions of serving mentally disabled residents were explored. These included: 1) the percentage of residents who were mentally disabled, 2) whether or not the HFA had denied admission to someone because the HFA could not meet his/her needs, 3) whether or not the HFA had discharged someone because the HFA could not meet his/her needs, and 4) whether or not the HFA used services from the local CSB. The HFAs were categorized as follows based on their licensed capacity: 1) 4-15 beds, 2) 16-43 beds, 3) 44-100 beds, and 4) more than 100 beds.

The licensed capacity of the facilities was found to be related to several characteristics of the HFAs. Smaller HFAs tended to have a much larger percentage of mentally disabled residents than did larger HFAs. Furthermore, while the average percentage of mentally disabled residents in the smallest HFAs was 58.5%, the average percentage of mentally disabled residents in HFAs with more than 100 beds was 22.3%. In general, as the size of the HFAs increased they were found to have a smaller percentage of mentally disabled residents (see Tables 6 and 7).

Two other analyses were conducted in order to examine admission and discharge practices as they relate to HFA size. HFA size was found to be related to whether or not the HFA had denied admission to someone because the HFA was unable to meet the needs of the applicant. Larger HFAs were more likely to deny admission to someone on these grounds than were smaller HFAs (see Table 9). However, no relationship was found between HFA size and whether or not the HFA had discharged someone due to the HFA's inability to meet the resident's needs (see Table 10).

Finally, use of CSB services was examined as it relates to HFA size. The results of this analysis indicate that there is a moderate relationship, with smaller HFAs more likely to use CSB services than larger HFAs (see Table 11). This may be related to the fact that smaller HFAs have more auxiliary grant recipients and that they are less likely to deny admission to people because they cannot meet their needs.

Admission and discharge practices were also examined in terms of the occupancy rates of the HFAs. There was no difference found between the occupancy rate of those HFAs that had denied admissions (89.5%) and those HFAs that had not denied admissions (see Table 12). On the other hand, there was a difference in occupancy rate between those HFAs that accepted people who had been discharged from State facilities and those HFAs that did not. Those HFAs that did accept such discharges had an occupancy rate of 91.5% compared to 80.9% for those HFAs that did not accept discharges from State facilities (see Table 13).

Additional more detailed data on HFA admission/discharge practices and use of CSB services is included in Tables 14-21, Appendix 4. In general, the facility data show a divergent system which varies greatly in size, staffing patterns, and services provided as well as in admission/discharge practices, percentage mentally disabled residents and CSB service linkages. Any changes in the financing and structure of services for mentally disabled residents would most greatly affect smaller homes, but must also accommodate the evident diversity of the system.

Sample Selection

The sample of residents used for this study was drawn from the pool of residents who were living in the 89 HFAs which participated in the survey. The sample was drawn in the following manner:

- If the occupancy in the HFA on the day of the survey exceeded 100 residents, then 20% of these residents were randomly selected for inclusion in the study.
- If the occupancy in the HFA on the day of the survey was less than 100 residents, then 50% of these residents were randomly selected for inclusion in the study.

The process described above yielded a total of 1,427 current HFA residents for inclusion in the survey.

To identify the mentally disabled individuals within the sample of 1,427 residents, surveyors met with HFA staff and discussed each of the 1,427 residents. Using a series of questions pertaining to diagnosis, history of hospitalization, current need for services, and other variables, surveyors determined on the basis of information provided by HFA staff that 519 (36.4%) of the 1,427 residents in the sample were mentally ill, mentally retarded, or substance abusers. This proportion of mentally disabled residents in HFAs is somewhat larger than previous estimates have indicated. Given that the total sample size was approximately 10% of the total number of HFA residents statewide, the estimated total HFA residents who are likely to be mentally disabled is approximately 5,190 individuals.

Through interviews with HFA staff, surveyors developed additional data about the mentally disabled HFA residents. (No further information was generated for those residents who were not considered mentally disabled). These data are presented below and in Appendix 5.

Demographic Data

Mental illness was noted by surveyors to be the primary disability of the vast majority of the mentally disabled sample group. There were 407 persons (78.4% of total) in this

category. Mentally retarded residents numbered 91 individuals (17.5% of total) while substance abusers numbered 21 residents (4% of total). The majority of mentally disabled residents in the study (352, or 68% of total) were also recipients of Auxiliary Grants from the Department of Social Services. Using the estimated total mentally disabled residents in HFAs statewide (5,190) and the 68% figure above, there are an estimated 3,529 mentally disabled residents of HFAs statewide who are also auxiliary grant recipients.

As might be expected when considering the mission of Homes for Adults in Virginia, the study sample was predominantly middle aged and elderly. The ages of the mentally disabled residents ranged from 21 years to 100 years. More than 85% of these residents were over 41 years of age, and the majority of this group were over 65 years old. The study sample of mentally disabled residents was almost evenly divided between males and females, and was predominantly white and single or widowed.

Almost half of the sample (248 or 47.9%) required medication on an ongoing basis for a chronic health condition and a slightly smaller number of residents (208 or 40.2%) were reported to have a chronic health condition that required special treatment, supervision, or nursing procedures. More than half of the residents in the sample (281 or 55%) were Medicare recipients and an even larger percentage (353 or 68.1%) were Medicaid recipients. Although very few residents (11 or 2.1%) had been screened by the Nursing Home Preadmissions Committee, several individuals had been patients or residents in other institutional settings during the previous 12 months, as follows:

Type of Facility	Number of Individuals (%)
Acute Care Hospital (Medical)	60 (11.6%)
DMHMRSAS Psychiatric Hospital	29 (5.6%)
Private Psychiatric Hospital	29 (5.6%)
Skilled Nursing Facility	0
Intermediate Care Facility	7 (1.4%)
DMHMRSAS Training Center	7 (1.4%)

A number of the mentally disabled residents had exhibited maladaptive or difficult-to-manage behavior within the previous 12 months. In addition, there were a significant

number of individuals in the study sample who lacked basic self-help and personal care skills such as bathing, toileting, dressing, etc. There were 196 residents (37.8% of total) who were judged by HFA staff to lack these skills.

Many of these findings regarding resident characteristics were further substantiated by a resident level-of-functioning assessment conducted by surveyors. To develop the level-of-functioning data, surveyors used the Resource Associated Functional Level Scale (RAFLS), a seven-point global assessment instrument (developed by Stephen Leff, Ph.D., and associates) with which surveyors assigned a rating to each mentally disabled HFA resident based upon that resident's mental condition, behavioral functioning, and his/her need for support, supervision, and assistance in carrying out daily roles. As indicated in the table below, most of the mentally disabled residents in the study (362 or 70%) were rated at levels which indicate daily or even continuous prompting, encouragement, and training in personal care and community living skills. (A more detailed description of the level-of-functioning scale appears in Appendix 5).

RAFLS Level of Functioning	Number (%) of Residents
1 (Dangerous)	1 (0.2%)
2 (Acute Symptoms)	29 (5.6%)
3 (Lacks Personal Care Skills)	161 (31.1%)
4 (Lacks Community Living Skills)	201 (38.9%)
5 (Needs Role Support)	77 (14.9%)
6 (Needs Periodic Services)	41 (7.9%)
7 (Systems Independent)	7 (1.4%)

In summary, the demographic data presented above shows that the mentally disabled clientele of Homes for Adults are primarily older individuals whose health problems and skill deficits in the majority of cases indicate a need for the level of routine assistance, support and supervision which might best be provided in an enhanced Home for Adults setting, with appropriately specialized ancillary services and staff training.

Service Linkages

For each mentally disabled resident in the study sample, surveyors also collected a variety of data related to placement, resident service needs, and service utilization.

These data are presented below.

Placement arrangements for this subset of residents into their present HFA living situation had been made by several individuals and agencies. The greatest proportion of mentally disabled residents had been placed into the HFA by a DMHMRSAS facility (173 or 33.4%). Family members placed almost a quarter of the sample (125 or 24.1%) while local Departments of Social Services had placed a smaller number of residents (62 or 12.0%).

The majority of residents in the study sample were also involved at the time of the survey with a variety of public and private agencies which provided services other than financial assistance to the resident. These providers included Community Services Boards (175 or 34.1%), private agencies such as physician groups (76 or 14.8%), local Departments of Social Services (58 or 11.3%) and many others. When questioned about which outside agency or provider would be contacted if the HFA had a concern about the resident, HFA staff responded most frequently that they would contact the local community services boards (203 or 39.1%) or another private provider (176 or 33.9%) which, in most cases, would be a physician.

Service Needs and Utilization

To identify the specific service needs and service utilization patterns of the mentally disabled HFA residents in the study, surveyors reviewed with HFA staff a list of fourteen categories and types of services which mentally disabled residents might need. HFA staff were asked to determine whether or not the individual resident needed these services and whether or not these services were provided to the resident. The following table presents these service need and utilization data.

Type of Service	(1)# Residents (%) Needing Svcs.	(2)# Residents (%) Receiving Svcs.	(1)-(2)
Case Management	351 (67.9%)	324 (62.7%)	27
Outpatient Counseling/Therapy	305 (58.9%)	249 (48.1%)	56
Day Support (Clubhouse, Workshop)	198 (38.2%)	100 (19.3%)	98
Psychotropic Medication	404 (78.0%)	392 (77.6%)	14
Emergency/Crisis Intervention	134 (25.9%)	167 (32.2%)	-33
Employment Svcs./Vocational Rehabilitation	74 (14.3%)	30 (5.8%)	44
Eligibility Determination (SSI, GR, etc.)	256 (49.4%)	271 (52.3%)	-15
Legal Services	41 (7.9%)	35 (6.8%)	6
Nurse/Physician Care	409 (79.0%)	426 (82.2%)	-17
Dental Services	254 (49.0%)	232 (44.8%)	22
Other Health Services (OT, PT, etc.)	70 (13.5%)	68 (13.1%)	2
Recreation/Socialization	468 (90.3%)	466 (90.0%)	2
Transportation	464 (89.6%)	473 (91.3%)	-9

The service need data above indicate that in general, residents in need of some specific services are not, in fact, receiving them. The widest such disparity, in terms of the proportion of residents needing a service who do not receive them, are for day support (49.5%), outpatient (18.4%), and vocational rehabilitation services (59.5%). For the most part, services which were needed but not provided to the resident were those which would not typically be provided on-site with current staffing in the HFA setting. It should be noted that the survey data above does not identify the extent to which mentally disabled residents are not receiving the level or intensity of a given service which they may already be receiving. (For example, an individual may be receiving 1 day per week of day support services but might actually need 3 or 4 days per week). For some types of service (i.e., emergency, eligibility determination,nurse/physician care, and transportation) the number of persons actually receiving these services exceeds the number of residents deemed in need of these services.

Lastly, HFA staff were asked by surveyors to identify from a list of ten agencies the primary provider of each service which the resident was receiving. Although these sources of services varied between types of service, the Community Services Boards were named most often as the primary providers of supportive mental health care (case management, counseling, day support, psychotropic medication, and emergency services), while private agencies and the HFA itself was most often the principal source

of other services (medical/dental, occupational and recreational therapy, transportation, etc.). Tables presented in Appendix 5 show the primary sources of service (more than 10% of valid cases) for each of the fourteen service categories.

Summary - Survey Data

The resident survey data shows that mentally disabled residents of Homes for Adults are generally older individuals whose ability to function independently (e.g., to manage their lives in their own home) is impaired by a combination of conditions which require structure, support, assistance, training, and/or supervision. Few of these individuals are seen as needing more intensive care (such as might be provided by a nursing home or hospital) on an ongoing basis.

The data show that the majority of these individuals are also currently receiving supportive services from agencies and organizations other than the Home for Adults. For the most part, these service providers are the local Community Services Boards, private providers, and a few other public agencies such as the local Departments of Social Services. The data also show, however, that many mentally disabled residents are not receiving the supportive services which HFA staff believe they need. As noted earlier, the greatest disparity between the proportion of residents needing a service and those who do not receive them are found in those service areas such as day support, vocational rehabilitation, and outpatient therapy services, which are the most difficult for HFAs to make available through their own program resources (staff, space, funds, etc.). These conditions support the need for additional resources to be available to HFAs to enable them to provide, secure, or access an increased level of services for their mentally disabled residents. This conclusion has been further substantiated by HFA operators and CSB staff, whose perspectives are presented below.

The resident survey data indicate that there are an estimated 5,190 mentally disabled residents of Homes for Adults statewide. The majority of these residents (over 78%) have a primary disability of mental illness, with the remainder having a primary disability of mental retardation or substance abuse. Of the mentally disabled HFA resident sample, 68% also receive Auxiliary Grant benefits, which indicates that approximately 3,529 persons residing in HFAs statewide are likely to be mentally disabled Auxiliary Grant recipients.

Provider Perspectives

As indicated earlier, input from both home operators and CSB providers was seen as an important addition to the data available from the facility/resident survey. Information obtained from this component of the study will be summarized here.

1. Summary of HFA Operators' Comments

In late August 1987, five public meetings were held (Abingdon, Roanoke, Richmond, Staunton, and Williamsburg) to receive comments from Homes for Adults operators regarding HJR 70. They were convened jointly by representatives from the Departments of Social Services and Mental Health, Mental Retardation and Substance Abuse Services. More than 100 HFA operators attended to present comments.

Management - Several repeated themes regarding management concerns were 1) additional training is needed about how to detect psychological problems and manage aggressive behavior; 2) there is a reluctance to mix young, aggressive, active clients with older, more stable residents; and 3) if mental health standards are added to existing licensure standards, they should be minimal and not create a hardship for small HFAs which may have just one or two mentally disabled residents.

Financial - In all public sessions, the most consistent comments concerned the need for differentiated public rate structures according to the service needs for each resident. The current $542 level is seen as too low to pay for specialized staff, special transportation, drugs, glasses, clothing, and dental services. Other financial concerns were: 1) there are reported delays in receiving payments during the first few weeks; 2) providers felt families or other sources should be able to contribute to a resident's account without jeopardizing the level of social services payments; and 3) other public services, such as clubhouses, should be available and accessible to residents.

Services - Addressing services needs, many HFA operators wanted more activities for their residents - public recreation, admission into Senior Centers, "day care" and workshop activities, and on-site occupational therapy. Also, at several meetings, the operators requested either social workers or case managers to be on

staff to do follow-along, a service cited as a particularly critical need for substance abuse clients. One operator commented that CSB services were necessary and should be accessible but that it was not feasible to offer many of these services in the home.

Interagency Cooperation/Coordination - The broader area of interagency coordination for necessary services was also a frequent topic of operators. The strongest and most frequent concerns of HFA operators centered around CSB emergency services being slow or inaccessible, especially in evenings and on weekends. Some HFAs report that they employed private psychiatrists in order to have quicker access to psychiatric services. One suggestion was that the CSB employ staff to develop referral networks between the HFAs in an area and state hospitals which may want to discharge residents to those homes. The CSB employee may facilitate placement by both decreasing the time for placement and providing the homes with appropriate background information, which some homes claimed not to receive. The HFA operators expressed a desire for a closer, more trusting relationship with the CSBs and would welcome their training, education, and off-site services.

2. Summary of CSB Provider Comments

Input was received (in writing with phone follow-up) from a sample of 15 out of 40 CSBs, including those with the highest density of HFAs. The CSBs were distributed around the state and included urban, rural, and suburban areas. Comments addressed four questions with responses summarized as follows:

1. **"How well do HFAs in your area serve residents who are mentally disabled?"**

   Some community services boards expressed dissatisfaction with the quality of HFA services, especially with clinical and rehabilitation services such as teaching activities of daily living and therapeutic interventions. CSBs reported that Homes for Adults' maintenance services (i.e., room and board) varied among homes from poor to good. More positive comments include that HFAs were of "great value, especially in communities that lack sufficient professionally sponsored programming." Even the best HFAs however, were seen as lacking "expertise in behavior management... and psychiatric crisis intervention".

2. **"What changes would be needed to improve HFA services for their mentally disabled residents?"**

The most frequent recommendation from CSBs was that HFAs should employ better trained staff. Staff should be skilled in the application of positive behavioral management techniques which focus upon the residents' acquisition of independent skills. For current staff who did not have these skills, the community services boards generally were willing to provide in-service education regularly to HFAs, and some CSBs (3-4) had done this in the past.

Related to the skill levels of HFA staff, the CSBs recognized that many HFAs paid only the minimum wage and thus attracted staff with few professional qualifications. The CSBs recommended that staff salaries be increased, especially on a differential scale which recognizes that some HFAs serve harder to manage residents. One board suggested that some HFA staff be certified after they have received requisite training and experience.

The provision of more structured daily activities was a common recommendation. Several CSBs comment that although psychosocial programming was available to more HFA residents, the homes did not encourage this involvement, nor did some homes provide appropriate social and recreational activities on-site. Regarding the inactivity of some of the residents, CSBs cited lack of transportation to board services as a major obstacle to rehabilitation, especially in rural areas.

Several boards recommended that there should be more stringent enforcement of licensure rules and regulations which regulate HFAs. One board recommended that CSBs should become involved in this activity, which now is a responsibility of the Department of Social Services.

Several CSBs suggested strengthening linkages with the HFAs as follows: 1) status reports or summaries of residents' conditions, skills and needs should be regularly exchanged; 2) the CSBs should agree to train HFA staff to understand the nature of various types of mental illness, daily living skills and how to teach them, behavioral management techniques,

and appropriateness of referral to CSB services such as emergency services; and 3) CSB and HFA staff should sit on the same committees when there are decisions concerning involvement of a mutual client in services, beginning with admission to an HFA.

3. **"What types of clients should/should not be served?"**

Several CSBs indicated that the most appropriate residents are those who require minimum supervision, are psychiatrically stable and relatively compliant. There should be a homogeneity of age, functioning level, and service needs (for example, no mixing of elderly and chronically mentally ill persons, mentally ill residents with alcoholics or persons with aggressive behavior, etc.). A Northern Virginia CSB summarized the reactions of a few boards by stating that "there is ... (no) conceptual limit to the kinds of persons to be served..." but "the real problem is providing a level of support and service commensurate with the client needs."

4. **"What are the current service linkages between you (the CSB) and HFA operators in your area? How could they be improved?"**

Current linkages were generally described as minimal, usually limited to case management and emergency services as needed. A few CSBs reported a more active role. For example, one CSB is involved with the HFAs around discharge from hospitals and also provides training to HFA operators; another conducts quarterly medication clinics at the HFA site.

The most frequent recommendations for improvements were 1) that oversight of HFAs involve the CSBs and 2) that more proactive client/case planning take place, especially upon discharge from state facilities. This would involve CSB screening of residents for appropriateness at a respective Home for Adults. Contact between the CSBs and HFAs was seen as needing to be more frequent and more specific to each resident's needs, based on a more collegial and less adversarial relationship.

IV. Issue Assessment: A Summary of System Trends/Patterns

The new data just presented along with the background information reviewed in an earlier section, provide an empirical basis for identifying major issues in improving HFA services to mentally disabled residents. These issues are described in this section.

1. By extrapolation from the sample in this study, over 1/3 of the current HFA residents may be mentally disabled. This reported prevalence rate among HFA residents is significant and confirms the major role HFAs play in serving this population as well as the need to develop improved rate structures, service planning mechanisms, and staff/service resources for this subgroup.

2. The mentally disabled population to be served, although clearly not homogenous, shows strong patterns of similarity. (Forty or older, significant physical care needs; needing a broad array of support services; not receiving sufficient day, vocational rehabilitation or outpatient services; not seriously disruptive but showing some difficult-to-manage behaviors; lacking some personal care and community living skills). Based on these similarities, it may not be necessary to distinguish multiple levels of care in order to address major service needs.

3. Staffing of HFAs is generally administratively focused rather than treatment/rehabilitation oriented, is low in numbers, and uneven in staff mix across the system. HFAs thus appear to lack the staffing necessary to meet the specialized needs of mentally disabled residents.

4. HFAs provide/contract for a broad array of services, but given the staffing data presented and the identified needs, it appears unlikely that these services are available in adequate quantity/frequency or adapted to the special needs of mentally disabled persons. Of particular importance are management of disruptive behaviors, training/rehabilitation in skills of daily and community living, day support services, vocational rehabilitation, and outpatient counseling. The lack of these services is cited by operators as a factor leading mentally disabled persons to be screened out at admissions or discharged from HFAs, potentially increasing hospitalization rates.

5. HFAs currently contract for a number of services and with additional funding, could expand contracting arrangements to allow for provision of special services.

6. The impact of any changes in financing, regulation, or service expectations for this population would appear to be greatest on smaller homes, which serve the largest proportion of mentally disabled auxiliary grant recipients and tend to make greater use of CSB services.

7. CSBs and HFAs both express the need to work together more closely, but in many cases do not operationalize this through the development of substantive and up-to-date service agreements. Incentives and structures promoting such linkages appear to be missing.

V. Major Policy Options

Overview

Based on the assessment of existing and new data reviewed in this study, the two Departments developed and reviewed a series of policy options/models for enhancing services to the target population. Each of these options was reviewed in terms of the following general criteria:

- o impact on target and general resident populations;
- o effects on HFA service providers and fit with comments;
- o effects on CSB and other mental health, mental retardation and substance abuse service providers and fit with comments;
- o fit with general policies for the two agencies;
- o administrative feasibility and efficiency; cost effectiveness;
- o consistency with study data; and
- o consistency with identified legislative intent.

In the next section, the identified options are summarized and then reviewed briefly along each of these dimensions.

Options

Option I: Separate HFA System

One model of tailoring HFA services to mentally disabled residents would involve establishing a separate DSS system of HFAs for mentally disabled auxiliary grant recipients, adapting care, regulation and financing to the special needs and characteristics of this population.

Option II: Shift System to DMHMRSAS

Building on the concept of a specialized system, the administration of a separate HFA system adapted to mentally disabled residents could be shifted to DMHMRSAS for funding, regulation, and all related administrative functions.

Option III: Targeted Variable Level-of-Care System (LOC)

While retaining DSS administration, a multi-tiered system of financing and regulation could be developed, with rates based on a determination of levels of care required/provided for mentally disabled residents (e.g., seriously, moderately, or minimally impaired).

Option IV: General Variable LOC System

The study resolution and the three preceding options focus exclusively on changing the financing and regulation of the HFA system as it affects mentally disabled residents only. It would, however, be theoretically possible to create a variable rate system for all HFA residents based on level of care requirements, to include mental and physical impairments/service needs in rate determination and regulatory requirements.

Option V: Targeted Supplements

A fixed single-level rate supplement could be available for residents determined to be mentally disabled, with enhanced CSB linkages and specialized certification/service oversight, to ensure targeting of additional funds to appropriate service needs.

Review of Options

Option I: Separate HFA System

- Resident impact: Some improvement through service specialization but loss of normalization in resident mix; could involve disruptive resident transfers;
- HFA provider impact: Not mentioned as preferred provider option. Could involve disruptive transfers and restructuring;
- CSB provider impact: Same as HFA providers;
- Fit with policies: Counter to DSS policy promoting heterogeneity in HFA populations, not addressed in DMHMRSAS policies;
- Feasibility and cost effectiveness: Some potential for administrative duplication and additional cost; transfers could be disruptive and inefficient;
- Consistency with study data: Data do not seem to support need for this degree of restructuring; and
- Legislative intent: Not identified as option.

Option II: Shift System to DMHMRSAS

- o Resident impact: Same as option I;
- o HFA provider impact: Same as option I;
- o CSB provider impact: Some improvement in service linkages. CSBs want additional residential services but not necessarily HFA model;
- o Fit with policies: Same as option I;
- o Feasibility and cost effectiveness: Potential for extensive duplication, slow start-up and significant increases in administrative costs;
- o Consistency with study data: Same as option I; and
- o Legislative intent: Same as option I.

Option III: Targeted Variable LOC System

- o Resident impact: Some improvements in services available to mentally disabled;
- o HFA provider impact: Primarily positive although administrative requirements could be problemmatic (i.e., varying rates and increased documentation);
- o CSB provider impact: Not mentioned as preferred option; some potential improvements in perceived quality of services;
- o Fit with policies: Not addressed in current policies;
- o Feasibility and cost-effectiveness: Would create extensive additional administrative processes and costs; redetermination of varying levels over time would pose administrative difficulties;
- o Consistency with study data: Fits with needs for increased special services but costs and extent of restructuring may not be fully justified by data; and
- o Legislative intent: Fits with original intent but Senate Document 30 identified many of above concerns/issues.

Option IV: General LOC System

- o Resident impact: Same as option III, with benefits to physically impaired as well;
- o HFA provider impact: Same as option III;
- o CSB provider impact: Same as option III;
- o Fit with policies: Same as option III;
- o Feasibility and cost effectiveness: Same as option III. Costs would be even higher;

- o Consistency with study data: Same as option III for mentally disabled; lack data for other populations; and
- o Legislative intent: Same as option III.

Option V: Targeted Supplements

- o Resident impact: Improvements in services available and service linkages;
- o HFA provider impact: Generally positive if administrative requirements streamlined;
- o CSB provider impact: Generally positive if funds available for CSB functions;
- o Fit with policies: Seen as consistent by both agencies;
- o Feasibility and cost effectiveness: Some additional administrative and service costs; but administration could be streamlined and costs contained more easily then other options;
- o Consistency with study data: Good if oversight allows targeting of services; staffing changes and improved linkages; and
- o Legislative intent: Not identified but fits with general intent.

VI. Recommended Option and Implementation Plan

Option V appears to provide the best foundation to balance improved resident services, acceptable provider impact, costs and feasibility/efficiency. Such a specialized rate supplement system thus is the recommended general model used for the development of more detailed implementation plans. These plans will include 1) an overview of the proposed structural changes, as well as 2) time frames/specific actions needed and 3) projected impact.

Overview: Proposed Structural Changes

The general framework within which this proposal has been developed was intended to adhere to these principles.

a. Be mechanically simple, to minimize workload increases at state and local levels of DMHMRSAS and DSS and to reduce costs of implementation and operation.
b. Target the most needy, specifically, auxillary grants recipients who are also in need of additional services/supports.

c. Include an assessment or screening procedure, which can be activated at any time prior to or after HFA placement or prior to transfer between HFAs.
d. Facilitate provision of services from different sources (e.g., HFA, other private providers, CSBs, etc.) while allowing an adequate payment mechanism for purchase/provision of these services.
e. Ensure appropriate use of CSBs for service management and oversight.
f. Maximize accountability for use of funds and quality of supplemental/special services provided.
g. Ensure individualization of service plans.

Within this framework, the two Departments propose to establish mechanisms to (1) identify the mentally disabled residents of HFAs and assess their service needs, (2) provide funding to support delivery to residents of supplemental services, (3) monitor delivery of services, and service planning/coordination between CSBs and HFAs, and (4) monitor the financing of in-home or off-site supplemental services.

The proposed program to establish service supplements for mentally disabled residents in HFAs would be operationalized in a manner similar to the "aftercare grant" concept recommended in the previously-cited Ernst and Whinney report on auxiliary grants. The components and process involved could be briefly outlined as follows:

1. HFAs serving mentally disabled residents could apply to be certified by DMHMRSAS. This certification would qualify the home to receive supplemental funding for services to eligible individuals. The intent of the certification would be to provide basic, initial assurances that the home is willing and able to make effective use of these funds for better services to mentally disabled residents.

2. HFAs could then propose selected residents for the supplemental funding program. These residents must be both (a) eligible for/already receiving auxiliary grants; and (b) mentally disabled. The determination that a given resident is mentally disabled will be made on the basis of CSB assessment, at the request of the HFA operator. Those persons deemed to need long-term mental health, mental retardation, and substance abuse services will be defined as mentally disabled for the purposes of this program.

3. For each eligible mentally disabled resident, a certified HFA could receive a supplemental of $150/month (@ $5/day). These funds would be used to

access/provide specialized supportive services, as defined in an individualized services plan. The services plan would be developed jointly by HFA and CSB staff. Specific services included would be appropriate to individual need, within the limitations of the funds made available. Service arrangements might include transportation to available off-site services or expansion of on-site services (e.g., behavior management, medication monitoring, skills training). In many cases, residents will already be active CSB clients. In a number of cases however, CSB services will be limited to oversight and coordination of services, with private or other public providers more directly involved in service delivery. This distinction is important because residents must retain freedom of choice as to providers.

4. Monitoring of supplemental service delivery and continued eligibility of residents would be accomplished by CSB staff in the newly established positions of HFA service coordinators.

5. Continued special certification of the HFA and investigation/resolution of problems specifically related to the supplemental services funding would be the responsibility of DMHMRSAS central office staff.

The proposed system clearly does not address the overall rate structure of HFAs, the medical/health needs of residents or the general needs for additional mental health, mental retardation, and substance abuse community services. It would however, accomplish several major goals:

- o increase by approximately 25% the rates paid for this special population;
- o target use of that rate increase to provide/assure appropriate support services;
- o tighten service management linkages between HFAs and CSBs, so that service delivery can be more effectively coordinated and existing services optimally utilized.

1. Eligibility, financing and audit mechanisms

Purpose: To provide $150/month payment per qualified resident to Home for Adults to support the delivery of pre-determined needed supplemental services to mentally disabled individuals requiring long term care.

Eligibility Criteria: Individual must reside in a home for adults licensed by DSS and certified by DMHMRSAS, need long-term mental health, mental

retardation, or substance abuse services, and be eligible to receive auxiliary grant funding from the Virginia Department of Social Services.

Funding Procedures

- o Supplemental services funds will be appropriated to DMHMRSAS.

- o The Virginia Department of Social Services will provide a monthly listing of auxiliary grant recipients who received a payment during that month. The list will provide the following information:

  - name of recipient and home of residence;
  - local Department of Social Services making auxiliary grants payment;
  - local Department of Social Services providing social services to the recipient, if applicable; and
  - list of auxiliary grants recipients initiated or terminated during the month.

- o A Home for Adults which seeks supplemental funds for services to mentally disabled individuals must first receive certification from the Department of Mental Health, Mental Retardation, and Substance Abuse Services.

- o The HFA will apply to its local (CSB) for supplemental funds for services to eligible residents.

- o A staff person (HFA Services Coordinator) within the CSB will:
  1. Assess the resident as being mentally disabled and in need of long-term care.
  2. Determine if the resident is currently an Auxiliary Grant recipient or eligible to receive such funds.

- o An individualized supplemental service plan for the resident will be jointly developed by the Home for Adults and CSB HFA Service Coordinator. In instances where a local Department of Social Services already has an active service case and plan for the resident, the local department social worker will be involved in the development of the resident's supplemental service plan to assure interagency cooperation and avoid duplication of effort. The support services needed, and funded, will be developed as appropriate to the supplemental services needs of the individuals. This service agreement will be signed by the Home for Adults and CSB Service Coordinator.

- Monthly, the Home for Adults will submit an invoice to the CSB to be reimbursed for supplemental services furnished to, accessed or purchased on behalf of the eligible resident. Only one invoice will be required monthly listing the names of all eligible residents.

- The CSB HFA Service Coordinator will review for accuracy, sign and forward to the Finance Office within the DMHMRSAS Central Office for processing.

- The DMHMRSAS Central Office-Finance Office will review invoice for accuracy, code, batch and issue a warrant to the State Comptroller's Office (Department of Accounts) for processing.

- A check will be issued in the name of the Home for Adults.

Audit Procedures

- The CSB HFA Service Coordinator is responsible for monitoring to assure delivery of service and continued client eligibility.

- The DMHMRSAS Central Office-Finance Office will maintain:
  1. A current signature card for all CSB HFA Service Coordinators.
  2. A data base for all participating certified Home for Adults and eligible residents.
  3. A monthly financial report detailing all claims paid.

2. Certification Process

To qualify to receive supplementary funds, an HFA which serves eligible mentally disabled residents would be required to be "certified" by DMHMRSAS. The objective of this certification will be to verify that the HFA has the necessary elements in place to ensure that mentally disabled residents will receive the additional services that the supplemental payments are intended to support. Thus the focus of this certification is on the preparedness or readiness of the HFA to coordinate, implement or access appropriate services for its mentally disabled residents who are eligible for service supplements.

The certification process would be entirely independent of current licensing requirements. As indicated earlier, the current licensing process is managed by the

Department of Social Services and all HFAs must be licensed to operate. The certification process described herein would be optional, e.g. any licensed home could request certification and be certified, but no home would be required to do so. Furthermore, the continued operation of a licensed HFA would not be dependent on the maintenance of certification. Secondly, certification would be optional even if a Home for Adults served many mentally disabled residents. In other words, a licensed Home for Adults which accepted mentally disabled individuals into its care would still not require certification.

A licensed HFA would be required to be certified only if it elected to pursue supplemental payment funds for eligible mentally disabled HFA residents. Certification would allow a licensed HFA to receive supplemental payments for eligible mentally disabled residents.

The certification will be conducted by DMHMRSAS staff affiliated with the Department's Office of Quality Assurance. Thus, the independence of DSS licensing and DMHMRSAS certification will be maintained.

Specific areas of focus of the certification will include the following (not mutually exclusive) elements:

1. Training and Consultation: Certification will address the extent to which the HFA administrator and staff have obtained training and consultation needed to ensure that staff in the HFA can work effectively with mentally disabled residents. Certification could require:

    - o Credentialing or minimum qualifications for certain staff.
    - o Minimum core training of all staff working with mentally disabled residents, to include the nature of mental illness, mental retardation, and substance abuse; concepts of habilitation/rehabilitation; behavior management; medication management; crisis management and intervention; Virginia's Mental Health, Mental Retardation and Substance Abuse system; etc.
    - o Minimum frequency of inservice training opportunities.
    - o Training/consultation affiliations or agreements with CSBs and/or other training/consultation resources.
    - o Documentation of the above.

2. Continuity of Care: Certification will address the extent to which the HFA, the CSB, and other public/private providers of appropriate services are jointly involved in the development, implementation and coordination of supportive services for mentally disabled residents. Certification could require:

   - o Current service agreements with CSBs and other appropriate providers describing responsibilities of respective organizations for service planning, delivery, and coordination.

3. Emergency Care: Certification will focus on the extent to which the HFA can assure prompt and effective response to emergencies involving mentally disabled residents. Certification could require:

   - o A clearly defined written emergency service/crisis intervention plan, developed in conjunction with the CSB, which describes the roles, responsibilities, and expectations of the HFA, the CSB, and other providers (as appropriate) in the delivery of emergency and crisis intervention services to the HFA and its residents.
   - o Evidence of HFA staff preparedness to identify and respond to potential crises involving mentally disabled residents.

4. Delivery of Basic Services: Certification will require that HFAs verify the availability, accessibility, and on- or off-site delivery of essential support services to mentally disabled residents. Certification could require:

   - o Documentary evidence that special service needs of mentally disabled residents are identified and that to the maximum extent possible, services are made available to residents to meet those needs.

5. Documentation: Certification will require that HFAs implement and maintain adequate accounting and documentation procedures to permit periodic auditing of supplementary funding income and delivery of services to eligible mentally disabled residents. Certification could also require:

   - o Periodic reporting of financial and service delivery data pertaining to mental disability supplemental funding to DSS and DMHMRSAS.

The review would be carried out by staff from the DMHMRSAS Office of Quality Assurance. The review would take place on-site. The "certificate" granted through this process would allow the HFA to receive supplements for services to eligible mentally disabled residents.

The certification process would include an opportunity to appeal the decision of DMHMRSAS reviewers, and would include provisions to implement contingencies or restrictions on "certified" HFAs in the event of non-compliance with certification requirements. DMHMRSAS licensing staff would be responsible for investigating and responding to complaints or problems with compliance.

3. Service Planning, Monitoring, and Coordination

As indicated earlier, supplemental funds could be used to purchase/provide/access appropriate additional services suited to the special needs of mentally disabled persons. These services will be outlined in individual supplemental service plans (SSPs) to be negotiated with CSB HFA service specialists. The types of services which data from the study indicate would be appropriate might include:

- o Transportation to specialized day support, vocational rehabilitation, or outpatient services.
- o Contractual arrangements for on-site special services.
- o Off-site special services requiring fees.
- o Supplemental part- or full-time qualified staffing for enhancing the adaptability of behavior management, resident skill training and special supervision.
- o Salary supplements for staff who obtain special training or credentialing for work with this population.

For each resident, approximately $1800/year in supplemental funds would be available. For homes with a significant number of mentally disabled auxiliary grant recipients the aggregate level of funding would be sufficient to allow for hiring of additional staff to increase on-site service provision. For homes with fewer eligible residents, funds can be used for transportation to off-site services or limited contracts for supplemental services provision.

Given indications from previous studies as well as the new data available here, enhancement of service linkages between HFAs and CSBs was seen as an essential goal,

closely related to the increases in available/accessible supplemental services, as outlined in these plans. It is for this reason that this proposal envisions the use of CSB staff as brokers/monitors for the implementation of supplemental services plans. According to this proposal, CSBs would receive additional special staff responsible for the following roles:

- o Assessments to determine if individual residents proposed by HFA operators for supplements are mentally disabled.
- o Negotiation and approval of supplemental service plans (SSPs).
- o Handling of invoices and general administration of the supplemental services program within that catchment area.
- o Oversight of services delivered in accordance with the SSP.
- o First-line complaint/problem-resolution where issues in the implementation of SSPs are identified.
- o Notification to DMHMRSAS central office staff where such efforts are not successful.
- o Provision as appropriate of training, technical assistance or consultation to HFAs in services to mentally disabled residents.
- o Enhancement and trouble-shooting for CSB-HFA relations.
- o Periodic reviews of disability assessments to determine if changes in this determination are warranted.

CSBs may also be the actual providers of some supplemental services, as appropriate, but private providers or other public agencies will continue in these roles as well. CSBs do not have the capacity to serve all mentally disabled auxiliary grant recipients in HFAs, nor would all such residents select CSBs as providers. This new role for CSBs focuses on service coordination or oversight.

DMHMRSAS central office staff will be involved in service monitoring and coordination not only through fiscal oversight and certification, as outlined earlier, but through these roles as well:

- o Training and establishment of guidelines for CSB disability assessments.
- o Consultation to CSB HFA service specialists.
- o Complaint/problem resolution where local efforts are not successful.
- o Linkage with DSS central office or regional staff as needed.
- o Coordination with DSS and HFAs of regional/statewide special training opportunities for work with mentally disabled residents.

- o Evaluation of the effectiveness and impact of this system, providing routine and special management reports as needed.

Given the extent and importance of these administrative roles, additional central office staff would be needed for system-wide implementation. Previous experience with consultation, service-monitoring and oversight functions indicates this administrative support is essential to ensure effective use of direct service funds.

Implementation Plans

Resource requirements for the targeted supplement model, along with a proposal for phase-in are described here.

1. The proposal requires additional staffing at the CSB level for eligibility determination and ongoing service monitoring. HFA service coordinators would be needed in CSBs and would be distributed in accordance with the density of HFAs statewide. This number of HFA Service Coordinators will be based on appropriate caseloads of residents.

2. The proposal requires additional DMHMRSAS central office staff to accomplish certification of HFAs, complaint/problem investigation and resolution, and administration of sanctions. Central office costs would include staffing a Program Director, HFA service specialists and an administrative assistant. Resources for the initial planning year could be up to $175,000.

3. The proposal requires funding to support supplemental payments for approximately 2500 eligible auxiliary grant recipients in licensed HFAs at $5 per day, or $1825 per year per resident. When the system is fully implemented, an estimated $4.56 million (2500 x $1825) will be required.

DMHMRSAS proposes a five-year implementation plan to put this HFA supplement system in place statewide. Only staff resources will be needed during FY 1989 to further develop standards, processes, and procedures for implementing the model. During the second year, $1,487,500 will be needed to pilot the model in a selected area of the state. This will include approximately $912,500 in supplemental payments. Budget requests will be developed for the following three fiscal years to cover the balance of the state. Total numbers of eligible residents could more accurately be estimated then as could final CSB and central office staffing requirements.

In terms of timeframes, the new system would require extensive start-up and development time, to include:

- o Development of specific certification standards and procedures.
- o Initial heavy load of resident assessments, as likely to be requested by HFA operators.
- o Initation of first phase of SSP development.
- o Finalization of financial procedures and necessary information system development.
- o Dissemination of information to CSBs and HFAs.
- o Training to CSBs in assessments, SSPs, and monitoring roles.

Thus it is proposed that a first phase, to include a limited number of CSB catchment areas, begin in FY 90, with FY 89 serving as a development year. The initial areas would be selected to include high density HFA regions. The phase-in approach reduces initial resource requirements and allows for more accurate assessments of total demand as well as refinement in the procedures proposed.

No specific statutory change or other legislative action beyond budget decisions would be required to initiate this system. The coordination of other necessary actions prior to the hiring of specifically designated staff would continue to be the responsibility of the current steering committee with support from specific agency sections as needed.

Implementation issues which might require special attention would include:

- o HFA provider concerns regarding 1 year delay in start up.
- o HFA system concerns about phase in, and issues of equity in selection of initial areas.
- o Need to assure (through new CSB funding and expansion) increased accessibility of essential supplemental services (e.g., emergency, day, outpatient).
- o CSB concerns regarding selection of initial sites and level of staffing and resources required to fulfill proposed responsibilities.
- o Coordination with other DSS initiatives relating to assessment and LOC requirements for physical/medical care needs.
- o HFA concerns that this approach does not as yet deal with the broader health care LOC concerns.

As suggested by several of these issues, the implementation of this proposed targeted supplement system would need to be coordinated closely with other related

developments in both Departments. Within DMHMRSAS, this proposal fits well with the policy direction of increasing CSB service management responsibilities and enhancing community service resources, particularly in the area of housing and associated support services. Coordination with these related initiatives would be important:

- o Start up of new services to be funded under the 89-90 community addendum.
- o Finalization of the CSB evaluation system.
- o Response to the current study of the Department's licensing staffing and functions.

Projected Impact

In general, the proposed targeted supplement system is seen as addressing the intent of HJR 70 by providing a cost-effective means to enhance services to this special population and to respond to concerns of both HFA and CSB providers. The impact thus is projected overall to be a positive one in terms of services, providers, and costs. Additional information here on several areas of impact may be useful, however, for policy-makers and legislators reviewing this proposal.

1. Staffing: In homes with significant numbers of mentally disabled residents, the supplemental funding could be pooled to allow for additional specialized staffing, if appropriate to resident needs. A home with 14 eligible residents would receive approximately $25,000 per year in supplemental funding. With these resources they could, for example, hire or contract with an occupational therapist to enhance on-site resident training and rehabilitation in skills of daily living and self-help skills. Funds could also allow for additional staff training and consultation to improve special skills in working with this population. Small but measurable improvements in quantity and quality of staff could thus be one positive outcome.

2. Services: As is true with staffing above, both the quantity and quality of services appropriate to this population should increase. Service gaps in identified areas such as day support, vocational rehabilitation, and outpatient counseling should decrease as operators use funds to provide, purchase, or otherwise access them. In many instances, funds may best be used to transport clients to existing but otherwise off-site services. The quality and frequency of other services now provided (recreation, skills training, emergency interventions) should improve, through both increased resources and improved service linkages. Overall, service planning should become a more substantive and individualized process given greater service resources, oversight, and the more specific expectations which would be

established in the SSP process. In some cases, residents' needs will not be able to be met in an HFA setting even with supplemental services. These cases of potential inappropriate placement can be more readily identified and placement alternatives sought. It should be clear that not all service gaps can be remedied with this approach but significant service improvements can be achieved.

3. CSB-HFA linkages: The increased involvement of CSBs in the cases of HFA residents should have several positive outcomes. As CSB case identification and access to information on client functioning improves, fewer people should "fall through the cracks" within the case management system. CSBs will be more aware of HFA operators' needs for support, training and consultation and will have some resources to be more responsive. Case planning and consultation can occur more regularly, so that service goals can be better coordinated.

4. Costs: If staffing, services, and coordination improve for mentally disabled HFA residents, it would be appropriate to expect some reduction in use of hospitals, or other more costly service settings. Residents currently are hospitalized in some situations where early identification and appropriate response to problems could have precluded that costly and disruptive outcome. The annual cost of this supplement per resident ($1800) is the equivalent of less than 2 weeks of state hospitalization. Cost avoidance could therefore be significant in some instances.

APPENDICES 1-5

Appendix 5

1986 SESSION

LD4177566

HOUSE JOINT RESOLUTION NO. 70

Offered January 20, 1986

Requesting the Department of Social Services and Mental Health and Mental Retardation to conduct a joint study of the aftercare needs of mentally disabled clients in adult homes.

Patrons--Marshall and Slayton; Senator: Gartlan

Referred to Committee on Health, Welfare and Institutions

WHEREAS, the Joint Legislative Audit and Review Commission noted in its study on state and local services for mentally ill, mentally retarded and substance abusing citizens that many post-hospitalized mentally ill clients admitted to homes for adults are not receiving the support and supervision they need to function; and

WHEREAS, mental health clients now being discharged into these homes are younger, more active and in need of more intensive support and treatment than a typical resident in this setting; and

WHEREAS, homes for adults have traditionally been regarded as long-term, purely domiciliary arrangements, but many clients today need intensive treatment with transitional living arrangements; and

WHEREAS, many staff members in homes for adults are not trained to provide the unique services needed by these mentally ill clients who require individualized assessment and treatment; and

WHEREAS, differential services provided to these clients should be identified for each client and the homes for adults compensated and regulated appropriately for provision of multiple levels of service; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Social Services and Mental Health and Mental Retardation are requested to conduct a joint study and to ultimately endorse a model for addressing the aftercare needs of mentally disabled clients in homes for adults. The study should include, but not be limited to:

1. The concept of maintaining more than one level of care in the adult home system where differential care is acknowledged and operators appropriately compensated and regulated; and

2. The development of a joint system whereby the Department of Social Services retains the responsibility for licensing and regulating basic safety and care and the Department of Mental Health and Mental Retardation sets standards and regulates the aftercare component; and, be it

RESOLVED FURTHER, That the Departments shall report their findings to the General Assembly prior to the 1988 Session; and be it

RESOLVED FINALLY, That the Clerk of the House of Delegates prepare a copy of this resolution for presentation to the Commissioners of the Departments of Social Services and Mental Health and Mental Retardation and the Secretary of Human Resources.

CURRENT

APPENDIX 2

POLICY MANUAL
STATE MENTAL HEALTH AND MENTAL RETARDATION BOARD
DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

POLICY 86- 13

SUBJECT: Placement of Patients/Residents in Homes for Adults

AUTHORITY: Board Minutes Dated October 22, 1986
Effective Date November 19, 1986

Approved by Board Chairman [signature]

REFERENCES: Sections 37.1-70 and 37.1-98, Code of Virginia (1950) as amended

Guidelines for Mental Health and Substance Abuse Pre-Admission Screening and Discharge Planning April 1, 1984

Medicaid Program Standards for Intermediate Care Facilities for the Mentally Retarded 42 CFR Parts 435 and 442.

BACKGROUND: It is the practice of the Department to return patients/residents to the community once they no longer require the active inpatient treatment or training services which are provided by the Department's treatment facilities. Such community placements are based on the individual's assessed needs, level of care required, and the ability of the designated community setting to meet these needs in conjunction with the appropriate community support services.

At a minimum, the following individuals participate in the discharge planning and placement process: the patient/resident, his or her family (if available and appropriate), state facility staff, CSB staff, and representatives from the local Department of Social Services and other human services agencies and providers.

PURPOSE: To establish a policy regarding the placement of appropriate patients/residents discharged from State facilities into suitable Homes for Adults, along with the provision of technical assistance, consultation and training to Home for Adults operators and staff, as appropriate.

POLICY: It is the policy of the State Mental Health and Mental Retardation Board that patients/residents who no longer require active psychiatric treatment in Department facilities, but who require the supervision and service provided by homes for adults should be placed in this type of residential setting. Determination of appropriate placement should be based on the individual's assessed needs, level of care required, ability of the designated community residential setting to meet these needs and availability of appropriate community support. The discharge planning and placement processes must follow the Patient Management Guidelines and ICF/MR Regulations.

It is also the policy of the Board that CSB and facility staff cooperate in the provision of technical assistance, consultation and training to staffs of Homes for Adults in working with former patients/residents regarding mental health/mental retardation issues.

APPENDIX 3

HJR 70 Homes for Adults Study

FACILITY QUESTIONNAIRE

(Office Use Only: HFAID _____)

General Information

FACILITY Name _____ (1- 5

Address _____ (51-10(

Licensed Bed CAPACITY _____ (101-103) Current OCCUPANCY _____ (104-10(

Current DSS Approved Rate (if any) $_____ (107-11:

Staffing Pattern of Facility: # of Full Time Equivalent Staff Positions

Position	Contracted/ Purchased	Salaried	Volunteer
di:al & Direct Care Staff			
1. M.D.'s	_____ (121-123)	_____ (124-126)	_____ (127-129
2. PSYCHIATRISTS	_____ (130-132)	_____ (133-135)	_____ (136-138
3. OTHER (RN'S, LPN'S, Aides)	_____ (139-141)	_____ (142-144)	_____ (145-147)
ICILLARY Services (OT'S, PT'S, Social Workers, Recreation Workers)	_____ (148-150)	_____ (151-153)	_____ (154-156)
MINISTRATIVE and Support Staff (Cooks, Clerical, Maintenance)	_____ (157-159)	_____ (160-162)	_____ (163-165)

III. Other Services

It is understood that some homes may provide services beyond those required by licensing or related regulations in order to meet special resident needs. What services, excluding those required by licensing regulations and religious activities, are provided by your home? Please check below to indicate whether these services are provided by staff in your home or through other sources.

Note: If it is unclear or not known whether a particular service is provided, write "UK" on the appropriate line. Blank lines will be interpreted as "not provided" for purposes of analysis. This is very important!

Services Provided	Provided by Home	Service Purchased or Contracted	Service Provided by Volunteers
Transportation	_____ (166)	_____ (167)	_____ (168)
Recreation/Trips	_____ (169)	_____ (170)	_____ (171)
Special Diets	_____ (172)	_____ (173)	_____ (174)
Occupational Therapy	_____ (175)	_____ (176)	_____ (177)
Physical Therapy	_____ (178)	_____ (179)	_____ (180)
Incontinence Care	_____ (181)	_____ (182)	_____ (183)
Employment Opportunities	_____ (184)	_____ (185)	_____ (186)
Podiatrist	_____ (187)	_____ (188)	_____ (189)
Beauty Parlor/Barber	_____ (190)	_____ (191)	_____ (192)
Banking Services	_____ (193)	_____ (194)	_____ (195)
Shopping Services	_____ (196)	_____ (197)	_____ (198)
Others	_____ (199)	_____ (200)	_____ (201)

IV. RATE(S) for PRIVATE Pay Residents

What is your facility's advertised rate(s) for non-auxiliary grant (private pay) residents?

$_____ (202-2

V. EXTRA CHARGES

List any services provided to residents either in your home or from other sources, for which you make an extra charge.

Service	In Home		Out of Home	
_____	_____	(209)	_____	(21
_____	_____	(211)	_____	(21
_____	_____	(213)	_____	(21
_____	_____	(215)	_____	(21
_____	_____	(217)	_____	(21

VI. DENIAL of Admission to ELIGIBLE Applicants

During the past year, has there been a time when you had bed space but decided not to admit a person because you felt you could not meet their needs?

Yes _____ (1) No _____ (0) (219)

If yes, why?

VII. DISCHARGE due to INABILITY to Meet Needs

During the past year, have you accepted any residents whom you later needed to discharge because you found you could not meet their needs?

Yes _____ (1) No _____ (0) 220

If yes, why?

VIII. Residents SERVED

Does your home accept residents who have been discharged from state (public) facilities for the mentally ill, mentally retarded, or drug or alcohol abusers?

Yes _____ (1) No _____ (0) (2:

If yes, do you obtain any services for these residents from your local community services board?

Yes _____ (1) No _____ (0) (22

IX. Relationship with Local COMMUNITY SERVICES BOARD

Describe your relationship with your local community services board.

Specifically, do you have a current written, service agreement with them?

How recently has it been reviewed and revised as needed?

Are you satisfied with this agreement?

X. Relationship with Local DEPARTMENT of SOCIAL SERVICES

Describe your working relationship with your local Department of Social Serivces.

HFA ID _____
(Office Use Only)

How many of your current residents are Auxiliary Grant recipients?

_____ (Number)

_____ Do Not Know

HJR 70 Homes for Adults Study

RESIDENT QUESTIONNAIRE

Name of Facility ______________________________ (1- 5

* *

I. Mental Disability

One of the objectives of this study is to determine what proportion of HFA residents are mentally disabled. For the purpose of this survey, we will define as "mentally disabled" those residents who require long-term mental health, mental retardation or substance abuse services from a community services board or other similar private or public provider. What information do you have which would help with this determination?

Note to interviewer: These items are only aids to making a decision and there does not need to be a response for each of them.

Has this person been PREVIOUSLY INSTITUTIONALIZED in a public or private psychiatric hospital or mental retardation facility or training center?

Yes ________ (1) No ________ (0)

Does this person now receive CSB or similar comprehensive mental health, mental retardation or substance abuse services?

Yes ________ (1) No ________ (0)

Will they be in CONTINUED NEED of those services for an extended time period?

Yes ________ (1) No ________ (0)

Does this person regularly use PSYCHOTROPIC MEDICATION for management of psychiatric symptoms?

Yes ________ (1) No ________ (0)

If yes, what medication(s)? ______________________________

____

How frequently are they taken? ______________________________

____

Does this person have a DIAGNOSIS of mental illnes, mental retardation, or substance abuse?

Yes _____ (1) No _____ (0)

If yes, what diagnosis? _____

_____

Who determined this diagnosis? _____

What, if any, other information could you add about this respondents mental status?

After reviewing and discussing this information, please respond as to whether you believe this individual is mentally disabled.

Yes, is MENTALLY DISABLED _____ (1)

No, is NOT MENTALLY DISABLED _____ (0)

Check one of the following to indicate what you believe to be the primary area of disability.

MENTAL HEALTH _____

MENTAL RETARDATION _____

SUBSTANCE ABUSE _____

II. Demographic Information

1. Is this resident an AUXILIARY GRANT recipient?

Yes _____ (1) (51- 5

No _____ (0)

Unknown _____ (.)

2. Clients MONTHLY PAYMENT for this home. (If client is an auxiliary grant recipient, exclude personal care funds). $_____ (52- 5

3. AGE (in years) _____ (59- 6

4. SEX _____ (62- 6
Female (0)

Male (1)

5. MARITAL STATUS _____ (63- 63
Single (1)

Married (2)

Divorced (3)

Separated (4)

Widowed (5)

Unknown (6)

6. RACE _____ (64-

American Indian (1)

White (2)

Hispanic (3)

Black (4)

Asian (5)

Other _____ (6)
(specify)

7. MEDICAID _____ (65- 6
Yes (1)

No (2)

Unknown (.)

8. MEDICARE _____ (66- 6
Yes (1)

No (0)

Unknown (.)

9. PLACEMENT in Home for Adult arranged by: _____ (67- 6

Self (1)

Family Member (2)

Physician (3)

Acute Care Hospital (4)

Private Psychiatric Hospital (5)

MHMR State Facility (6)

Community Service Board (7)

Department of Health (8)

Area Agency on Aging (9)

Department of Social Services (10)

Minister (11)

Attorney (12)

Veterans Administration Hospital Staff (13)

Other _____ (14)
(specify)

10. If you had a concern about how the resident was doing (i.e. behaivor, needed service, etc.), what OUTSIDE AGENCY/PROVIDER would you contact first?

_____ (69-

Department of Welfare/Social Services (1)

Department of Health (2)

Community Services Board (3)

Area Agency on Aging (4)

Department of Medical Assistance Services (5)

Department for the Visually Handicapped (6)

Department of Rehabilitative Services (7)

Home for Adult (8)

Other Agency: Public (9)

Other Agency: Private (10)

11. Does this person have INVOLVEMENT with the Department of Social Services, Community Services Board, or other public or private agency for SERVICES other than financial assistance?

If yes, please indicate which AGENCY. _____ (71- 71

Department of Welfare/Social Services (1)

Department of Health (2)

Community Services Board (3)

Area Agency on Aging (4)

Department of Medical Assistance Services (5)

Department for the Visually Handicapped (6)

Department of Rehabilitative Services (7)

Home for Adult (8)

Other Agency: Public (9)

Other Agency: Private (10)

12. Has this resident been SCREENED by the Nursing Home Preadmissions Committee within the last six (6) months? (-

Yes _____ (1)

No _____ (0)

Unknown _____ (.)

13. Has the client exhibited any of the following maladaptive or difficult to manage behaviors within the last 6-12 months?

1 = Yes

0 = No

FIRE SETTING _____ (73)

PROPERTY DESTRUCTION _____ (74)

ASSAULTIVE _____ (75)

SUICIDAL BEHAVIOR _____ (76)

WANDERING _____ (77)

MAJOR EATING DISORDERS _____ (78)

Significant LACK of SELF-HELP SKILLS (e.g. toileting, bathing, dressing) _____ (79)

Other (specify) _____

_____

14. Does the client have any CHRONIC HEALTH PROBLEMS that require supervised, special treatments, or nursing procedures? (80- 80)

Yes _____ (1)

No _____ (0)

If so, please specify _____

_____

15. Is there an ongoing requirement for administration of MEDICATIONS for chronic health problems? (81-

Yes _____ (1)

No _____ (0)

16. Institutionalization. Was this client a patient/resident during the last 6-12 months in any of the following? Indicate all that apply.

1 = Yes

0 = No

ACUTE CARE HOSPITAL (Medical)	_____	(82- ε
DMH/MR PSYCHIATRIC HOSPITAL	_____	(83- ε
PRIVATE PSYCHIATRIC HOSPITAL	_____	(84- ε
SKILLED NURSING FACILITY	_____	(85- ε
INTERMEDIATE CARE FACILITY	_____	(86- 8
DMH/MR TRAINING CENTER	_____	(87- 8

17. There are three columns for the services listed below. In each column record the appropriate code as indicated. In column 1 indicate whether the client needs the service listed or not (0=No 1=Yes). If the client is presently receiving a listed service, indicate this in column 2 (0=No 1=Yes). In column 3 indicate the primary source from which the client is receiving the service (use the list below).

Sources for Column 3.

1 Department of Welfare/Social Services
2 Department of Health
3 Community Services Board
4 Area Agency on Aging
5 Department of Medical Assistance Services
6 Department of the Visually Handicapped
7 Department of Rehabilitative Services
8 Home for Adult
9 Other Agency: Public
10 Other Agency: Private

COLUMN 1: Needs 0=No 1=Yes	COLUMN 2: Provided 0=No 1=Yes	COLUMN 3: Sources See List	Services	
____	____	____	Case Management	(88- 90
____	____	____	Outpatient Counseling/Therapy	(91- 93
____	____	____	Day Support (e.g. clubhouse, workshop)	(94- 96
____	____	____	Psychotropic Medication Maintenance	(97- 99
____	____	____	Emergency/Crisis Intervention	(100-102
____	____	____	Employment Services/Vocational Rehab.	(103-105
____	____	____	Eligibility Determination (e.g. SSI, GR, and financial services)	(106-108
____	____	____	Legal Services	(109-111)
____	____	____	Medical Nurse, Physician Care	(112-114)
____	____	____	Dental	(115-117)
____	____	____	Other Health (e.g. OT, PT)	(118-119)
____	____	____	Recreation/Socializaion	(120-122)
____	____	____	Transportation	(123-125)
____	____	____	Non-HFA Residential Services (e.g. group home, nursing home)	(126-128)

18. Select the most appropriate category from the attached list which best describes this client's FUNCTIONAL LEVEL. (129) _____

RESOURCE ASSOCIATED FUNCTIONAL LEVEL SCALE

1. DANGEROUS

   Danger to self, others, or property of value. Unable or unwilling to control violent, aggressive, or escape-seeking behavior. Requires continuous (24-hour) supervision, high staff/patient ratio, locked or limited-access facility.

2. UNABLE to FUNCTION, current, Acute Symptoms

   If suicidal or homicidal, is able/willing to control impulses with assistance. Symptoms result in behavior that is seriously disruptive or dangerous, and/or prevent role functioning. Examples of symptoms: lack of reality testing, hallucinations or delusion, impaired judgement, impaired communication, or manic behavior. May be able to carry out some activities of daily living. Requires continuous supervision, moderate staff/patient ratio, limited-access facility.

3. LACKS ADL/PERSONAL Care Skills

   Symptoms no longer result in behavior that is seriously disruptive or dangerous. (Nuisance behaviors should not be considered seriously disruptive or dangerous). Lacks sufficient ADL and/or personal care skills to carry out role functions. Skills lacking because: 1) never learned, or 2) lost through disuse from creation of extreme dependency, neglect, lack of motivation. Requires continuous (24-hour) prompting, skill training, and encouragement. Moderate staff/patient ratio needed.

4. LACKS COMMUNITY LIVING Skills

   Able to carry out ADL personal care skills. Role functioning impaired by lack of community living skills, such as: housekeeping, money management, using public transportation, ability to engage in competitive employment, maintaining interpersonal contacts. Require regular and substantial (e.g., 2 or more hours per day), but not necessarily continuous training, prompting, and encouragement.

5. NEEDS ROLE SUPPORT and/or Training

   Can perform role functions, at least minimally, in familiar settings and with frequent support to deal with the ordinary stresses of everyday life; e.g., can perform housekeeping tasks, although may need the regular assistance of a roommate, homemaker/aid, etc., or can work outside of sheltered situations with an understanding employer or on-site support or counseling. Becomes dysfunctional under the stresses associated with the frustrations of everyday life and novel situations. Requires frequent (e.g., weekly) information, encouragement, and instrumental assistance.

6. NEEDS SUPPORT/TREATMENT to Cope with Extreme Stress or Seeks Treatment to Maintain or Enhance Personal Development

   a) Can perform role functions adequately except under extreme or unusual stress. At these times, the support of natural or generic helpers such as: family, friends, clergy or physician is not sufficient. Mental disability services required for the duration of stress.
   b) Can perform role functions adequately, but seeks mental disability services because of feelings of persistent dissatisfaction with self or personal relationships. Intensity and duration of treatment can vary.

7. SYSTEMS INDEPENDENT

   Can obtain support from natural helpers or generic services. Does not require or seek mental disability services.

APPENDIX 4

TABLE 1

Staffing Ratio by Type of Position

Position	Range	Average
Physician	.00-.11	.005
Psychiatrist	.00-.03	.001
Other Medical	.00-.81	.187
Ancillary	.00-.43	.022
Administrative	.00-.84	.176

TABLE 2

Services Provided

Type of Service	HFAs Providing Service
Transportation	182 (92.4%)
Recreation/Trips	182 (92.4%)
Special Diets	168.5 (85.5%)
Occupational Therapy	32.5 (16.5%)
Physical Therapy	53 (26.9%)
Incontinence Care	113 (57.4%)
Employment Opportunities	39 (19.8%)
Podiatrist	79 (40.1%)
Beauty Parlor/Barber	145 (73.6%)
Banking Services	98.5 (50.0%)
Shopping Services	178.5 (90.6%)
Others	66 (33.5%)

NOTE: These data have been weighted.

TABLE 3

Method of Providing Service

Type of Service	Provided By HFA	Provided By Contract	Provided By Volunteers
Transportation	171.0 (94.0%)	24.5 (13.5%)	54.0 (29.7%)
Recreation/Trips	164.5 (90.4%)	9.5 (5.2%)	71.0 (39.0%)
Special Diets	168.5 (100.0%)	2.5 (1.5%)	2.5 (1.5%)
Occupational Therapy	10.5 (32.3%)	18.0 (55.4%)	5.0 (15.4%)
Physical Therapy	20.5 (38.7%)	34.5 (65.1%)	2.5 (4.7%)
Incontinence Care	109.5 (96.9%)	6.0 (5.3%)	0 (0.0%)
Employment Opportunities	25.5 (65.4%)	7.0 (17.9%)	8.5 (21.8%)
Podiatrist	21.0 (26.6%)	59.0 (74.7%)	0 (0.0%)
Beauty Parlor/Barber	101.5 (70.0%)	49.5 (34.1%)	10.0 (6.9%)
Banking Services	89.5 (90.9%)	10.0 (10.2%)	8.5 (8.6%)
Shopping Services	171.0 (95.8%)	4.5 (2.5%)	37.5 (21.0%)

NOTE: These data have been weighted.

TABLE 4

Percentage of Residents in Each HFA Who Were Mentally Disabled

Percentage of Residents	HFAs
0%	35.5 (18.1%)
0-33%	35.0 (17.8%)
33-66%	39.5 (20.0%)
66-100%	87.0 (44.2%)

TABLE 5

Percentage of Residents Receiving Auxilliary Grants

Percentage of Residents	HFAs
0%	35.5 (22.0%)
0-20%	42.5 (26.3%)
20-40%	45.0 (27.9%)
40-100%	38.5 (23.8%)

NOTE: All data have been weighted.

Table 6

Percentage of Mentally Disabled Residents By HFA Size

	Percentage of Mentally Disabled Residents			
HFA Size	0%	0-33%	33-66%	66-100%
4-15	7(25.9%)	2(7.4%)	3(11.1%)	15(55.6%)
16-43	4(12.5%)	3(9.4%)	9(28.1%)	16(50.0%)
44-100	2(15.4%)	5(38.5%)	3(23.1%)	3(23.1%)
Over 100	3(17.7%)	10(58.8%)	2(11.8%)	2(11.8%)
Total	16(18.0%)	20(22.5%)	17(19.1%)	36(40.5%)

Note. $X^2(9) = 27.7$, $p = .001$
Cramer's V = .322

Table 7

Average Percentage of Mentally Disabled Residents by HFA Size

HFA Size	Average Percentage of Mentally Disabled Residents	Number of of HFAs[a]
4-15	58.5%	27
16-43	58.0%	32
44-100	37.1%	13
Over 100	22.3%	17

[a] Actual number of HFAs in the sample.

Table 8

Mean Staffing Ratio by HFA Size

HFA Size	Mean Staffing Ratio	Number Of HFAs[a]
4-15	.42	27
16-43	.41	32
44-100	.32	13
Over 100	.29	17

[a] Actual number of HFAs in the sample.

Table 9

HFA Denied Admission By HFA Size

HFA Size	Denied Admission No	Yes
4-15	14(51.9%)	13(48.2%)
16-43	13(41.9%)	18(58.1%)
44-100	4(30.8%)	9(69.2%)
Over 100	2(11.8%)	15(88.2%)
Total	33(37.5%)	55(62.5%)

Note. 1 missing case
$X^2(3) = 7.7$, $p = .053$
Cramer's V = .296

Table 10

Discharges Due to Inability to Meet Needs By HFA Size

HFA Size	Discharges Due to Inability to Meet Needs: No	Yes
4-15	12(44.4%)	15(55.6%)
16-43	8(25.0%)	24(75.0%)
44-100	4(30.8%)	9(69.2%)
Over 100	6(35.3%)	11(64.7%)
Total	30(33.7%)	59(66.3%)

Note. $X^2(3) = 2.5$, $p = .467$
Cramer's V = .169

Table 11

Uses CSB Services By HFA Size

HFA Size	Uses CSB Services	
	No	Yes
4-15	7(25.9%)	20(74.1%)
16-43	7(22.6%)	24(77.4%)
44-100	6(46.2%)	7(53.9%)
Over 100	10(58.8%)	7(41.2%)
Total	30(34.1%)	58(65.9%)

Note. 1 missing case.
$X^2(3) = 8.1$, $p = .044$
Cramer's V = .303

Table 12

Occupancy Rate By HFA Denied Admission

HFA Denied Admission	Mean Occupancy Rate	Number of HFAs[a]
No	89.4%	33
Yes	89.5%	55

Note. 1 missing case.
[a] Actual number of HFAs in the sample.

Table 13

Occupancy Rate by Accepts Discharges from State Facilities

Accepts Discharges from State Facilities	Mean Occupancy Rate	Number of HFAs[a]
No	80.9%	18
Yes	91.5%	70

[a] Actual number of HFAs in the sample.

Table 14

HFA Denied Admission By Accepts Discharges from State Facilities

Accepts Discharges from State Facilities	HFA Denied Admission No	Yes
No	10(27.8%)	26(72.2%)
Yes	69.5(44.1%)	88(55.9%)
Total	79.5(49.1%)	114(58.9%)

Note. All data have been weighted. The weighted number of valid cases is 193.5 and the weighted number of missing cases is 4.

$X^2(1) = 3.2$, $p = .072$
Cramer's V = .129

Table 15

Discharges Due to Inability to Meet Needs By Accepts Discharges From State Facilities

Accepts Discharges from State Facilities	Discharges Due to Inability to Meet Needs	
	No	Yes
No	24(66.7%)	12(33.3%)
Yes	42(26.3%)	118(73.8%)
Total	66(33.7%)	130(66.3%)

Note. All data have been weighted; n = 196, missing = 1.
$X^2(1) = 21.5$, p = .000
Cramer's V = .331

Table 16

HFA Denied Admission By Percentage of Mentally Disabled Residents

Percentage of Mentally Disabled Residents	HFA Denied Admission	
	No	Yes
0%	16 (45.1%)	19.5(54.9%)
0-33%	8.5(24.3%)	26.5(75.7%)
33-66%	10 (27.0%)	27 (73.0%)
66-100%	45 (51.2%)	42 (48.3%)
Total	79.5(40.9%)	115 (59.1%)

Note. All data have been weighted; n = 194.5, missing = 2.5
$X^2(6) = 21.5$, $p = .002$
Cramer's V = .233

Table 17

Discharges Due to Inability to Meet Needs By Percentage of Mentally Disabled Residents

Percentage of Mentally Disabled Residents	Discharges Due to Inability to Meet Needs	
	No	Yes
0%	21 (59.2%)	14.5(40.9%)
0-33%	17.5(50.0%)	17.5(50.0%)
33-66%	5 (12.7%)	34.5(87.3%)
66-100%	22.5(25.9%)	64.5(74.1%)
Total	66 (33.5%)	131 (66.5%)

Note. All data have been weighted; n = 197.
$X^2(3) = 24.7$, p = .000
Cramer's V = .354

Table 18

Uses CSB Services By Accepts Discharges from State Facilities

Accepts Discharges from State Facilities	Uses CSB Services No	Yes
No	33.5(100.0%)	0(0.0%)
Yes	25.5(15.9%)	134.5(84.1%)
Total	59 (30.5%)	134.5(69.5%)

Note. All data have been weighted. The weighted number of valid cases is 193.5 and the weighted number of missing cases is 4.
$X^2(1) = 92.4$, $p = .000$
Cramer's V = .691

Table 19

Uses CSB Services By Percentage of Mentally Disabled Residents

Percentage of Mentally Disabled Residents	Uses CSB Services	
	No	Yes
0%	24.5(74.2%)	8.5(25.8%)
0-33%	18 (51.4%)	17 (48.6%)
33-66%	7.5(19.0%)	32 (81.0%)
66-100%	10 (11.5%)	77 (88.5%)
Total	60 (30.8%)	134.5(69.2%)

Note. All data have been weighted; n = 194.5, missing = 2.5
$X^2(6) = 64.1$, $p = .000$
Cramer's V = .403

Table 20

HFA Denied Admission By Uses CSB Services

Uses CSB Services	HFA Denied Admission	
	No	Yes
No	18.5(30.8%)	41.5(69.2%)
Yes	61 (46.2%)	71 (53.8%)
Total	79.5(41.4%)	112.5(58.6%)

Note. All data have been weighted. The weighted number of valid cases is 192 and the weighted number of missing cases is 5.
$X^2(1) = 4.0$, $p = .045$
Crammer's V = .145

Table 21

Discharges Due to Inability to Meet Needs By Uses CSB Services

Uses CSB Service	Discharge: Inability to Meet Needs	
	No	Yes
No	25 (41.7%)	35(58.3%)
Yes	38.5 (28.6%)	96(71.4%)
Total	63.5 (32.7%)	131(67.4%)

Note. All data have been weighted. The weighted number of valid cases is 194.5 and the weighted number of missing cases is 3.
$X^2(1) = 3.2$, $p = .073$
Cramer's V = .128

APPENDIX 5: Tables, Resident Data

Demographic Data

1. Age:

Resident Age	Number (%) of Residents
21-40	80 (14.5%)
41-65	214 (42.1%)
65+	225 (43.4%)

Median Age = 62 years

2. Race:

Race	Number (%) of Residents
White	384 (74.0%)
Black	125 (24.1%)
Native American	6 (1.2%)
Hispanic	2 (0.4%)
Asian	1 (0.2%)
Other	1 (0.2%)

3. Marital Status:

Race	Number (%) of Residents
Married	26 (5.0%)
Single	286 (55.5%)
Widowed	108 (21.0%)
Divorced	79 (15.3%)

4. Resident Use of Other Institutions in Previous 12 Months

Type of Facility	Number (%) of Residents
Acute Care Hospital (Medical)	60 (11.6%)
DMHMRSAS Psychiatric Hospital	29 (5.6%)
Private Psychiatric Hospital	29 (5.6%)
Skilled Nursing Facility	0
Intermediate Care Facility	7 (1.4%)
DMHMRSAS Training Center	7 (1.4%)

5. Maladaptive Behaviors Exhibited in Previous 12 Months

Behavior Exhibited	Number (%) of Residents
Fire Setting	8 (1.5%)
Assaultive	54 (10.4%)
Wandering	51 (9.8%)
Property Destruction	28 (5.4%)
Suicidal Behavior	17 (3.3%)
Eating Disorder	20 (3.9%)

6. Levels of Functioning (RAFLS Scale)

Level of Functioning (1-7)	Description	Number (%) of Residents
1	Dangerous to self/others. Requires continuous supervision in secure setting.	1 (0.2%)
2	Active psychiatric symptoms which are disruptive and impair role functioning. Requires continuous supervision in limited-access setting.	29 (5.6%)
3	Symptoms no longer result in disruptive/dangerous behavior. Lacks sufficient daily living and personal care skills to carry out role functions. Continuous prompting, skill training, and encouragement required.	161 (31.1%)
4	Able to carry out personal care functions but lacks community living and employment skills. Regular (daily) training, prompting, encouragement required.	201 (38.9%)
5	Able to carry out most role functions in familiar settings and in sheltered work situation. Novel situations and everyday stress can cause dysfunction. Weekly encouragement and/or assistance required.	77 (14.9%)
6	Generally successful role functioning except under extreme stress, during which professional support is required.	41 (7.9%)
7	Does not require or seek professional support and is systems independent.	7 (1.4%)

Service Linkages

1. Person/Agency Which Arranged Placement into HFA

Placement Arranged By	Number (%) of Residents
DMHMRSAS Facility	173 (33.4%)
Family Member	125 (24.1%)
Department of Social Services (local)	62 (12.0%)
Veterans Admin. Hospital	46 (8.9%)
Community Services Boards	33 (6.2%)
Other	29 (5.6%)
Self	19 (3.7%)
Private Psychiatric Hospital	11 (2.1%)
Physician	10 (1.9%)
Acute Care Hospital	6 (1.2%)
Attorney	2 (0.4%)
Minister	1 (0.2%)
Not Specified	1 (0.2%)

2. Current Agency Involvement

Service Agency	Number (%) of Residents
Community Services Boards	175 (34.1%)
Agency Not Specified	104 (20.3%)
Other Private Agency or agency not Specified	76 (14.8%)
Department of Social Services (local)	58 (11.3%)
Other Public Agency	58 (11.3%)
Home for Adult	24 (4.7%)
Department of Health	8 (1.6%)
Department of Medical Assistance	4 (0.8%)
Department of Rehabilitative Services	3 (0.6%)
Area Agency on Aging	2 (0.4%)
Department for Visually Handicapped	1 (0.2%)
Not Applicable	6

3. Outside Agency to Contact If Concerned About Client

Agency to Contact	Number (%) of Responses
Community Services Board	203 (39.1%)
Other Private Agency	176 (33.9%)
Other Public Agency	76 (14.6%)
Department of Social Services (local)	36 (6.9%)
Home for Adult	8 (1.5%)
Department of Health	7 (1.3%)
Department of Rehabiliative Services	4 (0.8%)
Department of Medical Assistance	3 (0.6%)
Agency Not Specified	3 (0.6%)
Area Agency on Aging	2 (0.4%)
Department for Visually Handicapped	1 (0.2%)

Service Needs and Utilization

1. Primary Sources of Services (10% or more of valid responses)

Sources of Case Management	Number (%) of Cases (N=324)
Community Services Board	151 (46.6%)
HFA	66 (20.4%)
Other Agency (Public)	52 (16.0%)
Department of Social Services (local)	32 (9.9%)

Sources of Outpatient Counseling/Therapy	Number (%) of Cases (N=249)
Community Services Board	113 (45.4%)
Other Agency (Private)	62 (24.9%)
Other Agency (Public)	61 (24.5%)

Sources of Day Support	Number (%) of Cases (N=100)
Community Services Boards	48 (48.0%)
HFA	18 (18.0%)
Other Agency (Private)	14 (14.0%)
Department of Rehabilitation Services	10 (10.0%)

Sources of Psychotropic Medication	Number (%) of Cases (N=392)
Community Services Boards	129 (31.9%)
Other Agency (Private)	125 (30.9%)
HFA	80 (19.8%)
Other Agency (Public)	61 (15.1%)

Sources of Emergency/Crisis Intervention	Number (%) of Cases (N=167)
Community Services Boards	86 (51.5%)
Other Agency (Private)	36 (21.6%)
HFA	23 (13.8%)
Other Agency (Public)	20 (12.0%)

Sources of Employment/Vocational Rehabiliation	Number (%) of Cases (N=30)
Department of Rehabilitative Services	12 (40.0%)
Community Services Boards	8 (26.7%)
HFA	4 (13.3%)
Other Agency (Public)	3 (10.0%)

Sources of Eligibility Determination	Number (%) of Cases (N=271)
Department of Social Services (local)	221 (81.5%)

Sources of Legal Services	Number (%) of Cases (N=35)
Other Private Agency	18 (52.9%)
HFA	6 (17.6%)
Community Services Board	4 (11.8%)

Sources of Nursing/Physician Care	Number (%) of Cases (N=426)
Other Private Agency	213 (50.0%)
HFA	147 (34.5%)

Sources of Dental Services	Number (%) of Cases (N=232)
Other Private Agency	151 (65.1%)
Other Public Agency	37 (15.9%)

Sources of Other Health Services (OT,PT)	Number (%) of Cases (N=68)
Other Public Agency	24 (35.3%)
HFA	21 (30.9%)
Other Private Agency	14 (20.6%)

Sources of Socialization/Recreation Services	Number (%) of Cases (N=466)
HFA	449 (96.4%)

Sources of Transportation	Number (%) of Services (N=473)
HFA	399 (84.4%)