national institute for advanced studies

ALTERNATIVES TO INSTITUTIONALIZATION: AN EVALUATION OF STATE PRACTICES

Contract No. HCFA-500-77-0029

REVISED OKLAHOMA CASE STUDY

November 1978

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Submitted to:

Department of Health, Education and Welfare
Health Care Financing Administration
330 C Street, S.W.
Washington, D.C. 20001

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INTRODUCTION

The Health Care Financing Administration (HCFA) has contracted with the National Institute for Advanced Studies (NIAS) to conduct a study of the development of alternatives to the institutionalization of the functionally disabled population, including the developmentally disabled, the physically handicapped and/or chronically ill, the mentally ill and the elderly. The objectives of the study are to help:

- reduce the inappropriate institutionalization of the functionally disabled
- facilitate the development of health and social services which prevent inappropriate institutionalization
- encourage states to utilize Medicaid programs which can help to support the goals of alternative care arrangements.

Four major tasks are identified as being the key activities involved in achieving the above objectives. These tasks include:

- conduct of a literature search and the development of a methodology and analysis plan
- on-site review of state practices

- analysis of collected data and preparation of a final report
- oral presentation of findings at a meeting of the Medicaid Management Institute.

The final product of this study will be a technical assistance ("how-to-do-it") manual for use by state agencies (and other concerned parties) in the planning and establishment of appropriate alternatives to institutional care. This manual will be presented at the meeting of the Medicaid Management Institute.

This document is a case study of the State of Oklahoma. It details Oklahoma's current involvement in the development of alternative care programs. The descriptions herein are based upon personal interviews with various individuals and supporting materials obtained on-site.

OVERVIEW

Oklahoma's ability to provide for its functionally disabled population is complicated by the current physician shortage which exists in the state. Many state agencies in Oklahoma have begun to address the task of creating suitable environments within communities which can support the needs of the functionally disabled who do not need to be institutionalized. These alternatives to institutionalization act to discourage the overutilization of physicians. Various programs have been developed which are briefly described below. Later in this report, each program will be described in detail, based upon the site visit information, and is discussed in terms of its process of development. There are five key stages of this process: 1) needs assessment, 2) program planning, 3) program development, 4) program operations, and 5) program evaluation. These individual stages are defined in the Appendix of this report.

Oklahoma's Department of Institutions, Social and Rehabilitative Services, through its Medical Services Unit, is responsible for the operations of the Non-Technical Medical Care Program. This program involves the provision of non-technical medical care (e.g., food preparation, personal hygiene, etc.) to the functionally disabled who are in their own homes, but are unable to function independently without some periodic assistance.

A Home Maintenance Aide Program is currently being developed by the Department's Division of Social Services. This program is designed to address only non-medical needs and will not duplicate the Non-Technical Medical Care Program.

Another division of the department is the Division of Rehabilitative and Visual Services, in cooperation with the State Mental Health Department and the Central State Griffin Memorial Hospital, operates a residential Vocational Rehabilitation Center. This center fills the gap which often exists after

the discharge of patients from mental hospitals. It is designed to help the individual become and remain gainfully employed and to prepare him for reentry into the community.

The Department of Mental Health, through the Community Mental Health Division, has developed an innovative aftercare/precare program for discharged patients of state mental hospitals and their families. This comprehensive program provides its clients with therapy and helps them to find a job, and there is a social component which encourages community acceptance and involvement.

DEPARTMENT OF INSTITUTIONS, SOCIAL AND REHABILITATIVE SERVICES

The Department of Institutions, Social and Rehabilitative Services is an umbrella agency, responsible for the provision of a variety of human services, assistance payments, social services, rehabilitative services, and food and nutrition services. The various units and divisions of the department conduct ongoing activities and programs to avoid duplication. Examples of the coordination which exists are the Non-Technical Medical Care Program and the Home Maintenance Aide Program.

Non-Technical Medical Care Program

This program is offered by the Medical Services Unit of Oklahoma's Department of Institutions, Social and Rehabilitative Services. It has been in operation since 1970 and involves the delivery of non-technical medical services (such as food preparation, personal hygiene, and keeping the home environment clean and comfortable) through the use of trained aides. The stated objectives of this program are:

- to keep people in their own homes where they may enjoy familiar surroundings and family integrity
- to strengthen, improve and safeguard the home and family life for individuals
- to reduce the period of hospitalization by providing trained people to give non-technical medical care in the home
- to reserve institutional facilities for those patients whose conditions require care which cannot be provided at home
- to improve the skills of those working in the home rendering the services.[1]

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[1] "Oklahoma's NTMC: A Feasible Medicaid Option," Medicaid, Vol. 3, No. 2, April 1973, p. 6.

More than 3,000 functionally disabled Oklahomans are receiving non-technical medical care services.

A "provider" (home health aide) is assigned to each recipient and must be certified by the attending physician as being capable of providing the level of care specified. Each provider must complete 20 hours of training. This training includes instructions in the performance of tasks in the areas of physical environment, personal care and nutrition needs. The provider is taught to identify and report physical and behavioral changes in the recipient.

Providers are supervised by nurses who are assigned to one of six districts. Each nurse has a caseload of approximately 80-100 recipients. Visits to the recipient's home to monitor the care given by the provider are conducted bimonthly. The typical provider of the program is one who lives in the neighborhood of the recipient and is often a friend or relative.

Needs Assessment

No formal needs assessment was conducted for this program.

Program Planning

An advisory board was created to help establish the basic format of the program. (A nurse consultant was also appointed; she acted to facilitate the functioning of the advisory board.) Specifically, this advisory board was responsible for designing the program, developing the educational materials to be used in training the program providers, acting as liaison to the nursing community and defining the geographical boundaries of the various districts within which the program would be implemented.

Program Development

Informal coordinative linkages exist between the Non-Technical Medical Care Program and other agencies. For example, some use is made of the Title VII meal programs which are offered through Oklahoma's State Agency on Aging. The nurses of the Non-Technical Medical Care Program maintain close contact with caseworkers from other divisions in the Department of Institutions, Social and Rehabilitative Servcies, who may be involved with a particular recipient.

Recipients of the program are identified through referrals from family, physician, friends, or the incapacitated individual himself.

Program Operations

All recipients of Oklahoma's Non-Technical Medical Care Program are Medicaid-eligible individuals. A caseworker assigned to a particular recipient initially prepares a medical-social summary and arranges for a complete examination of the recipient by a physician. The physician is also asked to prepare a plan of treatment which specifies the type of care to be given to the recipient. These reports are then sent to the Medical Evaluation Unit within the Department of Institutions, Social and Rehabilitative Services, which is responsible for authorizing non-technical medical care. To determine eligibility for the program, an assessment of need is done on the basis of the information submitted by the physician and caseworker. The condition of each accepted applicant is reviewed annually (in some cases, every six months) by the Medical Evaluation Unit to document continuing need.

The termination of the provision of non-technical medical care services is usually done at the request of the recipient. In some cases, the recipient has become too dependent upon the services or companionship provided by the program and must be terminated involuntarily. Follow-up is not done once a case has been closed.

Program Evaluation

The Non-Technical Medical Care Program has not been evaluated as yet. A very informal check on problems and solutions is occasionally done by the nursing staff of the Medical Services Unit.

Home Maintenance Aide Program

The Home Maintenance Aide Program is being developed "to help individuals and families (primarily ambulatory public assistance recipients) maintain, strengthen and regain their abilities to sustain themselves in their own homes, prevent institutional care, provide protective services, and to enrich the quality of their lives."[2] This program will not have a medical component and therefore will not duplicate the non-technical medical program.

Needs Assessment

The University of Oklahoma's School of Social Work provided demographic information about each of the state's 77 counties and about the total number of persons receiving certain services and the nature of services received.

A needs assessment was also conducted by the University's School of Social Work in preparation for the planning of the state's Title XX programs. This needs assessment involved the formation of committees the members of which completed a series of questionnaires about the service needs of their particular locale. This needs assessment indicated that a program such as the Home Maintenance Aide Program would fill an existing service gap.

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[2] Home Maintenance Aide Training Packet.

Program Planning and Program Development

The experiences of the Non-Technical Medical Care Program have been used as a guide in planning for the Home Maintenance Aide Program. For example, providers similar to those used for the Non-Technical Medical Care Program (i.e., those with little training or formal education) will be used to staff the Home Maintenance Aide Program. There will be some significant differences between these two programs; the Home Maintenance Aide Program, unlike the Non-Technical Medical Care Program, will include an educational component for the recipient as well as the provider.

The goals delineated by the Title XX legislation were adopted in the development of the Home Maintenance Aide Program.

Program Operations

Although this program is not yet in operation, it will function like the Non-Technical Medical Care Program in that a service plan will be developed which specifies the type of care to be given to the recipient. The service plan is jointly developed by the recipient, the home maintenance aide, and a social worker. The social worker is a part of a social service team consisting of supervisors, social workers and other professionals. The social service team is ultimately accountable for the provision of services to the program's clients.

Program Evaluation

The Home Maintenance Aide Program will be evaluated annually through the needs assessment component of the state's Title XX plan.

Central State Vocational Rehabilitation Center

The Central State Vocational Rehabilitation Center is a residential facility which is jointly operated by the Department of Institutions, Social and Rehabilitative Services, the State Mental Health Department, and the Central State Griffin Memorial Hospital. A cooperative agreement exists between these three parties which outlines areas of cooperation, responsibility and the authority of the staff of the facility.

The purpose of the vocational rehabilitation center is:

> to provide a place for the comprehensive evaluation, treatment, and particularly the rehabilitation of emotionally disturbed and mentally ill patients... Programs housed in this facility are designed to help the patients obtain, and more importantly, to maintain gainful employment or job efficiency after leaving the hospital.
>
> The services performed by the staff housed in this facility will fill a gap that often existed when patients were discharged from the hospital without adequate preparation for their return to their families or to their jobs.[3]

Services which are offered include vocational diagnosis and counseling, psychiatric treatment, home economics, and rehabilitation services.

Needs Assessment

In 1962 the Central State Griffin Memorial Hospital's rehabilitation program was evaluated, and it was recognized that there was a need to have the rehabilitation clients

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[3] Rehabilitation Manual, Central State Hospital, August 1976, p. 2.

collectively housed and separated from other hospital activities. A section of the hospital and a cottage were donated for use by the rehabilitation program. In 1966, when funds became available through the Hill-Burton Act for the construction of rehabilitation facilities, a new building for the program was planned. The facility was completed in 1968.

Program Planning and Program Development

The planning for the Central State Vocational Rehabilitation Center was based on the prior experience of the rehabilitation program which had been a part of the Central State Griffin Memorial Hospital. Input from the center's staff was also used in planning and developing its programs.

Program Operations

All referrals for the vocational rehabilitation center's programs are received from the Central State Griffin Memorial Hospital. Each referral is screened by a screening team prior to admission. This team is usually composed of a psychiatrist, a registered nurse, a rehabilitation counselor and a social work assistant. The screening team interviews the client and makes an assessment of his/her functioning. At this point, a decision is made to admit or not to admit the client into the center's programs.

Admitted clients are asked to complete initial intake forms and are interviewed by a counselor to determine which offered services they should receive while at the center. A series of evaluation interviews are held between the client and a member of the center's evaluation unit. During these interviews, the evaluator observes the client to report on these

aspects of client behavior: personal-social, physical limitations, abilities, and work habits.[4]

The evaluator and the client's rehabilitation counselor work together to assess the client's potential and to locate and develop work situations which are suited to the client's abilities. Background information on the client is obtained, and a rehabilitation plan is developed, which details services to be provided to the client. This plan may be revised if the client's vocational objectives change.

A client's case may be closed under certain circumstances. Specifically, the records of a closed case should show that:

- the program of rehabilitation services has been completed insofar as possible
- substantial rehabilitation services have been rendered to the client
- the client is suitably employed
- the basis for determining that the client is suitably employed at a job that is consistent with the client's physical and/or mental disabilities and limitations, his work skill, personal and/or adjustment problems.[5]

Follow-up is done in the form of field visits by the center's counselors. Clients who no longer need the services of the vocational rehabilitation center are introduced to the support systems in the community (e.g., mental health clinics).

Program Evaluation

Annually, the agreement which defines the shared responsibilities for the operations of the vocational rehabilitation center is formally reviewed by the participating parties

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[4] Ibid.

[5] Ibid.

(Central State Griffin Memorial Hospital, the State Department of Mental Health and the Rehabilitative Services Division of the Department of Institutions, Social and Rehabilitation Services). This review measures: number of clients; category of clients (e.g., alcoholics, schizophrenics); counselor caseloads; cases closed; and the weaknesses and strengths of the program.

STATE DEPARTMENT OF MENTAL HEALTH

Oklahoma's State Department of Mental Health is responsible for the provision of services to the state's mentally ill and mentally retarded populations. These services include aftercare services for former mental hospital patients.

Community-Based Aftercare Programs

The establishment of community-based aftercare programs for former Oklahoman mental hospital patients began in 1963 with a grant from the National Institutes of Health. This grant funded the development of four different aftercare programs, whose aims were:

- to make mental health services available to population groups within a geographic area
- to coordinate and expand existing community resources on behalf of the returning mental patient
- to provide professional consultation to various agencies in the designated communities that are involved in helping the discharged mental patient
- to provide precare and aftercare services in a definitely rural area for former patients and their families.[6]

The basic philosophy of these aftercare programs is that the former mental patient is an integral part of the community and should not be stigmatized; the community should assume responsibility for meeting the needs of the former mental

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[6]Holt, John and Javellas, Ina. "Continued Care of the Mentally Ill in Oklahoma Communities—A Social Work Approach" State of Oklahoma, Department of Mental Health, 1968, pp. vii-viii.

patient by working with community social workers in the development of aftercare and community education programs.[7]

Needs Assessment

Recognition of the need for aftercare programs is explained:

> As state hospital personnel become involved in the changing function of mental hospitals, old custodial models are gradually, but certainly giving way to new approaches that recognize the importance of hospital-community partnership in offering services to the mentally ill. Specific programs within hospitals reflect a growing awareness of social environment as an important area to be understood in terms of diagnostic formulations and subsequent treatment undertakings. The need for adequate follow-up programs comes clearly into focus under these circumstances.

Initially, four community aftercare programs were established in different geographic locations throughout Oklahoma, serving the existing mental hospitals and covering urban, semi-rural and rural areas. There are currently 11 aftercare programs, made possible by funding from the state.

Program Planning and Development[9]

The grant from the National Institutes of Health provided funding for the first four aftercare projects (in Tulsa, McAlester, Oklahoma City, and Lawton) which served as models for the other projects developed later. The staff of these four projects addressed the tasks of: 1) identifying and

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[7] Ibid.

[8] Ibid.

[9] Oklahoma Department of Mental Health, Community Services Division, Final Report Summary (Grant Reference Number RO 1 MH 14819), pp.1-11.

evaluating the multiplicity of needs of the former mental hospital patient, and 2) studying and evaluating attitudinal changes in terms of community acceptance and degrees of participation in behalf of the clients over a period of time.

Personnel from the three state mental hospitals and the project staff maintained close communications, and formal administrative guidelines defining respective roles and responsibilities were developed by the project's coordinator. A referral system for the state hospitals was also developed.

Project staff acquainted themselves with the resources that existed in each of the four communities; resource files were established based on contact with local social, health and welfare agencies, civic and lay groups and non-psychiatric community caretakers. A community education program was launched which included presentations at community meetings.

During the first year of the projects, a contract was signed with the Oklahoma State University's Department of Sociology to conduct a mental health survey in Tulsa. This study analyzed former mental hospital patients' utilization of community resources, role problems affecting reintegration into the community, areas of concern, ties to social groups outside the family, recreation patterns and daily routines, feelings of stigma and special problems affecting patient adjustment and reintegration into the community. The study produced information which facilitated the identification of solutions to client problems.

A training manual for use by the project staff was developed to provide important information about the development of aftercare projects, the kind of services that should be included and the manner of service delivery.

Program Operations

These aftercare programs offer a variety of services including counseling, vocational rehabilitation and life management. These programs are all different, to some degree. For example.

> It was observed that initially some of the staff of the two metropolitan communities tended to cling to traditional methods of service delivery, relied upon the casework method, and resisted the 'outreach' type approach. More formal communications systems were operative in the metropolitan areas; whereas, an attitude of candor, openness, and the degree of flexibility not present in cities existed in the more rural areas. Generally speaking, the rural communities exhibited an eagerness for establishing services which henceforth had been unavailable.[10]

The availability of resources, prevailing community attitudes, the communities socio-economic backgrounds are all factors which can influence and shape the oeprations of a particiular aftercare program.

Program Evaluation

Oklahoma's aftercare projects for former mental hospital patients thus far have only been evaluated in terms of their effects on decreasing the percentage of aftercare patients rehospitalized (in 1977, only 8% of the aftercare patients had to be rehospitalized). The aftercare projects have not yet been evaluated in terms of their socializing effects on the former patients and the communities involved.

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[10] Ibid.

APPENDIX I

DEFINITION OF TERMS

Needs Assessment

A needs assessment is usually designed to answer one basic question: what services are needed by this population? In order to answer this basic question, strategies should be developed which outline a means of: (1) defining the characteristics of the potential client population; (2) determining which services are most needed (demanded); (3) determining to what extent the services already available address the needs presented; and (4) determining the extent to which available services are coordinated and accessible to clients.

Analyses such as the above will help to identify the current needs of the client population, i.e., significant gaps between the services and clients' need and the services the clients receive.

Program Planning

In planning the actual alternative care program, the results of the needs assessment are utilized in conceptualizing the specific features of the program. At this point in the process, questions usually asked include:

- What should the program ultimately achieve? In other words, what are its goals and objectives?

- How will the program be organized? Will it be independent, or subsumed within another unit?
- What resources are available to be used by the program? Are there advantages over using some as opposed to others?
- What categories of services, i.e., direct or indirect, will be offered by the program?
- Given the category(ies) of service, what specific ones will be offered by the program?
- What philosophies will be adopted in providing these services? Will staff be encouraged to emphasize advocacy, education, or both?
- What will be the characteristics of the staff employed?
- How will important decisions be made? Will all staff and clients be encouraged to participate in the process, or will the decisions only be made by the Program Director?
- Where will the program physically be located? What factors will influence its placement?
- Will all or only a segment of the functionally disabled population be served by the program? If only a segment, how is it decided which segment will receive the services?

Program Development

To ensure the services provided to clients are efficient, administrative procedures should be developed which define the manner in which supportive functions, such as recordkeeping, reimbursement procedures and coordinative mechanisms, are to be conducted. These functions are thought to be essential to the development of a program which positively impacts client status.

The final step in developing an alternative care program is the recruitment of clients. Such recruitment often involves an extensive effort to educate the potential client population in terms of the services offered and the requirements for receiving these services. This can be accomplished by canvassing the communities involved and using the media, special presentations, distribution of literature, etc., to advertise the new program.

Program Operations

Operating a service delivery program basically involves the performance of procedures designed to provide the services to clients in the most effective manner possible. These procedures ensure the client's successful movement through the service system, from the time of his/her entry to the time when the services are no longer needed. There are six such procedures: (1) initial client intake and screening; (2) client diagnosis/assessment; (3) service plan development; (4) case monitoring; (5) service termination; and (6) follow-up.

Initial client intake and screening describes what first takes place between the client and program staffer. During this interaction, the staff person must obtain vital information about the background of the client and the services which should be provided. The background information received will help the staff person ascertain if the potential client is actually eligible for the services needed. If not, avenues of recourse for the client can be identified.

If it is determined that the client is eligible for services, the staff person proceeds to more accurately assess the problems of the client and the extent of assistance needed. This assessment/diagnosis will culminate in the

collection begins). Information resulting from the program evaluation will provide indicators as to what changes are needed.

The program discussed did not necessarily include each of these stages. Each program is unique in some respect. This case study has categorized the different approaches used in developing alternative services so as to facilitate the development of the technical assistance manual.