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ALTERNATIVES TO INSTITUTIONALIZATION: AN EVALUATION OF STATE PRACTICES

Contract No. HCFA-500-77-0029

REVISED OREGON CASE STUDY

November 1978

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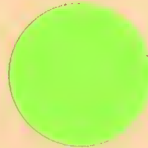

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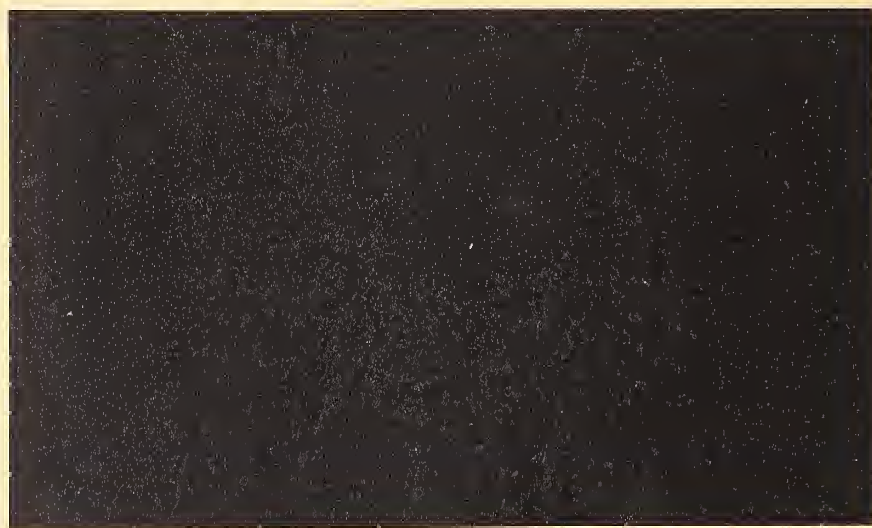

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Submitted to

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

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OREGON CASE STUDY

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, including the developmentally disabled, the physically handicapped and/or chronically ill, the mentally ill, and the elderly. The objectives of this 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 programs.

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

- conducting a literature search and the development of a methodology and analysis plan
- an on-site review of state practices
- an 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 procedural manual for use by state agencies (and other organizations and individuals) 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 Oregon. It details Oregon'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

The State Government of Oregon has designated the Department of Human Resources as the primary agency responsible for the administration of numerous programs dealing with chronically ill individuals. The Department of Human Resources is responsible for the administration of Title 19, Title 20, the Older Americans Act and numerous older federal legislation with supportive services for disabled persons. The specific divisions of the Department of Human Resources are as follows:

- Office of the Director, Department of Human Resources
- Office of Elderly Affairs
- Division of Children's Services
- Division of Corrections
- Division of Employment
- Division of Health and Social Services
- Division of Mental Health

This case study will focus upon the effects of some of the Department's divisions to establish or support alternative care programs. For each of these programs, five key stages of development are discussed: 1) needs assessment, 2) program planning, 3) program development, 4) program operations, and 5) program evaluation. These individual stages are described in detail in the Appendix of this report.

OFFICE OF ELDERLY AFFAIRS

The Office of Elderly Affairs reports directly to the Director of the Department of Human Resources. The office performs key tasks in meeting the needs of Oregon's elderly population. It is responsible for the administration of Project Independence, which is a program designed to ensure that the State's elderly are not inappropriately placed nursing homes or state institutions.

Project Independence

This program is a result of discussions which began at the 1971 White House Conference in Aging and the response to a subsequent report made by the state's delegation to this conference to the Governor. The program encourages the use of such services as home care, transportation, and outreach, to discourage the use of Medicaid funds to support the inappropriate institutionlization of the elderly.

Needs Assessment

The network of Oregon's Area Agencies on Aging is required to conduct local assessments of needs and availability of services in order to qualify for monies which are under the Department of Human Resources' jurisdiction. This process has served as an initial data base for the identification of the population to be served by Project Independence. The Area Agencies on Aging were asked to submit proposals to the Office of Elderly Affairs in order to qualify for funds under Project Independence. These proposals are to contain projections of the

number of individuals "at-risk" (of institutionalization), the number to be served by Project Independence, and also the specific components of the proposed program. Based upon this information, the Office of Elderly Affairs will develop a distribution formula for the funds from the State Legislature which have been allocated to the project.

Program Planning

Oregon's 1975 State Legislature appropriated almost a million dollars to be used in establishing Project Independence. Along with this appropriation, the legislature approved the creation of a new Governor's Committee on Aging. This committee assumed lead responsibility in determining the guidelines for Project Independence. The Department of Human Resources, however, is ultimately responsible for the administration of the program.

Program Development

The Office of Elderly Affairs has developed an operations manual of standards for record keeping procedures, client-provider reimbursement procedures, and coordinating mechanisms to be carried out by the Area Agencies on Aging. These procedures were developed to ensure compliance with federal requirements governing similar types of management activities. Thus, Project Independence did not develop a new set of management procedures but expanded the existing standards developed by the Area Agencies on Aging.

Project Independence established multiple mechanisms for ensuring that clients were informed of and recruited for Project Independence. The program was widely publicized through the television media. The Area Agencies on Aging, in providing consultation and referral services to individuals in

the community, were able to identify individuals who qualified for Project Independence.

Program Operations

Each Area Agency on Aging's Project Independence program varies in some respect. To ensure some uniformity of program operations, the Office of Elderly Affairs developed a client intake and assessment form to be used by all the Area Agencies on Aging that have Project Independence programs. This form assists the intake worker in determining that the client is at "high-risk" of institutional care."[1]

The majority of clients (60%) participants in Project Independence are receiving home care services, although many are also receiving transportation, outreach, and information and referral services.

Program Evaluation

Thus far Project Independence has been evaluated in terms of the risk level of its clients (97% during 1977, met the "high risk of institutional care" requirement) and in terms of the costs of these services (average cost per client per month found to be $79.00, (which is much less expensive than institional care).

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[1]Ruth Shepherd, Special Assistant on Elderly Programs "Oregon Project Independence for the Western Gerontological Soviety's Denver, Colorado Conference, March 20, 1977.

DIVISION OF MENTAL HEALTH

The Division of Mental Health of the Department of Human Resources is concerned with the improved coordination of placement, treatment and follow-up services to Oregon's mentally ill who can be maintained in communities as opposed to institutions. In an attempt to accomplish this goal, the Division has joined the Marion County Board of Commissioners in sponsoring the Marion County Community Mental Health Program's "Accountability in Long-Term Care" Training Project.

Marion County Community Mental Health Program's "Accountability in Long-Term Care" Training Project

This training project was designed to create a common approach to long-term care placement which would be used by the provider of mental health services (state institutional staff, community program staff, psychiatrists, social workers, etc.):

> "Limited local and state resources cannot be conserved and targeted on effective services unless there is a continuity and coordination of care focused around clients, rather than points of service, so that the concept of accountability can become more meaningful. The purpose of the training project was to catalyze the working together of the provider at the various levels, generating a common language and framework which will facilitate continuity and coordination and will make possible low-cost client accountability and program evaluation."[2]

This training project consisted of a series of three workshops, focusing on: 1) client assessment for placement, 2) active treatment oriented to reduction of dependency, and 3) assessment of placement environments. In addition, monies were obtained to increase and improve long-term care staffing levels.

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[2] Saslow, Michael G., Marion County Community Mental Program "Accountability in Long-Term Care" Training Project, Final Report, June 30, 1977 p.4.

Needs Assessment

An important indication of the need for a more organized approach to long term care placement was the frequency with which problems arose in establishing lines of accountability to clients and to funding sources. A major source of these problems was the involvement of more than one case manager on the case of a single client. This resulted in a lack of coordination between the parties involved and the services delivered. Once this situation was recognized by state agency officials, it was decided to implement a training project for long term care providers which would be designed to alleviate these problems by facilitating continuity and coordination or service delivery. Marion County was selected primarily because of the high percentage of discharged patients from the Oregon State Hospital that moved into this area and their continuing need for supportive services.

Program Planning and Development

A committee was formed to plan for and conduct the three training workshops. This committee was composed of a diverse group of long-term care providers and agency personnel. The planning committee met on several occasions to 1) make logistical arrangements for the workshops, 2) recruit participants for the workshops and 3) develop the curriculum for the workshops and 4) select the resource faculty to be used.

The training methodology employed required a maximum attendance of 65 participants at each of the training sessions. The specific format was small group discussions. Workshop participants were given field assignments following each session which necessitated the use of their newly acquired knowledge. This training methodology emphasized:

- active rather than passive involvement
- incentive and opportunity for field application of what is learned
- establishment of ongoing professional relationships and interagency channels

- Practice in trainer and consultant roles for members of the planning committee

- replicable packaged training materials and procedures for further local and statewide use

- participation in development of terminology, instruments, forms and procedures so that there will be a realistic feeling of ownership rather than an attitude of passive resistance or negativity.[3]

Program Operations

The aims of each of the three training sessions is presented below.

I. Client Assessment for Placement

- To develop a practical, shared approach to client assessment for placement, including:
  - The identification of problem categories most relevant to placement.
  - The development of scales of problem intensity.
  - The establishment of criterion points on the scales, for a variety of types and levels of placement.
- To develop a consensus on treatment priorities.
- To increase individual providers' skills in performing assessment for placement.
- To increase individual providers' skills in setting treatment priorities.

II. Active Treatment Oriented to Reduction of Dependency

- To increase individual providers' familiarity with various approaches to active treatment, and contact with consultation resources for the various approaches.

3- Ibid., P.6

III. Assessment of Placement Environments

- To develop a practical, shared approach to assessment of placement environments, including:

  - The identification of relevant dimensions of fexibility, warmth, individualization, clear expectations, etc.

  - The establishment of criterion points on the dimensions, for a variety of types and levels of placement.

- To increase individual providers' familiarity with various ways to improve placement environments, and contact with appropriate consultation resources.[4]

Program Evaluation

The training sessions were evaluated in terms of whether they accomplished their objectives and in terms of participant response. An analysis of the problems encountered (e.g., difficulty in stimulating participants to be specific and in obtaining appropriate training space) was also conducted. All objectives were not accomplished; some were found to be too ambitious. Based upon the instruments which were administered at the end of each workshop, it was found that the long-term care providers generally were more satisfied with the workshops than the agency personnel who attended.

4-Ibid., P.7

ADULT AND FAMILY SERVICES DIVISION

The Adult and Family Services Division of the Department of Human Resources shares administrative responsibility for the management of Oregon's F.I.G. (Flexible Intergovernmental Grant) Project. Other members of an administrative steering committee for the project are the State Program on Aging and the Office of Elderly Affairs.

F.I.G. Project

The Pacific Northwest Regional Commission represents the coalition of governors from the states of Idaho, Oregon and Washington. These governors appealed to the Department of Health, Education and Welfare for funding to support the planning of experimental social services block grant projects. These projects would focus on a specific target population within a specific geographic area, utilizing a pool of categorical funds which would improve the coordination of services. This application for funding was approved and Oregon selected senior citizens as its target group and the Medford region as its geographic area. The basic goal of the project is to "assist each Oregon senior citizen at risk of becoming dependent to establish and maintain physical and social support systems so as to remain as self sufficient as feasible."[5] In January of 1978 project proposals were prepared which presented plans for using a pool of categorical funds in providing services to the elderly. Three project sites are to be selected.

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[5] Department of Human Resources, Adult and Family Services Division, "Oregon - Medford F.I.G. Project: Working Synopsis". December 5, 1977

Needs Assessment

An analysis of Oregon's nursing home caseload indicated that nursing home populations could be reduced if adequate alternatives would be developed in the community. This analysis added fuel to the prevailing political strategy:

> One of Govenor Straub's main priorities last legislative session was to restore confidence in government through common sense. The state has various specific budgets that assist particular groups of elderly persons who can no longer meet all of their own needs. The state should be able to conduct these budgets in able to more effectively help its citizens maintain their self-sufficiency...[6]

This fact also convinced the state's legislative of the need for this program.

Program Planning and Development

The project has been designed to be conducted over a five year period. Two of the three project sites will be "control" sites. The purpose of the control sites is to enable the differentiation of the effects of implementation in various settings.

An administrative and a service goal were developed which summarized the intent of Oregon's F.I.G. project:

(administrative goal)

- To gradually waive, on a sub-state basis, categorical restrictions and governmental policies which constitute barriers to coordinated planning, management, and pooling of funding for a set of related programs supported by Titles XIX and XX of the Social Security Act, Titles III and VII of the Older Americans Act, state general funds, and local public and private funds.

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[6] Ibid.

(service goal)

- To provide in one region of the state effective comprehensive services to all elderly persons who are at risk of losing self-sufficiency, or who can no longer maintain self-sufficiency, in the most appropriate, least restrictive, residential placements which will maximize self-sufficiency.[7]

Guidelines also were established for project proposals which were to be prepared by January 1978. Each proposal was to contain six major divisions: 1) definition, 2) mechanisms 3) purpose, 4) expectations on project management, 5) expectations on project design, and 6) research issues.

Program Operations

Although the FIG Project was not as yet operational, Exhibit I outlines the predicted tasks and accomplishments which were to take place during the five year life of the three projects.

Program Evaluation

During the planning and development stages of the FIG project, provisions were made for an evaluation component. Annually, at each of the project sites, a comprehensive assessment of the physical and social capabilities of a sample of the serviced elderly will be conducted so as to provide information on needs and project outcomes.

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[7]Department of Human Resources, Adult and Family Services Division, "Project Analysis, Oregon-Medford F.I.G. Project" Decemebr 5, 1977

EXHIBIT I

F.I.G. PROJECT PLANNED ACTIVITIES*

A. ADMINISTRATIVE OBJECTIVES AND INTENDED ACCOMPLISHMENTS

Year 1 (Year 2 at Site #2)

1. Start project.
2. Generate funds for alternatives.
3. Simplify eligibility.
4. Plan the standardization of functions such as the forms and processes in intake, assessment, eligibility determination, case management/monitoring, follow-up assessments, fiscal administration at local level, program quality monitoring against standards.

Years 2 and 3 (Years 3 and 4 at Site #2)

1. Implement the planned standardization of the identified functions.
2. Exploration of potential savings, advantages, and disadvantages of assignment of some of the identified functions to single agencies.
3. Allocate funds to geographical sub-areas on the basis of the balance and priority of needs.

Years 4 and 5 (Year 5 at Site #2)

1. Implement the planned assignments of the identified functions to single agencies.
2. Develop proposed "hard-funded" mechanisms to maintain system after demonstration period.

* Source: "Project Analysis, Oregon - Medford F.I.G. Project".

EXHIBIT I (con't)

B. SERVICE OBJECTIVES, INTENDED ACCOMPLISHMENTS

Annually, at Sites #1, #2, and #3

1. Comprehensive assessment of the physical and social self-sufficiency of a sample of the seniors, by geographical subareas, to identify needs on both a baseline and an outcome basis.

Year 1 (Year 2 at Site #2)

1. Provide matched services by means of case management and provider training.

2. Orient case managers and providers to goal-directed service concepts.

3. Orient case managers and providers to methods for assessing and improving psychosocial aspects of services.

4. Orient case managers and providers to the concept of individualized comprehensive package of services, with both simultaneous and sequential continuity.

Years 2 and 3 (Years 3 and 4 at Site #2)

1. Provide individualized comprehensive packages of appropriate services, with annual encumbrance for highest priority predicted needs, quarterly commitments regarding other known needs, and provision for meeting urgent unanticipated situations.

Years 4 and 5 (Year 5 at Site #2)

1. Continue to provide comprehensive service packages as described above, but in the context of the assignment of certain selected common function to single agencies.

EXHIBIT I (con't.)

C. ADMINISTRATIVE STEPS AND INTERMEDIATE TASKS.

Year I

1. Obtain XIX waiver.

2. Obtain other waivers.

3. Establish advisory committee.

4. Establish role of advisory committee.

5. Establish task force to develop methods for coordinated management of pooled and unpooled funds.

6. Committee meetings to work on the plans for standardization of functions.

Year 2 and 3

1. Implement standardizations, using lead agencies with task forces, and utilizing such techniques as training, cross-training, and cross-agency rotations.

2. Committee to explore possible assignment of selected functions to single agencies.

3. Analysis of needs of persons in geographical subareas in order to determine priorities for allocations of funds and service capacity.

4. Implementation of policies and procedures to accomplish coordinated management of pooled and unpooled funds.

Years 4 and 5

1. Implement the planned assignments of functions, again using lead agencies with task forces.

2. Secure any additional waivers needed.

3. Establish "hard-funding" task force.

EXHIBIT I (con't.)

D. SERVICE STEPS AND INTERMEDIATE TASKS

Annually at Sites #1, #2, and #3

1. Develop sampling plans for the annual assessments.

Year 1 (Year 2 at Site #2)

1. Develop and utilize procedures and materials for accomplishing the service objectives, and provide orientation and training.

Years 2 and 3 (Years 3 and 4 at Site #2)

1. Develop and utilize systematic method for individualized comprehensive service planning based on the procedures developed in the previous year, and provide orientation and training.

Years 4 and 5 (Year 5 at Site #2)

1. Develop and utilize systematic methods for appropriate multi-provider access to information, without violation of confidentiality and without limitation of rights to appropriate, decent, and active service.

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

development of a service plan, which specifies strategies for meeting the needs of the client. A service plan might also define time limits for the accomplishment of certain goals or objectives (e.g., the client will be relocated to better housing before winter).

Once the service plan is developed, it must then be implemented. During the course of implementation, the progress of the client will be monitored by the assigned staff person; any problems will be identified at this point and solutions proposed.

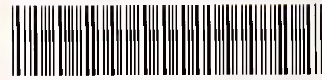
Assuming that any problems are eventually resolved, it is reasonable to expect the client to arrive at the point where he/she no longer needs the services that have been provided. Termination of services should only occur after consultation and counseling have taken place between the client and all service providers. If services are terminated, the client should be periodically contacted to determine how he/she is managing without the services.

Program Evaluation

Program staff and administrators need means of gauging how effective their program is in terms of meeting its specified goals and objectives. This can be accomplished by first identifying an evaluation model to be used in assessing the impact of the program. The next step is the collection of data which provide documentation on the program's efficiency, comprehensiveness, effectiveness, etc. (This information should include details about costs, client visits per month, average length of client visits, etc.) Following the collection of data, it should be analyzed according to an analysis plan (ideally, the analysis plan should be prepared before data

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.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