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ALTERNATIVES TO INSTITUTIONALIZATION: AN EVALUATION OF STATE PRACTICES

Contract No. HCFA-500-77-0029

REVISED VIRGINIA CASE STUDY

November 1978

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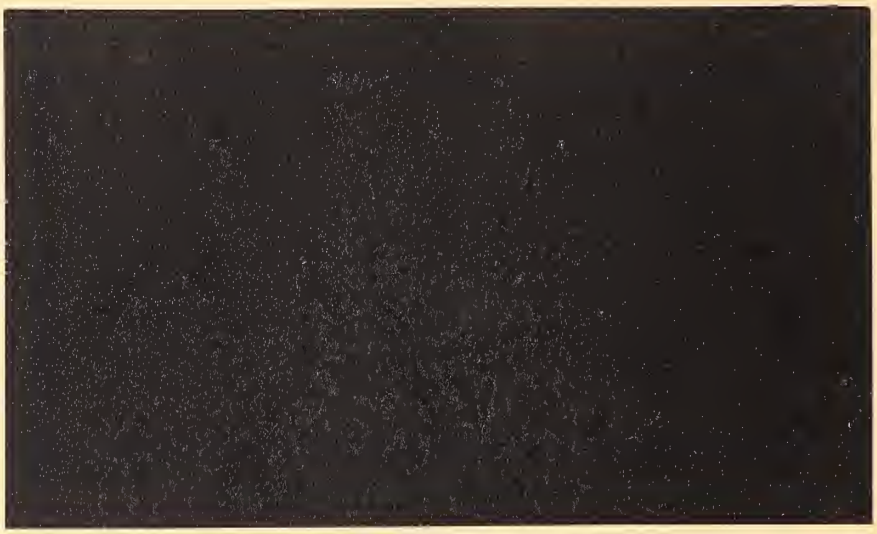

Submitted to

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 task 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 Virginia. It details Virginia'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

Virginia's functionally disabled population is substantial; for example, there are an estimated 621, 683 persons, aged sixty and over,[1] now residing in Virginia, many of whom are chronically impaired, and there are perhaps as many as 150,000 mentally retarded citizens.[2] Many of the state agencies in Virginia 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. Various programs have been developed which are briefly described below, based upon the site visit information. Later in this report each program 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 detail in the appendix to this report.

The Department of Mental Health and Mental Retardation cooperates in the provision of services for the mentally ill and the mentally retarded through Community Services Boards (known as Chapter 10 Boards). These boards are established and maintained by localities and provide services and facilities for the mentally ill and the mentally retarded using matching state and local funding. Three of the 37 service boards (for Roanoke, Chesterfield County, and Region X) are discussed in this case study.

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[1]Commission on the Needs of Elderly Virginians, Stand Up For Aging, 1977, p.2.

[2]Remarks delivered by Leo E. Kirven, Jr., M.D., Acting Commissioner, Department of Mental Health and Mental Retardation, at the first meeting of the Commission on Mental Health and Mental Retardation, August 8, 1977, p. 9.

The Virginia Department of Mental Health and Mental Retardation, in cooperation with the Virginia Housing Development Authority, has also developed a program to provide group housing for mentally retarded adults. This program utilizes the federal Section 8 Housing Assistance Payments Program (which is administered by the United States Department of Housing and Urban Development) to support the new construction of the group homes. The Virginia Housing Development Authority makes available 100 percent mortgage loans to eligible non-profit sponsors, and the Department of Mental Health and Mental Retardation is responsible for the provision of an appropriate system of supportive programs for the residents of the group homes.

Virginia's Department of Health is involved in the provision of home health services. These are nursing and related services which are provided to individuals and families in their place of residence. The Department also has recently instituted nursing home pre-admission screening procedures. These procedures are intended to identify those nursing home applicants who are capable of living in their own homes or at least in their own communities.

Home based care services, as well as home health services, are also a part of Virginia's network of alternative services for the functionally disabled. These home based social services are offered by the Department of Welfare's Division of Social Services. Home base care services include homemaker services, companion services, and chore services. All of these services are designed to preserve the home life of the aged or disabled adult and of family life within the community.

VIRGINIA'S DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

One of the goals of Virginia's Department of Mental Health and Mental Retardation is to "place continued emphasis on community development with alternatives for institutionalization and with prevention of institutionalization receiving major emphasis."[3] This goal has been accomplished in part by the development of local mental health and mental retardation services boards. These boards were first established by the General Assembly in 1968. They are often called Chapter 10 Boards, after the section of the Virginia Code which authorizes and defines their establishment. Chapter 10 Boards are locally managed but adhere to the standards designated by the Department. The purposes of these boards are threefold:

- to review existing programs, to evaluate what programs are already doing and to initiate new programs when needed
- to act as a governing board and central authority for mental health and mental retardation services
- to set fees for payment of services. The board also makes applications for federal grants when programs are eligible.[4]

Currently, there are 37 Chapter 10 Boards operating in Virginia. Each Board consists of 5 to 15 members. Many of these Boards have hired directors to administer the programs

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[3]Commonwealth of Virginia, Department of Mental Health and Mental Retardation, Information Paper, p.3.

[4]"Community Mental Health and Mental Retardation Services Boards" (Pamphlet).

and services offered by the board. The growth and development of these boards have varied. The experiences of the Roanoke, Chesterfield County, and Region X Boards are discussed below as examples.

Roanoke Valley Services Board

The Chapter 10 Board for the Roanoke Valley currently is involved in the provision of four types of program offerings for the mentally retarded: 1) outpatient services, 2) group homes, 3) supervised apartments, and 4) short-term care.

Needs Assessment

The development of these services began with needs assessment activities. A needs assessment plan was developed initially and sent to all area agencies which dealt with the mentally retarded. These agencies were asked to identify service priorities for this client population. The Chapter 10 Board also surveyed secondary consumers, e.g., the parents of the mentally retarded. Based upon this assessment, the needs of the mentally retarded in the immediate area were determined.

Client participation in existing programs was monitored as another means of determining need. For example, the response to a particular program (e.g., waiting list of those who also want the services) was used to determine the demand for additional programs.

Roanoke's Chapter 10 Board is affiliated with the area's Association for Retarded Citizens (ARC). To avoid the unnecessary duplication of existing services, the board worked with the ARC to ensure that its programs further developed those which the ARC already had in operation:

> The Roanoke Area Association for Retarded Citizens has significantly expanded and increased its programs since its affiliation with Mental Health Services of the Roanoke Valley. (For example) their sheltered workshops (Rehabilitation and Industrial Center) have grown to the point of providing both habilitation and production services. Approximately 65 clients are being served by a staff that numbers twelve.[5]

It is also the responsibility of individual counselors employed by the board to coordinate the provision of services to clients so that they are able to take advantage of relevant services offered by other agencies as well.

Program Planning

Goals and objectives based on the outcome of the needs assessment were then developed by the staff of the Roanoke Board. It was decided that the treatment strategy used by the various programs would be the principle of normalization. This principle embraces the theory that the mentally retarded should be taught to function independently in a normal environment.

Roanoke's Board is now in the process of trying to prioritize its program offerings. The criteria used include the impact of the program in terms of the number of persons reached. Resources will be allocated according to these priorities.

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[5]Mental Health Services of the Roanoke Valley, Extended Mental Retardation Services, p. 2.

Program Development

The administrative systems and procedures used by the board's programs include the Problem Oriented Recordkeeping System. Such recordkeeping systems have four sections: 1) identification of problem, 2) objective setting, 3) plan to achieve objectives, and 4) interdisciplinary notes.

Apart from the Welfare Department, the Roanoke Board also has other, less formal, coordinative arrangements with various area agencies. These agencies accept referrals from Chapter 10 Board programs and vice versa.

In order to educate and recruit clients for its program, the Roanoke Board met with parents and members of school faculties. Use was made of the local media and "open houses" were held. The board also developed referral systems with area agencies and institutions.

Program Operations

Once potential clients are identified, they are asked to supply supporting information (such as the results of a psychological exam). This supporting information is reviewed by an admissions committee which screens all applicants to determine whether they should be admitted to the program on a trial basis. The individuals' strengths and weaknesses are assessed in terms of their prospects for future independence. Admissions committees are usually composed of the program's supervisor, a social worker, a vocational rehabilitation counselor and a psychologist.

Parent input is used in diagnosing/assessing client problems. After an individual has been participating in a program for two months, he/she is assessed using the Adapted Behavior Scale to determine the level of functioning

and which areas need to be developed. (The focus here is on behavior rather than IQ.)

The results of the Adapted Behavior Scale and Information from the Problem Oriented Recordkeeping System are used in developing client service plans. The problem oriented records also provide for the monitoring of client progress on a monthly basis. The Adapted Behavior Scale is used only yearly basis to reassess client status. These two tools are also used to determine if and when a client has been rehabilitated to a point where services can be terminated. Specifically, the clients' functional level is evaluated in terms of his ability to conduct essential activities for independent living, such as cooking, and earning an income. If it is decided that a client can be terminated from a program, follow-up is conducted by the Board's counseling services every 8-10 days until it is mutually agreed that it is no longer needed.

Program Evaluation

The evaluation of Roanoke's Board is done in-house. For example, its group homes are evaluated using the format of the Program Analysis of Service Systems (PASS) which quantitatively depicts the group home's level of normalcy. Factors assessed include: how well the home blends into the surrounding community, the history of the home, its appearance and its surroundings. The group home's treatment program is also assessed in terms of the residents' appearance, their behavior and how they are being treated. Points are assigned to each of the various (50) categories and scores are developed between 0-2,000. Any score below 200 is considered a failure. All of the recommendations from these evaluations are incorporated into the program; however, if the recommendation

involves the allocation of resources which may be better used in another capacity, the recommendation may be disregarded.

Chesterfield County Services Board

The Chesterfield County Board has concentrated its efforts regarding the mentally retarded in three major areas: 1) client advocacy/case management, 2) vocational programming, and community living arrangements.

Needs Assessment

No formalized needs assessment was conducted to identify client demand for services in Chesterfield County. The determination of the demand for services was based on referrals which had been made to the Chesterfield County Board. The identified programs were seen as offering core services which are universally needed by mentally retarded clients. Also, the services for mentally retarded that existed previously were only offered in Richmond and it was decided that it was unrealistic to attempt to tap the counties' clients into Richmond's service system. Interagency meetings are held periodically to prevent duplication and efforts are being made to organize a formal interagency council to facilitate this arrangement.

Program Planning

In planning for its three major service areas, the Chesterfield County Board took the initiative in developing a funding package which included allocations from both the county and the state. This funding package was based upon identified priorities. For the actual design of the programs, the board examined other models presented in the literature which embraced similar program philosophies.

Program Development

During the development stages for the Chesterfield County Board programs, it was decided that the Individual Data Base (IDB) system would be used to gather client statistics and other pertinent information.

No recruitment drives were conducted to recruit clients for the programs offered by the Chesterfield County Board, although some use of the media has been made. Most potential clients are identified through contracts with other agencies and through the board's Client Service Advocacy component, which is designed to identify mentally retarded persons in the county.

Program Operations

In seeking placement in one of the Board's programs, a client first must have contact with a case manager who will conduct an initial assessment and refer the client to the appropriate program. Sometimes contact is made initially with an individual program, in which case the client will either be accommodated or referred elsewhere. The assessments which are conducted are not formal; in that standard diagnostic tests are not administered. An individual's functioning level is assessed to help guide placement.

The development of client service plans is tailored to meet the needs of each of the board's programs. A modified problem oriented record method is used in most cases.

Client progress is monitored periodically (usually every six months). For certain programs, case reviews are conducted by a psychologist, but most often, these are conducted by the program staff. Based on these assessments, staff

recommendations and client input, it may be ultimately decided to release the client from the program. When this happens, follow-up is done to the extent specified in the client's service plan.

Program Evaluation

The Chesterfield County Board's programs have not been formally evaluated. Meetings are occasionally held with the various program directors to ascertain how well the programs are operating. The program directors are expected to meet with their staff and develop plans for implementing any recommendations which are an outcome of these meetings.

Region X Service Board

The Region X Board (serving the City of Charlottesville, and the counties of Albermarle, Nelson, Green, Lousia and Fluvanna) offers both direct and contracted services. A dual approach is used: to train the mentally retarded for community living and to help the community adjust to the mentally retarded's presence in the community. In addition to offering the usual programs, including group homes and sheltered workshops, the Region X Board has a public information component which emphasizes the prevention of mental retardation.

Needs Assessment

The development of the Region X Board's program offering was based upon in-house knowledge of the prevalence of mental retardation in the area and estimates of the number of potential clients in need of services. A number of past surveys conducted by service agency personnel regarding

the needs of the area's mentally retarded citizens were also reviewed and considered.

The Region X Board maintains an up-to-date listing of all services in the community which are available to mentally retarded citizens. This listing is used to help assess the need for additional services in the area.

Program Planning and Development

The procedures used during the planning and development stages for the Region X Board's programs were products of an informal process which included brainstorming, trial and error, etc.

In publicizing its programs the Region X Board utilized community meetings and the media for purposes of announcement. Its public information component is used to educate and recruit clients. There are very few self referrals or even parental referrals; most referrals come from other service agencies.

Program Operations

Once a referral is accepted, the Region X Board's staff evaluate the reason for referral to determine if it is an appropriate one. After appropriateness of the referral has been determined, basic intake information is obtained from the client and he/she is assigned to a case manager. During the next three encounters, a complete assessment is done, covering the individual's psychological background, social history, etc. The client and case manger jointly develop a contract which specifies a plan for the delivery of services and the responsibilities of both parties. This contract is designed to meet both immediate and long-term needs, and will include provisions for monitoring client progress, the termination of services, and (sometimes) follow-up procedures.

Program Evaluation

An informal evaluation of the Region X Board's programs is conducted yearly. This evaluation is not systematic, but rather an informal attempt at assessing the success and coverage of the programs by drawing conclusions based on daily experiences. From this evaluation, a set of objectives is developed for the coming year.

A Program to Provide Community Housing Alternatives

The Virginia Department of Mental Health and Mental Retardation, in cooperation with the Virginia Housing Development Authority, has developed a program to provide group housing for mentally retarded adults. This program utilizes the Federal Section 8 Housing Assistance Payments Program (which is administered by the U.S. Department of Housing and Urban Development and is designed to support the new construction of the group homes). The Virginia Housing Development Authority makes available 100 percent mortgage loans to eligible nonprofit sponsors, and the Department of Mental Health and Mental Retardation is responsible for the provision of an appropriate system of supportive programs for the residents of the group homes.

Thus far, one group home has been opened in Newport News, Virginia, and three more are planned for other areas in the state (Richmond, Roanoke, and Alexandria). The provision of services to the residents of these group homes is often the task of the area's Chapter 10 Board.

Needs Assessment

In Virginia, where deinstitutionalization has long been a potent issue, it was found that for every 100 persons deinstitutionalized there existed only two beds in the community to support their needs. Armed with these statistics, the Developmental Disabilities Council and the Association for Retarded Citizens in Virginia, approached the Virginia Housing Development Authority about assisting in the provision of group home beds.

Program Planning

The Virginia Housing Development Authority and the Department of Mental Health and Mental Retardation held a number of meetings to explore the feasibility of rehabilitating existing structures for use as group homes. The costs involved in satisfying various regulations governing such rehabilitation (including Virginia's statewide building code and the licensing requirements of the Department of Mental Health and Mental Retardation) proved to be prohibitive; so it was decided to limit the program to new construction.

Once the Department of Mental Health and Mental Retardation and the Virginia Housing Development Authority were clear as to the scope of the program and their respective commitments, an Interagency Advisory Council was formed to assist in directing the program's development. Members of this council included:

- Virginia Housing Development Authority
- Department of Mental Health and Mental Retardation
- Department of Welfare
- Department of Vocational Rehabilitation

- Developmental Disabilities and Advisory Council
- Virginia Association of Retarded Citizens
- Local Chapter 10 Boards.

Program Development

The Virginia Housing Development Authority created a Seed Money Loan Program which was to provide funds to selected sponsors of the group homes for such items as land options, architectural fees, etc. These loans are later repaid from the construction loan.

To oversee the cost of services provided by the group homes, the Interagency Advisory Council appointed a Services Task Force. The specific purposes for the formation of this task force were:

- Provide programmatic expertise in determining the services needed in group homes and the cost of these services
- Identify funding restraints and means of utilizing funding resources
- Develop service model to be used by the group homes
- Provide the council with data as to the feasibility of proposed group home services budget.[6]

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[6]"Free Group Homes (Almost) a Multi-Organizational Approach to the Development of Group Homes" Papers delivered at the National Conference of the American Association on Mental Deficiency, June 1, 1977, p. 7.

Program Operations

Proposals were solicited and received from various non-profit groups or redevelopment authorities that wanted to be sponsors of group homes. Each applicant was asked to submit demographic data about the proposed site of the group home so that the demand for such a facility in the area could be determined. Each group home must have at least 12 residents who are self-medicated (this restriction avoids terming the group homes "medical facilities," which may not be eligible under the Section 8 Housing Assistance Payments Program that helps finance the group homes).

When a sponsor is selected, it is then the responsibility of the Virginia Housing Development Authority to work with the sponsor in: 1) locating the exact site for the home, 2) clearing the title, 3) acquiring the land, 4) addressing zoning and the requirements of the fire marshall, 5) selecting an architect, 6) soliciting bids, 7) completing the Section 8 construction and operations budget, 8) selecting a contractor, 9) supervising construction, 10) managing the facility, 11) processing the Section 8 rent subsidy applications, 12) executing client leases, 13) billing clients and, 14) maintaining the property.[7]

Also, it is the Department of Mental Health and Mental Retardation's responsibility to assure that adequate services are provided to the group home residents so that they are able to function as independently as possible. The Department has stated that these facilities will receive preferential attention in the preparation of service budgets.

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[7]Ibid, p. 9.

The actual operation of the group homes, in terms of intake, assessment, service plan development, case monitoring, service termination, and follow-up procedures will vary depending upon the particular philosophies of the sponsoring organization.

Program Evaluation

The Virginia Housing Development Authority has appointed a staff member to monitor the activities of the home; site visits are conducted to check the upkeep of the facility and the adequateness of the service provided. Problems are addressed by the Interagency Advisory Council, which in turn makes recommendations.

The individual sponsors of the group homes may also conduct their own evaluations, but they have not done so to date.

DEPARTMENT OF HEALTH

Virginia's Department of Health is able to help the state's functionally disabled population in two important ways: 1) through the use of its nursing home preadmission screening program, it helps to identify those nursing home applicants who could better function outside of such an institution; and 2) through the provision of home health services, it offers supportive services to these deinstitutionalized persons. The Department of Health not only encourages deinstitutionalization, but helps individuals to maintain this status by providing some of the needed services.[8]

Nursing Home Preadmission Screening Program

The Nursing Home Pre-admission Screening Program is offered within the Department of Health's Medical Assistance Program. This screening program became effective May 15, 1977. Under this program, all applicants for admission to nursing homes are to be screened by the home health services utilization review committees of local health departments, if they meet these conditions:

- The applicant is not in a community hospital or nursing home at the time of application
- The applicant is or will become Medicaid eligible within 90 days of admission. [9]

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[8] It was found that 28 percent of those referred back to their communities were in need of home health services.

[9] Memorandum to Deputy Director of Local Health Services, Local Health Directors at Headquarters and Branch Offices from F.C. Hays, M.D., Medical Director of Virginia Medical Assistance Program, April 8, 1977.

The utilization review committee is composed of (at least) a physician, a nurse, a social worker and, if possible, representatives of other agencies which provide services to the applicant.

Needs Assessment

To substantiate the need for this type of program, the Department of Health cited studies which stated that:

> If given a choice, most people would prefer to remain in their own homes rather than move to an institution. Similarly (it was found that) if a strong system of community services and alternate living arrangements is available, people who now find the nursing home their only option, would be able to remain in their own homes for a longer period of time.[10]

Also, the utilization review committees are to be composed of persons who are familiar with the alternative services being provided in the area and any unmet needs for such services.

Program Planning and Development

The Medical Assistance Program within Virginia's Department of Health first launched the nursing home preadmission screening program as a pilot study on July 1, 1976. The results of the pilot study indicated that such an interdisciplinary screening program did act to reduce unwanted and/or inappropriate nursing home admissions. The experiences of the pilot study were used in planning and developing the existing program.

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[10] Ibid.

Program Operations

The social worker on the review committee is expected to provide to the committee information about each referral for screening. This information is obtained from a basic social evaluation. A local health department nurse should complete an evaluation of nursing needs. Once these initial evaluations have been conducted, the committee meets to discuss the findings, and to determine if nursing home placement is needed. The findings of the review are then forwarded to the utilization review section of the Virginia Medical Assistance Program (see Exhibit 1). In the event that the committee finds that nursing home placement is unwarranted, the committee must refer the applicant to the appropriate community resources.

Program Evaluations

Periodically, the results of the nursing home preadmission screening program are tallied to determine the number of inappropriate placements that have been identified through use of the program. For example, it was found that from May 15, 1977, through October 31, 1977, 100 mental hospital screenings had been completed. Eighty-nine of these applicants were approved for nursing homes and 11 were not recommended for nursing homes.[11]

More in-depth analysis of the programs are planned so program trends and problem areas can be identified.

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[11]Memorandum from Charlie Carnes to Ann Cook, Department of Health, November 7, 1977.

Home Health Services

Home Health Services have been offered in Virginia since 1966. These services are provided by the Division of Local Health within the Department of Health, and are offered to any home-bound individual who is referred by a physician. Providers of these services include nurses, home health aids, physical therapists, speech therapists, occupational therapists and medical social workers.

Needs Assessment

It is not known if any initial needs assessment activities were conducted to determine the demand for home health services in Virginia. However, since that time data have been collected on the population that receives home health services. These figures have been used to make projections as to the number of persons needing home health services who are not currently receiving them.

No formal evaluation of the availability of similar services was conducted, although the program staff are generally aware of other service offerings in the area. Efforts as yet have not been made to evaluate service coordination and accessibility.

Program Planning and Development

Because home health services in Virginia were initiated in response to the mandates of Titles XVIII and XIX of the Social Security Act, the goals, objectives and program directions of the home health services program have been developed in accordance with the legislation.

The program is administered at the local level by health departments which have been certified as home health agencies. Each local health department is responsible for having a recordkeeping and billing system for their home health clients. Most home health services clients are eligible for Medicare, Medicaid or Title XX payments.

Liaison nurses placed in area hospitals and brochures placed in local health departments were used to advertise the availability of home health services for eligible individuals.

Program Operations

Home health services clients initially are referred by a physician. A plan of care is signed by the physician. All services delivered to the client are based upon the care plan. It is reviewed at least every two months by the physician to certify a continuing need for services.[12]

Program Evaluation

A statewide cost benefit analysis of home health services was done in 1974. This study found home health services to be cost beneficial.

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[12]Virginia Department of Health's Annual Report for Fiscal Year ending June 30, 1977.

THE DEPARTMENT OF WELFARE

Virginia's Department of Welfare is responsible for the delivery of various social services. These social services are provided to persons who satisfy the eligibility requirements. For example, home-based care services are available only to supplemental security income recipients, old age recipients, and to the permanently and totally disabled recipients.

Home-Based Care Services

The Division of Social Services of the Department of Welfare offers home-based care services, including homemaker, companion and chore services. Homemaker services are activities such as personal care, home management, consumer education, hygiene and child rearing. Companion services are activities such as personal aid, light housekeeping tasks and companionship services. Chore services are the performance of home maintenance tasks and heavy household cleaning such as window washing and floor maintenance.

Needs Assessment

In response to the mandate established by Title XX of the Social Security Act, the State of Virginia developed a policy which established home-based care services. Each locality was responsible for determining the need for these services in its area as a part of its annual Title XX plan (which addresses needs assessment, service availability and coordination). These local plans are reviewed by the Department of Welfare's Division of Social Services and allocations are made based upon this review.

Program Planning and Development

Home based care services were planned and developed in accordance with the Title XX legislation. Clients are accepted only through referrals; no recruiting has been done since it is known that the need for these services exceeds their present dimensions.

Program Operations

Local welfare departments are responsible for arranging home base care services. Procedures for the delivery of these services vary according to the locality. The services can either be contracted or provided directly. Most home-maker services are provided through outside agencies. Many of the providers of chore services and companionship services are relatives or close friends of the clients.

Program Evaluation

The delivery of home based care services,as a whole,have not been evaluated. However, any evaluation conducted would be in terms of determining the cost of the services provided and the care received as opposed to the care requested.

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.