6-1980

An Evaluation of the St. Louis Regional Community Placement Program

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ST. LOUIS REGIONAL COMMUNITY PLACEMENT PROGRAM

June 30, 1980
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1.0 EVALUATION OF ST. LOUIS REGIONAL COMMUNITY PLACEMENT PROGRAM - HISTORY AND PHILOSOPHY

1.1 History of the Community Placement Program (CPP)

OBSERVATIONS

In the late 1950's, the Division of Mental Diseases (presently the Department of Mental Health) began a program of de-institutionalization of the mentally ill. The legislature allocated money for the placement of patients; most patients were placed in nursing homes, but patients were placed in a variety of other sites. Resource procurement and placement itself was accomplished by whatever staff was developing the discharge plan of the patient. This staff person usually was a social worker on the treatment team of the patient. No one program nor one identified individual represented St. Louis State Hospital to the various placement sites and various communities.

The 1960's saw the de-institutionalization movement develop momentum and patient placements increased, but not on an organized, rational manner. St. Louis Chronic Hospital Building was condemned during this period and St. Louis State Hospital had to absorb this population for placement also.

Apartment placements for the mentally ill began in 1971 with Dr. Sandall, Nancy Flavell and Mildred Dunn developing this program. The nursing home placements and community apartments, though both working at St. Louis State Hospital, were not linked in any organizational manner. Due to the fact there was no organizaed aftercare of patients, patients were being "lost" after placement; concern developed for the need to organize a program that would centralize these placement functions and provide some accountability for the placement and aftercare of St. Louis State Hospital patients.

In 1971 Central Office created the St. Louis Regional Community Placement Program (Kansas City also developed a Regional Community Placement Program). Nursing home placement and aftercare were now the responsibility of a designated director and program. Community apartments remained a separate entity from the CPP until approximately 1975 when it merged organizationally, but not functionally with the CPP. Places for People began with staff from the CPP in 1975. After Places for People began, the community apartments program merged functionally with the CPP and the CPP then began to provide case management and monitoring for not only the nursing homes, but the community apartments also.

Presently the two programs have merged both functionally and organizationally except for the influence of Dr. Sandall and Places for People on the the CPP. The role of Places for People with the CPP is also a role that remains unclarified.

IMPACT

(a) The CPP has not had the opportunity of being "born" and allowing its identity to develop with age. Rather, the program suffers from being forced to continually acquire new identities, such that the program is overwhelmed with these new identities, and does not have one singular identity. This situation fosters role confusion, philosophical disorientation, lack of organized activity and basically a directionless posture for the program.

(b) The variety of placement sites were inherited by the CPP when they began. Many sites, significantly below standard, were utilized by inpatient staff as placement sites; the CPP then had to monitor, and when necessary, close sites they had not developed. This creates an extremely frustrating situation in which the program is forced to deal with other peoples' mistakes.

(c) The type and quality of the historical placements, i.e. those made prior to the CPP's creation, set the tone for present placements. The CPP still restrict's its activities to the nursing homes and community apartments as it did prior to its formal creation.

RECOMMENDATIONS

(a) The new Director of the CPP should be hired from outside the program. A new individual, not tied to history, will open the doors for innovative and fresh ideas, procedures, etc. The new Director should strive to put the CPP on a course that moves it from the restraints of its history and embarks it upon a path that will give it a strong clean purpose and identity.

Identity formation itself is a painstaking process that occurs when the Director purposefully selects inservice and communication for the program so as to shape the program's identity.

1.2 Community Treatment of the Mentally Ill - Philosophy

Inherent in any attempt to describe programmatic philosophy is that philosophy is like a rainbow; though one sees many colors, it is impossible to discriminate where one ends and another begins. The philosophy of the CPP movement can most simply be described as a continuum which on one end of the philosophical spectrum are those people who view patient placement as an end in and of itself which serves the purpose of "de-institutionalizing" the State Hospital. On the other end of the philosophical spectrum, patient placement is viewed as a method of treatment, that along with other treatment modalities, occurs in the community.

Placement, as an end in and of itself, very inexpensively allows the hospital to de-institutionalize, that is to move its

patients to "closets" in the community where it can effectively dumpt these individuals. Patients are given little if any supervision; supervision is not meant to improve significantly the development of the patient, but to maintain the placement of the patient, i.e. keep the patient out of the hospital. Though this situation allows the institution to expend little resources on these people, the community and the patient suffers. Most communities resent this dumping of problematic individuals in their neighborhoods. These patients are usually placed in marginal resource neighborhoods where these patients then compete with the residents of these neighborhoods for scarce resources. The former institutionalized patient, with little support, rarely becomes integrated into the community and often bears the brunt of the frustations and anger of the community. Patients become abused and victimized; slowly the community rejects the transplant of the individual to the neighborhood. The patient is then re-admitted into the institution. A revolving door of admission, placements and returns develops, which destroys the morale of not only the patient, but the staff assigned to care for and treat this individual.

If community placement is viewed as a treatment modality, then patients are placed in environments that are the least restrictive environment that meets the needs of the individual. This means that the patient's environment provides the necessary resources or treatment such that a patient moves along a continuum of placement services toward the least restrictive

environment. Theoretically, the patient moves along this continuum of services until they are able to be discharged from St. Louis State Hospital. Other patients may need to move along this continuum until they reach an environment that provides the necessary support for their level of functioning. Attachment 01 is a service system flow chart that visually describes the continuum of services available through community placement. In this systems loop, the patient can move from the community:

(a) To outpatient service

(b) From outpatient to placement

(c) To inpatient status OR

(d) From inpatient to placement.

From any of these programs, the patient can move to another program or back to the community. Within the CPP itself, a patient can move up or down the continumm of services, seeking out the placement service that provides the least restrictive environment possible to meet their needs. Thus, placement is a dynamic treatment modality.

The staff of the CPP should function as case managers, i.e. they develop an Individualized Treatment Plan (ITP), identify and mobilize the community resources and support mechanisms necessary to meet the demands of the ITP, and then tactically deploy these services with the intent of maximizing the patient's potential. These resources may be

provided by the placement site, community, POS, through the facility, etc. Community resources, and treatment in the community is always the first choice. The case managers, through use of community services, actively involves the community in the integration of the patient into the neighborhood. Integration of the patient insures that the community will not reject the transplanted patient.

Being that marginal resource communities would have their support systems taxed heavily, placements are not encouraged in these areas. The patient is placed in communities that have sufficent resources; these communities will not be as likely to reject the patient, because these neighborhoods are usually not as frustrated and angry as are resource poor neighborhoods. It is resource poor communities that vent anger upon the socially helpless.

The relationship between the CPP and the institution itself changes when placement is viewed as a treatment modality. Institutions must work prior to placement to keep the patient integrated in their community. The inpatient staff must also work to maintain and/or build the necessary skills the patient will need to return to their community. To accomplish this, the CPP staff must work actively to build and maintain a good working relationship and open dialogue with the inpatient and outpatient staff. This dialogue will be the format in which the CPP informs the treatment staff as to the social skills necessary to survive in that community. The institution itself, knowing

that a patient, when admitted, severs many of its community ties, will discourage easy re-admissions to the facility by CPP clients; this will encourage the CPP staff to actively seek out resources necessary to maintain the patient in their community.

Finally, when placement is viewed as a treatment modality, the spirit of the community mental health movement is met - to provide quality clinical service in the patient's community.

1.3 CPP Philosophy

The stated CPP philosophy is to "maximize the client's potential toward the least restrictive environment possible to meet his needs, and to effect optimal quality of life standards in his placement environment." Verbal statements of philosophy must be judged against behavior. How one behaves is influenced by the system that either provides behavioral incentives or disincentives.

OBSERVATIONS

(a) The CPP uses almost exclusively nursing homes to place patients. Attachment 02 shows the distribution of CPP patients. Independent living arrangements are few and many types of placements are extremely under-utilized. Of course, this distribution is influenced by resources available and the age of the patients as discussed in an upcoming section. Nonetheless, the distribution of patients does not reflect a strong continuum of services.

(b) POS money, as described in the financial section, is used primarily for social clubs and transportation and does not reflect a strong continuum of services.

(c) Placement sites are not only primarily nursing homes, but most of these homes are very large homes. Of the 1,400 patients in the CPP less than 100 placements sites are utilized. Attachment 03, (report 303C) shows the distribution of patients amoung the various facilities.

(d) Re-admissions of CPP clients to St. Louis State Hospital, reinforces the belief that a revolving door syndrome is present. Below is a chart showing returns from CPP to SLSH for 1979 and 1980 and replacements to CPP from inpatient treatment or General, Medical & Surgical services. This patient movement characterizes both a revolving door syndrome (return to MI) and a lack of use of community services for medical treatment (return to GM&S). It also shows that many patients are not replaced each month and presumably remain as inpatients.

	RE-ADMISSIONS TO SLSH FROM CPP			REPLACEMENT TO CPP
1979	MI	GM&S	TOTAL	
January	16	8	24	10
February	11	11	22	4
March	11	12	23	9
April	16	11	27	11
May	15	6	21	5
June	15	3	18	3
July	12	8	20	0
August	12	9	21	7
September	10	4	14	4
October	14	8	22	13
November	14	7	21	10
December	17	11	28	3

1980	RE-ADMISSIONS TO SLSH FROM CPP			REPLACEMENT TO CPP
	MI	GM&S	TOTAL	
January	16	6	22	5
February	16	11	27	5
March	16	7	23	0
April	15	6	21	8

IMPACT

The philosophical posture of the CPP must be rejected as not in concert with how it behaves. This behavior must be viewed in the context in which it operates. The CPP operates within the organizational environment and philosophical environment of St. Louis State Hospital. Many people debate whether SLSH is presently giving good custodial care, i.e. providing a safe and humane environment. The Goodman, etal v Parwatikar right to treatment case argued that SLSH was not providing a safe and humane environment, let alone adequate. The CPP appears to be on the same philosophical footing as SLSH. It appears that the CPP behaves in a manner that suggest its philosophy is one of placement per se rather than placement as treatment. As discussed in upcoming sections of this evaluation, how a program behaves is not necessarily how it wishes to behave; the CPP espouses a philosophy that it does

not implement. The reasons the CPP does not implement said philosophy are partially determined by the system it must operate under.

If the system were actively treating patients, one would expect certain types of reports or business records that provide data to management along lines that suggest the philosophy of placement as treatment. For example, one would expect the following kinds of data to be generated:

(a) Number of clients moved to a less restrictive environment each month.

(b) The number of hours of client programming per client per day.

(c) The number of clients employed competitively, with public assistance, in sheltered workshops or in pre-sheltered workshops.

(d) The number of clients that can use public transportation.

(e) The level of the clients' social, economic, educational, i.e. his ability to function in his environment.

RECOMMENDATIONS

(a) The CPP's Director needs to teach and provide the resources, i.e. the system necessary for staff to use placement as a community treatment modality. This entails not only education but also dramatic system change.

(b) The CPP needs to philosophically differentiate itself from St. Louis State Hospital. The CPP has the resources necessary to provide good case management, even it SLSH does not. To allign itself with the custodial care philosophy of SLSH, would not allow the CPP to grow clinically.

(c) The CPP needs to allign itself with other community placement programs that do provide treatment; these community programs exist, both in Missouri and in other states, and do provide community placement treatment.

The development of a program to move the CPP's clinical posture up the continuum towards the ideology of placement as treatment will need the involvement of good, talented management staff. The talent necessary for the provision of good, clinical case management is present; strong, knowledgeable management is not.

2.0 Client Service System

The Client Service System encompasses the input, process and output of the CPP, i.e. client referral, client treatment and services and movement within and out of the CPP. The service component has philosophical underpinnings - case management or direct clinical care - whereas the input/output components have administrative as well as philosophical underpinnings.

2.1 Patient Referral - Input to CPP

OBSERVATIONS

Patient referrals are presently made from two basic sources: Malcolm Bliss Medical Center and St. Louis State Hospital with both the inpatient and outpatient programs referring clients for placement. Though it is possible and feasible to receive referrals from the community directly, and facilitate a "paper admission," it is very rarely done. A few referrals are made to the CPP from other DMH facilities, and a few of these referrals are subsequently placed. Table 04 displays the areas from which referrals are made and in what number referrals to the CPP were made for the last few months.

Referral procedures are outlined below for a) Nursing/ Boarding Homes and b) Apartments. Attachment 05 is a flow chart referral system for the SLSH CPP.

2.1.1 Referrals to Nursing and Boarding Homes.

After the client's treatment team recommends placement, the social worker of that team sends the completed Family Care Referral form (attachment 06) to the screening committee. The CPP screening committee is comprised of Ruth Simon, Barbara Spencer and Judy Fahning. Barbara Spencer and Ruth Simon review all referrals except those to Places for People. Judy Fahning reviews all the referrals to Places for People, i.e. community apartments. Whomever reviews the referral is the designated liasion between the CPP and the referring area. The liasion also reviews the patient medical record, interviews the patient and talks to the referring treatment team regarding the patient. After this review of the referral, if the liasion believes the referral is not appropriate, a memo is returned to the social worker stating reasons why this referral is not appropriate. Attachment 07 is the Family Care Assessment sent to the referring social worker when a patient is either accepted or rejected.

If a patient is deemed acceptable for placement, the liasion determines which home of the 100 homes available for placement is the most appropriate home for that patient. The liasion informs the social worker and nurse assigned to that particular home to further assess this patient to determine whether this referral is appropriate for this particular home. This team, consisting of the nurse and social worker, utilize the medical record, an interview with the patient and meetings with the treatment team to make a determination of appropriateness.

The team is very aware of a particular site's idiosyncrasies and through consultation with the placement site, makes a final determination whether this placement is appropriate. If this placement is not appropriate, the team sends back a memo informing the liasion of their decision, and criteria upon which they based their decision. The liasion then must either find another home that is appropriate and go through this process again, or reject this referral, or place the referral on a waiting list. If the patient is found to be acceptable for placement in this home, the referring social worker is informed via a memo.

The referring social worker is responsible for the timely completion of all the paper work and activities associated with placement. The relationship between the CPP and the referring social worker is one of a consultant to a referee. Because the CPP acts as an consultant in assisting the placement of a patient, all paper work, which is quite significant in its volume, is completed by the referring social worker. The process of paper work begins once the liasion has accepted the referral for determination of appropriateness and is completed prior to the team's final acceptance or rejection.

If the patient is accepted, the liasion sends a memo to the referring team informing the team that there is either an immediat vacancy or the patient must be placed on a waiting list. If there is an immediate vacancy, this memo serves to hold the bed until the process of placement is completed. The referring social worker is also responsible for such things as facilitating

a visit by family and patient to the placement site, the arranging of the placement date and the delivery of the pre-admission information. The referring worker must contact the contract office five days in advance to allow for a contract to be drawn up and approved. A few of the other tasks the referring worker must complete are to:

(a) Secure a list of medications

(b) Prepare social worker's transfer summary

(c) Secure a medical transfer summary

(d) Complete the patient's ITP

(e) Arrange transportation for the patient

(f) Get medication and clothes ready for the patient

(g) Take the patient to the home

After these tasks have been completed, and the patient is placed in the facility, the case is then transferred to the CPP for monitoring. Once this case is transferred, there may or may not be contact between the treatment team and the team assigned to monitor this patient's placement.

2.1.2 Referrals to Community Apartments

Referrals to Community Apartments, i.e. Places for People, are initated after Judy Fahning receives a referral to the Community Homes Program from a referring treatment team (attachment 08). This liasion screens the referral for a general profile appropriateness, reads the medical chart, interviews the patient and staff then arranges an interview between Places for People, the patient and the referring social worker. As described in

2.1.1, the referring social worker is responsible for the activities of placement per se with the CPP staff acting as consultant to the placement program.

Places for People assist in the selection on an appropriate roommate with the client, and subsequently finds a suitable apartment for the client. If the patient were in need of further desensitization to apartment living, or the learning of apartment skills before actual placement, it is the duty of the referring social worker to accomplish this. After all these placement activities have been completed, the patient is transferred to the caseload of the CPP.

If a patient is rejected, the referring worker is notified as to why; if accepted, the referring social worker is also notified. If the client placement in the apartment does not succeed, client is returned to St. Louis State Hospital where he may or may not be referred to a nursing or boarding home for placement.

IMPACT

(a) Reference to Table 4 displays that few clients are admitted directly to the CPP from the community or from the outpatient clinic. This system of discrimination forces admissions to inpatient status with its inherent risk of institutionalizing the patient before placement in a community based facility is possible.

Theoretically, it can be assumed that with a proper referral system and with the availability of a continuum of resources, a majority of inpatient admissions will be avoided in lieu of appropriate community based services.

(b) The referral system organizationally segregrates rather than integrates placement resources into a continuum of placement sites. This increases miscommunication, frustrates and complicates referral of clients.

(c) Presently, the "screening committee" is composed of three individuals of which two are in the executive committee. This restricts the input of clients into the system and determines dependency of the system upon a few knowledgeable individuals. This restricts other CPP staff from becoming trained and knowledgeable in the process of screening clients for referral. By restricting input from all levels of staff, this system inhibits a vested responsibility of staff for input into the CPP. Besides restricting staff input, the dependency on a few individuals fosters weakness in the program.

The screening individual, or liasion, is responsible for the review of the patient's appropriateness and facility selection. This makes for a complicated centralization of the input into the CPP. Again, this

restricts input due to the fact that these duties are time consuming and there are only a few individuals to handle this task.

(d) A decision for appropriateness for placement is determined upon a review of the patient's present inpatient behavior. The literature quite strongly suggest that behavior in one environment is not a good, reliable predictor of behavior in another, different environment. For example, a patient that sets fire on a crowded ward will not necessarily behave in the same manner in an apartment. Yet this behavior disorder will probably be used to exclude the patient from placement.

(e) The social worker and nurse assigned to monitor the site which the liasion has determined the patient will be placed in, are not involved with this decision and can only reject it (if good supporting reasons for rejection are provided)or accept it. This system does not have built into it the involvement, responsibility and committment of this team to the maintenance of successful placement and treatment. If the placement becomes troublesome, the team can reject it easily with no fault of their own in their decision making.

(f) The referring social worker must expend a large amount of time and energy in the completion of the paper work necessary for referral, even though most referrals are not accepted for placement. Chart 09 compares referral by month with placement by month and shows the number of patients that are waiting for placement. This comparison shows there is little chance of reward for the energy expended in preparing the work for patient to be placed. This will dramatically reduce referrals. An interview with the various Unit Coordinators has revealed that they believe the system to be unresponsive and they do not actively encourage their staff to refer clients. Indeed, the referrals to the CPP appear to be extremely low.

(g) There appears to be little pre-placement clinical activity. For example, the active involvement of the CPP with the treatment team of a potential placement in the providing of the team with information as to what skills a successful placement will need, does not exist; this would also include providing the team with the necessary information regarding what types of placement resources are available. Without this involvement, it is not insured that appropriate clients

are referred. If client skills necessary for placement are not actively programmed in the client's ITP, successful maintenance of placement is not encouraged.

(h) Acceptance or rejection of a referral as well as reasons for this decision need to be provided to the Unit Coordinator also. This presently does not occur.

(i) Pre-placement activity such as the paper work, etc. is a responsibility of the referring team, but the system itself dees not provide a strong co-partner approach to this process. The CPP, as consultant to this process, needs to be actively involved with the referring worker in assisting in this process to insure that this process is effective, efficient and smooth. This will provide for a reduction in the referring social worker's frustrations of dealing with this time consuming process and by involving the CPP staff in this pre-placement process, insure that an acceptance of placement is done with the knowledge that placement resources are available and this process is viable.

RECOMMENDATIONS

(a) After procurement of an appropriate placement resource, outpatient and community referrals should be given high priority so that these patients need not be

admitted to inpatient status if community services will suffice. The literature supports the assumption that community based delivery of mental health services, in the patient's community is preferable to admission. Institutionalization of a patient does not have to occur if community placement is the key to continued effective clinical treatment. This will have the effect of reducing inpatient census by reducing the admission to St. Louis State Hospital. It should be noted that appropriate, potentially successful placements of inpatients are not to be lowered in priority, but a strong emphasis should be placed on the avoidance of outpatients becoming inpatients. The system described herein strives to provide a framework in which the staff are not frustrated by seeing clients, who could have been treated in less restrictive environments, undergo institutionalization.

(a_2) House Bill 1724 mandates that the least restrictive environment for patient treatment be utilized. This system fulfills both the spirit and the letter of the law.

(b) Chart 11 is a recommended referral system flow. The salient features of the recommended system are:

(b_1) All referrals are made to one centralized committee whose responsibility is to inspect the referrals for general appropriateness and subsequently route the referral to one of three teams, based upon the case load of each

team or (preferably) based upon random distribution of referrals such that inter-team comparisons are facilitated. This would effect the integration of resources and centralization of the input of referrals.

(b_2) Each of these teams should have a continuum of resources allocated to them so that each team has the opportunity to manage a variety of clients in placement. Each team is responsible for the placement of a client; the team must select the appropriate facility and insure the maintenance of the placement and subsequent movement of the patient along the continuum to the least restrictive environment needed to treat this individual. Each team is also responsible for working with the patient's referring team in all pre-placement activities; the CPP staff will work to do well in pre-placement, so as to insure successful placement.

(b_3) If the team rejects a client placement, this rejection must be explained not only to the referring team, but to the screening committee. The screening committee can accept or reject this explanation. This procedure allows for the application of pressure to the team to accept the placement and manage the referral appropriately.

(b_4) If the screening committee does concur with a rejection, the committee then indicates to the Resource Procurement Committee what the placement needs are. The Resource procurement Committee then has the data necessary to procure the resource that are truly needed of the CPP.

(c) The system described herein puts pressure on the CPP to make placements. It encourages sensible risk taking and by encouraging sensible risk taking, the CPP staff will be less likely to reject patients for simple behavior problems. Also, the team, who are most aware of the placement facilities, can convince these facilities that inappropriate behavior will probably extinguish itself in the new environment.

(d) As described above, when a team is involved in the decision process, vested interest will be encouraged and successful treatment placement should increase.

(e) Referrals must be encouraged, especially appropriate referrals. Unfortunately it is difficult to determine the length of time between completion of all pre-placement activities and placement. The Resource Procurement Committee can maintain an open dialogue with the unit coordinators so that the availability of various types of resources is always known.

(f) From the point in time that the CPP team receives a referral from the screening committee, the team should begin pre-placement activities with the patient's treatment team. The CPP team may provide the necessary information regarding which skills a client must possess to insure successful placement and what the activities are that the treatment team must accomplish.

(g) Rejections and progresss reports on placement referrals should all be reported to the Unit Coordinators to insure the efficient management of pre-placement activities and to enhance communication. The CPP screening committee and the CPP team should direct all correspondence and requests for information, etc., to the Unit Coordinator.

2.2 Facility Selection

OBSERVATIONS

Flow chart 05 shows that the actual selection of a facility is accomplished by the liasion from the screening committee. When a referral is accepted as appropriate, this referral is then routed to the team that monitors the home that the liasion has deemed as most acceptable placement for this particular referral. The monitoring team must normally accept the referral unless they have documented reasons which are acceptable to the liasion for this rejection of the particular referral. The monitoring team itself has no involvement in the selection of a placement site for a referral.

The criteria for selection is based upon the collective knowledge the liasion has with regards to the placement site's profile of the "ideal" patient that it wishes to have placed in its facility, not upon any objectively based criterion. Selection is also controlled by the resources available to place the patient in. Table 12 is the distribution of placement resources for monitoring the to the three teams of the CPP.

IMPACT

(a) The referral system segregrates the Nursing/Boarding Homes and the Community Apartment Program. This does not provide for a continuum of placement resources for the treatment team to select a facility from. Chart 01 displays a continuum of resources that should be available to utilize patient placement as a treatment modality. To organizationally segregrate the referral system into two components discourages continuity of treatment and communication in the process of facility selection.

(b) The actual selection of a facility is vested in one person, rather than a team. As the system is presently, the liasion selects a facility and the team can only reject if they have adequate support to this rejection. To vest the selection of a facility for client placement in the hands of a few individuals places the CPP in a position of strong dependency on these

individuals, with the services of the CPP referral system compromised. Also, the team has no vested responsibility in the selection of the placement; without vested interest, there is not as much energy expended to insure placement success. If the team participates in the placement decision, the team would then have vested responsibility in the maintenance of the patient in the placement site and the system would provide more accountability.

(c) When there exist only 100 placement resources, it may be feasible for an individual to know all the resources, but the CPP needs to develop many more placement resources. When this is accomplished, few individuals will not be able to thoroughly know all of the resources well enough to make a knowledgeable facility selection for a referral. To force a few individuals to know thoroughly all of the placement resources, discourages the increase in the number of resources because one individual cannot handle this quantity of information, especially new resources that are relatively unknown.

(d) Criteria for selection of a facility is subjective. A more objective means of matching client needs to resources is necessary.

(e) There appears to be much energy expended to meet the idiosyncrasies of a facility's ideal patient profile.

If placements were a treatment modality, a facility will have a general type of patient profile to work with, and not have such idiosyncratic demands for a particular type of patient.

(f) Chart 12 displays the distribution of placement facilities to the three teams. This distribution does not equitably provide resources for each team. Each team does not have a full continuum of resources that is available to them for the placement of the clients that are referred to them. Some of these distribution problems are due to the limitations of the number of placement sites available to them for distribution.

RECOMMENDATIONS

(a) As stated in section 2.1, the Community Apartment Program is part of the continuum of resources available to the CPP and as such, should not be organizationally distinct from the rest of the placement resources. By combining the screening functions into one committee, communication is enhanced and so is facility selection.

(b) As stated in section 2.1, referrals are made to a screening committee composed of many individuals who screen the referral for general appropriateness. Further client screening and facility selection is made by one of the three CPP teams. Chart 11 is a

flow chart that shows a recommended referral system. Each team has a full continuum of placement resources. The screening committee is aware of the work load and availability of resources and routes the referral to a particular team based upon these considerations. The team itself is responsible and accountable for facility selection and maintenance of a selection. This responsibility will encourage the allocation of time and energy to appropriate placement and maintenance of placement. Through a team approach, knowledge regarding resources is vested in many, rather than a few people.

(c) Facility selection must expand in its scope due to the fact that a Resources Procurement program, if successful will increase the number of resources available to the CPP. An increase in the number of resources will limit the effectiveness of a few individuals to thoroughly know these resources. To divide all the resources equitability into three components for the three teams to manage provides efficiency to the system.

(d) Presently the criteria for selection of a facility is subjective. Objective tools such as the New York Department of Mental Health's Level of Care Survey should be sought out and developed so that the teams

can have clinical tools available to assist them in selecting a facility. This is similar in manner to how a psychologist can use a MMPI to assist them in making a client diagnosis.

(e) The placement facility itself needs to philosophically see placement as treatment. Extremely idiosyncratic demands for specific client profiles should be discouraged in favor of the facility and team developing treatment modalities to work with the patient. This can occur only after enough resources are available to shift the posture of the CPP from a seller's market to a buyer's market. At present the CPP is forced, due to a constricted market, to adhere to these demands. As the market loosens up, the CPP can and should make demands upon the facilities.

(f) As resource procurement succeeds, new placement resources should be distributed so as to develop a distribution that provides each team with a full and equitable range of placement resources. This will encourage competition among teams to manage their resources more efficiently and allow the director to make comparisons amoung the teams. Of course, an equitable distribution of resources needs to be supported by an equitable distribution of patients referrals.

Theoretically, assignment of referrals to teams should be random with each team having to accept all referrals for processing.

2.3 Placement of a Client in a Community Facility

As described above, placements per se is accomplished by the referring social worker; after placement the CPP manages the patient's placement and the involvement of the referring treatment team ends; if a patient placement does not hold, then the referring team will have the patient returned to SLSH.

IMPACT

2.3.1 Without the post placement involvement of the referring treatment team, there is no continuity of patient care. The patient must endure the stress of placement without the benefits of the support that their previous treatment team could provide them. Also, the treatment team does not have the benefit and rewards of their work, i.e. do not have the benefit of seeing a successful patient placement.

RECOMMENDATIONS

2.3.1 After placement is made, the referring treatment team and the CPP team should work together in the implementation of the ITP and the subsequent review of the ITP. Though the CPP staff should act as case manager, they should also consult with the referring treatment team with regards to the patient's treatment so as to insure continuity of care and successful placement.

The involvement of the referring team should last from sixty to ninety days after placement occurs. Policy and procedures need to be developed that address this activity and clearly describes role and responsibility of each treatment team.

2.3.2 Demographics of Clients in Placement

OBSERVATION

When the CPP is viewed as a treatment modality, the population of these patients in placement should reflect, to a degree, the population of SLSH's general patient community. Patient demographics would include age, diagnosis, number of hospitalizations, total length of time hospitalized, etc.

Unfortunately, the computer data for diagnosis is unreliable; comparisons for diagnosis thus cannot be accomplished. Report 0160A, 0160B and 0160C generate the count by diagnosis, for the CPP, the inpatient and the outpatient programs. These reports reflect that the majority of the patients in all three programs do not have a primary diagnosis in the computer. Length of stay and number of admissions is not only very difficult to reach on the computer, but it appears to be also an unreliable data base. Only age and sex information is a valid and reliable data base. Though the sex of a patient appears to make little difference in either of the three programs, the age difference in each program is an extremely important piece of demographic data. Chart 13 is a population curve for the CPP residents.

This census curve shows a mean of 64.41 and the age group with the most residents (mode) are those in the 61-70 years of age category. Chart 14 shows the three major programs in comparison with each other. Both inpatient and outpatient have similar curves with a mean of 34.6 and 44.7 repsectively. It is apparent that the CPP residents are a population unlike the other two program. The CPP primarily serves a very old population with almost no services (less than 10%) being provided to those clients 50 years of age and under. Inpatient and outpatient on the other hand primary serve the under 50 age group.

IMPACT

It is unfortunate that other patient demographics are not available so that population of the three program can be analyzed. Nevertheless, age is a most important population characteristic and age analysis does reveal that the CPP serves a very different population that does the other two programs, which are the input to the CPP. This also has the effect of providing no placement resources for those DMH clients that are young; it appears that clients must be admitted, become institutionalized and old before the CPP will provide resources for them.

RECOMMENDATIONS

(a) Data systems should be developed so that the various programs, and their populations can be analyzed and compared along a variety of indexes including age of

first admission, diagnosis, number of previous admissions, average length of stay, total length of stay, etc.

(b) The CPP should aggressively develop a program that will serve the clients of all ages. The population of 18-25 must especially be targeted for placement. This age discrimination can only be ended after affirmative actions are taken with regards to the procurement of resources for, and the placement of patients in, facilities serving the younger DMH client.

2.3.3 Census Trends - The Output of the System

OBSERVATION

Chart 15 deplicts the CPP's and SLSH's census trends, i.e. how many clients each are serving each year over the past 10 years. It is clear that the CPP census and SLSH's census co-vary, with SLSH assuming a greater inpatient population as the CPP reduces its population.

IMPACT

Input into the system - admissions via the emergency room or outpatient clinic - continue to increase SLSH's inpatient population. Normally, SLSH inpatient census can be reduced by

(a) Placement from outpatient clinic to the CPP

(b) Inpatients being discharged when placements are made available.

The CPP should be viewed as one of the many outputs of SLSH. As the chart reflects, there is no increase in the ability of the CPP to accept this output, i.e. patient census is dropping. This dramatic decline in community placement census determines that the demand for client placement cannot be met. Thus, the inpatient program is constricted by demands for services that cannot be met and patients that could be treated in a less restrictive environment are not.

RECOMMENDATIONS

(a) The Director of the CPP and the Superintendent must consider the reversal of this census trend as a priority. The census trends should be monitored monthly with appropriate feedback provided to the CPP. Of course, as described in another section, the major solution of this situation will be procurement of resources that are appropriate. The CPP should be able to manage caseload of at least 2,000 clients. Presently the CPP is staffed with approximately the same staffing patterns that were available when the CPP managed 2,000 clients. A census of 2,000 should be the immediate goal of the CPP.

(b) This increase in census should include outpatient clinic clients so that these clients do not have to be admitted to a more restrictive environment than what is needed. The inpatient census can be reduced by restricting admissions of outpatient clients to inpatient status through the use of the CPP resources.

2.4 Monitoring Of Patients & Facilities.

After placement, the CPP sees its responsibility as monitoring of patient care and providing of patient services, i.e. case management and direct clinical management.

OBSERVATIONS

2.4.1 Monitoring of the placement site include such features as the compliance of the facility to the Master Agreement, compliance of the facility to health and safety features and miscellaneous monitoring of the environment of the facility. The primary means of accomplishing this is for the nurse and social worker assigned to each facility to survey the facility using the Monthly Facility Report (see attachment 16). Monitoring occurs when this social worker and nurse go to the facility to visit a client. This informal process of monitoring is thus accomplished at least monthly and as often as staff visit the placement site. Monitoring may be increased if a placement site is below standards (some standards are subjective). The treatment team, i.e. one of the three major CPP teams, discuss the placement site and patient care at the Monday morning staffings. If at this point the team wishes to increase monitoring, they may request the Director to do so. This process is not well established nor guided by written policies and procedures. The rating of a facility must be at least yearly and is guided by "Standards and Guidelines for the CPP staff" which is a document that was written in 1976. This document does not apply to all types of placement resources, nor is it up to date.

IMPACT

(a) The system of monitoring of a placement site appears to not operate under the benefits of standards, or policies and procedures; this would create a situation where the monitoring is subjective, unreliable and unpredictable. Also, staff would find a high level of role anxiety due to the fact that they do not have prescribed duties specified in writing for them.

(b) Not only are there no well written standards, or policies and procedures, but the Facility Monthly Report, which is at best a minimal effort, is not managed in such a way that it is submitted monthly.

(c) It appears as if there is no specific monitoring of a facility's compliance to the Master Agreement; thus this agreement is so much paper.

(d) Flow chart 17 is a representation of how the CPP handles behavior/medical problems. This flow chart well represents how facilities are also monitored. When a facility has an identified problem with its environment, the nurse and social worker team works with the facility to solve the problem. If no solution is available, the CPP either holds placements from that facility or removes clients from the facility and returns them to SLSH.

RECOMMENDATIONS

(a) Policies and procedures should be developed that implement standards set by Central Office., These

standards should address all types of placement resources and be kept up to date. Those standards which are presently in existence should be put into effect until other standards are developed. The CPP needs to write policies and procedures which can be utilized to implement the standards set forth by Central Office. Policies and procedures should have the effect of reducing staff role anxiety and strengthening the monitoring ability of the program.

(b) After policies and procedures are developed, data systems such as a Facility Monthly Report needs to be developed. The purpose of the data systems are to not only provide feedback to management regarding the monitoring functions of the staff, but to also provide staff with concrete, objective tool with which to monitor.

(c) The Master Agreement should be proactively monitored. Under the financial systems, recommendations were made as to how to best use the Master Agreement as a positive management tool.

(d) Flow chart 18 is a recommended flow chart for the handling of patient problems. The same chart well represents a system for managing facility problems. The differences between the present and recommended system is that the recommended system adds two more levels of intervention. If a solution to a facility

problem is not found, the facility and the team and a special Facility Problems Committee (see Organizational chart 19) work together to solve the problem. If a solution still cannot be found, then alternate placement sites and services are sought to move the client to. Only after these channels have been exhausted can the CPP move the patient back to SLSH. By making entrance back to SLSH more difficult and by bringing in a special committee or task force to work with the facility, chances for solution of the problem are enhanced and chances of returning patients to SLSH are reduced.

2.4.2 Monitoring of Patients

As case managers, the CPP staff has the responsibility of monitoring patient care as specified in the ITP, as well as monitoring the patient's contract.

OBSERVATIONS

Teams routinely make scheduled and unscheduled visits to placement facilities to monitor the treatment of patients. Though the Standards and Guidelines for the program staff are a good attempt to provide a more objective monitoring criteria they are old and not well suited for all the types of placement resources. There also appears to be no administrative system within the CPP for the implementation of a monitoring system.

Also the CPP appears to have no policies and procedures regarding the monitoring of patient care. Quarterly progress notes appeared to be the only requirement; attempts are made

to monthly monitor the patient's care, but this is not a written policy. Neither computer reports on monitoring, that is report number 318020-01 and report number 318030-01 reflect the monitoring of a patient's care on a regular basis. Title XX reports also do not reflect a routine patient monitoring. This does not mean that monitoring is not taking place, it does mean that these reports have not been managed so that they provide good accurate data to base a determination on.

The actual monitoring of the patient's care is accomplished by direct observation, review of the medical records and consultation with the facility staff. The nurse and social worker assigned to a facility and its patient's do report weekly at the team meeting on the condition of the patient's facility. This team meeting provides inservice education regarding various standards.

The CPP staff are also charged with the monitoring of the patient contract. For example, the patient contract might specify certain services such as wheelchairs, prosthetics, etc., the CPP staff must monitor that these services are provided. Of special note is that most contracts have written into them funds from 25 to 50 dollars that provide the patient with both money for clothes and miscellaneous spending. It is the duty of the facility to spend this money on the patient's clothes and to provide a patient with spending money. The facility is also bound to keep accurate books regarding the expenditure of these funds.

IMPACT

(a) Without well defined policies and procedures, monitoring is not effective and reliably implemented and maintained; thus patient care suffers as well as staff are not given clear objectives.

(b) Because management reports are not accurate or well maintained, supervisors have few tools with which to supervise the monitoring by the staff of the patient in placement. Without a reliable data base, management cannot reliably direct the programs.

(c) The weekly team meeting provides excellent feedback for the staff who do not have the benefit of policies and procedures, but it is simply not enough.

(d) There is some question as to whether some facilities are accurately keeping books regarding the expenditure of patient money for clothes and spending money; the CPP staff do not appear to be well qualified to monitor these activities. The ability to audit a facility's books with regards to expenditure of patient money is a skill that is not taught to social workers or nurses.

RECOMMENDATIONS

(a) For a system of monitoring to be successful three things are needed:

(a_1) Objective standards

(a_2) Policies and Procedures which state how these standards will be implemented.

(a_3) A management system including reliable data reports that provide feedback as to how well the policies and procedures are doing in meeting the stated standards.

Though objective standards do exist, Central Office needs to revise these standards. The CPP then needs to develop policies and procedures which clearly spell out the role of their staff in this process. The Director then needs to establish management practices that will insure the implementation of these policies and procedures. Management techniques would include a better use of Title XX documentation system with the program striving to report 100% of each worker's activities. The monthly facility report should have well defined policies regarding what must be contained in this report, how often this report is generated, etc.

(b) Recording in the patient's record needs to occur in a manner that reflects the activities of the case manager to a higher degree.

(c) Either the CPP staff need to be well trained in auditing procedures, or an accountant or program evaluator needs to be hired by the CPP so that the CPP can monitor the expenditure by the facility or the various patient monies. After the hiring of this individual or the training of CPP staff, a program should begin to monitor the expenditure of money for patient clothes and the provisions of money to patients for spending.

2.4.3 Close Monitoring, Stopping Placements and Withdrawing Patients from a Facility

OBSERVATION

2.4.3.1 If the physical plans and environment of a placement site or the care afforded to patients declines below acceptable objective or subjective standards, the CPP staff will put into effect certain actions cited below. It must be noted that there are no policies and procedures that determine written criteria for increased monitoring activity nor when to put into effect those procedures cited below. If, when, and how these actions are taken are determined by the subjective impressions of a variety of people rather than the objectives use of standards. These people include the staff monitoring the facility, the Director of the CPP etch; any and all of these individuals may become involved with the decision to increase monitoring or close the facility. The types of actions/steps that the CPP may implement are:

(a) Increased monitoring by staff assigned to that facility.

(b) Involving the Director in an ongoing description of the facility's condition.

(c) The withholding of all new placements to that facility.

(d) Actively removing certain or all DMH clients from that facility.

(f) Working with licensure people to close the facility.

IMPACT

Due to the lack of policies and procedures, the increased monitoring situation is not handled skillfully, nor reliably.

At best, the situation will work to the benefit of the CPP; at worse it could lead to very poor handling of the media or especially, patient care. This does not provide for the best possible care for the patients entrusted to SLSH's care.

RECOMMENDATIONS

(a) Development of policies and procedures which clearly define the actions, the roles, and the timetables for implementation of close monitoring, closing of the site, or withholding of patient placements. Both the placement site and the CPP staff must be aware of what determines increased monitoring, when this will take place, and what the consequences will be if the facility does not change its actions.

(b) Facilities should be told exactly what changes they must bring about, how these changes can be brought about, and what the consequences will be if they fail to act accordingly; this should be in writing to the facility.

2.4.3.2 Close Monitoring of Patient Care or Removal of a Patient.

OBSERVATION

If an individual patient develops behavior/medical problems, the social worker and the nurse assigned to the patient will begin a process of close monitoring of the situation and consulting with the facility staff on how to treat the patient accordingly.

If the patient's problem continues to remain unmanageable by the facility staff, the CPP staff will return the patient from placement to SLSH. Flow chart 17 describes this procedure. After the facility identifies a problem, both the facility and the CPP staff seek to solve the problem. If there is a solution, the patient remains; if not, the patient returns to SLSH.

IMPACT

Patients often develop behavior or medical problems that are not manageable in the facility that the patient is placed in. It should be noted that most of these facilities that are presently used for placements are not skilled, psychiatric treatment centers and subsequently cannot manage many types of psychiatric behavior. Also, due to the fact that CPP is on a defensive posture (seller's market) the CPP staff quickly heed the demands of the facility to remove troublesome patients. These patients may be removed to a more restrictive environment than is necessary to treat them; possibilities are high that they will not be returned to the community. Page 9 (1.3 - d) of the philosophy section reveals the high number of patients returned to SLSH and the low number that get replaced each month.

Patients are not effectively being treated in the community for either medical or behavior disorders, i.e. they are not being treated in the least restrictive environment possible through effective case management. This results in an increased

load not only for SLSH medical clinics, but also on its inpatient census. The patient must suffer the results of the revolving door treatment program.

RECOMMENDATIONS

(a) Chart 18 is a graphic representation of a system to deal with patient medical/behavior problems. After a facility identifies a problem, the treatment team works with the facility to solve the problem. If there is no solution, the treatment team nurse and social worker must ask for assistance from the committee that deals with Special Patient Problems (see organizational chart 19). This special task force is composed of individuals trained to deal with the nurse and social worker assigned to the facility to maintain a placement and provide crisis intervention and treatment. If a solution is not forthcomming, the task force must then bring in, through POS expenditures, alternate treatment and/or placement modalities to continue to maintain the client in the community.

(b) The task force should be aware of all the resources that can be mobilized and deployed to meet the client's referral needs. If no other alternate resources can meet the client's needs, then the patient can be admitted to SLSH. This admission to SLSH should be carefully screened so that SLSH is sure that all alternate resources

and treatment modalities have been utilized for patient care in the community. Patients are thus provided effective community treatment in the least restrictive environment possible; this also has the effect of reducing re-admissions to SLSH.

(c) SLSH inpatient needs to "close its doors to the CPP" that is, SLSH needs to actively force the CPP to seek alternatives to inpatient admissions. Through demanding explanations as to why a patient is admitted, and reviewing these explanations and rationale, SLSH can discourage easy returns.

2.5 Other Types of Patient Movement

Besides returning to SLSH as described in 2.4 patients can move into another facility served by the CPP, can be transferred to another CPP or state hospital or they can die.

OBSERVATIONS

Presently there is no great patient movement other than returning to SLSH. As previously stated, new placements are low, re-placements are low, and patient movement along the continuum of services appears to be non-existant. There are no reports that detail client movement to less or more restrictive environments, thus accurate analysis cannot be made. But a lack of these reports does suggest that such activities are relatively minimal. Transfers to other community placement programs have been few.

IMPACT

Placement as a treatment modality cannot be a reality without a philosophy and management system that encourages and monitors patient movement along a continuum of services. The CPP is a very stable program which, except for returning patients to SLSH, does not move patients about within the program. Because a system is not dynamic, treatment is not dynamic and patient conditions remain stable or deteriorate.

RECOMMENDATIONS

(a) The CPP Director should develop, supervise and manage a system that encourages and reports patient movement in, out and within the CPP. By shaping the programs into a dynamic posture, the patient's deterioration can be checked, or their conditions improved. By improving the dynamic qualities of the program, staff burn-out is decreased and higher quality professional staff can be enticed to join this program.

(b) The philosophy of patient movement along a continuum of placement sites, to the least restrictive environment possible to meet the clinical individual needs of the patient should be taught to the CPP staff by utilizing not only a variety of inservice presentations, but also by development of data systems that would force individuals to report this type of activity.

(c) Movement of clients with the CPP along a continuum of resources should be effected through the provisions of resources and the active management of staff.

(d) Movement of clients to other CPP's, when resources are available and this movement serves the client's best interest for treatment, should be encouraged. The Director of the CPP needs to link with a communication network so that they availability of other resources is known to the Director.

2.6 Direct Clinical Services Provided by the CPP

The CPP provides not only case management but also direct clinical services. Direct service delivery does demand increased staffing patterns as compared to case management. When both case management and direct care is provided, role confusions is observed in staff. This confusions of roles, exist not only within the staff, but between the CPP staff and facility staff.

OBSERVATIONS

2.6.1 The Individual Treatment Plan (ITP) and Medical Records

The ITP is written by the referring team as part of their pre-placement activities. The CPP team updates the plan as needed, but at least on a quarterly basis with progress notes. The CPP does not generally write new treatment plans. The ITP and progress notes are kept with the CPP on A-3, and the placement facility has it own medical records. No written policies and procedures exist to determine what the duties are of the CPP in the use of medical records and the ITP.

Licensure requirements of those facilities that are bound by the licensing, are based upon compliance to standards regarding medical records. The CPP staff do not monitor compliance to these standards.

IMPACT

Confusions exist as to what is the role the CPP plays in writing and updating the ITP. Treatment plans do not appear to reflect active case management and the CPP as a program does not have policies and procedures regarding when the ITP should be written.

RECOMMENDATIONS

(a) The case managers assigned to each patient should direct the placement facility's staff in the development and implementation of the patient's ITP. Every CPP patient should have the benefit of an ITP with the CPP being the case manager who, as case manager, organizes and directs treatment staff of the facility in the delivery of services. This activity should take place for all CPP clients, including those in Places for People.

(b) The CPP should immediately become active in the ITP project that SLSH is currently implementing. This includes use of the ITP plan that has been printed. Of course, the case manager will be addressing patient

needs through not only the resources the placement facility can provide, but also through POS and existing community resources. The ITP is a vehicle for moving the CPP staff into a philosophical posture that utilizes placement as a treatment modality.

(c) Policy and procedures should be developed as to the use of the ITP and the medical records of the CPP. The medical records department of SLSH should be consulted to the proper use of the medical record and the system of medical record keeping used by both the placement facilities and the CPP.

(d) The CPP should participate in the medical record audit as does every inpatient area of SLSH. A medical record audit should be initiated immediately so that the Superintendent is aware of the needs in this area.

2.6.2 The Uses of the Medical Clinics By CPP Clients

OBSERVATIONS

The CPP actively uses POS transportation money to move CPP clients from a placement site to SLSH for medical treatment. Though some patients are brought back to City and County Hospitals, no records are kept as to exactly how many patients receive services in the community and how many receive them at SLSH. It appears as if many patients were receiving medical services at SLSH. If a placement facility feels it cannot perform a medical

function, and there are no alternate resources, then, and only then, should the patient should be brought back to SLSH for treatment. An analysis of the types of clinic appointments that the CPP clients use, suggest that skilled nursing facilities, in varying degrees, do not provide medical services that one might expect them to provide.

IMPACT

By returning the CPP clients to SLSH, the dependency on the institution by the patient is fostered; the patient is also, of course not being treated in the community. SLSH must then support in its budget costly services and manage these services.

RECOMMENDATIONS

(a) The case manager should utilize community clinics, private physicians, etc. to provide these essential services. POS and medicaid will pay for most of these services. This would reduce both staff and patient dependency on the institution.

(b) An analysis should be implemented to determine what medical services a skilled nursing facility and an intermediate care facility can and should provide. These facilities should then be encouraged to provide essential medical services as part of their contract. For example, patient contracts should have written into them an expenditure for money by the facility for yearly physicals and routine clinic

visits. Those treatment facilities not oriented to providing medical care and coverage should work with the case manager in providing these needed services in the community in which the placement facility is located.

2.6.3 Medication of CPP Clients

OBSERVATIONS

As described in the financial section, some patients receive medication via SLSH pharmacy and some do not. There does not appear to be a good rationale in all cases, as to why this occurs. No written policy and procedure exist as to whom shall receive medication from SLSH.

IMPACT

Medication is not only a costly treatment service, to manage , but a very sensitive clinical practice. As such, the Director of the program needs to work out a policy for medication and how it is obtained.

RECOMMENDATIONS

(a) Whenever possible, the patient should have the opportunity to receive medication from their local pharmacy. It should be the placement site's responsibility to determine that the patient does receive and takes his medication. The CPP should monitor medication compliance, not provide it.

(b) The CPP Director should analyze the situation and develop policies and procedures that guide the distribution and monitoring of medication across all types of treatment resources.

(c) The Director should determine whether the case management staff is making full use of medicaid and POS money to pay for medications and delivery of medications from the community. Most patients should be eligible for medicaid reimbursement for their basic medical and medication costs.

2.6.4 Recreation and Social Program, Purchase of Clothes and Other Items, Physicals, Prescriptions and Other Medical Interventions - Direct Clinical Services

OBSERVATIONS

The above mentioned clinical services are provided to varying degrees by the CPP staff. The provision of these services varies from one staff to another staff and from one facility to another.

IMPACT

To provide patient care both as a case manager and a direct care provider, especially when written policy and procedures do not clearly establish one's roles and duties, determines inequitable care and treatment of the clients of SLSH. At best, one can

never predict what the role of the staff will be and subsequently what the care provided to that patient is. Staff will tend to become too independent, and accountability will be low.

RECOMMENDATIONS

(a) All staff should act as case managers and monitors only. Case management is the preferred role of staff involved in community treatment of patients, as detailed, not only by the literature, but by DMH Central Office. The provisions of direct clinical care should be provided, as determined by the case manager (CPP staff) and specified in the ITP, by the placement facility, or through the purchase of these services. By freeing staff to act as case managers, more time is alloted to the monitoring of the implementation of the ITP and the monitoring of the facility for compliance of the various contracts. The CPP staff should also be able to handle 2,000 and possibly more clients, when they cease direct care and become solely case managers.

2.6.5 Patient Clothes and Spending Money

OBSERVATIONS

Most patient contracts provide up to 50 dollars per month per patient for both clothes and for spending money. The placement facility is responsible for the allocation and distribution of this money, as well as keeping records of this money.

IMPACT

Staff have reported that there exist strong possibilities that the placement facilities abuse this system. Poor bookkeeping by the facility and poor monitoring by the CPP staff allows for the possibilities of this abuse to occur.

RECOMMENDATIONS

(a) As described in the personnel section, monitoring activities should take place on two levels. An accountant should be hired to act as a monitor on the second level of monitoring. This accountant should be utilized to audit placement contracts for compliance to bookkeeping requirements.

(b) The staff accountant should also work to train the CPP staff in basic monitoring of bookkeeping and train the staff in auditing of facilities to see what was purchased, compare receipts, and determine that the client did in fact receive those purchases. The CPP must also make the placement facilities aware that strong consequences will be the result of the facilities misuse of patient money.

2.6.6 Transportation of Clients

As described in the financial section (page 100) transportation of clients should be provided by the placement facility. The use of many hours of CPP staff time to manage a network of transportation of patient services is ill advised.

2.7 Clinical Programs Serving CPP

Three basic programs serve the CPP clients through placement money and POS. They are Ankh - which primarily serves the clients of the Ave Marie Boarding Home, Places for People - that serve the clients in the community home program and the Troy/New Haven Foster Community. Attachment 20 describes Ankh and Attachment 21 describes the Places for People. The foster community program of Troy/New Haven needs further discussion in as much as it is a very unique program and a possibility exist for a similar type of program being developed throughout the metropolitan St. Louis area.

OBSERVATION

Troy/New Haven Foster Community started out as a project of the Missouri Institute of Psychiatry over a decade ago, serving the chronically mentally ill of SLSH in a unique manner. This program is patterned after a similar town in Belgium that provides community integration for the mentally ill. The community in Troy/New Haven provide integration into its social, cultural, economic and religious life as well as providing housing for the mentally ill. This program provides a true community integration and community service program.

Some of the salient features are that this community is small, homogeneous and its life centers around the church.

IMPACT

The Troy/New Haven Foster Community program provides not only residential service, but integration of the patient into

the life of the community. Subsequently, the patient can be treated for their mental illness and return to a community to live a life under relatively "normal" conditions. The patients' social functioning is such that their community life provides the same rewards as it would for non-mentally ill patients.

RECOMMENDATIONS

(a) If one surveys the urban and suburban landscape of metropolitan St. Louis, one can see a host of small towns. These small towns center around neighborhood organizations, schools, businesses and most often, churches. That is, there exist vast untapped resources for patient integration into the community. If any one community would adopt, to integrate into its life, the patients that came to SLSH from that community, SLSH could significantly decrease its patient population.

(b) It is recommended that a program of Community Adoption of the Mentally Ill (CAMI) be developed. This program could be financed through federal grants, foundation grants and private grants. A non-profit corporation, at first funded by the DMH, could be developed to work as the umbrella organization in the coordination and implementation of CAMI.

(c) CAMI would survey and map the metropolitan St. Louis area for viable communities that could possibly integrate DMH clients into their social functions. One possible

method of opening the doors to the community is to utilize the services of the archdiocese of St. Louis or other church organizations to support this program. CAMI would develop a host of community organizations to which it would provide grass roots public education and public relations so that the residence of the community can learn about mental illness. Each organization would be asked to adopt an inpatient, outpatient or community placement patient. The work involved with adoption would vary such that a community would not have to provide more than it was capable of. For example, a community could be asked to bring a few patients to Sunday mass or to its bingo games. The concept would be to ask only a little at a time from a few people such that resources are not strained. Other communities may be able to not only provide some social programming for their adopted residents but also provide vocational opportunities, economic opportunities, etc.

(d) The benefits to SLSH inpatient, outpatient, community placement program is that the integration of the client into the community provides the client with treatment in the least restrictive and most normalizing environment possible. Integration of the patient into the community also insures that the client will respond to discharge in a more successful manner. The

community, through the provisions of social, economic and placement opportunities, also provide a wealth of resources to a resource poor SLSH. Even if SLSH were to receive no resources from this effort, the contacts with the community and the public relations developed with the community will provide better support for SLSH when it comes to voting on the DMH budget.

3.0 System Linkages

All social groupings operate within a complex constellation of intertwining behavior - simply stated, a social system. The CPP operates within a facility within the city within the state, etc. Any program operating within a system must be viewed as part of the system not as an island in and of itself. Due to the fact that the CPP must by nature of its task operate closely with the variety of other social systems and not be isolated, it is imperative to evaluate those important linkages with other systems.

3.1 Linkages with the Superintendent's Office

OBSERVATIONS

St. Louis State Hospital's CPP was tranferred to the direct supervision of the Superintendent of St. Louis State Hospital in 1978. Prior to that, the CPP reported directly to the Deputy Director of the Community Placement Program in Central Office. The purpose of this transfer was to give the CPP its direction, based upon the needs of SLSH, as determined by the Superintendent.

IMPACT

For the smooth functioning of SLSH's treatment program, it is imperative that community placement resources be available to the Superintendent. The Superintendent needs to be able to

set priorities, and supervise the direction the CPP takes. Without the supervision of the direction the CPP takes in its placement program, the Superintendent does not have the authority, nor the ability, to provide a smooth continuum of services for the patients of SLSH.

RECOMMENDATIONS

(a) The Superintendent should develop a strong program of support and dialogue with the Director and the executive committee of the CPP. This should include such activities as having the Director of the CPP part of the hospital executive committee, and integrated into the communication network of SLSH.

(b) External influences other than that of Central Office should be neutralized.

(c) Central Office's role should be well defined and clarified for all parties involved.

(d) The Superintendent should also meet with the CPP's Director and executive committee at least bi-weekly so that a mutual operational and philosophical direction can be implemented.

(e) The Superintendent also needs to request a system of monthly reports that generate where the CPP is at in its process to place SLSH patients.

3.2 Linkages with the Assistant Superintendent - Treatment

OBSERVATIONS

The CPP and the Unit Coordinators under the direction of the Assistant Superintendent of Treatment do not presently have a formal line of communication established. Questions have been raised as to how the CPP operates, what is it function and what is its methodology.

IMPACT

Due to the lack of dialogue between the Unit Coordinators via the Assistant Superintendent of Treatment and the CPP, a cycle has been developed whereby

(a) Unit staff do not know what is the type of behavior a patient must possess or must not possess so that they can be successfully placed in various types of facilities.

(b) The staff are not aware of what facilities there are available for placement.

(c) Staff are not aware of what patients make the best possible placements.

Subsequently, patients are not properly trained or treated in such a manner that placement success is assured. Also, there is a possibility that appropriate patients for placement are not being referred to the CPP. The ramifications of poor communication with the staff that will make these referrals is

to discourage a working relationship that would, if developed, work in the interest of providing the best care to the client.

RECOMMENDATIONS

(a) The CPP's Director and the Assistant Superintendent of Treatment are peers, both of which are running large organizations serving the needs of a very large number of patients. These two individuals need to function closely so as to provide a continuity of treatment of SLSH patients. It is recommended that a scheduled meeting regularly take place at which these two Directors discuss the status of communication systems and the referrals that have been made to the CPP.

(b) The CPP team assigned to any referred patient should make multiple contacts with the patient's treatment team not only to generate an approprite ITP, but to learn about the individual so that a knowledgeable placement can be made and maintained in the community.

(c) The Unit Coordinator should play a more active and invclved role in referrals, scheduling of staffings that deal with these referrals, and the determination as to the client's disposition at any point in time. Through increased managing and monitoring of this referral system, it is suggested that placements will move smoothly and patients may be maintained in the community for longer periods of time until successful transitions is made.

(d) The referring team themselves should remain active, in treatment subsequent to placement, for a period of 90 days. This would insure a better discharge planning and transition for the patient if the discharging staff were accountable for the placement immediately after discharge. If a patient is going to reject placement it is usually within 45 days. The new treatment team is possibly not sufficently knowledgeable about the patient to make the most effective intervention. Through contact with the referring team, intervention strategies can be mobilized to maintain a patient until the placement itself is successful.

(e) The CPP should regularly provide inservice to the Unit staff as to what skills patients need or types of patients that can be successfully placed in particular types of placement facilities. The CPP staff can make the unit staff aware of behaviors that usually arise in the community, what interventions are provided by the facility or what POS and the CPP staff can do.

3.3 Linkages with the Community At Large

OBSERVATIONS

An analysis of the reported role activities reinforces that the CPP believe there is a need for community relations even though there is no individual actively functioning in this capacity.

IMPACT

Successful de-institutionalization or discharge of patients into the community depends not only upon the acceptance of the patient by the community, but also the social system that the community provides to insure successful discharge. Without an identified individual to meet the informational needs of the community, suspicions, rumors and myths proliferate about the mentally ill patient.

RECOMMENDATIONS

(a) The Director of the CPP should appoint an individual to represent the CPP in every neighborhood patients are currently placed or neighborhoods that will be placement sites within the year. By placing responsibility on the line staff to make and maintain contact with neighborhood organizations, politics, economics, i.e. its political, social and economic support system, it encourages the community to accept rather than reject the CPP clients. Where ever possible, the CPP staff assigned to the neighborhood should be someone who lives in that neighborhood. Not only should this representative report on the quality of the relationship between the neighborhood and the DMH client, but also represent the CPP at various neighborhood funtions. This involvement by CPP staff will also make the staff aware of community resources for SLSH.

(b) The Director should develop an active program of informing and involving the community of the mental health movement. A program of information and support delivered by means of pamphlets, talks to groups, participation in community affairs, slide shows, etc. will make the community aware of the real facts and encourage the acceptance of the mentally ill and the mental health movement.

(c) This task of community involvement will bring the Director of CPP in contact with the media and through the provision of background information to the media will encourage the media to understand the CPP's problems and report their efforts in a more empathic way. This also encourages a grass roots public relations system for SLSH.

3.4 Linkages with the Placement Facilities

OBSERVATIONS

Though staff interviewed recognize the necessity for good open communication with the facilities that handle SLSH's patients and with other facilities not yet accepting DMH clients, this role is not being filled.

IMPACT

Without proactive communications with the facilities housing DMH clients, the relationship between the placement sites and the CPP Director is a reactive, crisis oriented

relationship. This type of relationship does not allow for a good working partnership in the treatment of the client. Client services are not optimized and neither is incorrect and damaging misinformation terminated before damage to the dialogue occurs. Facilities, through their information grapevine, will tend to hear the negative and complaint oriented description of the CPP; this effects not only the facilities CPP places with, but discourages good quality placement sites from actively seeking out,oor even accepting CPP clients.

RECOMMENDATIONS

(a) That the case manager's role in relationship with the facility's owner and manager be supervised and encouraged to grow along a positive line. This relationship should be well defined, for it is beyond the scope of the case manager himself to develop too strong a line of communication; a strong line of communication and decision making is a role of the Director of the CPP.

(b) The Director should actively develop a positive proactive working relationship with each facility's owner/manager. This can be accomplished through telephone contacts and scheduled meetings. This posture, as it becomes more proactive, will inhibit poor relations and encourage optimum client service delivery. Of course, the Director should also respond quickly, courteously and professionally to complaints from the owner/manager.

(c) The Director should develop an active, innovative program to encourage the development of placement resources to meet the specific needs of SLSH's clients. These clients' needs should be for both the inpatients and outpatients. Through the delivery of those services to outpatients, admissions to inpatient status is discouraged.

To encourage optimum relations with facilities not yet accepting patient placments from SLSH would be to seek out and adress organizations representing the various placement sites and by talking with service oriented groups and individuals so as to encourage their involvement and support. A newsletter or some other type of communication network should be established between various groups, organizations and placement sites in the CPP. It is recommended that the Director should allocate the minimum of 20% of his/her time to this project.

3.5 Linkages with other State Agencies

OBSERVATIONS

The CPP must interface with many other state agencies including the Division of Family Services, Department of Aging and of course, other Community Placement Programs. Presently the linkages remain problem oriented, "as needed" relationships.

IMPACT

As discussed previously, this type of relationship does not foster a proactive working relationship. Subsequently, this program should develop a better, positive interface with other state agencies, so as to provide the best service to the DMH client.

RECOMMENDATIONS

(a) The Director should develop a task force to meet bi-monthly with these other agencies so that dialogue is established. Each agency should have its own task force consisting of approximately three people.

(b) The Director should develop a line of communication with the supervising authority on the local level of these agencies. These state officials should work in concert with each other so that their representation to the various placement sites can be viewed as a coordinated effort. The coordination of postures with regards to placment sites insures that the state efforts to maximize patient care will stand a stronger chance of success.

3.6 Linkages to Central Office

OBSERVATIONS

The influence of Central Office over the Director of the CPP is presently in a developmental stage. History has shown

that this influence waxes and wanes with the various administrations. The present administration is politically and administratively a powerful office.

IMPACT

The historical fluctuation of leadership from Central Office has created a situation where the very survival of the CPP determines that the CPP remain relatively directionless and on a "holding pattern." It has much more survival value for the Director of the CPP to take a posture of "wait and see" rather than embark upon a program that will either be challenged or not provided with benefit of supervision. Thus planning and developing is kept on a holding pattern due to the lack of leadership (planning and developing is also kept on a holding pattern by a lack of strong fiscal management by Central Office). A strong Central Office leader can, with much prodding, get the program to move for some goals; but a strong leader is usually challenged by a number of political forces and is subsequently replaced by another, weaker director. The weaker director then changes the direction of the program and subsequently the CPP is back on a "holding pattern."

RECOMMENDATIONS

(a) The acceptance of the authority of a strong leader from Central Office can be most benefical in the moving of a program forward. But this acceptance, if it is to be, should be influenced by a needs and priorities of SLSH.

(b) A strong line of communication should not only remain with Central Office, but more especially, should be developed with the Director of the CPP, no matter who the Director of CPP reports to. Even if Central Office leadership is strong and positive, it is necessary that a pattern of dialogue and communication be established so that SLSH's Superintendent will be able to influence the CPP's direction via this dialogue. Due to the fact that CPP is located on SLSH's grounds, and depends heavily on a variety of SLSH services, the ability to develop and to reinforce a dialogue through support is ever present.

4.0 PERSONNEL SYSTEM

The personnel system is a complex system that encompasses communication, task communication, staff development, use of consultants, etc. The personnel system is not only the job or task staff does, but also the training and skills an individual has.

4.1 Organizational Chart

OBSERVATIONS

Attachment 22 is the present organizational chart as submitted by the CPP. The chart reflects the assignment of staff to discipline directors for supervision and the assignment of staff to team groupings for task activities. This attached chart displays the linkage the CPP has with the various discipline directors within SLSH and Central Office. Also, the chart reflects a CPP staff member who report directly to the Social Services Director and not the supervisor within the program.

IMPACT

This chart reflects a good system in as much as staff are grouped together by task, but report to a discipline supervisor for guidance. It should be noted that there is ambiguity regarding the role of the Director of the CPP in relation to The Deputy Director of the CPP and Central Office. Also,

ambiguity exist between the role of SLSH's discipline director with regards to the discipline staff within the CPP. The inpatient discipline directors exert varying degrees of influence on the CPP discipline staff. Confusion as to who, for example, the psychiatric social work supervisor reports to exist. One psychiatric social work supervisor reports that she is supervised by the discipline director within SLSH and not by the Director of the CPP. Also, the chart reflects an awkward situation where a social worker within the CPP reports directly to the discipline director of social services for inpatient SLSH and not to one of the two social work supervisors of the CPP.

RECOMMENDATIONS

(a) The present organizational chart, with discipline supervisors and task/team organization, is a good basic chart. Two positions do need to be added that report directly to the CPP Director - a clinical psychologist and an accountant or program evaluator with bookkeeping skills.

(b) The social worker in the program should, like all other social work staff, report to a CPP social work supervisor, not to the Director of Social Services within the inpatient program of SLSH.

(c) The role of the Director in relation to the Deputy Director of the CPP in Central Office should be clarified.

(d) The role of discipline director to the CPP staff should also be clarified. The CPP needs to detach themselves philosophically from the inpatient program at SLSH and should have a limited relationship to the discipline directors of SLSH. Also, due to the specialized nature of the CPP, the inpatient discipline directors cannot provide quality assurance nor the supervision that they can and should under the inpatient unit system.

(e) The Director should continue to report to the Superintendent and all CPP staff should report through a chain of command, to the Director of the CPP. That is, the CPP should function as a centralized unit with all staff reporting to the Director of the CPP. It should be noted that the CPP must serve the needs of not only the inpatient community but also the regional community. In as much as the Superintendent is aware of these needs, the Director of the CPP should report to the Superintendent.

(f) A functional organizational chart as depicted in attachment 19 is recommended for implementation. The features of this chart, which details how information should be processed, is as follows:

(f_1) The executive committee, lead by the Director, is composed of the staff that report directly to the Director. Reporting to the executive committee are three treatment teams and six committees.

(f_2) All staff in the CPP belong in this recommended chart to one of three teams. The team leader is from the executive committee. Each team has all the necessary staff, patient referrals, placement resources and operational money to manage the clients entrusted to their care. Each team should be equal in all respects such that inter-team comparisons can be made and team competition encouraged. Each team is responsible for the total care of the patients entrusted to them from the point in time the referral is made until the point the patient is discharged from the CPP. This includes case management, development of the ITP, monitoring of patient care, monitoring of the facility in which patients are placed, etc. Each team in essence is a small community placement program. This team is responsible to the executive committee for their work and as such reports to the executive committee. If the CPP were to grow, it would be advisable to increase the number of teams.

(f_3) The Resources Procurement Committee should be composed of five to seven members which include not only representatives from all three teams but also representatives from various organizational levels. This committee should be lead by the CPP Director because of its priority.

(f_4) The Special Patient Problem committee and the Special Facility Problem committee should both be composed of individuals who are from all levels of the organizational structure; these individuals should have proven capabilities of handling crisis situations, both in patient care and with facility management. For example, if a nursing home were to burn, the special facility problem committee would be contacted and the chairperson would assign committee members to handle the variety of task necessary in providing for smooth crisis management.

The special patient problem committee, as chart 19 shows, handles situations where patients may have to lose placement because the case manager and placement site cannot handle the situation. This committee then takes over and provides the necessary extra

buffer, through its services, between the patient and return to SLSH. A clinical psychologist well trained in behavioral problems is recommended to chair this committee.

(f_5) Next on the organizational chart are two quality assurance committees; one specializes in monitoring the facility and the other in patient care. The standards, policies and procedures applicable to both areas, are routinely monitored by these two committees. Composition of these committees should be across all three teams and all disciplines. The Patient Quality Assurance committee should be chaired by a psychiatrist and the Facility Quality Assurance committee should be chaired by the accountant or an individual well trained in safety standards and bookkeeping procedures. To avoid conflict of interest, only members from the two teams whose facility is not being audited will participate in an audit. The team assigned to a placement facility will monitor on a routine basis, but the team must work closely as partners with the facility, and as such the team develops a particularly subjective view of the facility. It is only

human nature to develop a relationship with the people and program one must work with, but this type of relationship does not foster objective decision making. The two committees on the other hand, have no vested interest in being subjective. They can come in and do a very thorough inspection, defined along objective and subjective standards, and then report back to the executive committee. This provides the executive committee with feedback as to the functioning of that team. The report generated by the quality assurance committee can be used by the executive committee to give direction and feedback to the team whose facility was audited.

(f_6) The staff development committee should link with SLSH staff development department and other necessary resources for training of the staff of the CPP in community treatment. This committee should be multi-disciplinary. The committee should provide training not only to CPP staff, but also provide training to the staff of the placement facilities. Presently there is no organized plan to provide staff development to placement sites staff. Other programs have developed a monthly calendar of training events and have encouraged CPP staff and facility staff to attend.

(f_7) The last committee, the Patient Referral committee, screens all patient request for referrals to one of three teams for processing (see Section 2.1 - Recommendations).

4.2 Communication Network

It should be apparent that a well functioning communication network is a must for a well functioning program. Management needs to attend strongly to how information is channeled to staff within a program, especially a complicated program such as SLSH's CPP.

OBSERVATIONS

On several occassions the evaluator witnessed either a lack of communication from the Acting Director to other staff, or communication by the Acting Director around a staff supervisor direct to line staff. Also, an individual outside the CPP presently exerts undo influence, through the Acting Director, upon the CPP.

IMPACT

Many staff have voiced concern regarding lack of communication and the subsequent confusion as how to act. Supervisory staff have expressed frustration regarding their staff being directed in their duties by the Acting Director without the Acting Director informing the supervisory staff that this is occurring. Staff, including executive committee staff, have expressed confusion, concern and amazement regarding the influence of individuals outside the CPP upon the CPP.

RECOMMENDATIONS

(a) The new Director must make sure that basic rules of communication are put into effect; the Director should not assume that there is any functioning communication network.

(b) Alien influences on the CPP should be neutralized as soon as possible so that the staff has the benefit of one direction in leadership.

4.3 Staff Development

Staff Development plays an important role in providing staff with the skills necessary to do their job. Besides skill training, staff development allows staff to avoid their duties temporarily as they "recharge their batteries." The Director can use staff development in a manner to shape the philosophical orientation of the entire program.

OBSERVATION

The CPP is involved in minimal organized staff development. Staff report that about one hour monthly is allocated to staff development. In this format, staff within the program provide the training to other staff. SLSH's staff development and the two discipline directors, all report that the CPP does not attend, to any large extent, or participate in the staff development programs they provide.

The CPP staff do not report any organized program of providing staff development and training to those staff within the facility serving SLSH clients. This is considered an

important function by other CPPs and the literature. The quality of the staff on many placement facilities is lower than that of the state's employees, and as such, are in need of staff development and training.

IMPACT

The CPP staff are isolated to a degree that the program has little input from the outside areas. This isolation does not encourage a healthy, viable program that is influenced by innovative directions in community placement.

The staff at many of the placement sites, especially the nursing homes, are not well trained. It is in the interest of DMH client care to provide encouragement for these staff to learn how to do their jobs better. Presently the CPP has no organized plan for development of placement site staff.

RECOMMENDATIONS

(a) The staff development committee should actively develop a program that will provide the CPP staff with the latest philosophy and techniques regarding community placement as a treatment modality. Possibly, staff should be required to earn a certain amount of staff development hours per month.

(b) This committee should develop a monthly calendar of special staff development events that could be distributed to all placement sites. Records should be kept as to how many staff attend, how many of these events. The facilities who actively provide training and staff development for their employees should have this fact entered into their rating.

4.4 Special Consultants

OBSERVATIONS

The CPP presently uses special consultants or linkages such as dietary, vocational rehabilitation, special education, etc. For example, dietary may be used to audit food at a placement site and provide feedback to the placement site regarding its menu.

IMPACT

The use of consultants outside the program, is a positive step that provides needed expertise to placement sites.

RECOMMENDATIONS

(a) The role these specialized consultants should be greatly expanded in both its scope and focus.

(b) Community consultants should be utilized whenever possible; consultants from DMH facilities should be used only when community consultants are not available, or are too expensive. Again, the CPP staff are case managers and are responsible for the procurring and managing of the referrals necessary to provide quality patient care. In this capacity, the CPP staff should be utilizing many special consultants that will provide training and insight into the facilities that handle DMH clients.

5.0 FINANCIAL SYSTEM

Of all the systemic determinants of a program's behavior, the finanical system is the most powerful. Economic influences, such as the strength of the financing, the quality of its implementation, the development of the budget process, predictability of the resources, etc. must be recognized and appropriately acted upon.

The Community Placement Program (CPP) is affected by three major sources of funding:

(a) The Department of Mental Health approved budget that is submitted as part of St. Louis State Hospital's budget. This includes an allocation for personnel, equipment and operations.

(b) Reimbursement monies for patient placement contracts which is allocated directly from the Central Office through the CPP.

(c) Purchase of Services (POS) monies allocated by the Comprehensive Psychiatric Services division in conjunction with the Office of Administration in Central Office.

5.1 Fiscal Year 80-81 Budget and Budget Development

The Department of Mental Health approved, fiscal year 80-81 budget was developed at St. Louis State Hospital by the CPP. Though the budget process was decentralized, it was not based upon a needs assessment that generated why this money for

staff and operations were needed. The basic budget process is to modify last year's request upward, supporting this request with various statistics that showed the number of patients served. Last year's budget had minimal Central Office involvement; it is assumed that this year's budget process i.e. Fiscal Year 81-82 will have maximum Central Office involvement. It is imperative that St. Louis State Hospital's CPP make a strong case for its budget, so that it is not short changed in FY 81-82's budget request to the legislature from Central Office. For that reason, a budget development section was added to this evaluation.

5.1.1 Fiscal Year 80-81 Budget

OBSERVATIONS

The Fiscal Year 80-81 Budget is composed of three areas: (a) the Personnel section, (b) the Operations section and (c) the Equipment section.

(a) The Personnel Budget is as follows:

POSITION	FTE	AMOUNT
Clerk Steno I	1	7,980
Clerk Steno II	2	18,552
Clerk Steno III	1	20,748
Clerk Typist II	3	37,792
Graduate Nurse III	8	130,608
Graduate Nurse IV	1	18,048
Graduate Nurse V	1	20,676
Community Mental Health Technician	16	214,228
Regional Community Placement Director	1	22,620
Clinical Caseworker Assistant I	2	21,384

Personnel Budget (cont)

POSITION	FTE	AMOUNT
Clinical Caseworker Assistant II	1	13,236
Psychiatric Social Worker I	3	39,708
Psychiatric Social Worker II	4	64,584
Psychiatric Social Worker Supervisor I	2	41,352
TOTAL	48.19	$641,794

(b) The Operations Budget is as follows: *

Travel - Field	25,000
Travel - Intra	100
Postage	2,040
Telephone & Telegraph	9,900
Other Operating Services	2,850
Printing and Photography Supplies	10
Transportation Equipment Supplies	10,800
Other Maintenance Supplies	100
Drugs and Medication	50,000
Laundry Supplies	8,735
Medical and Laboratory Supplies	2,950
Other Institutional Supplies	50
Office Equipment Rental	1,740
Office Supplies	840
Electronic Data Processing	20
TOTAL	$115,135

* Note: This budget is a spend plan that is not finalized at this point. This operating budget is 79-80's budget with a few changes. No major changes are expected, unless inflationary increases were allowed. At this point the CPP's operations budget does not have any inflationary allowance.

(c) The Equipment Budget - The CPP has not equipment budget per se. The equipment allocations are pooled into one amount under the Assistant Superintendent of Treatment.

IMPACT

(a) It appears as if the Personnel allocation for the CPP is sufficent in numbers, but does not reflect the specialized personnel need to provide the quality monitoring of the facilities and patients. A task analysis suggests a lack of psychologists and accountants.

(b) The Operations budget, if not incremented by the inflation rate will be in actuality a reduction of 18% (inflation rate) or approximately $20,700. Transportation cost and medical cost are high expenditures; better cost analysis and systems analysis would determine if these two items could be reduced.

(c) Being that the Assistant Superintendent of Treatment is not organizationally linked to the CPP, and handles the CPP's equipment budget, there is the possibility that CPP's request will be a low priority to the Assistant Superintendent of Treatment.

RECOMMENDATIONS

(a) Programmatic needs should be assessed as well as a complete task analysis be undertaken by the new CPP Director so as to generate staffing patterns communsurate with the jobs that need to be accomplished. It appears that a psychologist would be needed due

to the fact that a large number of the patients are returned to St. Louis State Hospital for behavior disorders. If a psychologist were hired, this psychologist would be used to implement strategies to maintain individuals who are acting out in their environment. Psychologist could also utilize the services of POS vendors in a more knowledgeable fashion. Also, it would appear as if an accountant would be extremely helpful in the monitoring and auditing of the placement facilities books with regards to patient's spending money, clothes, etc.

(b) The operations budget, if not increased by the inflation rate, would mean that the CPP must begin operating more frugally. Medication and transportation cost should be analyzed to determine if any of these cost can be written into the placement contract.

(c) It appears as if there will be the possibility of conflict with the equipment budgeting of the CPP if the Assistant Superintendent of Treatment handles the budget for the CPP. The Assistant Superintendent of Treatment has no vested interest nor organizational incentive to provide the CPP any priority in their equipment requests. It is recommended that the CPP be provided their own equipment budget or be provided an equipment budget under the Superintendent, to whom they report.

5.1.2 Budget Development

Presently the Community Placement Program's (CPP) process for developing a budget is not data based. The CPP budget is basically based upon a "wishing list" that the Director sees as their "needs." A data based assessment of needs has not been implemented. The arbitrary allocation of staff does not fill programmatic objectives appropriately.

Monies expended to reimburse facilities for the placement of St. Louis State Hospital patient's is acquired on an "as needed" and "if money is available" basis, i.e. if Central Office has the money, money is spent; if not, no patients are placed. There has been periods of time when, for example in the last fiscal year, money was not available for placements for four months. In this fiscal year, there is an abundance of money that will have to be turned back to the General Revenue. Due to an inability to plan fiscally, no attempt has been made to develop a "needs assessment" to base the budget on; the needs assessment should not only reflect the need to replace an inappropriate patient placement, but plan an appropriate placement for those patients in the discharge planning phase of the treatment at St. Louis State Hospital. Budget development should embrace personnel, operations, equipment and cost reimbursement for placement facilities.

Cost reimbursement for placement facilities are not now equitably distributed. A reference to the table 23 displays

cost per cell and standard deviation of that cell for the various placement sites. As it is demonstrated in Table 23, standard deviation can be interpreted to suggest that placement sites that are delivering similar services are being paid at different rates. It should be noted that the matrix was developed subjectively by the CPP staff, who assigned facilities to a particular cell. An attempt should be made to assign these facilities on a more objective basis. Nonetheless, this matrix is a good management tool inasmuch as it generates areas of possible concern that should be followed through with in-depth investigation.

IMPACT

(a) Without sound budget planning at the institutional level, a program must assume a posture of waiting aimlessly for money to appear from Central Office for placement and then frantically trying to spend it when it does appear. Due to the inability to predict when resources are available for placements, the program does not develop nor plan for the future, therefore the inpatient placement needs are not assessed.

(b) Without a rational and reliable data based assessment to use to build both a budget for present activities and for future expansion of activities, the legislature makes it appropriations unreliably and basically due to lobbying influences. A vicious cycle then begins of unpredictable appropriations, discouragement of planning and even less predictable allocations.

(c) Furthermore, when money is available, patients are often hurriedly and inappropriately placed in the most available homes. This is due largely to the fact that resource development in non-existant (why plan and develop resources if you may not be able to finance these resources?), and good appropriate resources have not been developed.

(d) This rush to place is further compounded by the Superintendent, who has been watching his inpatient population grow steadily, and when he knows that placement money is currently available, will push desperately to reduce this population, through the use of placement.

(e) Due to the lack of planning and thus the lack of placement resources, not only are patients inappropriately placed, but the facilities providing similar resources are not reimbursed equitably. The CPP purchases placement beds along the lines of what is available not necessarily what is the best for the best price.

RECOMMENDATIONS

(a) Budget development should begin immediately and be recognized as a high priority in the CPP; this budget development should not only be for present operations, but for predicted future expansionary needs.

(b) This data base for future needs should be a reliable, valid and objective data base that compares various profiles against each other to determine a needs assessment.

(c) When developing the bduget for future needs, it is inpcrtant to first survey the existing placments to determine the needs of those patients that are inappropriately placed.

(d) After sound planning and program development has been implemented, placements can proceed in an orderly fashion, based upon needs and resources allocated and avoid "emergency" placements predicated by desires to "empty" the institution.

(e) Needs assessment surveys will generate profiles that should be developed to the extent that inequitable cost reimbursement can be eliminated. A proposed budget development based upon a needs assessment is as follows: Matrix Profile - an instrument such as the New York Department of Mental Health's Level of Care Survey should be administered to all current Community Placement clients and inpatients of St. Louis State Hospital. This instrument had good inter-rater reliability; the validity of this instrument for placement of large numbers of patients, i.e. the "N" of any cell, if greater than 100, appears

to be high. Missouri Institute of Psychiatry (MIP) should be contracted to evaluate and improve this instrument to the point that it has very good validity for the prediction of placement of any individual client.

5.1.2.1 Matrix Profile - Inappropriate Placements

Matrix 1 is an example of a profile and explanation of each cell in the profile. Matrix number 2 is a hypothetical distribution of patients after the Level of Care survey had been administered to all clients presently it the Community Placement Program. The results are printed in matrix form by the computer in a fashion similar to the profile attached. Matrix number 3 is an actual example of placements (subjectively) developed by the CPP staff) and the cells in which these placements fall. Through a comparison of Matrix 2 to Matrix 3, Matrix 4 is generated. Matrix 4 shows those clients who are presently inappropriately placed in the CPP. The computer would then be programmed to take the profile of Matrix 4 and the profile Matrix 3 and redistribute patients and resources where commonalities exist. Thus profile number 3 and profile number 4 are regenerated and are now accurate, up-to-date profiles of the present placement situation. Matrix number 4 generates $Needs_1$, i.e. those individuals who are inappropriately placed and need resources developed to fit their needs.

5.1.2.2 Matrix Profile - Needs Assessment of Inpatient of St. Louis State Hospital

The next step is to administer the survey instrument to all present inpatients of St. Louis State Hospital; those patients

who have been deemed inappropriate for present or future placements due to the fact that they have existing community support system that will provide services of placement, do not need to be surveyed. Matrix 5 is a hypothetical example of the needs for placement of the inpatient population. The results are designated $Needs_2$. This hypothetical example would show that there are inpatients who have needs for immediate placement in facilities that do not exist. For example, group homes and independent living situations are a high priority for the inpatient population (based upon interviews with staff).

5.1.2.3 Matrix Profile - Staff Needs

Matrix 6 is a profile which demonstrates how many staff and what kinds of staff are needed per cell to monitor and evaluate as manager the delivery of services by the facility. This "ideal" staffing pattern should be utilized as a data base for projecting staff needs for future programmatic growth. Except for a few alterations, the premise of this ideal staffing pattern is that present staffing patterns are sufficient to run the program. Therefore, present staff should be distributed, based on programmatic considerations, to the various cells. After this profile is developed, using existing pay rates, the cost per cell is then affixed to the profile. This profile would then generate not only kinds of staff and numbers of these staff, but also the cost of this staff. Through comparing number 6 profile to number 4 profile, number 7 profile is generated. This profile is the cost of staffing any increase of placement

facilities (for those inappropriately placed). This is deemed $Cost_1$. Number 8 is a comparison of #6 with #5 matrix and this matrix is designated $Cost_2$, which is the cost of staff to monitor placement expansion for those inpatients that are ready to be placed. Matrix 9 is the actual cost per cell of present facilities utilized and the standard deviation of that cell. $Cost_3$ is the cost of the facilities need for moving inappropriate placements to appropriate placements and is generated through a comparison of matrix cell number 4 to matrix cell number 9. $Cost_3$'s matrix number is 10. $Cost_4$ is generated by comparing number 9 matrix to number 5 matrix. This is the cost of the facilities when inpatients are placed in their appropriate sites.

To recapitulate, this is a breakdown of the various matrixes and their functions.

Matrix Profiles:

1. General explanation of the characteristics of the profile and each of its cells.

2. Hypothetical profile of patients in placements after the administration of the level of care survey.

3. Actual distribution of facility (and total number of patients) currently placed. This actual distribution was developed by the CPP staff using subjective assignment of facilities based upon criteria established by the level of care survey.

4. The result of comparing number 2 profile and number 3 profile; this shows the hypothetical list of inappropriate placements. This comparison is labeled $Needs_1$.

5. A hypothetical example of the need for placement of the inpatient population after the Level of Care Survey has been administered. This profile generates $Needs_2$.

6. A hypothetical ideal staffing pattern needed to provide evaluation, support and monitoring of the placement facilities of each cell.

7. The results of comparing number 6 matrix to number 5. The result of this comparison generates $Cost_1$ - the cost of staffing new placement facilities for those patients inappropriately placed (hypothetical).

8. The result of comparing number 5 ($Needs_2$) with number 6. This generates $Cost_2$, i.e. the cost of staffing new facilities that will be utilized to provide placement services for those inpatients in need of placement (hypothetical).

9. An actual mean cost per cell and the standard deviation of placement facilities already in operation.

10. Through the comparison of number 9 matrix with number 4, $Cost_3$ is generated. $Cost_3$ is the cost by cell of the placement facilities needed to appropriately place present patients who are inappropriately placed (hypothetical).

11. Through comparison of number 5 matrix with number 9, $Cost_4$ is generated. This is the cost of facilities to handle inpatients that need placement (hypothetical).

Through the use of this profile matrix system of comparison, both a staff needs data base and the cost of these staff, and a

placement resources needs and the cost of these resource needs is generated. It is important to analyze these figures and manage them effectively; for example, the needs list may show that there is a parcity of group homes providing services for patients even though there are many patients who are in need of this type placement. Programmatic considerations deem it necessary that financial renumeration for group homes be increased, i.e. the cost per cell presently allotted does not encourage the use of this type of facility for Department of Mental Health clients and the provision of more pay would encourage the acceptance of more Department of Mental Health clients. It is not only feasible to increase money allocated to specific cells for programmatic considerations of encouraging investors to develop these services, but also, monetary increases can be given for philosophical reasons to increase development of any one particular cell. For example, if an individual was philosophically motivated to serve acute, independent clients rather than chronic patients, there would be a need to develop community resources by allocating more money for these services.

Besides this provision of economic incentives for expansion into areas that are undeveloped, it is also feasible, for programmatic reasons, to provide economic dis-incentives so that expansion is discouraged into certain over utilized areas. For example, the nursing home programs are the most utilized programs; to discourage these programs, all that has to be done

is to lower the rate that is being paid these institutions. Expectations are that economic dis-incentives would be based upon some political consideration above the level of the program director otherwise, the program director would simply not have to refer nor maintain clients in these facilities.

5.2 Purchase of Services (POS)

5.2.1 Overview of POS

OBSERVATIONS

POS monies given by the Division of Family Services (DFS) to the Department of Mental Health (DMH) are on a yearly basis. These yearly amounts are based upon Title XX receipts generated in the previous year by DMH and by federal allocations of Title XX monies. In Fiscal Year 79-80 (present Year) 12 million dollars was given to DMH to be spent. These allocations to DMH are based upon the previous year's collection of Title XX receipts by the DMH. DMH receives its money which it "promises" to spend on client services. These "promises" of services are then delivered and accounted for through the Title XX billing procedures. At the end of the year, an audit is made to determine what services were delivered, i.e. Title XX billing and what monies it has spent, i.e. POS. Theoretically these two areas should balance; if more POS was spent than Title XX was collected, then DFS could possibly lower DMH's allocation of POS funds. Of course, the increase or decrease is also dependent upon amounts of Title XX dollars were allocated to the DFS by the federal government.

DMH divides its allocation with 40% going to MRDD division, 30% to the Division of Psychiatric Services and 30% to the Division of Alcohol and Drug. This allocation is fixed within the DMH and not dependent upon which division raised what percentage of Title XX money, nor is it based upon which facility raised what percentage of Title XX money.

IMPACT

The impact of this process is multifaceted.

(a) The federal government is possibly reducing its allocation to DFS by 20%. DFS will pass on at least a 20% reduction to DMH. DFS has attempted to withdraw its total allocation to DMH, but present lobby efforts has reduced this possibility.

(b) Due to fixed cost in Title XX situation, including personnel funded through Title XX funds, the actual reduction in POS allocation to the various institutions will possibly be greater than 20%.

(c) Being that POS funds are divided within the division by percentages and not by the generation of Title XX monies, an inequitable system is potentiated. It is possible for a division or facility to acquire greater POS monies than it generates in Title XX expenditures. This in turn can affect the system by reducing POS allocations from DFS; those who do not carry their load can affect others. This system does not have designed into it a mechanism to insure the generation of Title XX monies.

RECOMMENDATIONS

(a) To insure that POS funded services are not adversely affected by the 20% potential decrease in funding, the essential services should be written into the CPP contract, i.e. the contracted facility should provide as many of the services previously bought through POS. Though this action leads to the potential creation of an institutional environment out of a placement site, reduces the flexibility a case manager has in purchasing services and determines an increase in monitoring activity the CPP must provide over a placement site, it does insure the continuation of essential services to CPP clients. The limitations cited above are not overwhelming and easily accommodated through a system of sound planning and management.

(b) Fixed cost associated with POS expenditures are a matter primarily external to the CPP, but should be recognized.

(c) The allocation for POS funds by percentage to division appears tc be arbitrary; but again, this allocation is outside the scope of the CPP's influence.

5.2.2 Community Placement Program's expenditures of of POS monies for Fiscal Year 78-79 and 79-80.

On the following page is a breakdown of the basic services, purchased vendors, and cost of these services for the last two years.

PURCHASE OF SERVICE EXPENDITURES

FISCAL YEAR 78-79

VENDOR	SERVICE PROVIDED	YEARLY COST
Places for People	Social club, apartment skills and transportation	$121,536.00
Care Cab	Transportation	
St. Louis Psychiatric Day Care	Transportation	
Abbott Ambulance	Transportation	81,000.00
Gateway Ambulance	Transportation	
Ankh	Developmental Activities and Activities of Daily Living.	0.00
Old Adult Transportation	Transportation and sheltered workshop	2,250.00

FISCAL YEAR 79-80

VENDOR	SERVICE PROVIDED	YEARLY COST
Places for People	Social club, apartment skills and transportation	$105,200.00
Care Cab	Transportation	
St. Louis Psychiatric Day Care	Transportation	
Abbott Ambulance	Transportation	90,700.00
Gateway Ambulance	Transportation	
Ankh	Developmental activities and activities of daily living.	77,700.00
Old Adult Transportation	Transportation and sheltered workshop	3,000.00

IMPACT

(a) In Fiscal Year 79-80, $90,700 was spent for transportation out of a total expenditure of POS funds in the CPP of $276,600 (it should be noted that CPP used 57.4% of all POS funds allocated to St. Louis State Hospital in 1980 and 45.4% of POS allocated in 1979). This large amount of money spent on transportation is thus not spent on delivery of clinical services.

(b) The POS funds expended by CPP are primarily spent on four vendors, rather than a variety of vendors. This situation has the inpact of reducing competition amound vendors for services and encourages a reliance or dependency by CPP on just a few vendors.

(c) This expenditure of POS funds does not appear to reflect a strong positive clinical approach to the use of these monies to provide treatment and rehabilitation services to CPP clients; these expenditures appear maintenance oriented.

RECOMMENDATIONS

(a_1) A more clinical use of POS funds for transporatation would be to hire staff to train individuals, where appropriate, to utilize public transportation systems. Also, before transfer from inpatient to the CPP, individual patients should be prepared by the inpatient

treatment staff for riding the public transportation system, where possible. By training individuals to use the public transportation system, the CPP is then improving the clients functioning rather than encouraging the client's dependency.

(a_2) An analysis of scheduling of transportation should be implemented to provide for the most economic use of this costly budget expenditure. This is in no way meant to imply that the present system is managed in an uneconomic fashion.

(a_3) Where possible, service now provided by St. Louis State Hospital, (necessitating transportation of patients to this facility) should be provided for by the facility (paid through the contract) or these services should be purchased in the community from private vendors with POS money or Medicaid/Medicare.

(a_4) Essential transportation costs should be provided for by the facility and written in the placement contract. For example, if a patient must routinely visit a clinic, the placement facility should be encouraged to provide this service and this service be paid for in the placement contract.

(a_5) A determination should be made clear as to whether the CPP has potentiated the utilization of state vehicles. This is possibly another resource.

(b_1) Through the use of only four principal vendors, competition is discouraged. Individuals who would possibly compete for this particular market are discouraged by the use of only primary vendors. An encouragement of competition for this market would tend to decrease the unit cost of any service provided and increase the clinical expertise of the services. Other vendors should be actively sought out and provided for in this market.

(b_2) Reliance on a few vendors allows the situation to develop where a vendor could possibly cease their activities and the CPP would not have a vendor to provide these essential services. Again, alternate vendors should be encouraged.

(c_1) The use of POS funds should be a clinical skill that, like any other clinical skill, needs to be learned, practiced, improved and supervised. A program for potentiating these skills should be developed and implemented. This program should include such essential features as appropriate inservice, supervision and feedback.

(c_2) In another section of this evaluation, it is recommended that the "open door" admission policy to St. Louis State Hospital from CPP be extremely restricted. POS funds should figure into a plan that would mobilize

the service delivery system to respond to any patient and subsequently prevent a patient's return to St. Louis State Hospital. For example, a patient begins to exhibit some behavior disorders (behavior disorders account for more than 80% of the returns to St. Louis State Hospital), the case manager would analyze the situation and through the use of POS provide the clinical services necessary to maintain the patient in their present environment and provide skill training that will prevent a patient's movement to a less trestrictive environment.

(c_3) POS funds should be used as resource necessary to develop a client so that the client may proceed to a less restrictive environment. This is the goal of CPP and case management per se does not improve the client's functioning; it is the resources that the case manager mobilizes and how these resources are managed that determines the client's movement into a less restrictive environment.

5.3 Contracts with the Placement Facility

There are two contracts signed between the placement facility and the Department of Mental Health's Community Placement Program: the Master Agreement, which includes a Human Rights Assurance section and the Patient Contract. Both of these contracts are to be signed and on file prior to the

placement of a patient in any facility. Violation of either of these contracts could mean the withdrawal of patients from the program or holding of funds until a deposition of the case is made.

5.3.1 Individual Patient Contracts

Attached is the DMH form 57 (attachment 24). This is the actual contract between the Community Placement Program (CPP) and the placement site. This contract titled "Community Placement Funding Authorization" is signed by the Superintendent. Prior to placement of a patient in a facility, the accounting office determines whether a placement facility has been rated. Rating is done for a new program or for existing programs on a yearly basis by one of the members of the executive committee excluding the physician. There are a variety of rating scales that are utilized to rate a particular type of facility. Unfortunately, the variety of rating scales does not equal the variety of placement facilities. Therefore, the rating scale may not validly rate different types of facilities. There are four basic rating scales varying in age from three to ten years, which attempt to rate seven distinct categories of placement facilities.

The accounting office utilizes this rating plus other information on the nursing home data sheet and then sends this form to Community Placement Department of Central Office to activate Report 04010 - Program 01P40415. With the receipt

of this form, Central Office assigns a number to this placement facility and opens a computer file on this home. Determination of cost reimbursement is made along five categories:

(a) Boarding Homes - the rating itself of a boarding home determines what reimbursement the home will receive. Central Office has a "Funding Authorization Guide and Conversion Scale" it uses to determine cost reimbursement.

(b) Practical Nursing Homes - are given a base rate of $554.00 per month plus $1.00 per point on the rated scale based upon a scale indigenous to practical nursing homes. This total figure cannot exceed a sum set by Central Office. This rate set by Central Office and distributed to the accounting office is based upon the current Division of Family Services reimbursement schedule.

(c) Professional Nursing Home (SNF) - rates are set from the Department of Mental Health list. This list entitled "Basic Rates for Title XX Nursing Homes" determines the cost per day per patient of any facility. This rate is set by the Division of Family Services and is utilized by the Community Placement Program. Being that most SNF's have already been rated by DFS, the CPP does not have to use the rating scale for the use of these homes.

(d) Rates for Residential Treatment Centers and Residential Group Homes is based upon the the DFS POS rate plus the DFS's established room and board rate. Through the summation of these two reimbursement rates, DMH rates are set. Most of these homes are homes providing placement services for children.

(e) A variety of other categories like group homes and apartments have their rates set through negotiation with Central Office. These rates are increased over time through negotiations with Central Office.

Ancillary Services, that is, services provided beyond the board, room and routine care can be added to the contract. Such things as personal spending money, clothing, laundry, medication etc. are contract items. Determination of reimbursement for these services is made by the case manager using the "Community Placement Reimbursement Guide." This guide shows what is the maximum allowable amount a facility can charge for these basic services. Other services can be written into the contract through negotiations with Central Office. These contracts for services are written in the accounting office, but the list of needed services is furnished by the case manager assigned to the patient. It is noted that these ancillary services are often re-negotiated or changed depending on the patient's need for treatment. An example is medication. A patient may have their medication changed once or twice a

month; the contract must be rewritten to show the change in medication cost. Also, if a patient is transferred from one facility to another, there is a need to change not only the facility rate, but the medication rate due to different cost for medication in differing communities.

Basically a bed may be held for a patient that has been admitted to a hospital for ten days with the facility receiving pay for those ten days. If the patient is not returned to their bed, or a patient is not used to fill this unused bed, and the staff still wish to hold the bed, approval must be gotten from Central Office for the holding of this bed. Beds may be held for a period up to thirty days with approval from Central Office. No beds are held for a patient for beyond thirty days. Approximately 18-20 beds of the 1,400 beds being purchased at any one time are not utilized due to patients being hospitalized. Those percentage wise these numbers are small, these unused beds cost the DMH approximately $600.00 daily.

The computer receives both changes in contract, new contracts and cancelled contracts only once a month. These entries are made on the 18th of the month and any changes in the computer must be submitted prior to this date or wait until the next month. If a contract is cancelled after the 18th of the month for example, the facility will continue to be paid until the next 18th of the month and then asked to return this overpayment.

IMPACT

(a) It was observed that a variety of scales, must of which are old, and whose validity is questioned are used to rate all facilities; due to the questionable validity of these scales, homes which provide very good services are possibly inequitably rated. Also, the scales themselves are difficult to manage in as much as no clear cut scale is to be utilized for the variety of facilities that are available for placement.

(b) The reinbursement rate paid to facilities by DMH is anchored very closely to the DFS rate. This anchoring assumes that the treatment needed by a DFS client is equal to the treatment needed by a DMH client. But it is difficult to assume that a DFS client is identical to a DMH client and should be receiving the same services at the same contract rate.

Ancillary Services - these services are basically kept to the standard services described in the contract. The use of "other" ancillary services is not highly utilized but should be where needed. The situation with ancillary medication cost are problematic. First, if there is a medication change then form 57 must be changed to reflect this medication change; due

to the fact that there is only one entry date for input into the computer for contract changes, it is possible the system can lag months behind in updating a contract. Also, these medications are varying in cost and pharmacies vary their prices. A pharmacy in one neighborhood, which is utilized by one placement facility can vary greatly from a pharmacy in another neighborhood. Nonetheless, through the use of contract medication, St. Louis State Hospital's budget does not have to assume the cost of medication.

RECOMMENDATIONS

(a) Rating scales utilized to rate facilities should be very seriously looked at to determine their validity and appropriateness in performing the task that is needed. Thus, it must be done statewide.

(b) The DFS rate for DMH clients should not be firmly set due to the fact that DMH clients and DFS clients are not a similar population.

(c) Ancillary services need to be utilized more so that services needed for patients are provided on this contract as discussed in another section of this evaluation.

(d) Medication - a study should be made of how this medication situation can be improved. Presently the evaluator cannot make a recommendation as to whether to strike this complicated service from the contract and thus pay for it from St. Louis State Hospital's

budget or allow it to remain an item in the contract. Nonetheless, a more simplified manner of correcting the contract should be investigated.

5.3.2 Master Agreement

OBSERVATIONS

The Master Agreement is a new legal tool utilized by the Central Office Community Placement Program to bind the placement facility to certain agreements. It is also very useful in as much that the DMH clients can be withdrawn from a placement site without the site having to have its license revoked. The Master Agreement package is in two parts: (a) the Master Agreement Proper and (b) the Human Rights Assurance for Applicants for Financial Assistance from Missouri Department of Mental Health.

There are also two basic Master Agreements; one is medical and the other is non-medical. A third Master Agreement is proposed to cover those placement facilities which are in the category of apartments, communities or foster communities.

5.3.2.1 The Master Agreement Proper notes a variety of points. The attached 13 page document, attachment 25 is a copy of the Master Agreement and thus details the major points which are:

(a) Conditions of the Agreement
(b) Authorization for Service
(c) Services of the Provider
(d) Services of the Department
(e) Notification of Changes in Conditions
(f) Management of Resident's Property
(g) Invoicing
(h) Partial Payments
(i) Controls, Reports and Monitoring

(j) Human Rights (employee)
(k) Indemnity and Insurance
(l) Resident's Rights
(m) Subcontracting
(n) Retention of Records
(o) Termination
(p) Third Party Payments
(q) Miscellaneous
(r) Rate of Reimbursement
(s) Identification of Landlord
(t) Negotiating Authority

This document clearly identifies many of the roles that are necessary to provide the needed services of the DMH client.

5.3.2.2 Human Rights Assurance for Applicants for Financial Assistance from the Department of Mental Health

This extensive document details the various laws that the vendor, i.e. placement facility must assure the Department of Mental Health it is in compliance with. These laws can be loosely described as "human rights" legislation.. Not only is there a detailing of the laws but there is a series of questionnaire and assurances that must be completed. These assurance forms include an analysis of the work force and provisions of standard demographic data.

IMPACT

The Master Agreement Proper is a powerful legal document than can be extremely useful in assuring the proper management of the DMH client. This legal tool clearly specifies what role of the department and the vendor is to be. Unfortunately, it appears as if the CPP's monitoring of the Master Agreement is a more reactive that proactive posture. Rather than monthly

determining whether the agreement is being met and managing the facility in such a manner as to encourage the implementation of the agreement, it appears as if when a facility has been deemed unacceptable, this agreement is used tc remove patients from that facility. The authorization to remove patients comes under Section 15, Part B which states, " at any time when in its sole judgement, the health and welfare of any of its residents are threatened by their continued presence in the provider's facility, the notice provisions are waived and the department may terminate this agreement." Thus this section can be quickly used to remove patients from a home without going through the complicated and involved process of removing a facility's license. As stated above, the CPP staff does not appear to report in their Facility Monthly Report whether a facility is following the provisions of the Master Agreement and what steps are being taken to encourage the implementation of this agreement; this is reactive, not proactive management.

The Human Rights Assurance Section is a complex document that is difficult to complete unless a facility has legal resources to complete such a form. It is reported that the facilities are distressed by both documents, but primarily, the Human Rights Assurance document.

RECOMMENDATIONS

Master Agreement Proper - The facility monthly report should be used to document the monthly monitoring for adherance to the provisions of the Master Agreement and what actions will be taken to insure its compliance.

Human Rights Assurance - Being that this Human Rights Assurance section is a complex document, it is recommended that Central Office provide the necessary consultative staff to the facility to assist in the completion of this document.

5.4. House Bill 1724

With the eminent signing into law of House Bill 1724, provisions have been made in that law that will allow for "seed money" to be used to encourage the development of community placement resources, if the resources are deemed necessary by the Director of the Community Placement Program in Central Office.

IMPACT

The impact of this law is that there is now a legal tool for the necessary development of CPP resources.

RECOMMENDATION

It is recommended that the Director of the Community Placement Program utilize the needs assessment matrix profile to determine which resources need to be developed and then utilizing the provisions of 1724 embark upon a campaign of developing resources. This section will be further covered under the resources development section of System Linkages in this evaluation.

6.0 DATA SYSTEMS

Data systems or reports serve three basic functions:

(a) They provide management with a tool that summarizes an employee's or program's activities so that a manager can determine whether programmatic objectives are being met and to what extent.

(b) Reports shape an employee into behaving in a particular manner. If a report requests that staff monitor movement of patients along a continuum of resources, staff will be aware that movement along this continuum is desirable and will work to meet these requirements.

(c) Reports can be used by the manager to feedback to the staff whether their actions are on line with the objectives to the program or not. This provides management with an opportunity to reward staff for appropriate behavior.

OBSERVATIONS

Presently, a variety of reports exist within the CPP, some of which appear to be functional, some are possibly not. It has been the experience of this evaluator that many types of seemingly important data is not presently reachable within the confines of the CPP's data system.

It is beyond the scope of the evaluator to determine what the data systems are that are needed and what are not. This is due not only to the fact that kinds of information that management wishes to review is subjective, but also to the fact that objectives have not been set for the program which would determine what data system is necessary.

IMPACT

After priorities have been set for the CPP, the Superintendent needs to be aware of how well the CPP is meeting its objectives. Present data systems are inadequate and to an extent, unreliable.

RECOMMENDATIONS

(a) The Director of the CPP should thoroughly analyze the data system taking into account the three major points mentioned above. New reports should be implemented that demand the kinds of information that are necessary for proper management.

(b) The Superintendent also needs to determine what the objectives and priorities of the CPP are to be and then request reports that provide feedback to the Superintendent as to the compliance of the program to the objectives. The Superintendent needs to continue to provide feedback based upon these reports as to whether the program is meeting the objectives or not.

(c) It would appear that reports needed within the CPP data system would at least include the following reports:

(c_1) Census statistics, monthly based, using a graph like the one included in this report so that visual determinations can be made as to whther the CPP census is increasing or decreasing.

(c_2) Age distribution reports that will help determine whether the CPP is providing placement sites for a multitude of ages.

(c_3) A report should be developed that details the types of services being provided through POS expenditures, for example transportation, training, clinical, etc. as well as reporting on the number of POS vendors the POS utilizes.

(c_4) A report should be provided that details how many patients move up or down the continuum of resources; a matrix formula such as utilized in this evaluation would be appropriate.

(c_5) Reports should be generated that details the number of clients that have returned to SLSH for inpatient services or clinical services.

(c_6) A report should generate the number of clients receiving POS expenditures for transportation rather than having transportation written into a contract.

(c_7) Using a matrix formula as this evaluation does, reports should generate the type and number of resources that are available and being procured for placement purposes.

(c_8) Data should be generated that reports the number of clients referred to CPP each month and from what area they are referred. This report should also show the number of clients that are placed each month.

(c_9) A report should generate Title XX certifications that are completed each month.

(c_{10}) Data systems should be able to determine the number of hours a patient or the average number of hours all patients are receiving programming.

(c_{11}) Logging of case management services on every client should be implemented and this logging procedure should account for 100% of the case manager's time.

(c_{12}) A report should be developed that shows the number of clients that have been kept from placement through pre-placement counseling and case management, i.e. those clients who through pre-placement case management remain in the community and out of placement.

7.0 CONCLUSIONS

The usefulness of an evaluation resides in its ability to objectively provide a view of an entire system, to then describe that system, discuss its impact and subsequently make recommendations for change. Recommendations for change in and of itself accomplishes nothing; it takes a concerned and active posture on the part of the administration to implement recommendations that have been accepted.

7.1 The evaluator suggest that the executive committee and the Superintendent review those recommendations the Superintendent agrees with, and using a MBO/Gant chart, prioritize these recommendations. The attached chart - attachment 26- is recommended in as much as it is a powerful management tool well suited for the purpose of prioritizing and organizing changes in a program. The real work of changing the system will depend upon the dedication and perserverance of not only the Superintendent and Director, but by the executive committee and the line staff. By involving all groups of staff, in a variety of problem solving tasks, suggestions as well as how to best implement recommendations are thus generated at the level that is affected by these changes. Through the involvement of the staff with change, change is insured.

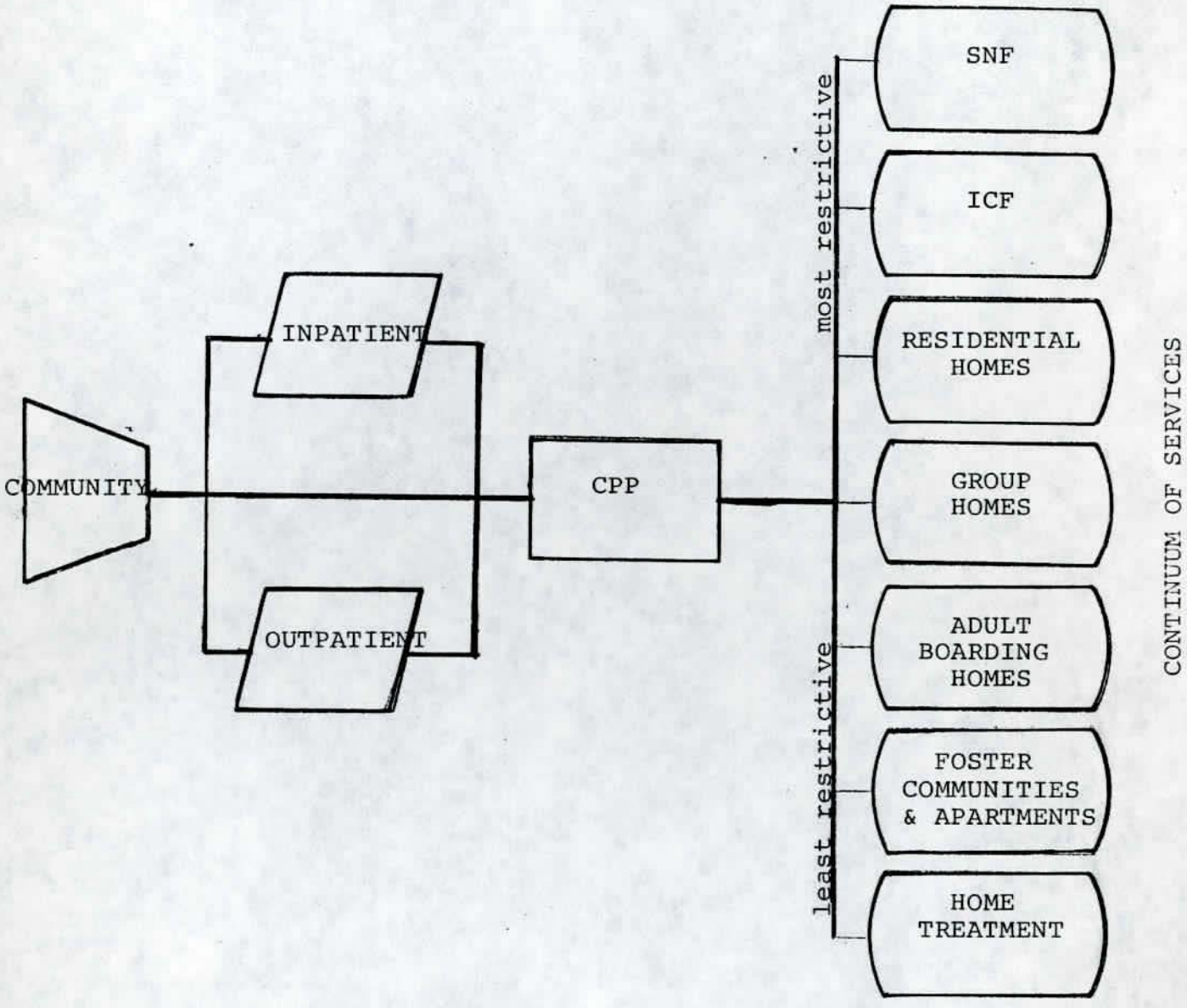
7.2 Recommendations of change connotes, unfortunately, that change is necessary due to "problems" with the program. This is not necessarily correct; all programs, all activities, can be changed for the better, for the "best" is a relative term. A point has been made in this evaluation to show how system changes can solve problems and how systems development and structure cause the problems in the first place. Most of the recommendations for change are systemic changes that the CPP staff had no control over nor do not have control over now. Also, any system that interfaces with a complex environment, needs to change and flex in order for it to survive. A system that was implemented five years ago, for example, is no longer a system that is relevant and flexible enough to meet the challenges of the future. An example in industry is that five years ago motor homes such as Winnebagos were extremely growth oriented companies; today they are giving Winnebagos away. The system the company developed did not change, the environment did, thus the company died. It is not the fault of the CPP's staff that the system needs change; it is not their fault that the world changes nor that they were leaderless for almost two years, nor that their financial system is unpredictable, etc. The evaluator feels confident in saying that the program is a good one considering the systematic restraints it has, and must now operate under.

7.3 Because the CPP staff, especially the executive committee, are such good, dedicated and professionally competent people, the evaluator fears that recommendations for

change of a program that staff so closely identify with, will affect them personally. Criticism of the system is not meant to be a reflection on the staff themself; these people have worked hard under a frustrating and unpredictable system that provides little rewards for such dedicated work. These recommendations for change are not meant in the spirit of criticism but in an attempt to design and build a system that allows and encourages good, hard working and competent people the opportunity to express themselves constructively.

The evaluator wishes to thank the CPP and especially the executive committee for an enjoyable and educational experience.

ST. LOUIS STATE HOSPITAL'S
COMMUNITY PLACEMENT PROGRAM (CPP)
SERVICE DELIVERY SYSTEM FLOW CHART



TOTAL PATIENT ASSIGNMENT AND PERCENTAGE OF TOTAL POPULATION

PSYCHIATRIC SYMPTOMS

PHYSICAL CARE LEVEL

	ACUTE	REHAB	COMMUNITY
SNF	12	8 405 26.6%	4 17 1.2%
ICF	11	7 546 39.9%	3 25 1.8%
SUPV	10	6 2 0.1%	2 193 14.1%
INDP	9	5 179 13.1%	1

LEGEND

SNF = Skilled Nursing Facility
ICF = Intermediate Care Facility
SUPV = Supervised Living Arrangement
INDP = Independent Living Arrangement
1 = Outpatient/Discharged/Family Care
2 = Boarding Home
3 = Residential Care Facility
4 = Skilled Nursing Facility (few or no psychiatric problems)
5 = Apartments/Foster Homes/ Foster Communities
6 = Group Homes
7 = Intermediate Care Facility
8 = Skilled Nursing Facility (with behavior and psychiatric problems)
9 = Acutely Ill (inpatient or outpatient)
10 = Acutely Ill (inpatient)
11 = Acutely Ill (inpatient)
12 = Acutely Ill (inpatient)

		FACILITY NAME
COUNT BY FAC-NAME	17	A-OKAY HOME FOR THE ELDERLY
COUNT BY FAC-NAME	3	AFFTON NURSING HOME
COUNT BY FAC-NAME	46	AVA MARIE MANOR
COUNT BY FAC-NAME	39	BELL MANOR INC
COUNT BY FAC-NAME	54	BERNARD NURSING HOME
COUNT BY FAC-NAME	1	BERNARD WEST PINE NURS HOME
COUNT BY FAC-NAME	52	BIRCHWAY NURSING HOME
COUNT BY FAC-NAME	12	BREN-CLAY NRSG HOME
COUNT BY FAC-NAME	1	BROWER FOSTER HOME
COUNT BY FAC-NAME	1	BURROUS MELBA M FOSTER HOME
COUNT BY FAC-NAME	2	BURT MANOR INC
COUNT BY FAC-NAME	1	CATES MANOR
COUNT BY FAC-NAME	3	CEDAR GROVE BOARDING HOME #2
COUNT BY FAC-NAME	43	CEDAR GROVE NURSING HOME
COUNT BY FAC-NAME	2	CEDARCREST MANOR, INC.
COUNT BY FAC-NAME	10	CEDARCROFT NURSING HOME
COUNT BY FAC-NAME	44	CHASTAINS OF DES PERES INC
COUNT BY FAC-NAME	24	CHESTERFIELD MANOR, INC.
COUNT BY FAC-NAME	3	CHILD.CTR OF OUR LADY OF GRACE
COUNT BY FAC-NAME	10	CHRISTIAN OLD PEOPLES HOME
COUNT BY FAC-NAME	5	COLONIAL REST HOME
COUNT BY FAC-NAME	1	CONVERSE AUDREY GROUP HOME
COUNT BY FAC-NAME	1	DAVIS DIMPLE
COUNT BY FAC-NAME	19	DELMAR GARDENS WEST
COUNT BY FAC-NAME	32	DELMAR GARDENS, INC. (EAST)
COUNT BY FAC-NAME	10	FAIRWAYS NURSING HOME
COUNT BY FAC-NAME	15	FERRIER HARRIS HOME FOR AGED
COUNT BY FAC-NAME	7	FESTUS REST HOME
COUNT BY FAC-NAME	12	FIESER NURSING HOME
COUNT BY FAC-NAME	25	FRAZIER NURSING HOME
COUNT BY FAC-NAME	22	GARCIA RESIDENCE
COUNT BY FAC-NAME	3	GOOD SHEPHERD BOARDING HOME
COUNT BY FAC-NAME	8	GOOD SHEPHERD NURSING HOME
COUNT BY FAC-NAME	6	GRAND MANOR #1
COUNT BY FAC-NAME	2	GRAND MANOR BOARDING HOME
COUNT BY FAC-NAME	41	HALLS FERRY MEMORIAL HOME, INC
COUNT BY FAC-NAME	11	HEMZO BOARDING HOME
COUNT BY FAC-NAME	43	HILLTOP HOUSE NURSING HOME
COUNT BY FAC-NAME	1	HUBBART NURSING HOME
COUNT BY FAC-NAME	1	JEWISH CENTER FOR THE AGED
COUNT BY FAC-NAME	2	JONES HILDA FOSTER HOME
COUNT BY FAC-NAME	2	KOCH'S REST HOME
COUNT BY FAC-NAME	1	KUHN MRS HAROLD HOME #1
COUNT BY FAC-NAME	2	KUHN MRS HAROLD HOME #2
COUNT BY FAC-NAME	2	KUHN MRS HAROLD HOME #3
COUNT BY FAC-NAME	2	KUHN MRS HAROLD HOME #4
COUNT BY FAC-NAME	3	KUHN MRS HAROLD HOME #5
COUNT BY FAC-NAME	7	LEMAY NURSING HOME
COUNT BY FAC-NAME	1	LIFE SKILLS FOUNDATION #3

	FACILITY NAME
COUNT BY FAC-NAME 12	LITTLE FLOWER NURSING HOME INC
COUNT BY FAC-NAME 3	LITTLE SISTERS OF THE POOR
COUNT BY FAC-NAME 1	LOFTON FOSTER HOME
COUNT BY FAC-NAME 16	MARSHALL BOARDING HOME
COUNT BY FAC-NAME 9	MARYMOUNT MANOR
COUNT BY FAC-NAME 5	MARYMOUNT MANOR RETIREMENT #2
COUNT BY FAC-NAME 1	MAXWELL CLAIRE
COUNT BY FAC-NAME 27	MERCY CONVALESCENT CNTR
COUNT BY FAC-NAME 1	MIHAN SANDRA
COUNT BY FAC-NAME 1	MOORE MARIE
COUNT BY FAC-NAME 8	NICHOLS RESIDENCE
COUNT BY FAC-NAME 54	PARKSIDE TOWERS NURSING HOME
COUNT BY FAC-NAME 139	PLACES FOR PEOPLE APTS INC
COUNT BY FAC-NAME 14	PIDGEWAY NURSING HOME
COUNT BY FAC-NAME 30	ROCKWOOD MANOR NURSING HOME
COUNT BY FAC-NAME 27	ROCKWOOD NURSING HOME
COUNT BY FAC-NAME 25	ROGERS NURSING HOME
COUNT BY FAC-NAME 1	RYDER MARY HOME
COUNT BY FAC-NAME 4	RYDER MARY HOME FOR AGED
COUNT BY FAC-NAME 37	SHAMROCK NURSING HOME
COUNT BY FAC-NAME 3	ST JOSEPH'S HILL INFIRMARY
COUNT BY FAC-NAME 2	ST JOSEPHS HOME FOR THE AGED
COUNT BY FAC-NAME 33	STAMER'S NURSING HOME
COUNT BY FAC-NAME 19	STELLAR BOARDING HOME
COUNT BY FAC-NAME 1	STEVENSON ISAAC
COUNT BY FAC-NAME 47	SUNSET RETIREMENT HOME
COUNT BY FAC-NAME 2	TROY FOSTER COMMUNITY APT 1
COUNT BY FAC-NAME 1	TROY FOSTER COMMUNITY APT 2
COUNT BY FAC-NAME 1	TROY FOSTER COMMUNITY APT 5
COUNT BY FAC-NAME 1	TROY FOSTER COMMUNITY APT 6
COUNT BY FAC-NAME 1	TROY FOSTER COMMUNITY APT 7
COUNT BY FAC-NAME 8	TWAIN MARK MANOR INC
COUNT BY FAC-NAME 10	UNITED CHURCH OF CHRIST SR CTR
COUNT BY FAC-NAME 56	VALLEY PARK NURSING HOME
COUNT BY FAC-NAME 29	WALTON NURSING HOME
COUNT BY FAC-NAME 1	WATERMAN JONATHAN B H INC
COUNT BY FAC-NAME 2	WATKINS JUANITA BOARDING HOME
COUNT BY FAC-NAME 3	WESTMORELAND RESIDENCE INC
COUNT BY FAC-NAME 10	WILKINSON BOARDING HOME
COUNT BY FAC-NAME 1	WILLIAMS MARY JO

TOTAL NUMBER OF ITEMS RETRIEVED 1301

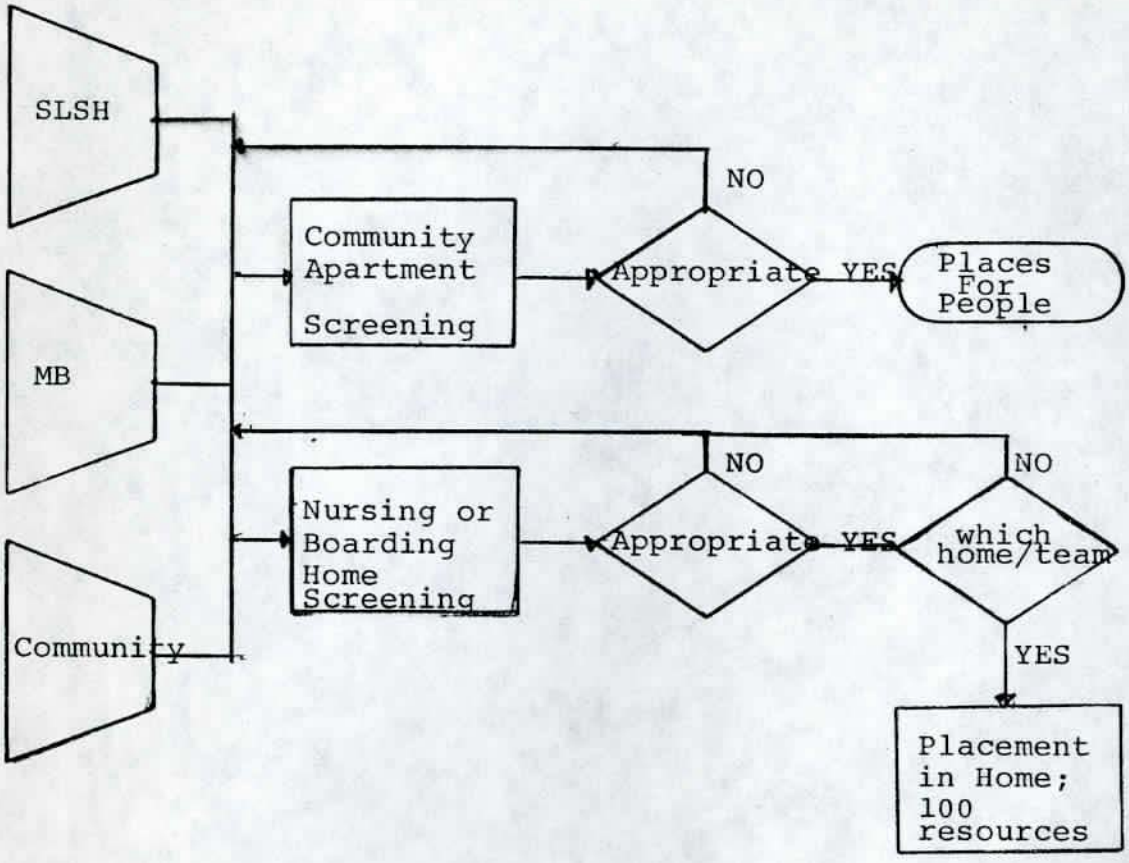
		NURSING HOME #
COUNT BY HOMENBR	30	
COUNT BY HOMENBR	2	036009
COUNT BY HOMENBR	1	057025
COUNT BY HOMENBR	4	096023
COUNT BY HOMENBR	1	096110
COUNT BY HOMENBR	1	096201
COUNT BY HOMENBR	2	097162

TOTAL NUMBER OF ITEMS RETRIEVED 41

REFERRAL BY MONTH WITH
PLACEMENTS BY MONTH

Year	Referrals/Placements From the Various Programs										Awaiting Referral
1980	In-Patient		Out-Patient		Youth Center		Non-SLSH		Malcolm Bliss		Waiting List
January	30	2	4	-	2	-	5	-	5	2	5
February	16	16	1	-	3	-	1	-	8	4	7
March	18	11	4	-	3	-	1	-	3	3	12
April	6	11	1	-	1	2	-	1	5	4	15
1979											
January	8	3	-	-	-	-	-	1	-	-	-
February	3	2	1	-	-	-	-	-	-	-	-
March	19	2	2	-	-	-	1	-	-	-	-
April	6	2	-	-	-	-	-	-	-	-	1
May	7	2	-	-	-	-	-	-	-	-	-
June	20	6	-	-	16	8	1	-	2	-	1
July	37	3	-	-	-	1	2	-	2	1	-
August	26	12	2	1	-	-	1	-	-	2	2
September	15	5	-	1	-	-	-	-	-	1	1
October	31	13	1	-	-	-	-	-	-	-	3
November	18	22	2	-	-	-	-	-	5	-	4
December	10	15	1	-	-	-	1	-	4	-	7

REFERRAL SYSTEM FLOW CHART



FAMILY CARE REFERRAL

SOCIAL WORKER:

TELEPHONE NO.:

PATIENT'S WARD:

DATE:

ADMISSION INFORMATION:

DATE ADMITTED:
TYPE OF ADMISSION:
REASON FOR ADMISSION:

DIAGNOSIS:

PSYCHIATRIC:

MEDICAL:

MEDICATION:

CURRENT BEHAVIOR: (Please describe as completely as possible, does he participate in activities, socialize with others, if he has been a behavior problem, how long has it been since problematic behavior has been displayed).

PHYSICAL CONDITION: Describe any physical problems including degree of ambulation, wheelchair, walker, etc., whether continent, special dietary problems, etc.

NURSING CARE: Describe the amount of nursing care needed including adjustment to daily living, supervision, etc.

RELATIVE INFORMATION:

Legal Guardian: Name _____ Address _____ Phone _____

Responsible Relatives: Name _____ Address _____ Phone _____

Other:

Do they visit - how frequently? Attitudes toward placement? Describe any special problems or consideration.

Patients attitude toward placement:

FINANCIAL RESOURCES:

Social Security: Amount Payee

V.A. Amount Payee

Other (specify, include private resources or other pensions).

Welfare applied for? Eligible

Date

Remarks and recommendations - include type of home you think patient needs. If you have a specific home in mind list.

FAMILY CARE ASSESSMENT

Patient's Name and Number:

DATE SEEN:

STAFF:

IS PATIENT PLACEABLE:

IF YES: Type home:

Suggested home:

Can be placed now:

Put on waiting list (specify home).

Financial problems to be worked out first:

Relative Problems:

Other:

If NO: Reason:

Behavior Problem:

Describe -- what behavior would have to change and for how long before you would consider him placeable.

Physical Problem - describe as above

Other - describe

Would this patient be placeable if we had some different resources? If so, describe the type of resource you think he needs.

St. Louis State Hospital Complex

Referral to Community Homes Program

Date: _____

Name of Applicant: _____ SLSH#: _____ Sex: ____ Race: _____

Present Address: _____ Telephone: _____

D.O.B.: _____ Marital Status: _____ S.S.#: _____

Employed? (At the Present Time) _____

Attending School? (At the Present Time) _____

Current Admission: (month, day, year) _____ Hospital: _____

Type of Admission: (voluntary, court commitment) _____

Primary Diagnosis: _____

Present Medication: _____

Special Problems: (violent, suicidal, epilepsy) _____

_____

Alcohol/Drug Abuse: yes ☐ no ☐

Financial Resources:

Type:	Amount: (monthly, weekly)	Type:	Amount: (monthly, weekly
1.) Job	_____	4.) General Relief	_____
2.) SSI	_____	5.) VR	_____
3.) SSDI	_____	6.) Food Stamps	_____

Referring Agency: _____

Address of Agency: _____ Telephone: _____

Referred by: _____

Date Screened: _____

Assigned Staff: _____

Provisional Plans or Reason for Rejecting: _____

_____

_____

Director: _____

REFERRAL BY MONTH WITH
PLACEMENTS BY MONTH

Year	Referrals/Placements From the Various Programs										Awaiting Referral
	In-Patient		Out-Patient		Youth Center		Non-SLSH		Malcolm Bliss		
1980											Waiting List
January	30	2	4	-	2	-	5	-	5	2	5
February	16	16	1	-	3	-	1	-	8	4	7
March	18	11	4	-	3	-	1	-	3	3	12
April	6	11	1	-	1	2	-	1	5	4	15
1979											
January	8	3	-	-	-	-	-	1	-	-	-
February	3	2	1	-	-	-	-	-	-	-	-
March	19	2	2	-	-	-	1	-	-	-	-
April	6	2	-	-	-	-	-	-	-	-	1
May	7	2	-	-	-	-	-	-	-	-	-
June	20	6	-	-	16	8	1	-	2	-	1
July	37	3	-	-	-	1	2	-	2	1	-
August	26	12	2	1	-	-	1	-	-	2	2
September	15	5	-	1	-	-	-	-	-	1	1
October	31	13	1	-	-	-	-	-	-	-	3
November	18	22	2	-	-	-	-	-	5	-	4
December	10	15	1	-	-	-	1	-	4	-	7

TOTAL MONTHLY COST
OF PLACEMENT CONTRACTS

PSYCHIATRIC SYMPTOMS

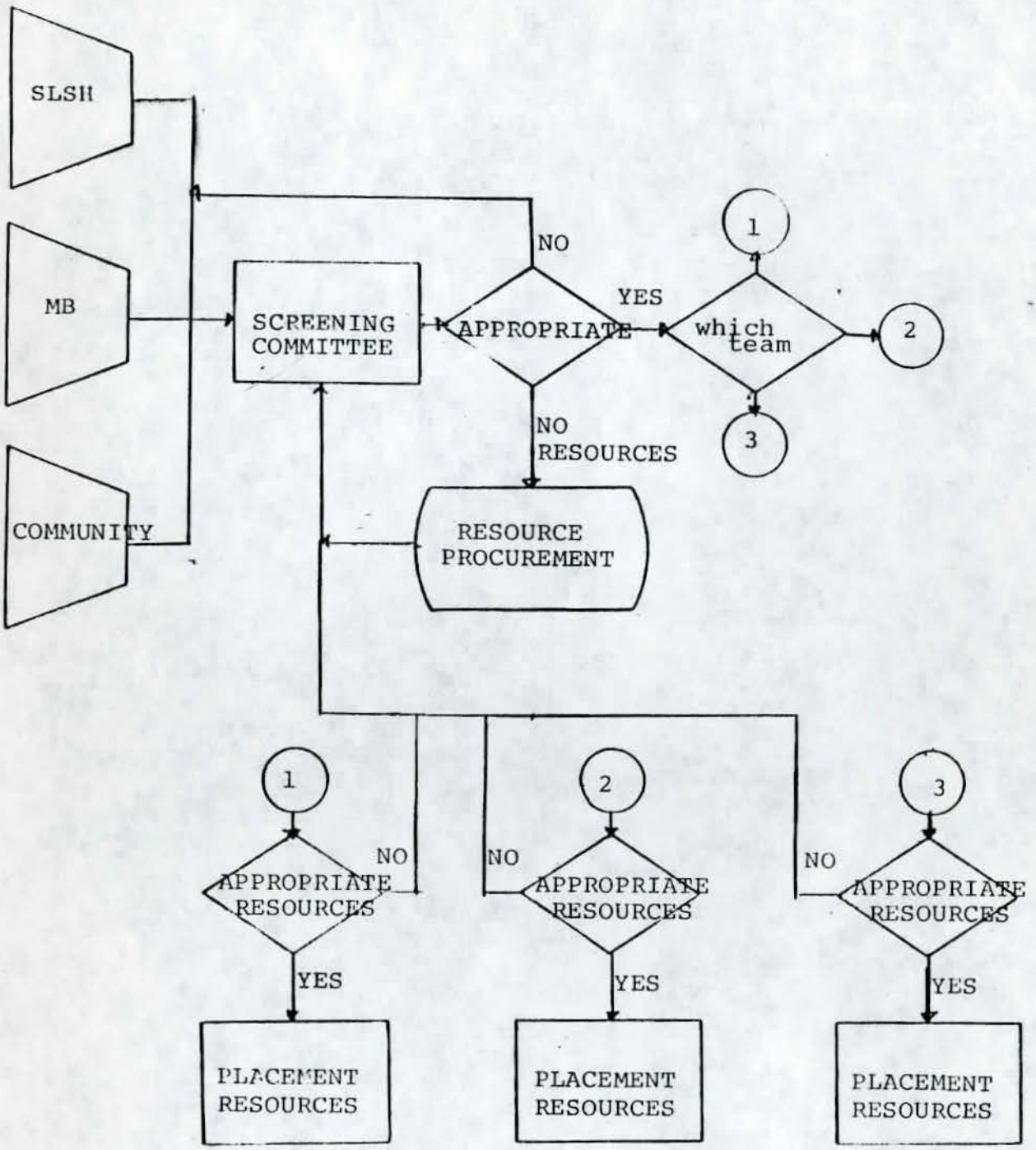
PHYSICAL CARE LEVEL

	ACUTE	REHAB	COMMUNITY
SNF	12	8 310,620.88	4 13,845.00
ICF	11	7 367,077.83	3 10,546.62
SUPV	10	6 1,055.00	2 80,989.71
INDP	9	5 66,924.08	1

LEGEND

SNF = Skilled Nursing Facility
ICF = Intermediate Care Facility
SUPV = Supervised Living Arrangement
INDP = Independent Living Arrangement
1 = Outpatient/Discharged/Family Care
2 = Boarding Home
3 = Residential Care Facility
4 = Skilled Nursing Facility (few or no psychiatric problems)
5 = Apartments/Foster Homes/ Foster Communities
6 = Group Homes
7 = Intermediate Care Facility
8 = Skilled Nursing Facility (with behavior and psychiatric problems)
9 = Acutely Ill (inpatient or outpatient)
10 = Acutely Ill (inpatient)
11 = Acutely Ill (inpatient)
12 = Acutely Ill (inpatient)

RECOMMENDED REFERRAL SYSTEM FLOW CHART



DISTRIBUTION OF PLACEMENT RESOURCES BY TEAM
BY FACILITY/BED AND %

PHYSICAL CARE LEVEL

PSYCHIATRIC SYMPTOMS

	ACUTE	REHAB	COMMUNITY
SNF	12	8 I - 6/140 35% II - 6/132 33% III - 4/133 33%	4 I - 2/15 88% II - 1/1 6% III - 1/1 6%
ICF	11	7 I - 11/206 38% II - 6/161 29% III - 8/160 29%	3 I - Ø 0% II - 3/18 72% III - 1/7 28%
SUPV	10	6 I - 1/1 50% II - Ø III - Ø N/A - 1/1 50%	2 I - 7/69 36% II - 3/71 37% III - 9/53 27%
INDP	9	5 I - 13/67 37% II - 2/62 35% III - 1/49 27%	1

LEGEND

SNF = Skilled Nursing Facility
ICF = Intermediate Care Facility
SUPV = Supervised Living Arrangement
INDP = Independent Living Arrangement
1 = Outpatient/Discharged/Family Care
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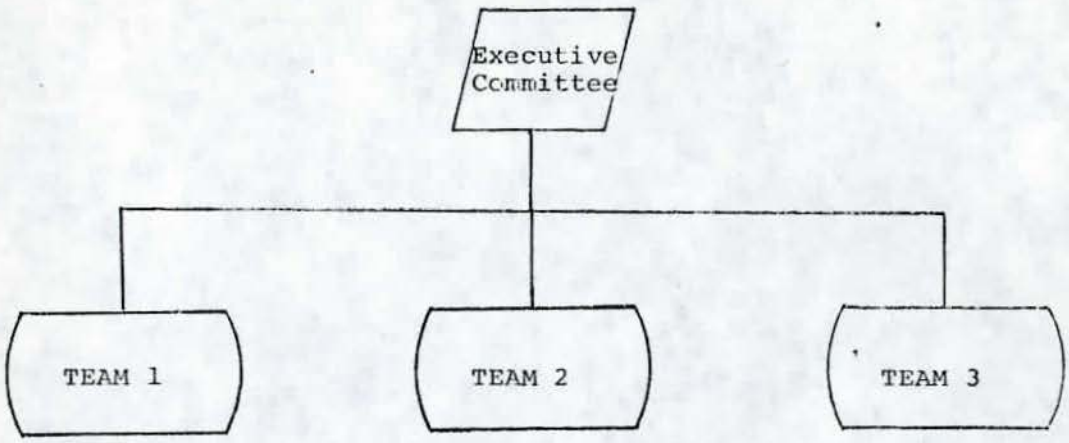
10 = Acutely Ill (inpatient)
11 = Acutely Ill (inpatient)
12 = Acutely Ill (inpatient)

FUNCTIONAL ORGANIZATION CHART OF THE CPP



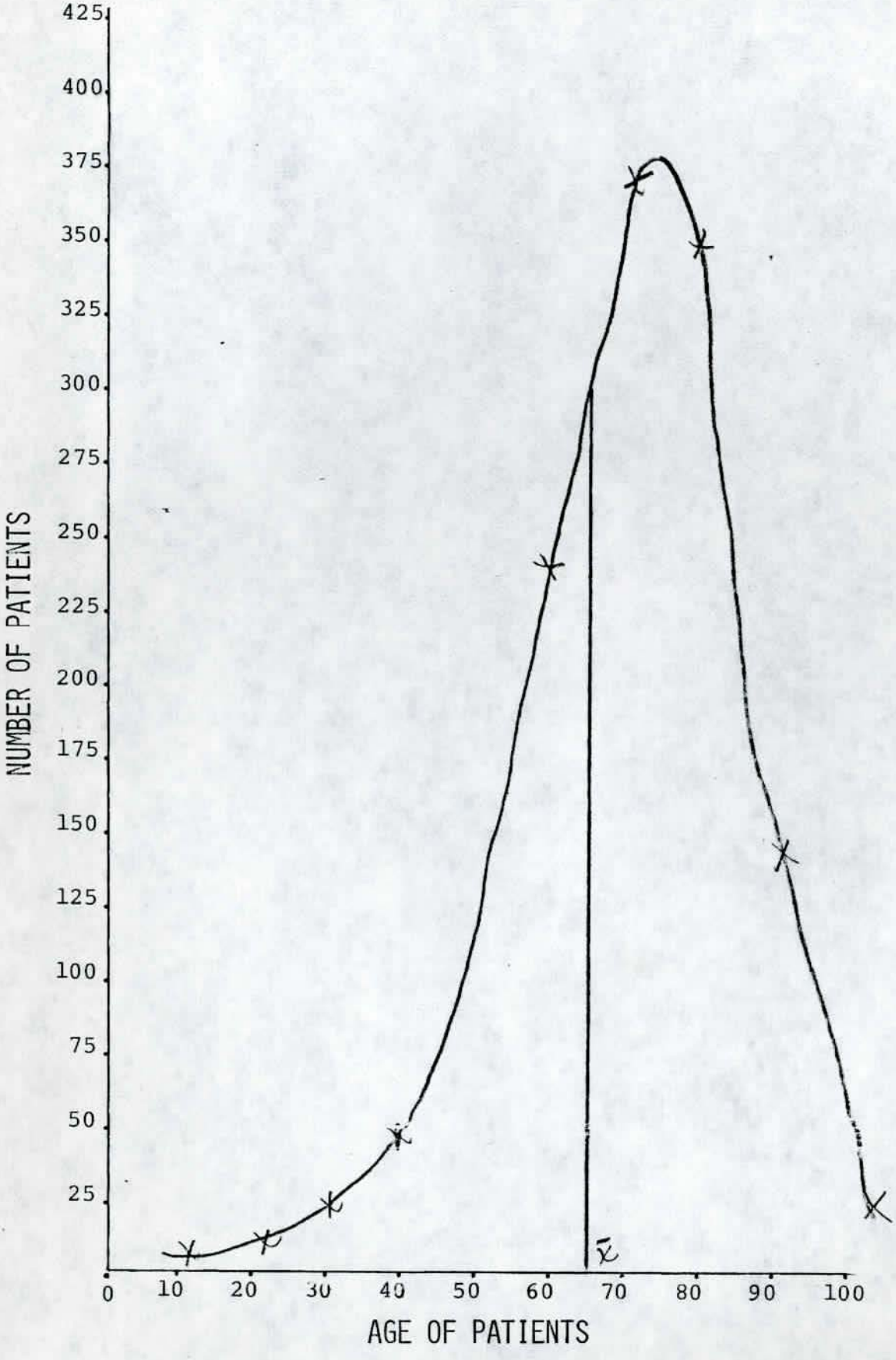
A-Okay N. H.
Watkins B. H.
Maxwell B. H.
Reavis B. H.
Marshall
Good Shepher B.H.
Waterman B. H.
Wilkinson B. H.
Welch B. H.
Christian Old Peoples Home
Marymount Manor
Troy Foster Comm.
Places for People
Bonnie Foster H.
Davis Foster H.
Jones Foster H.
Moore Foster H.
Stevenson Foster H.
Williams Foster H.
Mihan Foster H.
Williams Foster H.
Bourrous Foster H.
Brower Foster H.
Lofton Foster H.
Life Skills
Golden Years (Fulton)
St. Joseph's Home for the Aged
Colonial Rest H.
Marymount Manor
Mark Twain Manor
Evergreen N. H.
Halls Ferry Memorial
Chesterfield Manor
Birchway N. H.
Ferrier Harris Home for the Aged
Little Sisters of the Poor
Fairways N. H.
Bell Manor, Inc.
Bren-Clay N.H.
Hilltop House N. H.
Shamrock N. H.
Stamers N. H.
Hubbartt N. H.

Hemzo B. H.
Ava Marie
United Church of Christ Senior Citizens Center
Ridgeway
Mary Ryder #1
Mary Ryder #2
Jewish Center for Aged
New Haven
Places for People
Sunset N. H.
Walton Nursing Home
Rockwood Manor
Rogers N. H.
Fieser N. H.
Good Shepherd N. H.
Cedarcrest Manor
St. Joseph's Hill Infirmary
Chastains of Des Peres
Rockwood N. H. Ellis
Delmar Gardens - West
Delmar Gardens - East

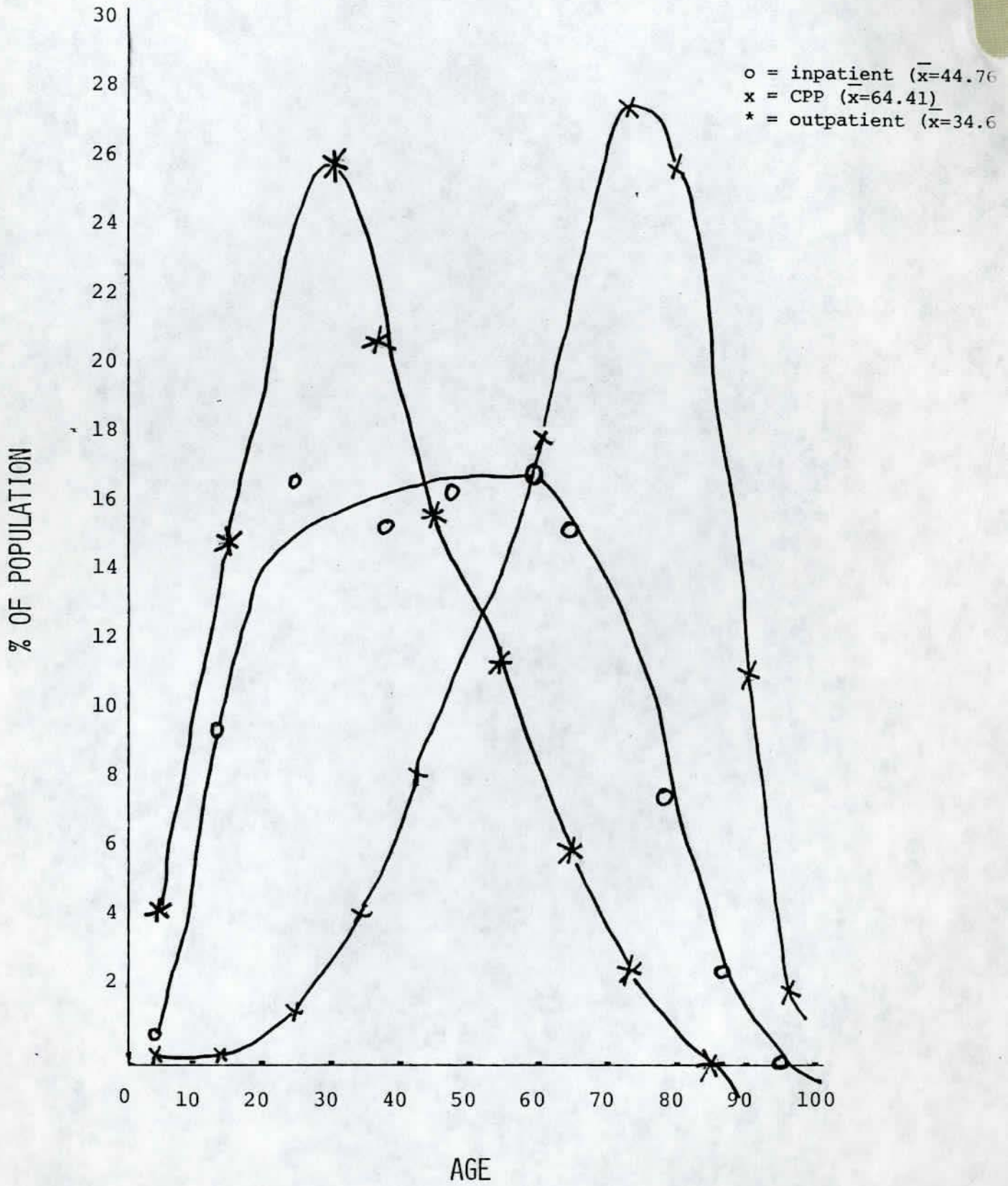
Stellar
Cedar Grove B. H.
Kochs N. H.
Garcia
Nichols
Grand Manor B. H.
Westmoreland Hotel
Festus N. H.
Bernard W. Pine
Places for People
Cedargrove N. H.
Burt Manor
Grand Manor, Inc.
Mercy Convalescent Center
Frazier N. H.
Valley Park N. H.
Lemay N. H.
Affton N. H.
Bernard N. H.
Parkside Towers
Little Flower N. H.
Cedarcroft N. H.

Not Assigned: Child Center for Our Lady of Grace and Converse Group H.

NUMBER OF PATIENTS BY AGE FOR THE CPP

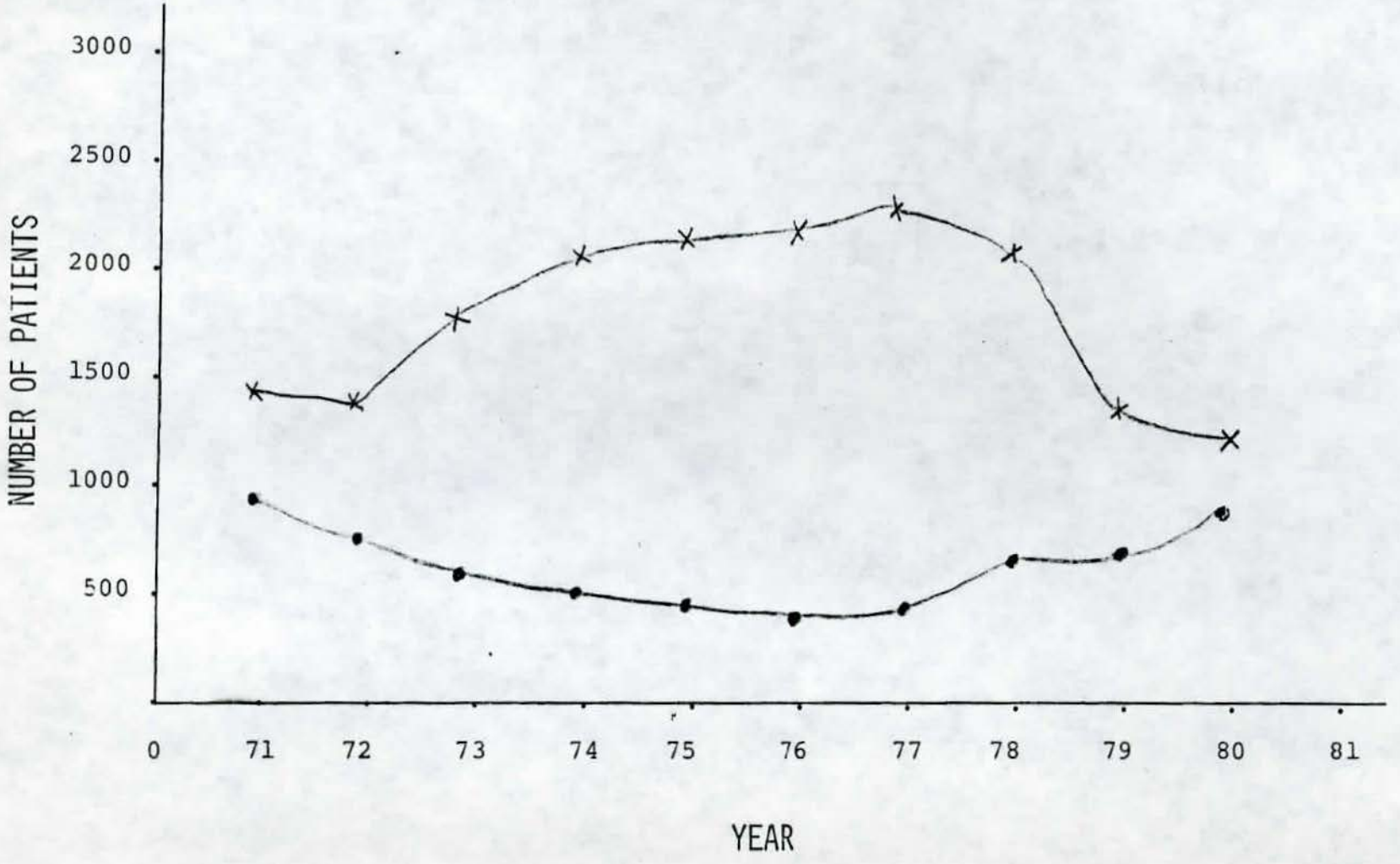


POPULATION CURVES OF 3 MAJOR PROGRAMS



15

CENSUS TRENDS



x = Community Placement Progr
o = St. Louis State Hospital

ST. LOUIS STATE HOSPITAL
COMMUNITY PLACEMENT PROGRAM

16

NURSING/BOARDING HOME VISIT REPORT

NAME OF FACILITY _____ FOR MONTH OF _____

Using S for Satisfactory and U for Unsatisfactory, describe each of the following categories. If item is not applicable, mark N/A.

NOTE: All items marked U must be explained in "Comments" section, and "action taken" must also be reported.

A. Physical Surroundings
   1. Exterior . . . . . _____
   2. Interior
      a. Space . . . . . _____
      b. Cleanliness . . . . . _____
      c. Decor . . . . . _____
      d. Comfort . . . . . _____
      e. Safety. . . . . _____

B. Care/Supervision
   1. Supervision . . . . . _____
   2. Nursing Care. . . . . _____
   3. Medications . . . . . _____
   4. Appearance of Clients . . . . . _____
   5. Staffing. . . . . _____
   6. Tolerance . . . . . _____
   7. In-Service. . . . . _____

C. Meals
   1. Special Diets . . . . . _____
   2. Nutrition (Balanced Meals). . . . . _____
   3. Assistance (with Feeding) . . . . . _____

D. Activities
   1. Staffing. . . . . _____
   2. Variety . . . . . _____
   3. Equipment/Supplies. . . . . _____
   4. Posted Schedule . . . . . _____

E. Emotional Atmosphere
   1. Staff Attitude and Approaches . . . . . _____
   2. Privacy . . . . . _____
   3. Freedom . . . . . _____
   4. Spending Money. . . . . _____

F. Record Keeping
   1. Medical Chart . . . . . _____
   2. Bookkeeping . . . . . _____

G. Miscellaneous
   1. Working Relationship with CPP Staff . . . . . _____
   2. Cooperation with Procedures and Policies. . . . . _____
   3. Attitude Toward CPP Monitoring Activities . . . . . _____
   4. Relative Complaints . . . . . _____
   5. Client Complaints . . . . . _____

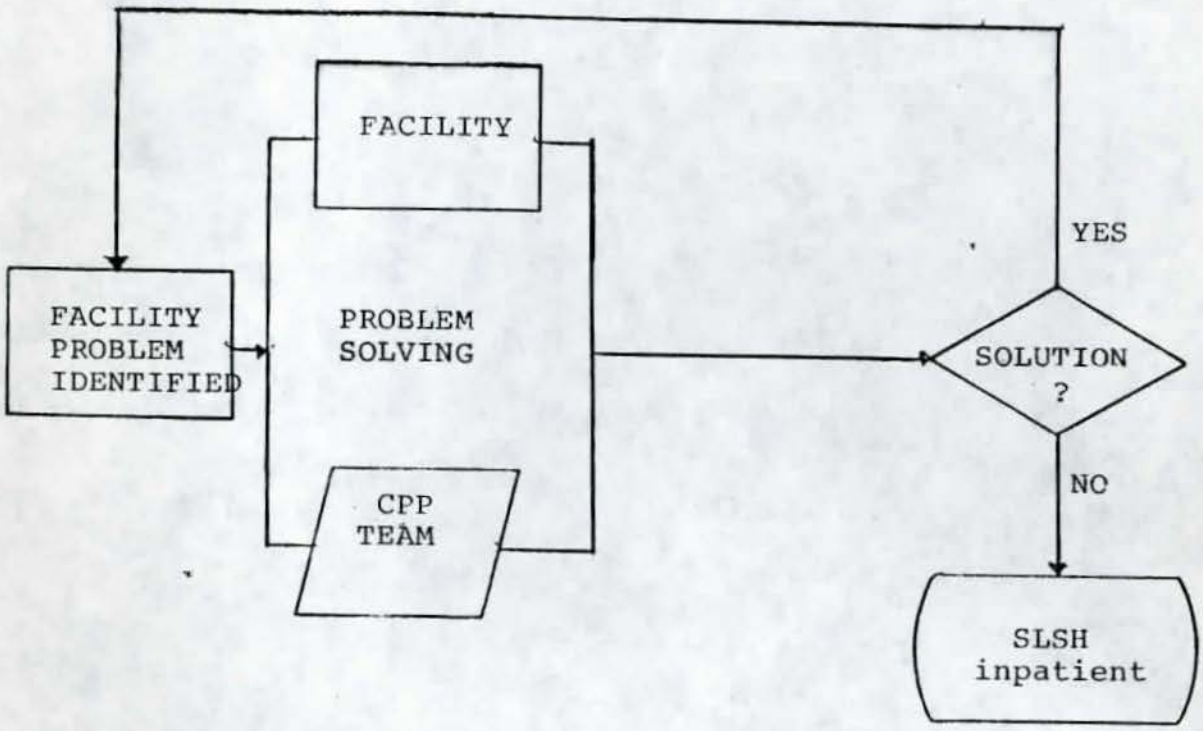
USE THE FOLLOWING SPACE FOR TEAM COMMENTS ON EACH CATEGORY:

ACTION TAKEN (IF ANY):

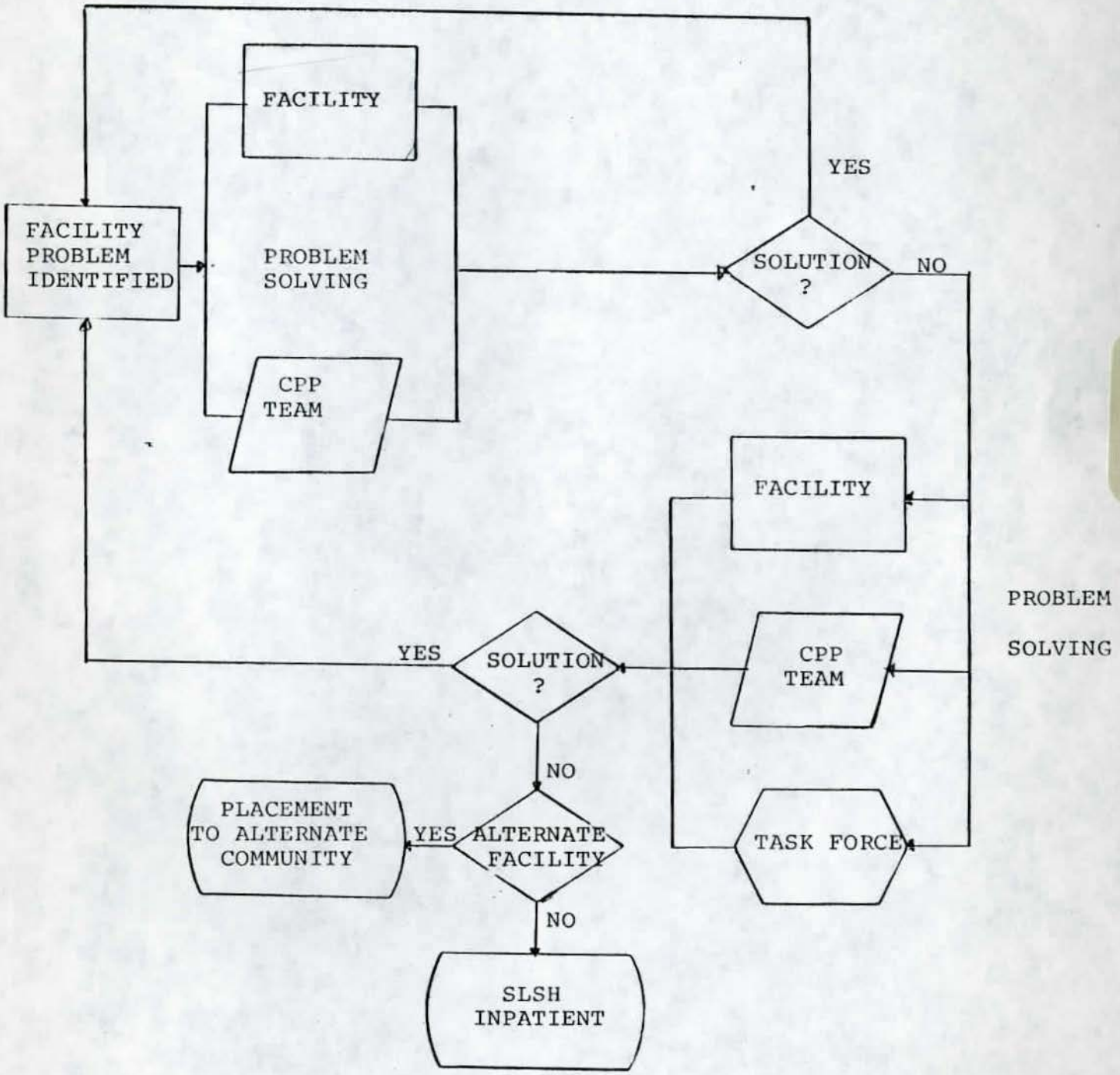
SIGNATURE OF STAFF MEMBER(S) PREPARING REPORT _____

DATE OF REPORT _____

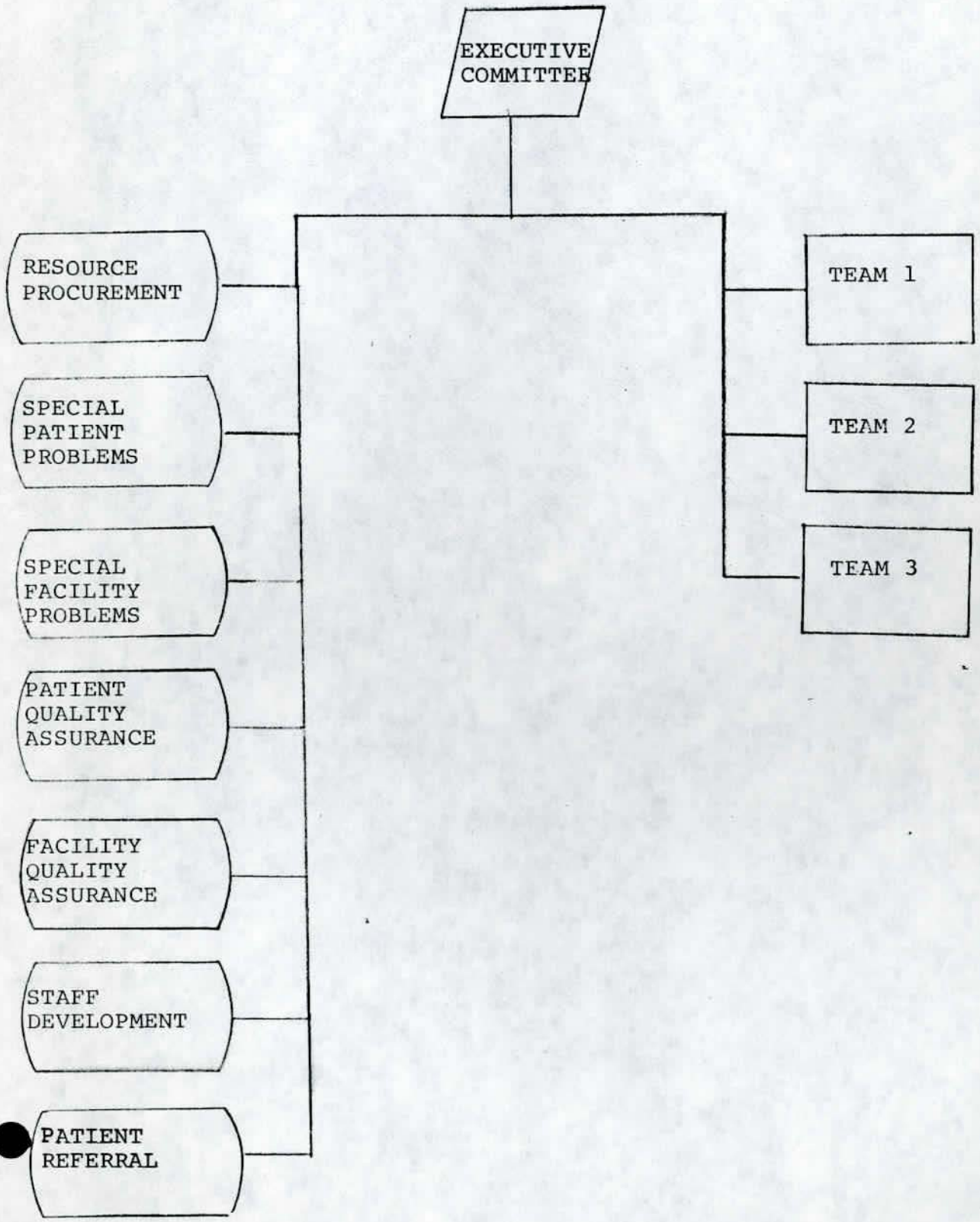
CPP CLIENT MOVEMENT SYSTEM
BEHAVIOR/MEDICAL DISORDERS



RECOMMENDED CPP CLIENT MOVEMENT SYSTEM
BEHAVIOR/MEDICAL DISORDERS



RECOMMENDED FUNCTIONAL ORGANIZATION OF THE CPP



MISSOURI

DEPARTMENT OF MENTAL HEALTH

OFFICIAL MEMORANDUM

DATE June 24, 1980

TO Daved Fnerker OFFICE SLSH

FROM Barbara Spencer, ACSW OFFICE MRCPP

SUBJECT Description of Ankh Program

Per your request for description of Ankh program is following:

Background:

In September, 1978, the population of the Ava Marie Boarding Home consisted of approximately 60 male and female residents. These people had been clinically determined to be mentally ill, and unable to live independently in the community. They were: 1) ambulatory, 2) had some verbal skills, 3) were in general contact with reality, 4) usually handled their impulses and anger in a nondestructive manner, and 5) generally did not exhibit suicidal gestures, or ideation. Because of their dependence upon others to provide for their basic needs, they had not developed any daily living skills. Because of this institutionalization, they had lost contact with any feelings of personal and social responsibility, or personal growth.

Phase I of Program:

Since SLSH Community Placement Program staff did not possess either the educational skills or time to offer skill training, the program contracted with Ankh Services, Inc. to provide Developmental Skill classes to 18 family care residents at the home. Between September, 1978 and July 1979, an average of 29 residents were regularly involved at a given time; approximately 40 residents participated in Phase I of the program.

Initially, the program was financed by POS monies. When these funds ran out in December, 1978, it was picked up and retained on DMH monies until June, 1979.

Generally, the first phase provided a new enthusiasm among the AVa Marie residents who seemed to enjoy the attention of staff not associated with either the home or the St. Louis State Hospital. Although some improvement in both appearance and behavior was seen in many Ava residents, substantial change was noted in those DMH residents directly involved in the Ankh classes, i.e. decreased withdrawal, acting out, and/or bizarre behavior. Also, these residents tended to react more responsibly in everyday person-to-person interactions; and demonstrated the potential to learn or relearn certain skills necessary to improve the quality of their lives. Some of them demonstrated the potential to move toward more independent living.

Phase II of Program:

With the above goals in mind, SLSH, Community Placement contracted with Ankh Services, in July 1979 to provide a more intensive Social Developmental Skill and Recreational Program to 28 Ava Marie Residents.

Living Groups - In order to facilitate personal responsibility, and awareness of others, the 28 residents were divided into four living units/classes, each composed of seven residents. Each living unit was both encouraged to take responsibility for managing its own living area, and participate in decisions concerning community shared living area.

Classes - Each group was involved weekly in three, two hour Social Developmental Skill classes, including Home Management, Cooking, Grooming, Community Interests, and Current Events. Each group also participated in one, two hour recreational activity per week. Recreational classes included kitchen band, fishing, picnics, dancing, eating at restaurants, field trips to pick apples and attending sports events.

Community Meetings - During the first six months of Phase II, Community meetings were held each week. All participating residents, MRCPP, Ankh, and Ava Marie staff were expected to regularly attend community meetings. Staff also generally attended "post" meetings to process community meetings.

During the second six months, community meetings were held, five days a week. On Fridays, Ankh, MRCPP, and Ava Marie staff, met to discuss residents progress, handle problems, and discuss treatment plans.

Outcome -

Between July 1979 and May 1980, approximately forty residents were involved in the second phase. Residents remained in classes until Ankh and MRCPP staff determined that they would no longer benefit from the program. New participants were selected by MRCPP staff from non-participating residents, and from patients placed from the St. Louis State Hospital. In December 1979, DMH Central Office exempted fifty resident limit on home, for those residents placed for inclusion in the Ankh Program.

During the entire program, approximately ten residents were transferred to apartments, one resident was accepted by Community Homes, however, has not been transferred due to medical problems, and five residents have recently been referred to both Community Homes and Foster Community Apartment programs.

During the second phase, the atmosphere at Ava continued to become less institutionalized. Residents participating in the program began to take even more responsibility for managing themselves, and their living space. With staff assistance, they participated in community meetings, and sat on a steering committee. Latter organized programs and handled facility problems. The residents also cooked a Thanksgiving dinner, planned and managed a store, handled numerous clerical and cleaning tasks associated with lounge area, and initiated decorating and furnishing of lounge area.

Future Programming:

Of the 50 DMH residents currently living at Ava Marie, five would probably benefit from continued skill training. The remaining residents badly need a recreation program. Perhaps one of the characteristics most evident during the second phase was the residents' need to be involved in an ongoing program, to receive consistent staff support, and attention, and to have activities to occupy their time.

A subsequent phase might consist of:

1) One Social Developmental Skill Group consisting of ten residents. In addition to current Ava residents, additional SLSH residents could be placed into this group. Also, between thirty and forty residents could be involved in an extensive activity program. This might include community meetings, lounge area events, store services, steering committee meetings, dances, movies and field trips.

2) A recreation program could be offered about forty DMH residents. No Developmental Skill program would be offered.

I hope this information will be helpful. If you have any questions, I can be reached at 8308, or messages can be left at 8311.

cc: Mildred Dunn, R.N.
Ankh Master File
Ava Master File

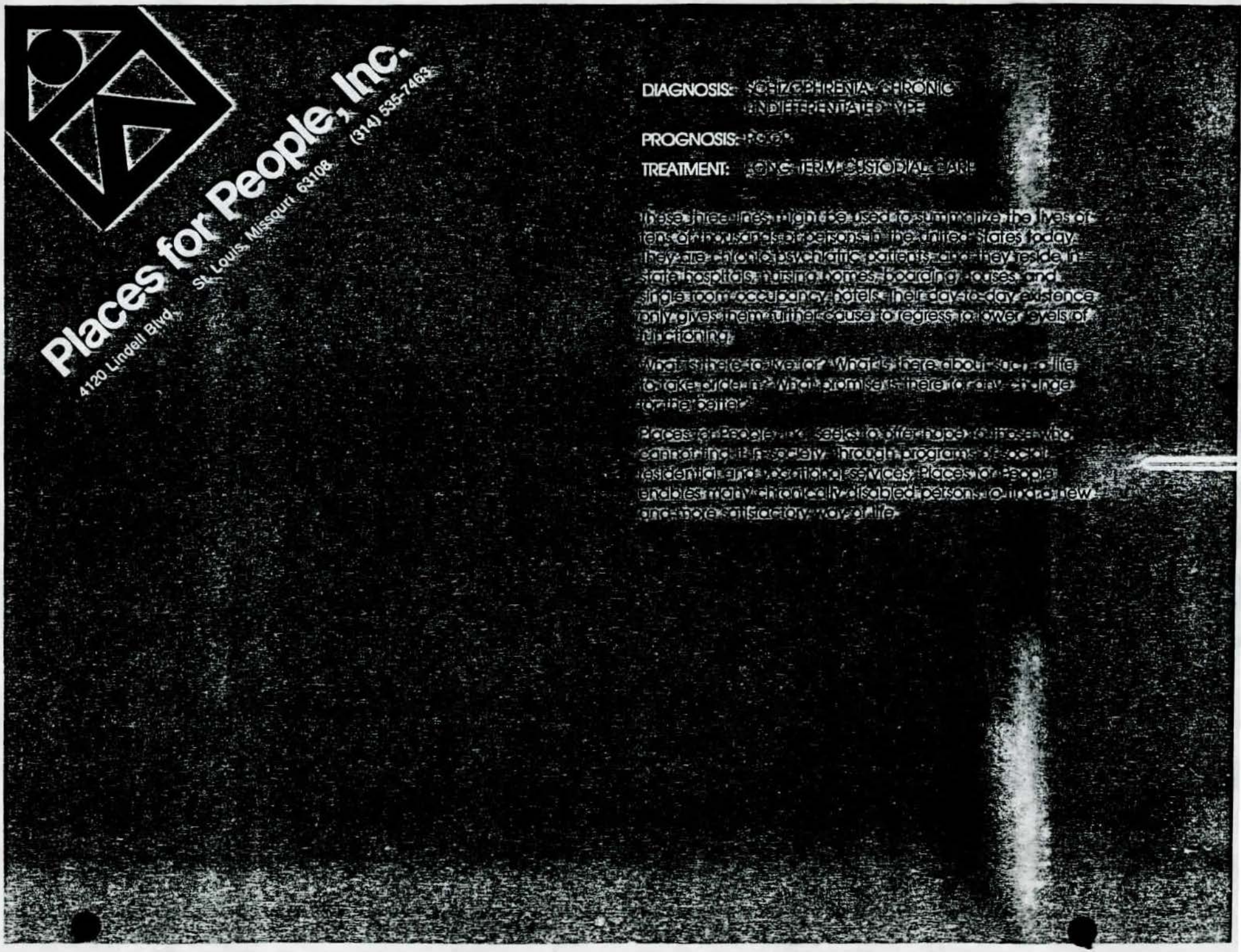
BS/lem

Places for People, Inc.

4120 Lindell Blvd.

St. Louis, Missouri 63108

(314) 535-7463


Places for People, Inc.
4120 Lindell Blvd.
St. Louis, Missouri 63108
(314) 535-7463
DIAGNOSIS: SCHIZOPHRENIA, CHRONIC UNDIFFERENTIATED TYPE
PROGNOSIS: POOR
TREATMENT: LONG TERM CUSTODIAL CARE
These lines might be used to summarize the lives of tens of thousands of persons in the United States today. They are chronic psychiatric patients who reside in state hospitals, nursing homes, boarding houses and single room occupancy hotels. Their day-to-day existence only gives them further cause to regress to lower levels of functioning.
What is there to live for? What is there about such a life to take pride in? What promises here to make change worthwhile?
Places for People, Inc. seeks to offer hope to those who confront life's reality through programs of social, residential and vocational services. Places for People enables many chronically disabled persons to find new and more satisfactory ways of life.

THE PSYCHO-SOCIAL REHABILITATION CENTER

Throughout human history, people have formed themselves into groups to share responsibility and carry out tasks that would be impossible for the individual to achieve. Psychiatrically disabled persons feel this same need to contribute to the accomplishment of shared goals.

This was the first great lesson learned by Francie Broderick when she became the first- and only — employee of the Psycho-Social Rehabilitation Center of Places for People, Inc.

"I used to ask myself why I hated filling out weekly schedules for arts and crafts groups and other activities and classes at the Club," Francie recalls. "Finally I understood. The whole thing was just too unlike reality. Grown people don't spend their days doing recreational activities. They go to work, perform tasks, maintain their homes, and then they do recreational activities."

From this realization grew the new focus of the Social Center — work. Lunch needed to be prepared. The building had to be cleaned. Clerical tasks and a small thrift shop required the help of a number of persons. Soon each member of the Center (usually referred to as the "Social Club") had something important to contribute.

Within a few months, the Club changed from a sedate, rather sterile recreational center into a dynamic rehabilitation facility. As people began using long-forgotten work and social skills — or learned new skills — their behavior began to change. Mute people started talking. People whose behavior had been autistic started to express an interest in getting involved in Club operations.

After a year, the Social Club outgrew its small storefront in South St. Louis, so Places for People bought a new facility in the Central West End to house both the Club and administrative offices. Client membership soared to some three hundred persons, and about sixty members attended on a daily basis.

"But," Francie is quick to point out, "the work focus of our program has not eclipsed its recreational aspects. The program has always emphasized the importance of good times for its members. Parties are regular events. Arts and crafts are scheduled for those interested, and special events — like camping trips, picnics and visits to museums — provide diverse recreational experiences for members with different interests."

Club members function personally and socially at many different levels. A large proportion of those who regularly attend the daytime programs at the Club are long-term psychiatric patients. They may have spent decades in the wards of state hospitals. Now many of them live in nursing and boarding homes. There are no arbitrary time limits stating how long an individual may come to the Club. Behavior patterns that developed over many years are not easily overcome.

THE ST. LOUIS COMMUNITY HOMES PROGRAM

The germinal program of Places for People concerned itself with group apartment living. It is now known as the St. Louis Community Homes Program.

In May of 1971, Dr. Hilary Sandall and Ms. Mildred Dunn, R.N., both on the staff of St. Louis State Hospital, placed the first group of three chronic psychiatric patients in an apartment on Davis Street in South St. Louis. The three women in the group had been long-term in-patients on the ward where Dr. Sandall and Ms. Dunn worked.

Within a few months a second apartment was rented, then a third and a fourth. Five years later, the St. Louis Community Homes Program had over 80 apartments and some 145 residents.

Each apartment is home for small groups of ex-patients who share such duties as shopping, cooking and cleaning. Most are in older, working class neighborhoods of the city, and the majority are in old-fashioned four- and six-family dwellings. Ex-patients occupy one or two units in such dwellings, and the rest are occupied by other members of the community.

Ex-patients living in apartments require differing kinds and amount of services. Some participate in counseling programs. Others need help with homemaking. Most require assistance with financial management.

"They mostly have their checks from Social Security," explains Adele McAnany, Office Manager of Places for People. "They endorse these to Places for People, and we put the money into a special account. We pay utilities and rent from that fund, and we make sure that every resident is putting in their fair share of expenses. We advance grocery and personal spending money to residents each week and keep accounts for them. As soon as they've reached the point where they can manage, they keep their own checks and pay their own bills. Many are just too anxious about finances, though, and so we do the money management for them for a long, long time."

One key to the success of the program has been a close working relationship between Places for People and the Missouri Department of Mental Health. Major funding for the program comes from this department, and psychiatric and nursing services are provided by the St. Louis Community Placement Program, a Department of Mental Health facility. Hospital backup is provided by St. Louis State Hospital.

The Community Homes Program does not function with arbitrary expectations and time limits. The program staff works at helping residents assume increasing responsibility and independence. But ultimately, this personal growth is seen more as a natural process than being the result of therapy or other programmatic input. When given the opportunity and support, many chronic psychiatric patients can shake off the stigma attached to being a "mental patient" and become a part of normal society. The program recognizes the fact that individuals require different lengths of time to achieve such a goal — and that some individuals will never achieve it. Therefore, flexibility is a guiding principle of the program.

Criteria for acceptance into the program are purposely vague. The only persons automatically excluded are those with a recent history of violence or extremely disruptive sexual behavior, and those who have significant problems with alcohol or drug abuse.

SPECIAL RESIDENTIAL PROJECTS

The Community Homes Program offers one option for individuals needing residential services. But it is not a panacea. Many people need more supervision than is available in the apartment setting. Others are unable to cope with living so close to other persons.

Places for People tries to provide as broad a range of residential alternatives as are financially and programmatically feasible. Other group living situations than apartments have come to be called, for lack of a better name, the Special Residential Projects.

Places for People has experimented with several such group living situations. As with the Community Homes Program, flexibility is the cornerstone of Places for People's approach. Criteria for acceptance are the same as for the apartment program, although some special need is generally evident to indicate that a person is not quite ready to adjust to the more independent living setting of an apartment.

Programming for residents of a group home is very individualized, depending on the level of functioning of each person. Vocational and community survival goals are stressed, and people are encouraged to assume as independent a lifestyle as is possible.

THE TRANSITIONAL EMPLOYMENT PROGRAM

Employment is one of the most difficult challenges facing the person with a psychiatric disability. Most long-term psychiatric patients must overcome nearly insurmountable obstacles if they want to enter the work force. How do they explain those "missing years"? How do they convince a potential employer of their ability? How do they deal with their own feelings of inadequacy and fear?

To help them cope with such problems, Places for People has adapted a vocational rehabilitation model called "Transitional Employment" that was originally developed by an agency in New York City called Fountain House.

Initially, Places for People provides opportunities for work experiences in the Social Club. When members have gained sufficient confidence, Places for People obtains jobs for them in private industry. These jobs usually consist of regular full-time positions that are split into two half-day jobs that two members work. Places for People guarantees to the employer that someone who is able to do the job satisfactorily will report for work each day. If a member is unable to report, Places for People will see that someone else — another client or perhaps a staff person — does so instead. The employer has the advantage of knowing that a capable worker will show up every day.

The advantages to the member are several. First, the member can ease into the work force on a part-time basis. The jobs are real and real wages are earned, at the normal rate of pay for the job. The Places for People staff provide them with support and supervision, providing assistance, when necessary, to the members' supervisor.

As in other programs of the agency, flexibility of approach is a key. Clients are evaluated and an individualized plan is prepared for everyone. Some members may be placed directly in a Transitional Employment position with little experience working at the Social Club. Others may even be placed in full-time jobs. There are no rigid limits for how long a member may stay at any level in this program. Someone successfully adapting to the half-time position may stay in it indefinitely. Someone else may quickly move on to a higher employment level.

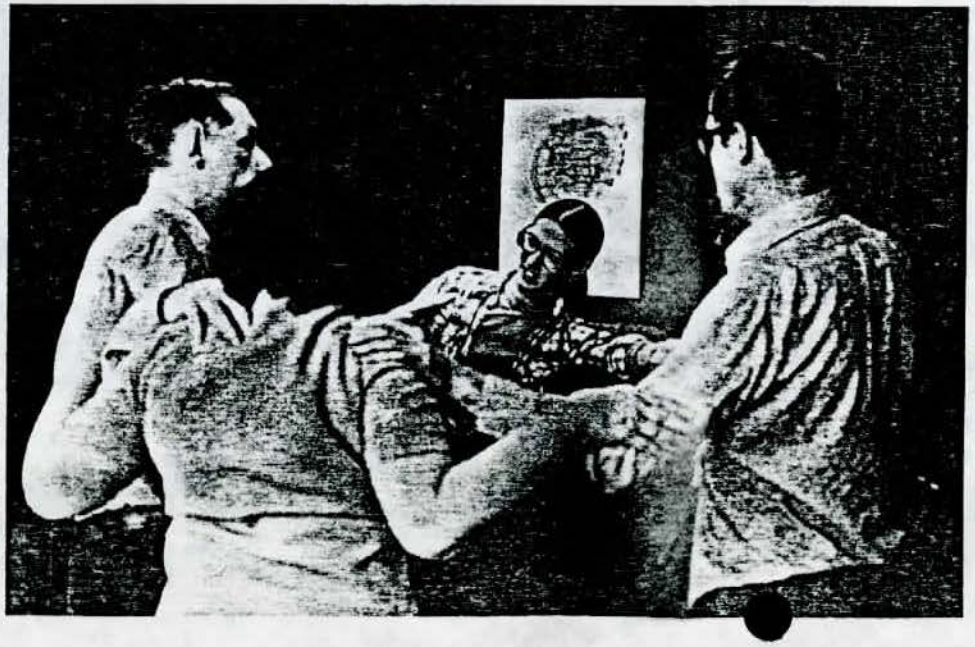
AN INTER-RELATED NETWORK OF SERVICES

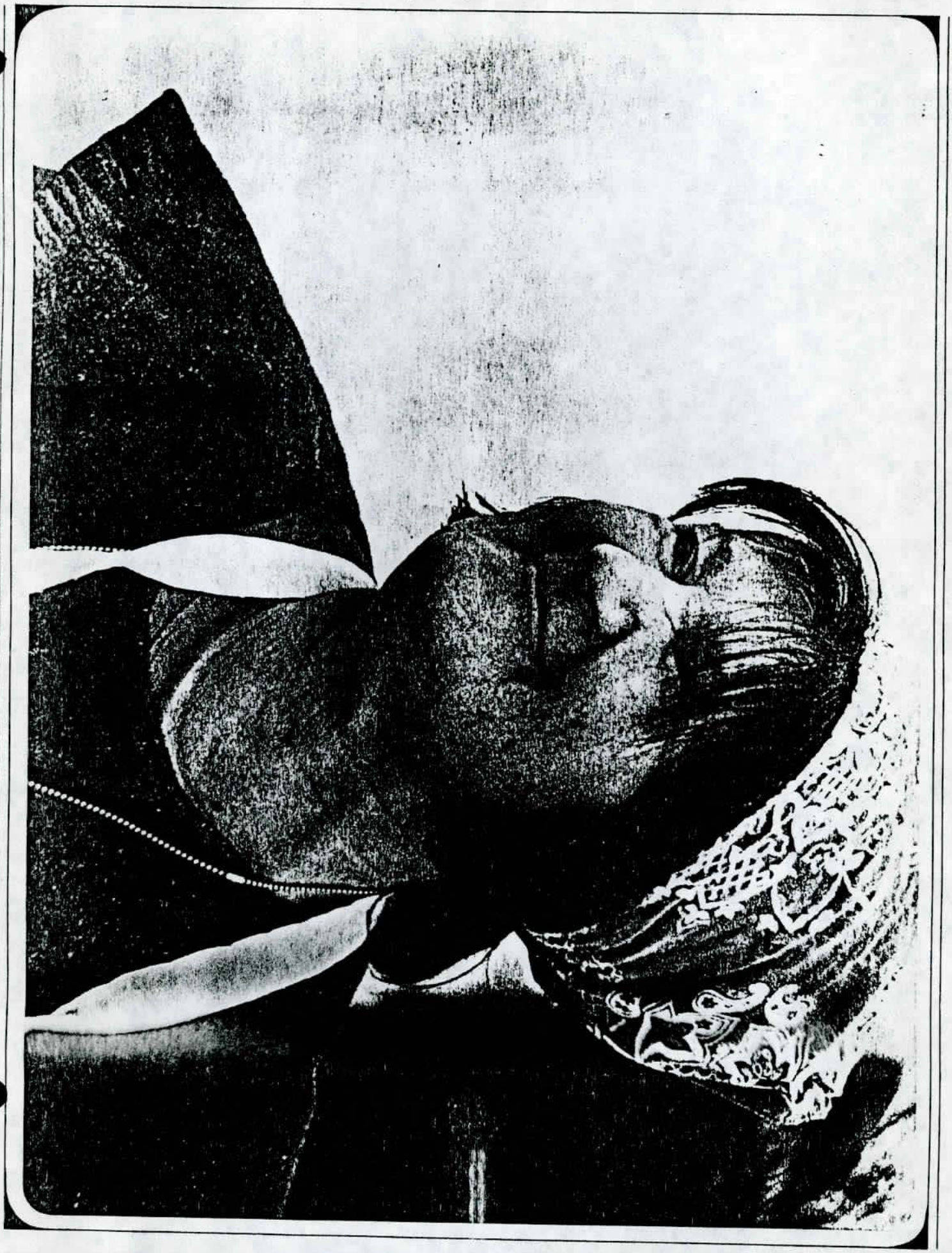
Social, Residential and Vocational services. These are thee independent — but very interdependent — components of the Places for People program. Each meets some aspect of the needs of the chronically disabled psychiatric patient. Together, they form a network of services that can mean a whole new way of life for people who had lost hope for any sort of change in their lives.

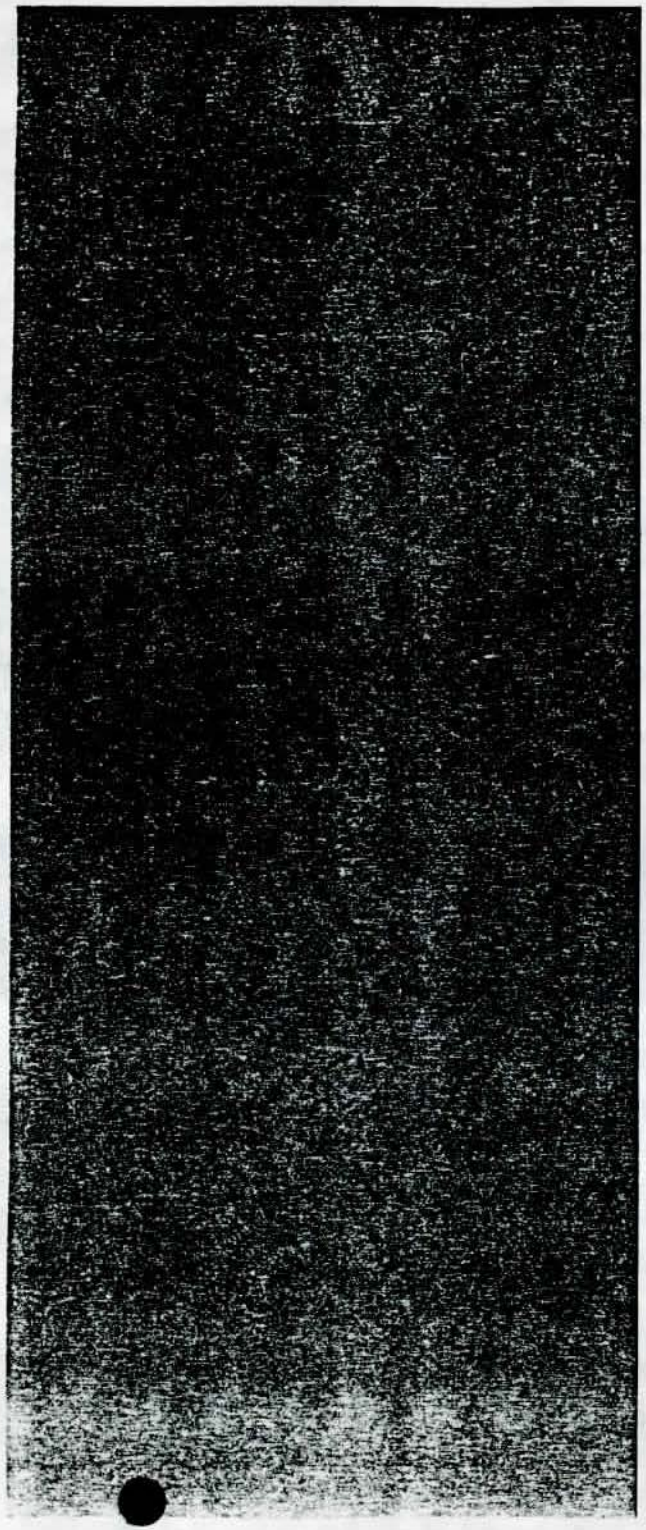
Years of institutionalization and the dependency fostered by institutional care can rarely be erased completely. Many clients of Places for People have found, however, that they have the strengths necessary for change that can be brought to bear on the problems of daily living and can lead to a formerly unimagined independence.

The struggle of individual clients, residents and Club members is often mirrored in the struggles of the agency itself. While public and private funding have enabled Places for People to expand significantly its services to St. Louis area residents, the need far outstrips the services presently available. Places for People must constantly search for new sources of income so that it can both improve existing services and develop in directions that will meet the needs of a larger number of persons.

Places for People, Inc. is a private, not-for-profit agency entitled to receive tax-deductible contributions from individuals and foundations interested in furthering its goals.







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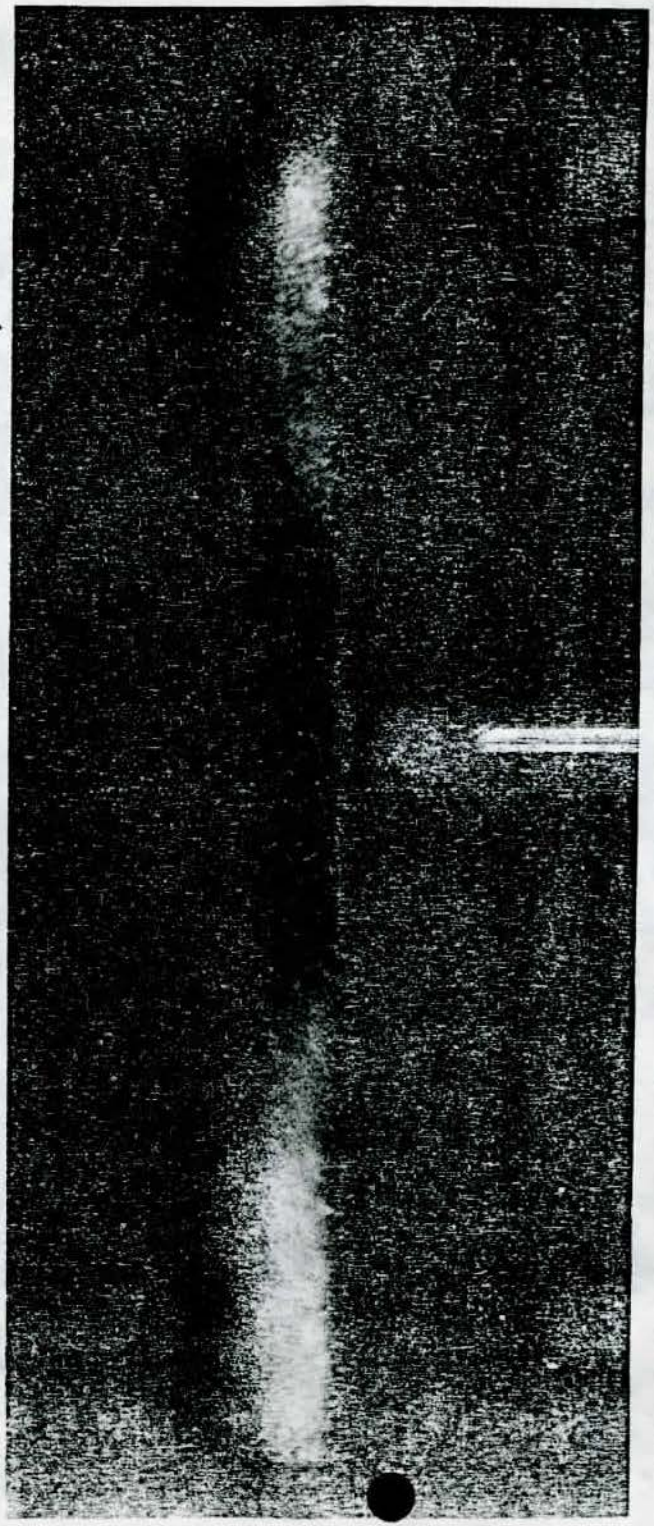
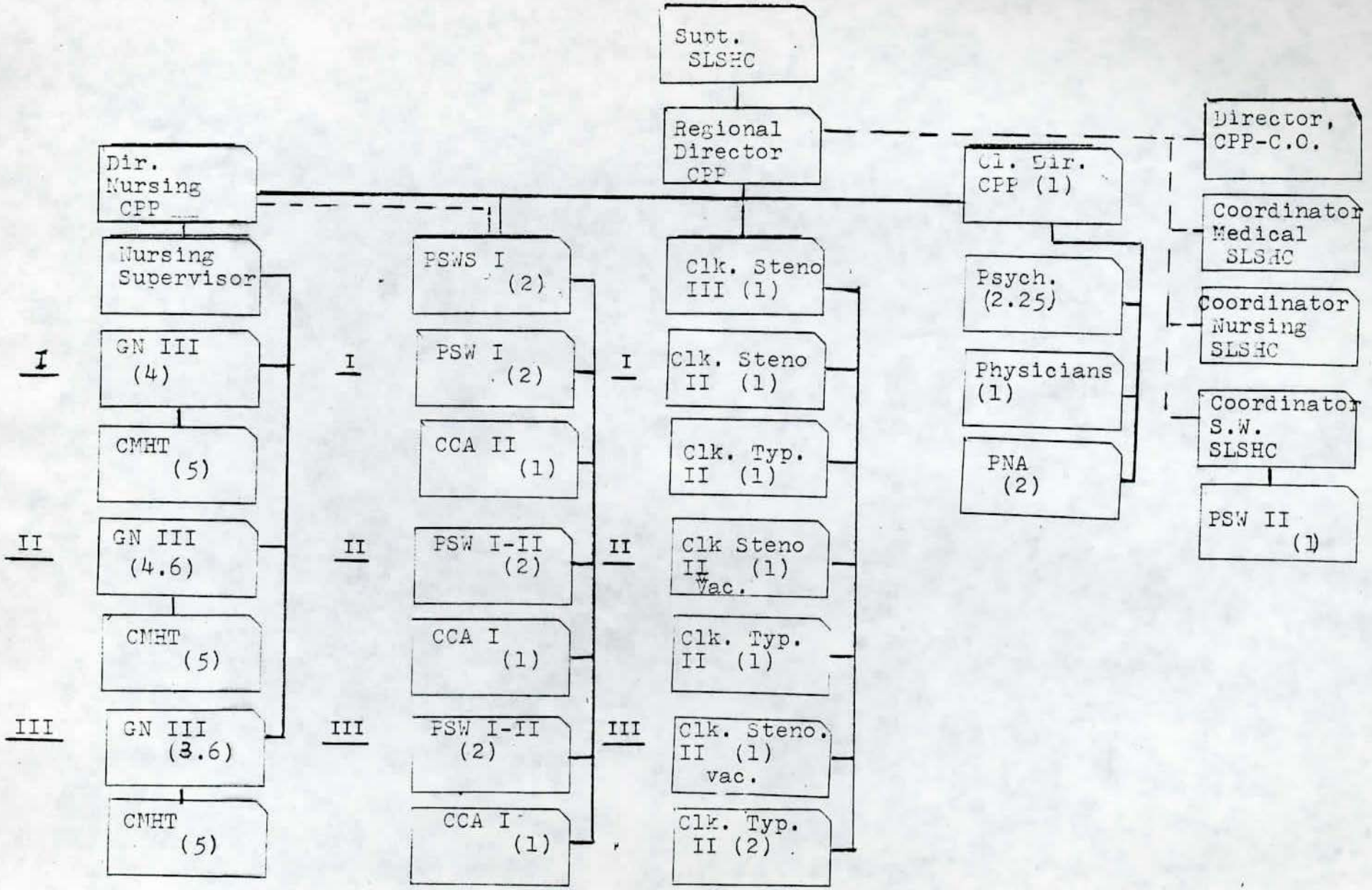
MEMBER: INTERNATIONAL ASSOCIATION OF PSYCHO-SOCIAL REHABILITATION SERVICES — AND "THE NATIONAL REHABILITATION ASSOCIATION"

INFORMATION CONCERNING PROGRAMS OR CURRENT FINANCIAL NEEDS MAY BE OBTAINED BY CALLING (314) 535-7463 OR BY WRITING TO:

TIMOTHY HAWLEY, PH.D.
EXECUTIVE DIRECTOR
PLACES FOR PEOPLE, INC.
4120 LINDELL BLVD.
ST. LOUIS, MISSOURI 63108

PHOTOGRAPHY COURTESEY OF:
GERALD S. UPHAM




Supt. SLSHC
Regional Director CPP
Director, CPP-C.O.
Dir. Nursing CPP
Cl. Dir. CPP (1)
Coordinator Medical SLSHC
Coordinator Nursing SLSHC
Coordinator S.W. SLSHC
Nursing Supervisor
PSWS I (2)
Clk. Steno III (1)
Psych. (2.25)
Physicians (1)
PNA (2)
PSW II (1)
I
GN III (4)
CMHT (5)
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PSW I (2)
CCA II (1)
I
Clk. Steno II (1)
Clk. Typ. II (1)
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GN III (4.6)
CMHT (5)
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PSW I-II (2)
CCA I (1)
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Clk. Typ. II (1)
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GN III (3.6)
CMHT (5)
III
PSW I-II (2)
CCA I (1)
III
Clk. Steno. II (1) vac.
Clk. Typ. II (2)

MEAN COST & STANDARD DEVIATION OF PLACEMENT FACILITIES

PSYCHIATRIC SYMPTOMS

PHYSICAL CARE LEVEL

	ACUTE	REHAB	COMMUNITY
SNF	12	8 $\bar{X}$ = 699.00 SD = 213.52	4 $\bar{X}$ = 841.00 SD = 118.33
ICF	11	7 $\bar{X}$ = 661.92 SD = 186.34	3 $\bar{X}$ = 366.75 SD = 94.72
SUPV	10	6 $\bar{X}$ = 527.50 SD = 147.79	2 $\bar{X}$ = 391.16 SD = 113.06
INDP	9	5 $\bar{X}$ = 285.64 SD = 32.51	1

LEGEND

SNF = Skilled Nursing Facility
ICF = Intermediate Care Facility
SUPV = Supervised Living Arrangement
INDP = Independent Living Arrangement
1 = Outpatient/Discharged/Family Care
2 = Boarding Home
3 = Residential Care Facility
4 = Skilled Nursing Facility (few or no psychiatric problems)
5 = Apartments/Foster Homes/ Foster Communities
6 = Group Homes
7 = Intermediate Care Facility
8 = Skilled Nursing Facility (with behavior and psychiatric problem
9 = Acutely Ill (inpatient or outpatient)
10 = Acutely Ill (inpatient)
11 = Acutely Ill (inpatient)
12 = Acutely Ill (inpatient)

COMMUNITY PLACEMENT FUNDING AUTHORIZATION

D.M.H. FACILITY | DATE

D.M.H. Facility Code	Case Number	Resident's Surname	Resident's First Name	Effective Date

Name of Community Placement Facility	Street Address

City - State - Zip	Type of C.P. Facility	C.P.F. No.

1. PLACEMENT (FULL MONTH)

Type of Placement: A ☐ NEW B ☐ REPLACE C ☐ INACTIVE ADJ. | Sex | Level of Care | FULL MONTH

Date of Birth	D.F.S. ID. No.	S.S.I. Number

2. REVISION (FULL MONTH)

	Total Contract	D.F.S.	S.S.I.	Direct Pay	Pat. Fund	D.M.H.		Adj.
Increase/Approval	☐	☐	☐	☐	☐	A ☐	C	☐
Decrease/Cancel	☐	☐	☐	☐	☐	B ☐		

3. CANCELLATION (PART MONTH)

A ☐ RETURNED TO D.M.H. B ☐ DIED
C ☐ DISCHARGED D ☐ TRANSFERRED

PART MONTH

4. SERVICES	OLD CONTRACT	NEW CONTRACT
Board, Room and Routine Care	$	$
Personal Allowance		
Clothing		
Diapers & Underpads		
Laundry (Personal)		
Medical Supplies		
Medication		
Physical Therapy		
Physician Services		
Special Training Programs		
Spoonfeeding		
Transportation		
Wheelchairs & Walkers		
Other (Specify in Remarks) Code		
TOTAL SERVICES COST	$	$

5. FINANCIAL		
Number of Days of Care		
Division of Family Services	$	$
Supplemental Security Income		
Direct Pay*		
Patient Fund		
Department of Mental Health		
TOTAL AMOUNT DUE	$	$

Amount Underpaid A $	Amount Overpaid B $
Increase In Encumbrance $	Decrease In Encumbrance $

Remarks:

*Name

St. Address

City - State - Zip

6. CORRECTIONS OR NEW DATA

Case Number	Resident's Surname	Resident's First Name	C.P.F. No.

Level of Care	Date of Birth	D.F.S. ID. No.	S.S.I. Number

7. AUTHORIZATION

Submitted By | Approved By

COMPUTATION OF AMOUNTS OVERPAID & UNDERPAID BY D.M.H.

LINE NO.	DESCRIPTION	REVISION 2	REVISION 3	REVISION 4	REVISION 5
1	Beginning Date				
2	Ending Date				
3	Total Contract (sum of lines 4 thru 8)	$	$	$	$
4	Division of Family Services				
5	Supplemental Security Income				
6	Direct Pay				
7	Patient Fund				
8	Amount required from D.M.H. (line 3 less sum of lines 4 thru 7)				
9	Amount Paid By D.M.H.				
10	Amount Overpaid or Underpaid by D.M.H. (line 8 less line 9. If line 9 is greater than line 8, prefix amount with minus (-) sign.)	$	$	$	$
11	Number of months (difference between dates on lines 1 and 2)				
12	Total Overpayment or Underpayment (line 10 times line 11. If line 10 is minus, retain minus sign).	$	$	$	$

Total the sum of Revisions 2 through 5 on lines 12 and enter total Overpayment or Underpayment in appropriate block on front side.

COMMENTS:

PAUL R. AHR, PH.D., M.P.A.
DIRECTOR

DIVISIONS OF
ALCOHOLISM DRUG ABUSE
MENTAL RETARDATION
DEVELOPMENTAL DISABILITIES
PSYCHIATRIC SERVICES

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
2002 MISSOURI BOULEVARD
P. O. BOX 687
JEFFERSON CITY, MISSOURI 65102
(314) 751-4122

Dear Owner/Administrator:

Our department is again requesting your cooperation in our human rights compliance system. We ask that you complete the appropriate forms in the attached kit, "Human Rights Assurances for Applicants for Financial Assistance from the Missouri Department of Mental Health." Completed forms should accompany your application for a Master Agreement.

After four pages of explanation is an instruction page (DMH 7701) on how to complete the forms.

I would call your attention to several items on DMH 7702:

Item 3 -- Enter legal name. If one corporation or owner operates more than one facility, complete only one assurance to cover all facilities and list names and addresses of all facilities (whether DMH patients there or not) on an attached page. If each facility is a separate corporation, complete assurances for each corporation.

Item 8 -- Check box 4 only.

Item 9 -- Check box 2 only.

Item 10 - For this request, indicate a one-year period; for example, 07-01-80 (to) 06-30-81

Item 11 - You may base the amount on your anticipated monthly payment from our department for patient care. This payment includes: patient fund and DMH payment; it does not include: SSI, Division of Family Services and direct payment. Determine this monthly payment from our department, multiply it by twelve (12) and enter the total as item 11. The total you enter is an estimate only for the purpose of this request. The total does not affect your reimbursement, which depends upon the actual services you provide.

The instructions ask that you send the forms at the time of application. Please attach the originals of the applicable human rights forms to the Master Agreement when you submit it.

Thank you for your cooperation.

If you have any questions, please feel free to write or telephone.

Sincerely,

Edward L. Bode

Edward L. Bode, STD
Assistant Human Rights Administrator
Telephone: (314) 751-2441

Attachment: Human Rights Assurances

JOSEPH P TEASDALE
GOVERNOR

PAUL R. AHR, PH D., M.P.A.
DIRECTOR

DIVISIONS OF
ALCOHOLISM-DRUG ABUSE
MENTAL RETARDATION -
DEVELOPMENTAL DISABILITIES
PSYCHIATRIC SERVICES

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
2002 MISSOURI BOULEVARD
P. O. BOX 687
JEFFERSON CITY, MISSOURI 65102
(314) 751-4122

Dear Owner/Administrator:

The Missouri Department of Mental Health is a human-service agency dedicated to the ideal that equal respect and treatment be accorded to each person because of his/her individual worth and dignity. Due to this commitment, the Department is concerned about equal employment opportunity and equality in the provision of services. This concern extends not only to the Department itself but also to our contractors who provide services to patients or clients.

In addition, federal and state laws, executive orders and administrative rules and regulations spell out specific obligations regarding non-discrimination on the bases of race, color, national origin, sex, religion, age, handicap and veteran status.

I ask your cooperation in our human rights contract compliance program.

Sincerely,

Paul R. Ahr, Ph.D., M.P.A.
Director

HUMAN RIGHTS ASSURANCES
FOR
APPLICANTS FOR FINANCIAL ASSISTANCE
FROM
MISSOURI DEPARTMENT OF MENTAL HEALTH

Contract Compliance
Human Rights & Development Section
Missouri Department of Mental Health
2002 Missouri Boulevard
P. O. Box 687
Jefferson City, MO 65102

Telephone: 314/751-3084

HRA 1/80

INTRODUCTION

Federal and state laws, executive orders and regulations require that recipients (persons or agencies) of governmental financial assistance do not discriminate either in employment or in provision of services. The precise types and acts of affirmative action and prohibited discrimination depend upon the amount of funding and the number of the recipient's employees.

The purpose of this document is to help providers of service in preparing applications for financial assistance from the Missouri Department of Mental Health (DMH). "Financial assistance" includes all grants, contracts and payments for services.

As a human-service agency, the DMH is committed to the ideal that equal treatment and respect be given each employee and applicant for employment as well as each patient (client) because of his/her individual worth and dignity as a human being. One step toward the implementation of such an ideal involves all contractors' (vendors') observing all civil liberties and human rights. As specific guidelines in such an endeavor, the DMH must insist on compliance with all applicable federal and state laws, rules, regulations and executive orders.

Applicants are urged to consult applicable source documents for a thorough understanding of their obligations.

We present here a brief summary of legal obligations of contractors (vendors). The summary should NOT be interpreted as a comprehensive or definitive outline of all applicable obligations. Rather, the summary offers a convenient reference for further investigation.

1. **Handicapped Persons:**

   A handicapped person, who is otherwise qualified, shall not solely by reason of handicap be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity.

   For employment, "qualified" means a person can perform the essential functions of the job in question when reasonable accommodation is made. "Reasonable accommodation" implies accommodation that does not impose undue hardship on the program operation.

   For patients (clients), "qualified" means a person has the essential eligibility requirements to receive services from the program or activity.

   Each contractor must evaluate and modify, both with assistance of interested persons including the handicapped, non conforming policies and practices and then take appropriate remedial steps, after consultation of interested persons including the handicapped, to eliminate any effects of discrimination.

   If the contractor (vendor) employs fifteen (15) or more persons, the contractor shall:

   (1) designate a person to coordinate compliance;
   (2) adopt grievance procedures with due process for prompt and equitable resolution of employee complaints of non-compliance;
   (3) give public notice of non-discrimination.

   If the contractor (vendor) employs less than fifteen (15) persons, such a contractor may refer a handicapped patient (client) to an accessible service when such a contractor cannot comply without a significant alteration in existing facilities.

   Source: Sections 503 and 504 of Vocational Rehabilitation Act of 1973 (P.L. 93-112) as amended (P.L. 93-516; 95-251; 95-602); Executive Order 11758; 41 CFR 60-741; 45 CFR 84; RSMo 8.6, 296, 314; Governor's Executive Order.

2. Race, color, religion (creed), sex, national origin (ancestry):

a. Concerning patients (clients): No person shall on the basis of race, color, religion, sex or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination.

Source: Title VI of Civil Rights Act of 1964 (P.L. 88-352); RSMo 314; Governor's Executive Order.

b. Concerning employment: An employer shall not: (1) fail or refuse to hire, or discharge any person, or otherwise discriminate with respect to compensation, terms, conditions or privileges of employment because of such a person's race, color, religion, sex or national origin; (2) limit, segregate or classify employees or applicants for employment in any way which would deprive or tend to deprive any person of employment opportunities or otherwise adversely affect employee status because of such a person's race, color, religion, sex or national origin.

If a contractor(vendor) receives a contract for at least $50,000 and employs at least 50 persons, such a contractor must develop an affirmative action plan covering race, color, sex, religion and national origin.

Source: Title VII of Civil Rights Act of 1964 (P.L. 88-352) as amended (P.L. 92-261, 92-608); 29 CFR 1608; 9 CSR 10-6.010; RSMo 296; Governor's Executive Order.

3. Age:

a. Concerning patients (clients): No person shall on the basis of age be excluded from participation in, be denied the benefits of, or be subjected to discrimination.

Source: Age Discrimination Act of 1975 (P.L. 92-135); 45 CFR 90, 91.

b. Concerning employment: An employer shall not: (1) fail or refuse to hire, or discharge any person, or otherwise discriminate with respect to compensation, terms, conditions or privileges of employment because of such a persons's age; (2) limit, segregate, or classify employees or applicants for employment in any way which would deprive or tend to deprive any person of employment opportunities or otherwise adversely affect employee status because of such a person's age.

Source: Age Discrimination in Employment Act of 1967 (P.L. 90-202) as amended (P.L. 93-259; 95-256); 29 CFR 1625, 1627; Governor's Executive Order.

4. Disabled and Vietnam-era veterans:

Employers receiving at least $10,000 shall not discriminate against any qualified employee or applicant for employment because such a person is a disabled or a Vietnam-era veteran. "Disabled" means (1) a disability compensation rated at 30% or more, or (2) discharge for a disability incurred or aggravated in the line of duty.

Job openings are to be listed with the state employment service system. If the contract is for at least $50,000 and the contractor employs at least 50 persons, such a contractor shall prepare and maintain an affirmative action program for disabled and Vietnam-era veterans. The plan may be separate from, or integrated into, other affirmative action programs. The plan is to be reviewed and updated annually.

Source: Section 402 of Vietnam Era Veterans Readjustment Assistance Act of 1974 (P.L. 93-508); 41 CFR 60-250.

The DMH utilizes federal and state laws, rules and regulations as guidelines in interpreting and monitoring human rights policies, procedures and practices of its contractors (vendors.)

To fulfill its commitment to human rights, the DMH implements a Human Rights Contract Compliance System (HRCCS) in accordance with 9 CSR 10-6.020.

The HRCCS applies to all DMH contracts for services with the exception of: natural and foster homes; transportation for an individual by family or neighbors; an individual consultant providing services at a DMH facility; contracts between the DMH and one of its facilities. Contracts for goods are not subject to the HRCCS.

All contracts subject to the HRCCS include a clause which describes the human rights obligations of the contractor.

The HRCCS obligates the contractor to prepare and submit documentation on its human rights program for approval by the Human Rights and Development Section. This documentation consists of three phases:

(1) Assurances — The applicant completes a human rights assurance kit to indicate intention of complying with applicable human rights requirements. Human rights requirements depend upon the number of employees, the amount of the contract and the source of funding.

(2) Implementation — If a contract is awarded, the contractor has sixty days to implement the Assurances through policy action. Implementation includes an approved written policy of non-discrimination: (a) in the provision of services on the bases of race, color, religion, national origin, sex, age and handicap, and (b) in employment practices on the bases of race, color, religion, national origin, sex, age, handicap and veteran status. If the contractor employs at least 50 persons and holds contract(s) totaling at least $50,000, then such a contractor must implement an affirmative action plan.

(3) Progress Report — An applicant completes a progress report on human rights as part of the Assurances for an additional contract covering a time-period subsequent to an awarded contract.

The DMH will not approve a contract subject to the HRCCS unless the Assurances are completed and submitted.

This brochure is the human rights assurance kit referred to above.

You should retain these introductory pages, which provide basic information relevant to your obligations. As you know, being unaware of the law does not constitute a defense. The best defense against possible complaints by employees and patients (clients) is compliance with applicable obligations.

The following forms, as applicable, are to be submitted at the time of each application. These materials are in addition to other departmental requirements.

The chief executive officer (person authorized to sign legal contracts) is to use the Questionnaire (DMH 7701) in order to complete the Information (DMH 7702) and the Assurance (DMH 7703). The Questionnaire explains the conditions under which the Rehabilitation Act Assurance (DMH 7704), the Work Force Analyses (DMH 7705) and the Progress Report (DMH 7808) are applicable.

If you have any questions, please feel free to write or telephone.

DMH Use: File: [ ] - [ ]

MISSOURI DEPARTMENT OF MENTAL HEALTH
HUMAN RIGHTS ASSURANCES QUESTIONNAIRE

1. a. Do you have an IRS Employer Identification Number? [1] Yes [2] No
   b. If "yes," enter number in DMH 7702, item 1.
   c. If "no," enter your social security number in DMH 7702, item 1.
2. a. Do you have a current contract (grant) in force with the State of Missouri?
   [1] Yes [2] No
   b. If "yes," enter vendor number on DMH 7702, item 2.
   c. If "yes" and you do not yet have a vendor number, check here [3]
3. Enter your official (legal) name, address, and chief executive officer information in DMH 7702, items 3 through 5.
4. Enter the total number of persons presently employed in DMH 7702, item 6.
5. Enter source of funding, type of funds and proposed contract period and amount in DMH 7702, items 8 through 11.
6. a. Enter type of applicant ("Private" or "Public") in DMH 7702, item 7.
   b. If "Public," and if funds are "Federal" (DMH 7702, item 9, box 1), then you must give assurance of implementing a personnel merit system and do so within 60 days of beginning of contract.
   If "Public" applicant and "Federal" funds, check DMH 7703, item 7.
7. a. Do (did) you have a previous DMH contract (grant) for which you completed Human Rights Assurances? [1] Yes [2] No
   b. If "yes," did the most recent contract (grant) begin at least eight (8) months ago?
   [1] Yes [2] No
   c. If answers to both "a" and "b" are "yes," attach a Human Rights Compliance Progress Report (DMH 7808) covering the contract period of the previous contract (grant).
8. All applicants must give assurance of not discriminating against employees or patients (clients) on the basis of race, color, sex, religion, national origin or age. Check DMH 7703, items 1 and 2.
9. All applicants must give assurance of not discriminating against handicapped employees. Check DMH 7703, item 3. If federal funds are involved, complete DMH 7704.
10. a. Do you employ at least 15 persons? [1] Yes [2] No
    b. If "yes," you must make reasonable accommodation to provide services for handicapped patients (clients) and you must designate a person to coordinate your efforts not to discriminate against handicapped employees and patients (clients).
    If "yes," check and complete DMH 7703, item 4.
    c. If "no," you may refer handicapped patients (clients) to providers of accessible services if you cannot serve such persons without significant alteration of existing facilities.
11. a. Do you employ at least 20 persons? [1] Yes [2] No
    b. If "yes," you must give assurance of not discriminating against employees between 40 and 70 years of age.
    If "yes," check DMH 7703, item 5.
12. a. Is proposed contract for at least $10,000? [1] Yes [2] No
    b. If "yes," you must give assurance of not discriminating in employment on the basis of disabled or Vietnam-era veteran status.
    If "yes," check DMH 7703, item 6.
13. a. Is proposed contract for at least $50,000? [1] Yes [2] No
    b. Do you employ at least 50 persons? [1] Yes [2] No
    c. If answers to both "a" and "b" are "yes," you must:
    (1) Complete work force and utilization analyses. See DMH 7705.
    (2) Implement an affirmative action employment program (covering race, color, sex, religion, national origin, age, handicapped persons and veterans) within 60 days of beginning of contract.

DMH Use: File: |_|_| - |_|_|_|_|_| New: ☐ Change: ☐

MISSOURI DEPARTMENT OF MENTAL HEALTH
APPLICANT FILE INFORMATION

DMH Use

1. IRS Employer Identification Number: |_|_| - |_|_|_|_|_|_|_| ☐
2. Missouri Vendor Number: |_|_|_|_|_|_|_| ☐
3. Official Name of Applicant: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| ☐
4. Applicant Address: a. |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| ☐
   b. |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| ☐
   c. |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| ☐ (City)
   d. |_|_| (State) |_|_|_|_|_| (Zip) ☐
5. Chief Executive Officer:
   a. Name: |_|_|_|_|_|_|_|_|_|_|_|_|_|_| (Last), |_|_|_|_|_|_|_|_|_|_| (First) |_|. (I) ☐
   b. Title: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| ☐
   c. Telephone: |_|_|_| (Area) |_|_|_| - |_|_|_|_| (Number) ☐
6. Total Number of Persons Employed: |_|_|_|_|_| ☐
7. Type of Applicant: [1|] Private (non-governmental) [2|] Public (governmental) ☐

---

8. Source of Proposed Financial Assistance (Check all applicable boxes):

   [1|] Alcohol and Drugs
   [4|] Placement
   [6|] DMH Facility Program — Facility Name: ______________________
   [2|] Community Mental Health
   [5|] Purchase of Service
   [3|] Mental Retardation-Developmental Disabilities

   Code: |_|_|_|_|

9. Type of Funds Requested: [1|] Federal [2|] State
10. Proposed Contract Period: |_|_| (Month) - |_|_| (Day) - 19 |_|_| (Year) to |_|_| (Month) - |_|_| (Day) - 19 |_|_| (Year)
11. Proposed Contract Amount: $ |_| , |_|_|_| , |_|_|_| . |_|_|

12. DMH Use: Progress Report
   [1|] Complete [2|] Incomplete [3|] Not Attached
   [4|] Not Applicable

DMH Use: File: [ ] - [ ]

DMH 7703

MISSOURI DEPARTMENT OF MENTAL HEALTH
ASSURANCE OF APPLICANTS
FOR FINANCIAL ASSISTANCE

The undersigned hereby gives the following assurances in consideration of and for the purpose of receiving financial assistance (payment) for services in the proposed amount of $ _____ from the Missouri Department of Mental Health:

1. [X] The undersigned will not discriminate against patients (clients) on the basis of race, color, national origin, religion, sex or age in accordance with Title VI of the Civil Rights Act of 1964 (P.L. 92-261) as amended, with the Age Discrimination Act of 1975 (P.L. 92-135) and with all applicable federal rules and regulations, with RSMo 314, with Missouri Executive Order and with all applicable state regulations.

2. [X] The undersigned will not discriminate against employees on the basis of race, color, sex, religion, national origin or age in accordance with Title VII of the Civil Rights Act of 1964 (P.L. 92-261) as amended and with all applicable federal rules and regulations, with RSMo 296 and 314 and with Missouri Executive Order and with all applicable state regulations.

   If: (1) proposal is for at least $50,000 and (2) undersigned employs at least 50 persons check here [ ] and attach DMH 7705.

3. [X] The undersigned will not discriminate against handicapped persons either in employment or as patients (clients) in accordance with Sections 503 and 504 of the Vocational Rehabilitation Act of 1973 (P.L. 93-112) as amended and with all applicable federal rules and regulations, with RSMo 8.6, 296 and 314 and with Missouri Executive Order.

   If application is for federal funds, check here [ ] and attach DMH 7704.

4. [ ] To coordinate all applicable human rights and/or affirmative action efforts, the undersigned designates:

   (Name): [ ] (Last) , [ ] (First) [ ] (I).

   (Title): [ ]

   (Telephone): [ ] (Area) [ ] (Number) - [ ]

5. [ ] The undersigned will not discriminate against employees between 40 and 70 years of age in accordance with the Age Discrimination in Employment Act of 1967 (P.L. 90-202) as amended and with all applicable federal rules and regulations.

6. [ ] The undersigned will not discriminate in employment against disabled and Vietnam-era veterans in accordance with Section 402 of the Vietnam Era Veterans Readjustment Assistance Act of 1974 (P.L. 93-508) and with all applicable federal rules and regulations.

7. [ ] The undersigned will maintain a personnel merit system in conformity with the standards for a Merit System of Personnel Administration in accordance with 45 CFR Part 70 and any standards prescribed by the U.S. Civil Service Commission pursuant to Section 208 of the Intergovernmental Personnel Act of 1970 (P.L. 91-648) modifying or superseding such standards.

Signed: _____ Date: _____

Name: _____ Title: _____

DMH Use: Signature [1] Yes [2] No [3] Not Match 7702, item 5

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DMH Use: File: [ ] - [ ]

DMH 770

MISSOURI DEPARTMENT OF MENTAL HEALTH ASSURANCE OF COMPLIANCE WITH SECTION 504 OF THE REHABILITATION ACT OF 1973, AS AMENDED

The undersigned (hereinafter called the "sub-grantee") HEREBY AGREES THAT it will comply with Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by the applicable U.S. Department of Health, Education and Welfare regulation (45 CFR Part 84), and all guidelines and interpretations issued pursuant thereto.

The sub-grantee gives this assurance in consideration of and for the purpose of obtaining any and all federal grants, contracts, property, discounts, or other federal financial assistance extended through the Department of Mental Health after the date of this assurance including payments or other assistance made after such date on applications for federal financial assistance that were approved before such date. The recipient recognizes and agrees that such federal financial assistance will be extended in reliance on the representations and agreements made in this assurance and that the United States will have the right to enforce this assurance through lawful means. This assurance is binding on the sub-grantee, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the sub-grantee.

This assurance obligates the sub-grantee for the period during which federal financial acceptance is extended to it through the Department of Mental Health or, where the assistance is in the form of real property, for the period in which the real property is used for the purpose involving the same or similar services, or, where assistance is in the form of personal property, for the period in which ownership or possession is retained.

The recipient: (Check applicable item)

[1] employs fewer than fifteen persons

[2] employs fifteen or more persons and has designated the following person to coordinate its efforts to comply with the U.S. Department of Health, Education and Welfare regulation:

Name of Designee: [ ] (Last) , [ ] (First) [ ] (I).

Name of Applicant: [ ]

Address: [ ]

[ ]

[ ] (City) [ ] (State) [ ] (Zip)

IRS Employer Identification Number: [ ] - [ ]

I certify that the above information is complete and correct to the best of my knowledge.

(Date) _____ (Signature and Title of Authorized Official) _____

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DMH Use:

[1] Complete (Corresponds)

[2] Name of Designee not match 7703, item 4

[3] Applicant not match 7702, item 3 or 4

[4] IRS Number not match 7702, item 1

[5] Signature not match 7702, item 5

MISSOURI STATE DEPARTMENT OF MENTAL HEALTH
WORK FORCE AND UTILIZATION ANALYSES

DMH [illegible]

DMH Use File [ ] - [ ]

Applicable Labor Area [ ]

(Check one) ☐ County ☐ SMSA ☐ State ☐ Nation

(Official Name of Agency) [ ]

I certify that the analyses below are true and accurate to the best of my knowledge

Reporting Period: [ ] [ ] - 19[ ] to [ ] [ ] - 19[ ]
(Month) (Day) (Year) (Month) (Day) (Year)

(Signature) _____

Submission Date: [ ] [ ] - 19[ ]
(Month) (Day) (Year)

(Name) [ ] , [ ] [ ]
(Last) (First) (I)

Directions for completion are on reverse side

IRS Employer Identification Number [ ] - [ ]

(Title) [ ]

JOB GROUPS		WORK FORCE ANALYSIS												AVAILABILITY ANALYSIS						UTILIZATION ANALYSIS				
		All Employees	Minority Employees											% Women										
		Grand Total	Total		Black		Hispanic		American Indian		Asian American			Non Minority	Minority	% Black	% Hispanic	% Amer. Indian	% Asian Amer.	Women	Black	Hispanic	Amer. Indian	Asian Amer.
			M	F	M	F	M	F	M	F	M	F												
Official/ Managerial	N																							
	%	100																						
Professional	N																							
	%	100																						
Technical	N																							
	%	100																						
Office/ Clerical	N																							
	%	100																						
Skilled Craft	N																							
	%	100																						
Protective Services	N																							
	%	100																						
Para-Professional	N																							
	%	100																						
Service/ Maintenance	N																							
	%	100																						
GRAND TOTAL ALL JOBS	N																							
	%	100																						

DMH Use [1] Complete [2] Heading Incomplete [3] Analysis Incomplete [4] Heading and Analysis Incomplete

APPLICABILITY: An applicant who propo[illegible]s a contract (grant) for $50,000 or more and employs 50 or more persons must develop an affirmati[illegible]e action plan covering race, color, sex, age, religion, national origin, handicapped persons and veter[illegible]ns. As a preliminary step, such an applicant needs to analyze his work force (Work Force Analysis) in comparison with the available labor force personnel in the applicable labor area (Availability Analysis) in order to determine utilization of women and minorities (Utilization Analysis). Such analyses are to be submitted on this form as part of the application for Department of Mental Health financial assistance.

INSTRUCTIONS: The chief executive officer of the applicant or a designee is to complete the requested information. The chief executive officer must sign, even if a designee completed the analyses.

WORK FORCE ANALYSIS: For each minority group and all employees in each "Job Group," enter the number ("N") of males ("M") and females ("F") and of the "Grand Total." Then, calculate all percentages ("%") for each "Job Group" with the "Grant Total N" as the denominator for each division. Enter zeros as appropriate. Repeat the procedure for "Grand Total All Jobs" in terms of the entire work force.

AVAILABILITY ANALYSIS: The "Applicable Labor Area" reflects the applicant's recruitment area, which may be various sizes (e.g., county, SMSA, state, nation) and which may vary for different Job Groups. Enter appropriate name of "Applicable Labor Area" and check appropriate box to indicate "county," "SMSA," "state," or "nation." Enter the percentage of women ("% Women") according to "Non Minority" and "Minority" status and the percentage of each minority ("% Blacks," "% Hispanic," "% American Indian," "% Asian American") in the labor force of the "Applicable Labor Area" for each "Job Group" and "Grand Total All Jobs." The denominator of each of these percentage calculations is the total number of persons in the labor force for the "Applicable Labor Area" for the "Job Group." Enter zeros when appropriate.

Example: An "Applicable Labor Area" has 1,000 "Professional" workers in the labor force: 200 non-minority women, 100 minority women, 250 Blacks, and 0 Hispanics, American Indians and Asian Americans. The percentages to be entered are: 20 non-minority women, 10 minority women, 25 Blacks, 0 Hispanics, 0 American Indians, 0 Asian Americans.

Notes: 1. Information on the available labor force of women and minority groups is available from the Missouri Division of Employment Security. Usually such information contains percentages based on the minority group rather than the "Job Group." This necessitates conversion to raw numbers and then calculation of percentages to complete the "Availability Analysis."

2. If information for the "Availability Analysis" is not available, applicant may base estimates on percentages of women and minority groups in the general census population.

UTILIZATION ANALYSIS: This analysis is to determine whether the applicant's work force contains any underutilization of women or minority groups. In regard to "Women," enter a check (✓) for any "Job Group" and "Grand Total All Jobs" IF the percentage of women employees (cf. "Work Force Analysis:" "%" of "All Employees" "Total" "F") is less than the percentage of women available in the labor force of the applicable labor area (cf. "Availability Analysis:" "% Women" "Non Minority" plus "Minority"). In regard to each minority group, enter a check (✓) in the appropriate column of each minority for any "Job Group" and "Grand Total All Jobs" IF two conditions are both met: (1) Total minorities or a minority group has at least a 2% representation among the available labor force in the applicable labor area (cf. "Availability Analysis") and (2) the percentage of minority employees (cf. "Work Force Analysis") is less than the percentage of such a minority in the available labor force of the applicable labor area (cf. "Availability Analysis").

Example: "Work Force Analysis" indicates that the total ("M" plus "F") percentage ("%") of "Professional" "Blacks" is 4%. "Availability Analysis" indicates a 25% availability of "Blacks" among "Professionals" available in the labor force of the applicable labor area. Thus, a check is to be entered in "Utilization Analysis" in the "Black" column of the "Professional" row since Black availability is greater than 2% (namely, 25%) and Black professional employees are underutilized (4% is less than 25%).

DMH 7808

A R D

MISSOURI DEPARTMENT OF MENTAL HEALTH
HUMAN RIGHTS COMPLIANCE
PROGRESS REPORT

1. This Progress Report concerns contract (grant), DMH File Number: ☐☐-☐☐☐☐☐-☐☐
(File Number appears at top right of all correspondence concerning Human Rights.)

This report concerns the entire agency (corporation, partnership, ownership, etc.) for the period of time covered by the above contract (grant). If the agency has more than one contract (grant) with the Missouri Department of Mental Health (DMH), then enter above the DMH File Number of all contracts (grants) covered by the time period of this report. The following information is usually required as a prerequisite for a further contract (grant) with the DMH — See DMH 7701, item 7.

Please: (1) print DMH File Number on all attachments;
(2) number all attachments in accordance with item numbers of this Progress Report form.

Thank you for your cooperation.

2. Our agency received a complaint of discrimination about **patients (clients)** based on:

a. Race/Color	1☐ Yes	Number:_____	2☐ No	
b. Religion/Creed	1☐ Yes	Number:_____	2☐ No	
c. Sex	1☐ Yes	Number:_____	2☐ No	
d. National Origin/Ancestry	1☐ Yes	Number:_____	2☐ No	
e. Handicap	1☐ Yes	Number:_____	2☐ No	
f. Other	1☐ Yes	Number:_____	2☐ No	

If any answer above is "Yes": (1) enter number above, and (2) attach a summary of action taken to resolve each complaint.

3. Summary of patients (clients) served:

a. Total unduplicated number (N) of patients (clients): _____

		N	%			N	%
b. Race:	White	____	____	d. Age:	0-17	____	____
	Black	____	____		18-54	____	____
	Other Minority	____	____		55-above	____	____
c. Sex:	Male	____	____				
	Female	____	____				

4. Our agency received a complaint of discrimination concerning **employees or applicants** for employment based on:

a. Race/Color	1☐ Yes	Number:_____	2☐ No	
b. Religion/Creed	1☐ Yes	Number:_____	2☐ No	
c. Sex	1☐ Yes	Number:_____	2☐ No	
d. National Origin/Ancestry	1☐ Yes	Number:_____	2☐ No	
e. Handicap	1☐ Yes	Number:_____	2☐ No	
f. Age	1☐ Yes	Number:_____	2☐ No	3☐ Not Applicable
g. Disabled/Vietnam-Era Veteran	1☐ Yes	Number:_____	2☐ No	3☐ Not Applicable

If any answer above is "Yes": (1) enter number above, and (2) attach a summary of action taken to resolve each complaint.

a. Total unduplicated number (N) of employe: _____

Items 5.b. through 5.f.: If your contract(s) oblig[illegible]e you to an affirmative action plan ($50,000 or more and 50 or more employees), you may: (1) complete the[illegible] items or (2) have the data available upon request for a site visit. If you choose (2), check here ☐.

		N	%
b. Race:	White		
	Black		
	Other Minority		
c. Sex:	Male		
	Female		

		N	%
d. Age:	16-17		
	18-39		
	40-69		
	70-above		
e. Handicap:	Yes		
f. Veteran:	Disabled		
	Vietnam-Era		

6. Our agency has completed a self-evaluation concerning care and/or employment of handicapped person
[1] Yes, and previously reported on DMH 7808 [2] Yes, but not yet reported on DMH 7808
[3] No
   a. If "Yes, but not yet reported," attach summary of any modifications and remedial steps required in each of these five areas:
      (1) employment practices (3) employment criteria (5) service accessibilit
      (2) reasonable accommodation (4) pre-employment inquiry
   b. If "No" attach: (1) explanation of reason for incompletion, and (2) date of expected completion.

7. Our agency has prepared an affirmative action plan (required if 50 or more employees and contracts/grant totaled $50,000 or more):
[1] Yes [2] No [3] Not Applicable
   a. If "Yes":
      (1) Did you reach all your goals and objectives in accordance with your timetable?
      [1] Yes [2] No If "No," attach brief explanation.
      (2) Did any unplanned results occur in connection with your affirmative action plan?
      [1] Yes If "Yes," attach brief explanation. [2] No
   b. If "No," prepare and attach your affirmative action plan.

8. Our agency maintains a merit system of personnel administration: [1] Yes [2] No
   a. If "Yes," attach brief report on accomplishments, problems and solutions.

9. For all positions filled during the contract period of this report, an announcement was filed with the stat employment service (required if contract amount $10,000 or more):
[1] Yes [2] No [3] Not Applicable [4] No Person Hired
   a. If "Yes," attach one example.
   b. If "No," attach explanation for non-compliance.

10. Our agency hired one or more employees during the contract period of this report:
[1] Yes [2] No
   a. If "Yes," attach one example of the public advertisement for one position.

11. Our agency has a bargaining or other agreement with a labor union: [1] Yes [2] N
   a. If "Yes," attach a copy of written notice to all such unions concerning the applicable human righ commitments with the Department of Mental Health.

12. Our agency used DMH funds to (sub)contract with another agency: [1] Yes [2] No
   a. If "Yes," attach for each (sub)contractor: (1) official name, (2) total number of persons employed, (3 amount of (sub)contract, (4) human rights obligations with which (sub)contractor is complying.

Community Placement Services Master Agreement Professional And Practical Nursing Homes And Residential Centers Providing Medical Services

This master agreement entered into this _____ day of _____, 19_____ between the Department of Mental Health of the State of Missouri ("Department") P. O. Box 687, Jefferson City, Missouri 65101,

AND

Name of Community Placement Facility _____ ("Provider")

Street _____

City, State, Zip Code _____

Licensed/Certified by _____

shall govern the terms and conditions of placement of persons by the Department therein with the Provider pursuant to Chapter 202, RSMo.

Subject to the provisions of the termination paragraph (XV), this agreement shall become effective on _____ _____, 19_____, and shall terminate on _____ _____, 19_____. This agreement shall automatically extend for a period of one year from and after the termination date unless either party shall give written notice of termination to the other party at least sixty (60) days prior to the termination date, in which case this agreement shall terminate on the termination date.

Community Placement Funding Authorizations ("Form DMH-57") shall be executed for each Department resident served by the Provider and are incorporated into this agreement by reference.

In consideration of the mutual undertakings and agreements hereinafter set forth, the Department and the Provider agree as follows:

I. Conditions

A. The Provider shall be licensed or certified as required by state law and regulations. If a license or certification is revoked or expires, the Provider shall notify the Department within seven (7) days and obtain a new license or certification within 60 days of the date of revocation or expiration.

B. In the event that the Provider is required to obtain a license or certification that it shall make application for same within 30 days upon receipt of notification.

JOSEPH P. TEASDALE
GOVERNOR

B. WILSON, M.D.
ACTING DIRECTOR

DIVISIONS OF
ALCOHOLISM-DRUG ABUSE
MENTAL RETARDATION -
DEVELOPMENTAL DISABILITIES
PSYCHIATRIC SERVICES

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
2002 MISSOURI BOULEVARD
P. O. BOX 687
JEFFERSON CITY, MISSOURI 65102
(314) 751-4122

May 9, 1979

Dear Owner/Administrator:

The Department has received complaints on the wording of Item C in Part I, Conditions, of the Community Placement Service Master Agreement. The enclosed amendment, for your approval, reflects the revision of Item C.

If you concur with this amendment and desire this amendment made a part of your present agreement, please sign and date all 3 copies and return two copies to me at the above address.

David L. Roberts
Deputy Director (Admin)

Enclosure

AMENDMENT TO PART I-C OF
COMMUNITY PLACEMENT SERVICES MASTER AGREEMENT

Strike Subsection C and replace with the following:

C. The amounts to be paid under the agreement are subject to the availability of sufficient appropriations from the General Assembly of the State of Missouri. The determination of the availability of sufficient appropriations shall be vested solely with the Department. In the event that sufficient funding is unavailable, the Department shall, upon the giving of 30 days notice, shall promptly remove all Department residents.

Name of Community Placement Facility _____

Street Address _____

City _____

_____ _____
Date (Signature of Owner/Admin. of Provider Facility)

May 9, 1979 _____
Date (Signature of Department Official)
Deputy Director (Admin)

C. The amounts to be paid under the agreement are subject to the availability of appropriations from the General Assembly of the State of Missouri. The determination of the availability of appropriations shall be vested solely with the Department. In the event the Department shall determine that there are not appropriations available to fully pay the Provider under the terms hereof, then the Department shall give 40 days written notice of the modifications in payments necessary to meet the contingency of insufficient funding. If this contingency occurs, the Provider may, at its option and after 30 days notice to the Department, terminate this agreement.

D. The Provider shall not exceed its licensed bed capacity.

II. Authorization for Service

A. Nursing care and ancillary services provided for a particular Department resident shall not be reimbursed unless a Form DMH-57 is executed authorizing it. However, emergency medical care shall be an exception and shall be attended to promptly by the Provider.

B. Payments for ancillary services shall be authorized only if rendered on or after the effective date specified on any Form DMH-57.

C. The Department reserves the right to resolve all controversies on all ancillary services authorized by any Form DMH-57.

D. The Department may withdraw authorization for an ancillary service to any Department resident after 5 days written notice for causes relating to resident prognosis, appropriateness of the ancillary service to the resident, or the availability of funds.

III. Services of the Provider

A. The Provider shall provide room, board, routine care and ancillary services. Ancillary services shall not be reimbursed unless authorized in accordance with the Community Placement Reimbursement Guide.

B. The Provider shall provide nursing care and supervision on a continuous basis.

C. The Provider shall provide, without additional reimbursement, non-prescription supplies (e.g. rubbing alcohol, body lotions, rubbing compounds) and ordinary nursing supplies (e.g. rubber gloves, bandages).

D. The Provider shall implement individual treatment plans for Department residents as prescribed by the Department.

E. The Provider shall assist the Department in revising individual treatment plans for Department residents whose physical and/or mental conditions have significantly changed since placement.

F. The Provider shall provide activity and recreational programming appropriate to the needs and conditions of the residents. Reimbursement by the Department shall be in accordance with Departmental policy.

G. The Provider shall obtain an annual physical examination for all Department residents receiving care from the Provider. A record of the examination will be included in the resident's chart maintained by the Provider. If any Department resident is not a Medicaid recipient, the cost for physician services shall be an approved reimbursable ancillary service.

IV. Services of the Department

A. The Department shall supply the Provider with individual treatment plans and other pertinent information needed to provide for the proper care of the Department residents.

B. The community placement staff of the Department shall visit the resident periodically as provided for by law.

C. The Department shall consider the needs of Department residents on an individual basis whenever special medical and/or psychiatric problems occur.

D. The Department shall purchase or supply available medication prescribed by a physician for a Department resident if it is not obtainable under the Title XIX Drug Vendor Program. The Department after medical consultation may substitute medication if the originally prescribed medication is not available or not obtainable under the Title XIX Drug Vendor Program.

E. The Department shall assist the Provider in providing psychiatric, educational, social, psychological, medical, recreational, occupational, and speech services for Department residents by utilizing Provider resources, Department resources, Medicaid benefits, Medicare benefits, Title XX benefits and other resources. The services

shall be specified in the residents' individual treatment plans approved by the Department.

F. The Department shall purchase, provide, or replace ancillary items not included in the base rate of the Provider which the Department deems essential for its residents. The authorization of ancillary services shall be governed by the Community Placement Reimbursement Guide as amended from time to time and shall be specified on a Form DMH-57 for each resident. This agreement does not obligate the Department to pay maximum charges for ancillary services reflected in the Guide.

V. Notification

A. Notice to the Department under this agreement shall be communicated either to the facility of the Department which placed the patient with the Provider or to the Community Placement Office of the Department.

B. The Provider shall notify the Department in writing within seven (7) days after it determines that it would be unable to continue to provide either the quality or quantity of care required.

C. In the event it is unwilling or unable to provide an ancillary service as prescribed on Form DMH-57 for that Department resident, the Provider shall give notice in writing to the Department within seven days of receipt of Form DMH-57.

D. The Provider shall notify the Department within the time indicated whenever any of the following occur:

1. A noticeable change other than medical emergencies in a Department resident's physical or mental condition on the day of occurrence or during business hours of the first Department working day after the occurrence.

2. The death of a Department resident within 24 hours after the death or unless otherwise agreed.

3. The unauthorized absence of a Department resident within 24 hours after the absence is noticed.

4. A change in Provider's name, address, telephone number, administration, or of controlling ownership within 7 days of the occurrence.

5. Medical emergencies and the Provider's response shall be reported to the Department within 24 hours after the occurrence.

E. The Provider shall notify the Department in writing within seven (7) days after the Provider is notified about changes that occur in the ownership of the property or premises used by Provider to provide services under this agreement.

VI. Management of Patient Monies

A. All money received for a Department resident for clothing and personal spending shall not be used for any other purpose without prior Department approval. Furthermore, money belonging to Department residents shall be placed collectively in a separate fund and held in trust for the residents. This fund shall not be commingled with any other Provider funds.

B. The Provider shall maintain records of receipts and disbursements of clothing and personal spending monies by or on behalf of individual Department resident.

C. The Provider shall notify the Department whenever the combined account balances for clothing and personal spending for a Department resident exceeds $200.00.

D. Upon the death or transfer of a Department resident, the Provider shall return to the Department all unspent clothing and personal allowance monies belonging to the resident that was paid to the Provider pursuant to a Form DMH-57.

E. The Provider shall notify the Department whenever it receives monies for a Department resident from a source not designated, or in excess of the amount designated on the Form DMH-57. These monies shall not be distributed to the resident if other funds are available in his personal account. The monies shall be deposited to the resident's personal account and held until such time the Department determines its disposition.

F. The Department shall have the right to audit clothing and personal allowance accounts of Department residents.

G. The Provider shall make no charge for the maintenance of a resident's personal account.

VII. Invoicing

A. The Provider shall submit his claims for reimbursement on invoices provided by the Department on a calendar month basis to the facility of the Department designated on the invoices.

B. Except in the event that an invoice is returned to the Provider for corrections, invoices for care received three months or more after the month of care designated on the invoice shall not be honored by the Department for payment.

C. The Department reserves the right to audit all invoices and to reject any invoice for good cause, including but not limited to the following reasons:

1. The original invoice is not signed by the appropriate official of the Provider.

2. The invoice includes residents not authorized for care by the Department.

3. The contract amount for care for a Department resident differs from the invoiced amount.

D. The Department retains the right to deduct from subsequent invoices from the Provider any overpayments made by the Department on earlier invoices.

E. The Department shall deduct from the Provider's invoice, if not deducted by the Provider, all amounts to be collected by the Provider from the resident, his financially responsible person, Division of Family Services, or any other third-party payor.

F. Within 30 days after receipt of any invoice, the Department shall audit the invoice and either forward it to the Office of Administration for payment or return it to the Provider for correction.

VIII. Partial Payments

The Department shall adjust its payment for a Department resident because of his month of placement, death, discharge, or months in which he is absent on days not approved for payment. The total amount due for a resident's partial-month care including ancillary services shall be computed by dividing his total monthly contract amount by the number of days in the month and then multiplying this daily amount by the number of days present in the Provider's facility that month. The Department's amount to be paid shall be the computed amount reduced by any amounts paid by the Division of Family Services,

Social Security Administration, resident, guardian, or other third-party payors.

Except for patients receiving Intermediate Care Facility (ICF) or Skilled Nursing Facility (SNF) care, absences of 10 days or less which are approved by the placing Department Facility in a month shall not affect the monthly amount paid to the Provider. Full monthly payments may be made for absences in excess of 10 days of Department residents if prior approval is obtained from the Central Office of the Department.

IX. Controls, Reports and Monitoring

A. The Provider shall maintain auditable records reflecting care provided, resident progress, and other relevant programs. The Provider agrees to allow the Department or its authorized representative to inspect and examine the premises which relate to the performance of this agreement at any time during its term. The Provider further agrees to allow the Department or its authorized representative to inspect, examine, and audit any of the Provider's records pertaining to the performance of this agreement at any time during the term of this agreement and within the period specified for the retention of records in Section XIV of this agreement.

B. The Provider shall maintain the confidentiality of residents' records and not disclose any information concerning a resident for any purpose not directly connected with the administration of this program except as specified by applicable federal and state laws and regulations.

X. Human Rights

A. The Provider hereby makes the following human rights assurances:

1. The Provider shall not discriminate either in the provision of services to residents or in employment practices on the basis of race, color, religion, national origin, sex, age or handicap status.

2.1. If the Provider employs 20 or more persons, then the Provider shall not discriminate in employment practices against persons 40 to 70 years of age.

2.2. If the Provider receives a contract or contracts which total in face or maximum amount $10,000 or more, then the Provider shall not discriminate against disabled or Vietnam-era veterans.

3. If the Provider is a government entity and is receiving federal funds through the Department, then the Provider shall have and maintain a personnel merit system.

4. If the Provider employs 15 or more persons, then the Provider shall designate an executive of its organization to coordinate all applicable human rights efforts.

5. If the Provider receives a contract or contracts which total in face or maximum amount $50,000 or more and employs 50 or more persons, then the Provider shall have, maintain, and implement an affirmative action program covering race, color, religion, national origin, sex, age, handicap, and disabled and Vietnam-era veterans.

B. Applicable state and federal laws, executive orders and administrative rules and regulations referring to the requirements of clauses A-1 through A-5 above are incorporated herein by reference.

C. Human Rights Assurances (DMH Forms 7703, 7704, and 7705) which the Provider filed with the Department as part of the application process for this agreement are incorporated herein by reference.

D. The Provider who has a bargaining or other agreement with any labor union shall give written notice of the above commitments (clauses A-1 through A-5) to all such labor unions.

E. The Department shall have the right to enforce all applicable causes above (A through D) by appropriate and reasonable procedures, including but not limited to requests, reports, site visits and inspection of relevant documentation of the Provider.

F. Where the human rights assurance is conditional, the Human Rights Section of the Department shall notify the Provider in writing which clauses apply to the Provider. The determination of applicability of clauses will be based on information which the Provider provided in the Human Rights Assurances package.

G. If the Provider uses any funds of this agreement in a subcontract, then the Provider shall require such a subcontractor to comply with the applicable human rights clauses above, namely, A, B, D and E.

XI. Indemnity and Insurance

A. The Provider shall, at all times hereafter during the term of this agreement, indemnify and save harmless the State of Missouri, its departments, officers, employees, and agents against loss, damages, cost or expenses which the State, its departments, officers, employees and agents may hereinafter sustain, incur or be required to pay as follows:

1. By reason of any resident suffering personal injury, death, or property loss or damage resulting from the negligent, careless, reckless, or willful acts of Provider, either while the resident is participating in or receiving care by Provider under this agreement, or while on premises owned, leased, or operated by Provider or while being transported to or from said premises in any vehicle owned, operated, leased, chartered, or otherwise contracted for by the Provider or any officer, agent, or employee thereof; or

2. By reason of any resident causing injury to or damage to the person or property of another person when said injury or damage results from the negligence, carelessness, recklessness, or willful acts of Provider during any time when Provider or any officer, agent, or employee thereof has assumed physical custody of said resident or is furnishing the care and services called for under this agreement.

B. The Provider shall carry and provide the Department within 60 days after the execution of this agreement with a certificate of insurance during the term of this agreement in the minimum amounts of $50,000 per occurrence/$150,000 aggregate for professional liability and $50,000 per occurrence for premises liability to insure against any liability, loss, damages, costs or expenses which the Provider might incur resulting from the negligent, careless, reckless, or willful acts or omissions of Provider, its officers, agents or employees.

XII. Grievances

The Provider shall establish a system satisfactory to the Department through which recipients of services under this agreement may present grievances concerning the quality and availability of the care provided.

XIII. Subcontracting

The performance under this agreement shall not be assignable except with the written permission of the Department. Except as to consultants and others providing services within the

terms of this agreement, none of the care to be furnished by the Provider may be subcontracted without the written consent of the Department.

The Department shall not honor any assignments of amounts payable under this agreement to any creditor without the written consent of the Department.

XIV. Retention of Records

The Provider shall retain all records pertaining to this agreement for five (5) years after the expiration of this agreement unless one of the following conditions occurs:

A. The Department has been notified of the completion of an audit by the State Auditor with no unresolved audit questions and the Department agrees to the destruction of such records. In no event shall this occur prior to three (3) years after the expiration of the agreement.

B. Audit questions have arisen within the five (5) year limitation and have not been resolved. The Department shall give notice to the Provider that all records shall be retained until all audit questions have been resolved.

XV. Termination

A. Unless otherwise specified in this agreement, termination of this agreement may occur prior to the date agreed upon by either party giving 60 days advance written notice of intent to terminate to the other party at its principal address as indicated herein. For failure or threatened failure strictly to comply with this notice provision, either party shall be entitled to injunctive or other equitable relief.

B. At any time when in its sole judgment the health and welfare of any of its residents are threatened by their continued presence in the Provider's facility, the notice provisions are waived and the Department may terminate this agreement.

XVI. Third Party Payments

A. All amounts paid in behalf of a Department resident by the Division of Family Services, Social Security Administration, guardian, the resident and other sources shall reduce the amount payable by the Department for any resident's care.

B. The Provider shall be responsible to notify the Department whenever it obtains monies that have not been

identified by the Department on a Form DMH-57.

C. The Provider understands that he shall be required to collect all or a portion of the cost for a resident's care from the resident or his financially responsible person in direct pay as designated on a Form DMH-57.

D. The Department shall assume the financial responsibility to pay for the care and ancillary services of a resident only if the resident or the financially responsible person is unable to pay the amount in accordance with the Standard Means Test.

E. In any event, the Department shall not assume retroactive responsibility for third-party payments for more than 90 days prior to the date the Department receives notice that the Provider has failed to receive third-party payments.

F. Monies received from the Department under this agreement shall not be used to supplant other sources of reimbursement for which the resident is eligible.

G. The Department shall reimburse the Provider for the loss incurred whenever the amounts received by the Provider from the Supplemental Security Income program and/or the Nursing Grant program of the Division of Family Services are less than the amounts specified on a Form DMH-57. However, if the loss occurred because the Social Security Administration or the Division of Family Services made policy changes, the Department does not guarantee payment of the loss.

H. The Provider shall not charge or increase charges for a Department resident's care to his relatives or guardian without the written consent of the Department.

XVII. Miscellaneous

A. The Provider shall release or return a resident at any time to the Department upon request of the Department.

B. The Provider shall not transfer a resident to another place of residence without the prior written consent of the Department.

C. The Provider shall not return a resident without 30 days prior notice to the supervising Department facility; however, residents who require immediate psychiatric, medical, or other special attention may be returned earlier if their conditions so warrant.

D. Nothing in this agreement will impair the statutory rights of the Department to charge a Department resident, a resident's estate or the persons obligated to pay for a resident's care for services rendered or expenditures made by the Department for the resident.

E. Nothing in this agreement shall deny the right of a resident or his responsible person to appeal to the Department for a redetermination of the amounts payable by him to the Provider.

F. All money received from the Division of Family Services shall be applied to the basic nursing home charge.

G. The Provider shall not incur financial obligations for the Department without prior approval of the supervising Department facility except for a medical emergency which shall be attended to promptly.

H. The Provider shall abide by all applicable federal, state and local laws, rules and regulations.

I. The Provider shall not by virtue of this agreement represent himself, his employees, officers or agents to be agents of the State of Missouri.

J. Nothing in this agreement shall impair the right of the Department to promulgate reasonable policies, procedures, standards, rules and regulations the Department may deem necessary for the operation of the program, which shall thereupon be binding upon the Provider as though a part of this agreement.

K. Except as provided in Part II-C of this agreement, this agreement contains the parties' entire understanding of the matters discussed herein and cannot be amended or cancelled except by writing signed by both parties.

L. Time and strict performance of all the covenants herein agreed to be performed by the Department or the Provider shall be of the essence of this agreement.

XVIII. Rate of Reimbursement

A. The base rate of $_____ per month is approved for board, room and routine care for each Department resident who is not in vendor programs (Title XIX ICF/SNF) approved by the Division of Family Services. The Department may authorize more than one base rate if the Provider is qualified to furnish more than one level of room, board and routine care for Department residents. The Department may approve or authorize changes in the base rate or additional base

rates by amending this agreement in writing and attaching the amendments to this agreement.

B. The Division of Family Services shall determine the rate for care of Department residents who are residing in Title XIX certified beds. If a resident is residing in a Title XIX certified bed and is a Title XIX recipient, the Department's responsibility shall be no greater than the sum of the recipient resident's budgeted surplus, if any, and the amount specified for Departmental approved ancillary services reduced by payments by the Social Security Administration, guardian, resident and any other third-party payor.

XIX. Identification of Landlord

The person or entity that owns the property and premises used by Provider is _____,

whose address is _____

In the event that the owner of the property or premises is not the Provider, the Provider shall provide to the Department a written statement (Form DMH 7805) signed by Provider and the owner of the property to the effect that the landowner shall notify the Provider sixty (60) days before evicting or otherwise requiring the Provider to quit the premises. A copy of a lease or other agreement which provides for the above notice provisions to be given Provider by the landowner may be provided in lieu of the statement. If the Provider receives a notice from the landowner to quit the premises, then it shall notify the Department within 24 hours of the receipt of such notice.

XX. Negotiating Authority

The Department enters into this agreement pursuant to and by authority of its Director. Provider enters into this agreement individually, or if incorporated, pursuant to and by authority of its Board of Directors at its meeting of _____, 19____. If the Provider is incorporated, the person from the Provider signing this agreement understands that he must complete and attach to this agreement Form DMH-87, Affidavit of Corporation Authorization.

IN WITNESS THEREOF, the Department and Provider execute this agreement on the dates indicated below:

_____	DEPARTMENT OF MENTAL HEALTH
(Name of Provider Facility)	
By: _____	By: _____
(Signature of Owner/Admin)	(Signature of Department Official)
Title: _____	Title: _____
Date: _____	Date: _____

DMH Form 7805
June/78

LANDLORD - TENANT MODIFICATION AGREEMENT

Whereas, by a lease/rental agreement dated _____,

19____, lessor/landlord, _____,

let to lessee/tenant _____,

property and premises located at _____

_____ for

a term of _____ years, to commence _____, 19___;

and

Whereas, the parties desire to modify lease so as to provide 60 days' previous written notice of landlord/lessor's intention to cancel the lease.

Now, therefore, in consideration of _____,

_____, it is agreed that lease be modified as

follows:

If default be made in the payment of the rent or any part thereof as herein specified, or if, without the consent of lessee/landlord, lessee/tenant shall fail to comply with any of the statutes, ordinances, rules, orders, regulations and requirements of the federal, state and city government or of any and all their departments and bureaus, applicable to said premises, or hereafter established as herein provided, or if lessee/tenant shall file a petition in bankruptcy or arrangement, or be adjudicated a bankrupt, or make an assignment for the benefit of creditors or take advantage of any insolvency act, landlord may, if lessor/landlord so elects, at any time thereafter terminate this lease and the term hereof, on giving to lessee/tenant 60 days' notice in writing of lessee/landlord's intention so to do, and this lease and the term hereof shall expire and come to an end on the date fixed in such notice as if the said dates were the date originally fixed in this lease for the expiration hereof. Such notice may be given by mail to lessee/tenant addressed to lessee/tenant at the demised premises.

And the other terms and conditions of the lease/rental agreement shall continue to remain in full force and effect, except as herein modified.

Lessor/Landlord	Lessee/Tenant
_____	_____
by_____	by_____
_____ Title	_____ Title
Date:_____	Date:_____

DMH FORM 87
June/78

AFFIDAVIT OF CORPORATION AUTHORIZATION

STATE OF MISSOURI)
)ss
COUNTY OF)

Comes now _____, to me personally known and being first duly sworn, states that he is the _____ of _____, a corporation; that he is the duly authorized agent and executed the contract for and on behalf of _____ _____of _____, Missouri; under authority granted him by action of the Board of Directors and in the minutes of the corporation on the _____ day of _____, 19____; that the seal affixed to the foregoing instrument is the corporate seal of the corporation; and that said instrument was signed and sealed on behalf of said corporation by authority of its Board of Directors and that _____acknowledges the instrument to be the free act and deed of the corporation.

(CORP)
(SEAL)

_____

_____
(Title)

Subscribed and sworn to before me this _____day of _____, 19____, in my office in the State and County aforesaid.

_____
Notary Public

My Commission Expires_____.

Community Placement ervices Master Agreement
Domiciliary Nursing Homes An Non-Medical Residential Centers
Boarding, Grou and Foster Homes

This master agreement entered into this _____ day of _____, 19_____, between the Department of Mental Health of the State of Missouri ("Department") P.O. Box 687, Jefferson City, Missouri 65101,

AND

Name of Community Placement Facility _____
("Provider")

Street _____

City, State, Zip Code _____

Licensed/Certified by _____

shall govern the terms and conditions of placement of persons by the Department therein with the Provider pursuant to Chapter 202, RSMo.

Subject to the provisions of the termination paragraph (XV),

this agreement shall become effective on _____, 19_____,

and shall terminate on _____, 19_____. This agreement shall automatically extend for a period of one year from and after the termination date unless either party shall give written notice of termination to the other party at least sixty (60) days prior to the termination date, in which case this agreement shall terminate on the termination date.

Community Placement Funding Authorizations ("Form DMH-57") shall be executed for each Department resident served by the Provider and are incorporated into this agreement by reference.

In consideration of the mutual undertakings and agreements hereinafter set forth, the Department and the Provider agree as follows:

I. Conditions

A. The Provider shall be licensed or certified as required by state law and regulations. If a license or certification is revoked or expires, the Provider shall notify the Department within seven (7) days and obtain a new license or certification within 60 days of the date of revocation or expiration.

B. In the event that the Provider is required to obtain a license or certification that it shall make application for same within 30 days upon receipt of notification.

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
2002 MISSOURI BOULEVARD
P. O. BOX 687
JEFFERSON CITY, MISSOURI 65102
(314) 751-4122

May 9, 1979

Dear Owner/Administrator:

The Department has received complaints on the wording of Item C in Part I, Conditions, of the Community Placement Service Master Agreement. The enclosed amendment, for your approval, reflects the revision of Item C.

If you concur with this amendment and desire this amendment made a part of your present agreement, please sign and date all 3 copies and return two copies to me at the above address.

David L. Roberts
Deputy Director (Admin)

Enclosure

AMENDMENT TO PART I-C OF
COMMUNITY PLACEMENT SERVICES MASTER AGREEMENT

Strike Subsection C and replace with the following:

C. The amounts to be paid under the agreement are subject to the availability of sufficient appropriations from the General Assembly of the State of Missouri. The determination of the availability of sufficient appropriations shall be vested solely with the Department. In the event that sufficient funding is unavailable, the Department shall, upon the giving of 30 days notice, shall promptly remove all Department residents.

Name of Community Placement Facility _____

Street Address _____

City _____

_____ _____
Date (Signature of Owner/Admin. of Provider Facility)

May 9, 1979 _____
Date (Signature of Department Official)
Deputy Director (Admin)

C. The amounts to be paid under the agreement are subject to the availability of appropriations from the General Assembly of the State of Missouri. The determination of the availability of appropriations shall be vested solely with the Department. In the event the Department shall determine that there are not appropriations available to fully pay the Provider under the terms hereof, then the Department shall give 40 days written notice of the modifications in payments necessary to meet the contingency of insufficient funding. If this contingency occurs, the Provider may, at its option and after 30 days notice to the Department, terminate this agreement.

D. The Provider shall not exceed its licensed bed capacity.

II. Authorization for Service

A. Room, board, routine care, and ancillary services provided for a particular Department resident shall not be reimbursed unless a Form DMH-57 is executed authorizing it. However, emergency medical care shall be an exception and shall be attended to promptly by the Provider.

B. Payments for ancillary services shall be authorized only if rendered on or after the effective date specified on any Form DMH-57.

C. The Department reserves the right to resolve all controversies on all ancillary services authorized by any Form DMH-57.

D. The Department may withdraw authorization for an ancillary service to any Department resident after 5 days written notice for causes relating to resident prognosis, appropriateness of the ancillary service to the resident, or the availability of funds.

III. Services of the Provider

A. The Provider shall provide room, board, routine care and ancillary services. Ancillary services shall not be reimbursed unless authorized in accordance with the Community Placement Reimbursement Guide.

B. The Provider shall provide appropriate supervision on a continuous basis.

C. The Provider shall provide, without additional reimbursement, non-prescription supplies (e.g. soap and linen).

D. The Provider shall cooperate with the Department in implementing the individual treatment plans as prescribed by the Department.

E. The Provider shall provide activity and recreational programming appropriate to the needs and conditions of the residents. Reimbursement by the Department shall be in accordance with Departmental policy.

F. The Provider shall cooperate with the Department in obtaining an annual physical examination for all Department residents receiving care from the Provider. A record of the examination will be included in the resident's chart maintained by the Provider. If any Department resident is not a Medicaid recipient, the cost for physician services shall be an approved reimbursable ancillary service.

IV. Services of the Department

A. The Department shall supply the Provider with individual treatment plans and other pertinent information needed to provide for the proper care of the Department residents.

B. The community placement staff of the Department shall visit the resident periodically as provided for by law.

C. The Department shall consider the needs of Department residents on an individual basis whenever special medical and/or psychiatric problems occur.

D. The Department shall purchase or supply available medication prescribed by a physician for a Department resident if it is not obtainable under the Title XIX Drug Vendor Program. The Department after medical consultation may substitute medication if the originally prescribed medication is not available or not obtainable under the Title XIX Drug Vendor Program.

E. The Department shall assist the Provider in arranging psychiatric, educational, social, psychological, medical, recreational, occupational, and speech services for Department residents by utilizing Provider resources, Department resources, Medicaid benefits, Medicare benefits, Title XX benefits and other resources. The services shall be specified in the residents' individual treatment plans approved by the Department.

//

F. The Department shall purchase, provide, or replace ancillary items not included in the base rate of the Provider which the Department deems essential for its residents. The authorization of ancillary services shall be governed by the Community Placement Reimbursement Guide as amended from time to time and shall be specified on a Form DMH-57 for each resident. This agreement does not obligate the Department to pay maximum charges for ancillary services reflected in the Guide.

V. Notification

A. Notice to the Department under this agreement shall be communicated either to the facility of the Department which placed the patient with the Provider or to the Community Placement Office of the Department.

B. The Provider shall notify the Department in writing within seven (7) days after it determines that it would be unable to continue to provide either the quality or quantity of care required.

C. In the event it is unwilling or unable to provide an ancillary service as prescribed on Form DMH-57 for that Department resident, the Provider shall give notice in writing to the Department within seven days of receipt of Form DMH-57.

D. The Provider shall notify the Department within the time indicated whenever any of the following occur:

1. A noticeable change other than medical emergencies in a Department resident's physical or mental condition on the day of occurrence or during business hours of the first Department working day after the occurrence.

2. The death of a Department resident within 24 hours after the death or unless otherwise agreed.

3. The unauthorized absence of a Department resident within 24 hours after the absence is noticed.

4. A change in Provider's name, address, telephone number, administration, or of controlling ownership within 7 days of the occurrence.

5. Medical emergencies and the Provider's response shall be reported to the Department within 24 hours after the occurrence.

E. The Provider shall notify the Department in writing within seven (7) days after the Provider is notified about changes that occur in the ownership of the property or premises used by Provider to provide services under this agreement.

VI. Management of Patient Monies

A. All money received for a Department resident for clothing and personal spending shall not be used for any other purpose without prior Department approval. Furthermore, money belonging to Department residents shall be placed collectively in a separate fund and held in trust for the residents. This fund shall not be commingled with any other Provider funds.

B. The Provider shall maintain records of receipts and disbursements of clothing and personal spending monies by or on behalf of individual Department resident.

C. The Provider shall notify the Department whenever the combined account balances for clothing and personal spending for a Department resident exceeds $200.00.

D. Upon the death or transfer of a Department resident, the Provider shall return to the Department all unspent clothing and personal allowance monies belonging to the resident that was paid to the Provider pursuant to a Form DMH-57.

E. The Provider shall notify the Department whenever it receives monies for a Department resident from a source not designated, or in excess of the amount designated on the Form DMH-57. These monies shall not be disbributed to the resident if other funds are available in his personal account. The monies shall be deposited to the resident's personal account and held until such time the Department determines its disposition.

F. The Department shall have the right to audit clothing and personal allowance accounts of Department residents.

G. The Provider shall make no charge for the maintenance of a resident's personal account.

VII. Invoicing

A. The Provider shall submit his claims for reimbursement on invoices provided by the Department on a calendar month basis to the facility of the Department designated on the invoices.

B. Except in the event that an invoice is returned to the Provider for corrections, invoices for care received three months or more after the month of care designated on the invoice shall not be honored by the Department for payment.

C. The Department reserves the right to audit all invoices and to reject any invoice for good cause, including but not limited to the following reasons:

1. The original invoice is not signed by the appropriate official of the Provider.

2. The invoice includes residents not authorized for care by the Department.

3. The contract amount for care for a Department resident differs from the invoiced amount.

D. The Department retains the right to deduct from subsequent invoices from the Provider any overpayments made by the Department on earlier invoices.

E. The Department shall deduct from the Provider's invoice, if not deducted by the Provider, all amounts to be collected by the Provider from the resident, his financially responsible person, Division of Family Services, or any other third-party payor.

F. Within 30 days after receipt of any invoice, the Department shall audit the invoice and either forward it to the Office of Administration for payment or return it to the Provider for correction.

VIII. Partial Payments

The Department shall adjust its payment for a Department resident because of his month of placement, death, discharge, or months in which he is absent on days not approved for payment. The total amount due for a resident's partial-month care including ancillary services shall be computed by dividing his total monthly contract amount by the number of days in the month and then multiplying this daily amount by the number of days present in the Provider's facility that month. The Department's amount to be paid shall be the computed amount reduced by any amounts paid by the Division of Family Services, Social Security Administration, resident, guardian, or other third-party payors.

Absences of 10 days or less which are approved by the placing Department facility in a month shall not affect the monthly amount paid to the Provider. Full monthly payments may be

made for absences in excess of 10 days of Department residents if prior approval is obtained from the Central Office of the Department.

IX. Controls, Reports and Monitoring

A. The Provider shall maintain auditable records reflecting care provided, resident progress, and other relevant programs. The Provider agrees to allow the Department or its authorized representative to inspect and examine the premises which relate to the performance of this agreement at any time during its term. The Provider further agrees to allow the Department or its authorized representative to inspect, examine, and audit any of the Provider's records pertaining to, the performance of this agreement at any time during the term of this agreement and within the period specified for the retention of records in Section XIV of this agreement.

B. The Provider shall maintain the confidentiality of residents' records and not disclose any information concerning a resident for any purpose not directly connected with the administration of this program except as specified by applicable federal and state laws and regulations.

X. Human Rights

A. The Provider hereby makes the following human rights assurances:

1. The Provider shall not discriminate either in the provision of services to residents or in employment practices on the basis of race, color, religion, national origin, sex, age or handicap status.

2.1. If the Provider employs 20 or more persons, then the Provider shall not discriminate in employment practices against persons 40 to 70 years of age.

2.2. If the Provider receives a contract or contracts which total in face or maximum amount $10,000 or more, then the Provider shall not discriminate against disabled or Vietnam-era veterans.

3. If the Provider is a government entity and is receiving federal funds through the Department, then the Provider shall have and maintain a personnel merit system.

4. If the Provider employs 15 or more persons, then the Provider shall designate an executive of its organization to coordinate all applicable human rights efforts.

5. If the Provider receives a contract or contracts which total in face or maximum amount $50,000 or more and employs 50 or more persons, then the Provider shall have, maintain, and implement an affirmative action program covering race, color, religion, national origin, sex, age, handicap, and disabled and Vietnam-era veterans.

B. Applicable state and federal laws, executive orders and administrative rules and regulations referring to the requirements of clauses A-1 through A-5 above are incorporated herein by reference.

C. Human Rights Assurances (DMH Forms 7703, 7704, and 7705) which the Provider filed with the Department as part of the application process for this agreement are incorporated herein by reference.

D. The Provider who has a bargaining or other agreement with any labor union shall give written notice of the above commitments (clauses A-1 through A-5) to all such labor unions.

E. The Department shall have the right to enforce all applicable causes above (A through D) by appropriate and reasonable procedures, including but not limited to requests, reports, site visits and inspection of relevant documentation of the Provider.

F. Where the human rights assurance is conditional, the Human Rights Section of the Department shall notify the Provider in writing which clauses apply to the Provider. The determination of applicability of clauses will be based on information which the Provider provided in the Human Rights Assurances package.

G. If the Provider uses any funds of this agreement in a subcontract, then the Provider shall require such a subcontractor to comply with the applicable human rights clauses above, namely, A, B, D and E.

XI. Indemnity and Insurance

A. The Provider shall, at all times hereafter during the term of this agreement, indemnify and save harmless the State of Missouri, its departments, officers, employees, and agents against loss, damages, cost or expenses which the State, its departments, officers, employees and agents may hereinafter sustain, incur or be required to pay as follows:

1. By reason of any resident suffering personal injury, death, or property loss or damage resulting from the negligent, careless, reckless, or willful acts

of Provider, either while the resident is participating in or receiving care by Provider under this agreement, or while on premises owned, leased, or operated by Provider or while being transported to or from said premises in any vehicle owned, operated, leased, chartered, or otherwise contracted for by the Provider or any officer, agent, or employee thereof; or

2. By reason of any resident causing injury to or damage to the person or property of another person when said injury or damage results from the negligence, carelessness, recklessness, or willful acts of Provider during any time when Provider or any officer, agent, or employee thereof has assumed physical custody of said resident or is furnishing the care and services called for under this agreement.

B. If the Provider houses in excess of nine (9) residents, including private patients, then the Provider shall carry and provide the Department within 60 days after the execution of this agreement with a certificate of insurance during that term of this agreement in the minimum amount of $50,000 per occurrence for premises liability to insure against any liability, loss, damages, costs or expenses which the Provider might incur resulting from the negligent, careless, reckless, or willful acts or omissions of Provider, its officers, agent or employees.

XII. Grievances

The Provider shall establish a system satisfactory to the Department through which recipients of services under this agreement may present grievances concerning the quality and availability of the care provided.

XIII. Subcontracting

The performance under this agreement shall not be assignable except with the written permission of the Department. Except as to consultants and others providing services within the terms of this agreement, none of the care to be furnished by the Provider may be subcontracted without the written consent of the Department.

The Department shall not honor any assignments of amounts payable under this agreement to any creditor without the written consent of the Department.

XIV. Retention of Records

The Provider shall retain all records pertaining to this agreement for five (5) years after the expiration of this agreement unless one of the following conditions occurs:

A. The Department has been notified of the completion of an audit by the State Auditor with no unresolved audit

questions and the Department agrees to the destruction of such records. In no event shall this occur prior to three (3) years after the expiration of the agreement.

B. Audit questions have arisen within the five (5) year limitation and have not been resolved. The Department shall give notice to the Provider that all records shall be retained until all audit questions have been resolved.

XV. Termination

A. Unless otherwise specified in this agreement, termination of this agreement may occur prior to the date agreed upon by either party giving 60 days advance written notice of intent to terminate to the other party at its principal address as indicated herein. For failure or threatened failure strictly to comply with this notice provision, either party shall be entitled to injunctive or other equitable relief.

B. At any time when in its sole judgment the health and welfare of any of its residents are threatened by their continued presence in the Provider's facility, the notice provisions are waived and the Department may terminate this agreement.

XVI. Third Party Payments

A. All amounts paid in behalf of a Department resident by the Division of Family Services, Social Security Administration, guardian, the resident and other sources shall reduce the amount payable by the Department for any resident's care.

B. The Provider shall be responsible to notify the Department whenever it obtains monies that have not been identified by the Department on a Form DMH-57.

C. The Provider understands that he shall be required to collect all or a portion of the cost for a resident's care from the resident or his financially responsible person in direct pay as designated on a Form DMH-57.

D. The Department shall assume the financial responsibility to pay for the care and ancillary services of a resident only if the resident or the financially responsible person is unable to pay the amount in accordance with the Standard Means Test.

E. In any event, the Department shall not assume retroactive responsibility for third-party payments for more than 90 days prior to the date the Department receives notice that the Provider has failed to receive third-party payments.

F. Monies received from the Department under this agreement shall not be used to supplant other sources of reimbursement for which the resident is eligible.

G. The Department shall reimburse the Provider for the loss incurred whenever the amounts received by the Provider from the Supplemental Security Income program and/or the Nursing Grant program of the Division of Family Services are less than the amounts specified on a Form DMH-57. However, if the loss occurred because the Social Security Administration or the Division of Family Services made policy changes, the Department does not guarantee payment of the loss.

H. The Provider shall not charge or increase charges for a Department resident's care to his relatives or guardian without the written consent of the Department.

XVII. Miscellaneous

A. The Provider shall release or return a resident at any time to the Department upon request of the Department.

B. The Provider shall not transfer a resident to another place of residence without the prior written consent of the Department.

C. The Provider shall not return a resident without 30 days prior notice to the supervising Department facility; however, residents who require immediate psychiatric, medical, or other special attention may be returned earlier if their conditions so warrant.

D. Nothing in this agreement will impair the statutory rights of the Department to charge a Department resident, a resident's estate or the persons obligated to pay for a resident's care for services rendered or expenditures made by the Department for the resident.

E. Nothing in this agreement shall deny the right of a resident or his responsible person to appeal to the Department for a redetermination of the amounts payable by him to the Provider.

F. All money received from the Division of Family Services shall be applied to the basic room, board, and routine care charges.

G. The Provider shall not incur financial obligations for the Department without prior approval of the supervising Department facility except for a medical emergency which shall be attended to promptly.

H. The Provider shall abide by all applicable federal, state and local laws, rules and regulations.

I. The Provider shall not by virtue of this agreement represent himself, his employees, officers or agents to be agents of the State of Missouri.

J. Nothing in this agreement shall impair the right of the Department to promulgate reasonable policies, procedures, standards, rules and regulations the Department may deem necessary for the operation of the program, which shall thereupon be binding upon the Provider as though a part of this agreement.

K. Except as provided in Part II-C of this agreement, this agreement contains the parties' entire understanding of the matters discussed herein and cannot be amended or cancelled except by writing signed by both parties.

L. Time and strict performance of all the covenants herein agreed to be performed by the Department or the Provider shall be of the essence of this agreement.

XVIII. Rate of Reimbursement

The base rate of $4. _____ per month is approved for board, room and routine care for each Department resident. The Department may authorize more than one base rate if the Provider is qualified to furnish more than one level of room, board and routine care for Department residents. The Department may approve or authorize changes in the base rate or additional base rates by amending this agreement in writing and attaching the amendments to this agreement.

XIX. Identification of Landlord

The person or entity that owns the property and premises used by Provider is _____,

whose address is _____

In the event that the owner of the property or premises is not the Provider, the Provider shall provide to the Department a written statement (Form DMH 7805) signed by Provider and the owner of the property to the effect that the landowner

shall notify the Provider sixty (60) days before evicting or otherwise requiring the Provider to quit the premises. A copy of a lease or other agreement which provides for the above notice provisions to be given Provider by the landowner may be provided in lieu of the statement. If the Provider receives a notice from the landowner to quit the premises, then it shall notify the Department within 24 hours of the receipt of such notice.

XX. Negotiating Authority

The Department enters into this agreement pursuant to and by authority of its Director. Provider enters into this agreement individually, or if incorporated, pursuant to and by authority of its Board of Directors at its meeting of _____, 19_____. If the Provider is incorporated, the person from the Provider signing this agreement understands that he must complete and attach to this agreement Form DMH-87, Affidavit of Corporation Authorization.

IN WITNESS THEREOF, the Department and Provider execute this agreement on the dates indicated below:

_____ DEPARTMENT OF MENTAL HEALTH
(Name of Provider Facility)

By: _____ By: _____
(Signature of Owner/Administrator) (Signature of Department Off.)

Title: _____ Title: _____

Date: _____ Date: _____

DMH Form 7805
June/78

LANDLORD - TENANT MODIFICATION AGREEMENT

Whereas, by a lease/rental agreement dated _____,

19_____, lessor/landlord, _____,

let to lessee/tenant _____,

property and premises located at _____

_____ for

a term of _____ years, to commence _____, 19___;

and

Whereas, the parties desire to modify lease so as to provide 60 days' previous written notice of landlord/lessor's intention to cancel the lease.

Now, therefore, in consideration of _____,

_____, it is agreed that lease be modified as

follows:

If default be made in the payment of the rent or any part thereof as herein specified, or if, without the consent of lessee/landlord, lessee/tenant shall fail to comply with any of the statutes, ordinances, rules, orders, regulations and requirements of the federal, state and city government or of any and all their departments and bureaus, applicable to said premises, or hereafter established as herein provided, or if lessee/tenant shall file a petition in bankruptcy or arrangement, or be adjudicated a bankrupt, or make an assignment for the benefit of creditors or take advantage of any insolvency act, landlord may, if lessor/landlord so elects, at any time thereafter terminate this lease and the term hereof, on giving to lessee/tenant 60 days' notice in writing of lessee/landlord's intention so to do, and this lease and the term hereof shall expire and come to an end on the date fixed in such notice as if the said dates were the date originally fixed in this lease for the expiration hereof. Such notice may be given by mail to lessee/tenant addressed to lessee/tenant at the demised premises.

And the other terms and conditions of the lease/rental agreement shall continue to remain in full force and effect, except as herein modified.

Lessor/Landlord	Lessee/Tenant
_____	_____
by_____	by_____
_____	_____
Title	Title
Date:_____	Date:_____

DMH FORM 87
June/78

AFFIDAVIT OF CORPORATION AUTHORIZATION

STATE OF MISSOURI)
)ss
COUNTY OF)

Comes now _____, to me personally known and being first duly sworn, states that he is the _____ of _____, a corporation; that he is the duly authorized agent and executed the contract for and on behalf of _____ _____ of _____, Missouri; under authority granted him by action of the Board of Directors and in the minutes of the corporation on the _____ day of _____, 19____; that the seal affixed to the foregoing instrument is the corporate seal of the corporation; and that said instrument was signed and sealed on behalf of said corporation by authority of its Board of Directors and that _____ acknowledges the instrument to be the free act and deed of the corporation.

(CORP)
(SEAL)

_____

_____
(Title)

Subscribed and sworn to before me this _____ day of _____, 19____, in my office in the State and County aforesaid.

_____
Notary Public

My Commission Expires _____.

MBO/GANT CHART

Program: _____

Action	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Actor
1.													
2.													
3.													
4.													
5.													
6.													
7.													
8.													
9.													
10.													
11.													
12.													

PSYCHIATRIC SYMPTOMS

PHYSICAL CARE LEVEL

	ACUTE	REHAB	COMMUNITY
SNF	12	8	4
ICF	11	7	3
SUPV	10	6	2
INDP	9	5	1

LEGEND

SNF = Skilled Nursing Facility
ICF = Intermediate Care Facility
SUPV = Supervised Living Arrangement
INDP = Independent Living Arrangement

1 = Outpatient/Discharged/Family Care
2 = Boarding Home
3 = Residential Care Facility
4 = Skilled Nursing Facility (few or no psychiatric problems)
5 = Apartments/Foster Homes/ Foster Communities
6 = Group Homes
7 = Intermediate Care Facility
8 = Skilled Nursing Facility (with behavior and psychiatric problems
9 = Acutely Ill (inpatient or outpatient)
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HYPOTHETICAL
PSYCHIATRIC SYMPTOMS

PHYSICAL CARE LEVEL

	ACUTE	REHAB	COMMUNITY
SNF	12	8 205	4 117
ICF	11	7 246	3 225
SUPV	10	6 202	2 193
INDP	9	5 179	1

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TOTAL PATIENT ASSIGNMENT AND PERCENTAGE OF TOTAL POPULATION

PSYCHIATRIC SYMPTOMS

PHYSICAL CARE LEVEL

	ACUTE	REHAB	COMMUNITY
SNF	12	8 405 26.6%	4 17 1.2%
ICF	11	7 546 39.9%	3 25 1.8%
SUPV	10	6 2 0.1%	2 193 14.1%
INDP	9	5 179 13.1%	1

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HYPOTHETICAL
PSYCHIATRIC SYMPTOMS

PHYSICAL CARE LEVEL

	ACUTE	REHAB	COMMUNITY
SNF	12	8 -200	4 +100
ICF	11	7 -300	3 +200
SUPV	10	6 +200	2 ϕ
INDP	9	5 ϕ	1

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HYPOTHETICAL

PSYCHIATRIC SYMPTOMS

PHYSICAL CARE LEVEL

	ACUTE	REHAB	COMMUNITY
SNF	12	8 20	4 20
ICF	11	7 10	3 10
SUPV	10	6 30	2 40
INDP	9	5 60	1

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HYPOTHETICAL

PSYCHIATRIC SYMPTOMS

PHYSICAL CARE LEVEL

	ACUTE	REHAB	COMMUNITY
SNF	12	8 12 FTE	4 8 FTE
ICF	11	7 14 FTE	3 10 FTE
SUPV	10	6 22 FTE	2 21 FTE
INDP	9	5 20 FTE	1

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HYPOTHETICAL

PSYCHIATRIC SYMPTOMS

PHYSICAL CARE LEVEL

	ACUTE	REHAB	COMMUNITY
SNF	12	8 $$$	4 $$$
ICF	11	7 $$$	3 $$$
SUPV	10	6 $$$	2 $$$
INDP	9	5 $$$	1

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HYPOTHETICAL

PSYCHIATRIC SYMPTOMS

PHYSICAL CARE LEVEL	ACUTE	REHAB	COMMUNITY
SNF	12	8 $$$	4 $$$
ICF	11	7 $$$	3 $$$
SUPV	10	6 $$$	2 $$$
INDP	9	5 $$$	1

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MEAN COST & STANDARD DEVIATION OF PLACEMENT FACILITIES

PSYCHIATRIC SYMPTOMS

PHYSICAL CARE LEVEL

	ACUTE	REHAB	COMMUNITY
SNF	12	8 $\bar{X}$ = 699.00 SD = 213.52	4 $\bar{X}$ = 841.00 SD = 118.33
ICF	11	7 $\bar{X}$ = 661.92 SD = 186.34	3 $\bar{X}$ = 366.75 SD = 94.72
SUPV	10	6 $\bar{X}$ = 527.50 SD = 147.79	2 $\bar{X}$ = 391.16 SD = 113.06
INDP	9	5 $\bar{X}$ = 285.64 SD = 32.51	1

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HYPOTHETICAL

PSYCHIATRIC SYMPTOMS

PHYSICAL CARE LEVEL

	ACUTE	REHAB	COMMUNITY
SNF	12	8 $$$	4 $$$
ICF	11	7 $$$	3 $$$
SUPV	10	6 $$$	2 $$$
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HYPOTHETICAL
PSYCHIATRIC SYMPTOMS

PHYSICAL CARE LEVEL

	ACUTE	REHAB	COMMUNITY
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INDP	9	5 $$$	1

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