# MINUTES

## JOINT COMMITTEE ON WAYS AND MEANS/APPROPRIATIONS

September 29, 1993
Room 313-S -- Statehouse



### Members Present

Representative Rochelle Chronister, Chairperson
Senator Bill Brady
Senator Jerry Karr
Senator Barbara Lawrence
Senator Jerry Moran
Senator Stephen Morris
Senator Marge Petty
Senator Richard Rock
Senator Alicia Salisbury
Senator Robert Vancrum
Representative Tom Bradley
Representative Tim Carmody
Representative Betty Jo Charlton
Representative Dick Edlund
Representative Denise Everhart
Representative Fred Gatlin
Representative Kent Glasscock
Representative Gilbert Gregory
Representative Delbert Gross
Representative David Heinemann
Representative Phil Kline
Representative Jim Lowther
Representative Eloise Lynch
Representative Bob Mead
Representative Melvin Minor
Representative Jo Ann Pottorff
Representative Richard Reinhardt
Representative Rand Rock
Representative George Teagarden

### Members Absent

Senator Gus Bogina
Senator Dave Kerr
Representative George Dean
Representative Wanda Fuller
Representative Robin Jennison

**Staff Present**

Alan Conroy, Kansas Legislative Research Department
Tim Colton, Kansas Legislative Research Department
Laura Howard, Kansas Legislative Research Department
Russell Mills, Kansas Legislative Research Department
Jim Wilson, Revisor of Statutes Office

**Conferees**

Secretary Gary Stotts, Kansas Department of Corrections
Deputy Secretary Elizabeth Gillespie, Kansas Department of Corrections
George Vega, Commissioner of Mental Health and Retardation, Kansas Department of Social and Rehabilitation Services
Warden David McKune, Lansing Correctional Facility
Warden Mike Nelson, El Dorado Correctional Facility

**Morning Session**

The joint meeting of the Senate Ways and Means and the House Appropriations committees was called to order by Representative Rochelle Chronister, Chairperson, at 10:00 a.m. The Chair announced that several legislators would be attending the funeral of former Senator Bill Morris and would not be present at the Joint meeting. Guests present are shown on Attachment 1.

**Presentations by the Department of Corrections on Recent Prison Violence and FY 1994 Community Corrections Funding**

Warden David McKune, Lansing Correctional Facility, reported on the May 22, 1993, homicide at the recreation building at the Lansing Facility. He said that the three victims assaulted were initially sent to St. John Hospital at Lansing. Officer Bydash and inmate Wright were then transported to Providence Hospital and Officer Avery was transferred to the University of Kansas Medical Center in Kansas City, where he died. Due to the number of inmates on the yard and the seriousness of the offense, three KBI investigators and Daryl Perrin, Chief Investigator, Central Office of KDOC, assisted in the internal investigation. As a result of this incident, nine inmates were charged with both first degree murder and aggravated battery on a law enforcement officer. An additional two inmates were charged solely with first degree murder and another inmate was charged with aggravated battery on an officer. The investigation is continuing and the recreation building has been demolished because of its deteriorating condition. Warden McKune responded to questions and said that preliminary hearings are starting this week and he anticipates that more charges will be filed. He also said that the reason for the melee has not been determined and that the incident was not gang-related.

Warden Mike Nelson, El Dorado Correctional Facility, reported on an incident at the facility when an officer was injured by glass wielded by an inmate and about a dozen inmates

surrounded two officers. The facility had an immediate show of force by the weapons team and the incident was squelched in an hour. A lockdown was enacted for two days. In response to a question by Representative Charlton, Warden Nelson explained that the weapons team is a special group of officers called when there is an emergency situation such as this one.

Elizabeth Gillespie, Deputy Secretary for Community and Field Services, Kansas Department of Corrections, briefed the Committee on the community corrections budget process and funding. She said that the 29 programs are governed by 26 administrations, who submit budget requests in July of each year. For FY 1995, budget requests were received in July, 1993 for each program. Just prior to the beginning of the new fiscal year, DOC staff determines the distribution of approved community corrections grant funds. One method of determining where to allot the funds is to establish priorities. By the end of June each year, DOC staff notifies local programs how much they will receive for the ensuing fiscal year. She also explained the appeal process developed by DOC for use by the community corrections programs. Ms. Gillespie explained the priorities for FY 1994 community corrections grants and FY 1994 grants approved by DOC in the amount of $12.857 million. DOC proposes to use $300,000 in unexpended FY 1993 funds to develop a statewide community corrections database and to direct the remaining $532,226 toward financing FY 1995 community corrections programs. FY 1995 budget requests and average daily populations were also reviewed by Ms. Gillespie (Attachment 2). In response to a question by Representative Glasscock, Ms. Gillespie said that the unexpended FY 1993 funds will stay in local accounts to be used for FY 1994. Responding to a question from Representative Lowther, she said that although boot camps for juvenile offenders are less costly than other facilities, preliminary research studies have shown recidivism statistics are not very good.

Secretary Gary Stotts, Kansas Department of Corrections, explained how DOC handles unexpended funds left in local accounts at the end of each year. He said that these funds have been used to reduce the amount of new money put into the programs. This year DOC wanted to leave enough for appeals and set aside funds for a database, but when the appeals came in DOC abandoned the database project. Secretary Stotts said that when DOC became aware of the $800,000 excess FY 1993 funds, they hoped to use $300,000 of that money for the database. The Committee and Secretary Stotts then discussed the juvenile corrections issue. The Secretary said that he had always thought there was some utility to using community corrections as a vehicle for doing juvenile programs and there appears to be some duplication of juvenile programs at DOC and SRS. He also said that the adult residential program is high-cost, is isolated to two of the largest counties, and is a major issue for further study. Senator Moran requested information on the grants and vendors in the community corrections programs. Senator Lawrence requested DOC provide a county-by-county breakdown of boot camp populations.

The Chair recessed the meeting for lunch.

## Afternoon Session

Chairperson Chronister reconvened the meeting at 1:30 p.m. and called for the staff background report on mental retardation issues.

Tim Colton, Kansas Legislative Research Department, presented an institutional overview and described conditions of mental retardation and developmental disabilities. He said that Kansas has three institutions for people with these disabilities -- Kansas Neurological Institute,

Parsons State Hospital and Training Center, and Winfield State Hospital and Training Center. The population at the end of FY 1993 was 875 at the three hospitals, with 320 at Winfield, 300 at KNI, and 255 at Parsons. Mr. Colton explained that the funding for the three institutions comes from four primary sources, *i.e.,* the State General Fund, Medicaid funds, institutional fee funds, and federal Chapter I funds. He detailed the history of and proposals for downsizing and closing mental retardation institutions in Kansas and the process of determining which hospital to close. In a review of client-placement methodology, Mr. Colton said that 125 clients will have to move out of the state institutions during the course of FY 1994 if the FY 1994 end-of-year target census set for each institution is to be reached. He reviewed the pilot project recommended by a Senate Subcommittee to develop community placement settings by the state institutions and said that on August 3, 1993, SRS reported that it had done nothing to carry out the pilot program (Attachment 3).

Laura Howard, Kansas Legislative Research Department, presented an overview of community services for mentally retarded and developmentally disabled provided in other settings apart from the three state institutions. She said that these clients receive services through community mental retardation centers and in small and large intermediate care facilities for the mentally retarded. Ms. Howard explained the various funding sources available to finance the community services. She then reviewed the 1993 Session activity concerning budget issues affecting mental retardation institutions and the waiting list for community services. The primary waiting list currently consists of 500 persons. Also reviewed were recommendations for client placement and initiatives to facilitate movement of clients from state institutions to the community. Ms. Howard said that during the 1993 Omnibus Session, the Legislature recommended the deletion from the SRS budget of $500,000 (SFG) in special purpose grants with the idea of taking advantage of federal funding under the HCBS Medicaid waiver (Attachment 3).

**Presentation by the Department of Social and Rehabilitation Services on Individuals Who are Mentally Retarded or Otherwise Developmentally Disabled Who are Waiting for Community Services**

George Vega, Commissioner of Mental Health and Retardation, Kansas Department of Social and Rehabilitation Services (SRS), reviewed an SRS report entitled *An Analysis of Profiles of Individual Characteristics of Persons with Developmental Disabilities.* The data for the report was gathered through the application of a functional assessment instrument called the Developmental Disabilities Profile (DDP). The analysis was conducted to develop criteria which could be used to reliably differentiate between persons who might be appropriately served in community settings, persons who might be appropriately served in state MR/DD institutions, and persons who might be appropriately served in private ICFs/MR. Mr. Vega explained that in addition to demographic information and descriptors which categorize various characteristics of individuals, the DDP provides index scores on adaptive behavior, maladaptive behavior, and health needs. He also explained the categories of clients requiring health support and psychological services. Mr. Vega said that this analysis and the success of the CID does not support the premise that clients with certain characteristics must be served in specifically designed settings. They do suggest adoption of the principle of consumer and parent/guardian choice can be supported in any setting in the Kansas MR/DD service system (Attachment 4).

Mr. Vega then reviewed the SRS *Preliminary Report on Kansans Who are Mentally Retarded or Otherwise Developmentally Disabled Waiting for Community Services.* The report concluded that despite the large variety of services for people who are MR/DD, as many as 3,554 are unserved

in Kansas. Current available data estimates the cost of providing people with immediate service needs at $11.6 million per year (Attachment 5).

Also reviewed by Mr. Vega was an SRS report titled *Assuring Consumer and Family Involvement in the Provision of Services.* The report detailed the Quality Enhancement Program which is being adopted by MR/DD Services as opposed to using exclusively regulatory surveys and/or national professional standards to monitor services (Attachment 6).

Responding to questions, Mr. Vega said he is concerned that clients are not being moved from state hospitals to community settings as fast as planned and SRS intends to review this situation. Representative Gross expressed concern with conflicting data showing the number of severely disabled clients at the Winfield facility compared to KNI. Mr. Vega responded, saying that the information that was used in comparison of institutions during the 1993 Session relating to the idea of closure was based on information about how many people were in the institutions who were difficult to serve and those who were not difficult to serve. Also, the Developmental Disabilities Profile has information on criteria that SRS did not believe should result in someone staying in an institution. Representative Lowther requested information before the 1994 Session regarding tiered funding for services for people who have been placed in community settings. Mr. Vega said that during a tour of ten Kansas cities, he heard comments from many people that they want more resources for community programs and he heard few comments about closing any of the state hospitals. He added that the SRS goal is to move more people into community settings but is concerned that clients who remain in state hospitals may not be adequately serviced due to budget problems. Chairperson Chronister said that it is imperative for the committees to understand that the 124 clients in the state institutions who want to leave be allowed to do so or the state could be sued. Mr. Vega commented that he had requested his staff about a week ago to prepare an analysis to try to determine reasons for the slow migration to community settings, but he thinks the problems may lie in several areas in the system. This report is scheduled to be completed by the end of this week, according to Mr. Vega. Senators Brady and Rock suggested that there could possibly be more private, not-for-profit competition for community services.

A letter on the number of school age children in the process of placement from state mental retardation hospitals to community services was submitted by MR/DD Services (Attachment 7).

Chairperson Chronister adjourned the meeting at 4:40 p.m.

Prepared by Lenore Olsen
Edited by Russell Mills

Approved by Committee on:

December 1, 1993
(date)

JOINT COMMITTEES ON
HOUSE APPROPRIATIONS AND SENATE WAYS AND MEANS

DATE 9/29/93

| NAME | ADDRESS | REPRESENTING |
|---|---|---|
| Elysteen Gillespie | LSOB Topeka, KS | KDOC - Community & Field Services Division |
| Robert Sanders | LSOB Topeka, KS | " " |
| Michael Nelson | El Dorado | KDOC |
| Jan Johnson | Topeka | KDOC |
| Mike Miller | Topeka | City of Topeka |
| Paul Shelby | Topeka | OJA |
| Alan Steppat | Topeka | Pete McGill & Assoc. |
| John & Margo Cassmeyer | Milwaukie Oregon | Visitors |
| M. Martin | Wichita | Sedgwick Co. |
| Darwin Hirsch | Topeka | SRS/MH&RS |
| Robin Nichol | Wichita | Wichita Public Schools |
| HAROLD PITTS | TOPEKA | AARP-CCTF |
| KAY JONES | Olathe | MH/RS - Wyandotte/Jo. County |
| Paula McHenry | Wichita | MH/RS - Sedgwick County |
| George D Vega | Topeka | SRS MHRS |
| Josie Torres | Topeka | Families Together, Inc. |
| Jan Rhys | Topeka | KS Planning Council on Dev. Dis. |
| Sharon Phillips | Topeka | City of Topeka |
| Dwayne Oakes | | SOE |
| Martha McGrevill | Topeka | KARF |
| Lila Parlan | Topeka | TARC |
| | | |
| | | 9/29/93 |

Joint Committee on Senate Ways and Means and House Appropriations

Attachment 1

September 29, 1993

# KANSAS DEPARTMENT OF CORRECTIONS
# COMMUNITY AND FIELD SERVICES DIVISION
# COMMUNITY CORRECTIONS SECTION

The Kansas Legislature enacted the Community Corrections Act (K.S.A. 75-5290 et. seq.) in 1978. The original goal of community corrections was to assist in reducing prison overcrowding and to avert new prison construction by providing the courts with an additional sentencing option. This sentencing option existed as a part of the continuum between probation and prison. The term "community corrections" refers to correctional programs and services that are administered in the community rather than in prison. Community corrections programs provide structured intensive supervision for offenders and enforcement of supervision conditions through development of individualized supervision plans designed to meet the needs of each offender. The program premise is that selected offenders can be controlled in the community without presenting an unacceptable risk to the public. Historically, community corrections has been a cost effective means to assist in reducing prison overcrowding. The advantage of community corrections to the state was that it diverted offenders from prison and saved the tax payers money by establishing the least restrictive appropriate sanction and controls for these offenders. The advantage of community corrections to the county or counties is that it allows the offender to maintain family ties, pay taxes and restitution, and develop the support necessary to be a productive member of the community.

With the implementation of the Sentencing Guidelines Act, the purpose or goal of community corrections has changed. The Sentencing Guidelines Act was developed, in part, to manage the size of the prison population. With the implementation of the Act on July 1, 1993, crime severity and criminal history determine sentencing. Those offenders who fall within the presumptive probation portion of the sentencing grid are assigned to probation under the courts, to community corrections, to house arrest, or to the Labette Correctional Conservation Camp. Therefore, the purpose of community corrections is now to provide the courts with another sentencing option for offenders who require greater supervision than regular probation.

The Community Corrections Act authorizes a variety of programs eligible for grant funds including: restitution, victim services, preventive or diversionary correctional programs, and facilities and services for the detention, confinement, care or treatment of adult and juvenile offenders. A comprehensive plan is developed annually by each local program. The comprehensive plan sets forth the objectives and services planned for each program. The advisory board and board of county commissioners annually approve the comprehensive plan with final approval by the Kansas Department of Corrections. The Kansas Department of Corrections requires that each community corrections comprehensive plan includes Adult Intensive Supervision which is the department's number one priority service to be included in each plan.

The Department of Corrections is responsible for oversight of all community corrections programming. This is carried out through interpretation of state statutes; promulgation of regulations and administrative policies and procedures; periodic auditing; provision of technical assistance and dissemination of information. The Department approves all budgets, plans, amendments and program content of local programs. The Department has the responsibility to fund, within amounts appropriated, approved community corrections program budgets. Any unexpended funds remaining in the local accounts due to delay in program or project startup, overestimate of costs or operating expenditures, employee turnover, etc. shall be used to reduce subsequent distributions of funds from the state or returned to the state for allocation elsewhere as needed unless the Secretary determines that these funds may be retained by the county for approved programming purposes. With the abolishment of the State Community Corrections Board in FY94, the Department created a three-stage appeal process so that local programs may dispute the amount of funds each receives during a fiscal year.

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1 Joint Senate Ways + Means and House Appropriations Cmtes

Attachment 2

There are currently 29 community corrections programs serving the 105 counties of Kansas. Some of the programs are multi-county groups, some are single county programs, and some counties have chosen to contract for community correctional services from nearby community corrections programs.

The 29 community corrections programs are delineated as follows:

## Counties participating prior to 1990

| | |
|---|---|
| Bourbon/Linn/Miami | Multi County Program |
| Douglas | Single County Program |
| Johnson | Single County Program |
| Leavenworth | Single County Program |
| Montgomery | Multi County Program (includes Chautauqua County) |
| Riley | Single County Program (Clay contracts with Riley) |
| Saline | Single County Program (Ottawa contracts with Saline) |
| Sedgwick | Single County Program |
| Shawnee | Single County Program |
| Wyandotte | Single County Program |
| 2nd Judicial District (Jackson, Jefferson, Pottawatomie, Wabaunsee) | Contracts with Shawnee County Community Corrections for Services |

## Counties newly participating in the Community Corrections Act in 1990

| | | |
|---|---|---|
| Atchison | (1st Jud. Dist.) | Single County Program |
| Cowley | (19th Jud. Dist.) | Single County Program |
| Reno | (27th Jud. Dist.) | Single County Program |
| Sumner | (30th Jud. Dist.) | Single County Program |
| 4th Judicial District (Anderson, Coffey, Osage, Franklin) | | Multi County Program |
| 5th Judicial District (Chase, Lyon) | | Multi County Program |
| 8th Judicial District (Dickinson, Geary, Marion, Morris) | | Multi County Program |
| 9th Judicial District (Harvey, McPherson) | | Multi County Program |
| Southeast Kansas (11th & 31st) (Allen, Cherokee, Crawford, Labette, Neosho, Wilson, Woodson) | | Multi County Program |



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| | |
|---|---|
| 12th Judicial District<br>(Cloud, Jewell, Lincoln,<br>Mitchell, Republic, Washington) | Contracting for Service from<br>Saline Community Corrections |
| 13th Judicial District<br>(Butler, Elk, Greenwood) | Multi County Program |
| Northwest Kansas<br>(15th, 17th, & 23rd)<br>(Cheyenne, Decatur, Ellis,<br>Gove, Graham, Logan, Norton,<br>Osborne, Phillips, Rawlins,<br>Rooks, Sheridan, Sherman,<br>Smith, Thomas, Trego, Wallace) | Multi County Program |
| Santa Fe Trail (16th Dist.)<br>(Clark, Comanche, Ford, Grant,<br>Gray, Haskell, Kiowa, Meade,<br>Morton, Seward, Stanton, Stevens) | Multi County Program (currently undergoing re-organization) |
| Central Kansas (20th Dist.)<br>(Barton, Ellsworth, Rice,<br>Russell, Stafford) | All other counties within the<br>20th Judicial District contract<br>with Barton for service. |
| 22nd Judicial District<br>(Brown, Doniphan, Marshall,<br>Nemaha) | Contracts with Riley County<br>Community Corrections. |
| 24th Judicial District<br>(Edwards, Hodgeman, Lane,<br>Ness, Pawnee, Rush) | Multi County Program |
| 25th Judicial District<br>(Finney, Greeley, Hamilton,<br>Kearney, Scott, Wichita) | Multi County Program |
| South Central Kansas (30th Dist.)<br>(Barber, Harper, Kingman, Pratt) | Multi County Program |

Departmental staff in consultation with community corrections directors develop a list of program priorities for community corrections each year to respond to the limited funding available to community corrections programs in Kansas. It is important to assess the status of resources available and the offender populations that use them. Based on a yearly assessment, a list of program service priorities for community corrections is developed and provided to all local community corrections programs as a guideline for use in the development of the annual comprehensive community corrections plan.

In October of 1989, the first priorities list for funding consideration was developed by the Department for use in planning for FY91 community corrections programs. Local Advisory Boards also play a major role in identifying and planning local priorities, needs and resource allocation. It is important to note that the local advisory board's function is to develop a local program comprehensive plan with the local program director. Prioritization of primary correctional needs on a statewide basis should be a useful tool in developing a local comprehensive plan for community corrections.

The FY94 primary priorities (see table below) for community corrections program services were organized with emphasis on adult offender populations. Adult Intensive Supervision is considered the primary or core service for all community corrections programs and is, therefore, highest on the list of priorities. The second priority is Day Reporting Centers which are less costly alternatives to residential services and provide a highly structured environment for offenders. The Day Reporting Center concept encourages the coordination of these efforts in a concentrated location on a daily basis. This type of community coordination can be accomplished at a lower cost than residential care, with very similar community controls by use of "partnerships". The Department believes that the Day Reporting Center service should be a higher level priority than residential services on the priority list of services and funding due to the level of risk control it provides, the ability to involve the community in sanctioning, and the relatively low cost for services that this option provides.

Adult residential services are placed lower on the priority list (third) because the cost is higher than other services which offer similar levels of supervision, education, and treatment. Residential services are seen as too costly to offer statewide, therefore, only two counties operate adult residential centers, Johnson County with 33 beds and Sedgwick County with 70 beds. Juvenile services are listed as the fourth and fifth priorities since the Department's primary emphasis is with adult offender populations.

The Department realizes that these priorities may not always conform to local concerns, however they have been developed as a statewide strategy to provide an efficient method of delivering correctional services in the community.

## FY 1994 Priorities

1. Adult Intensive Supervision
2. Adult Day Reporting Centers
3. Adult Residential Services
4. Juvenile Intensive Supervision
5. Juvenile Residential Services

September 29, 1993

# KANSAS DEPARTMENT OF CORRECTIONS
# COMMUNITY AND FIELD SERVICES

## Priorities for FY 1994 Community Corrections Grants

Departmental Priorities:

1. Adult Intensive Supervision
2. Adult Day Reporting
3. Adult Residential Services
4. Juvenile Intensive Supervision
5. Juvenile Residential Services

Priorities as Amended (Legislative Mandate):

1. Adult Intensive Supervision
2. Adult Day Reporting
3. Juvenile Intensive Supervision
4. Juvenile Residential Services
5. Adult Residential Services

* The 1993 Legislature instructed the Department of Corrections to continue funding juvenile community corrections programs at FY93 levels.



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# KANSAS DEPARTMENT OF CORRECTIONS
# COMMUNITY AND FIELD SERVICES

## Community Corrections Grants - Fiscal Year 1994

| | | |
|---|---|---|
| Total amount requested by local programs | = | $17,247,973 |
| Total grant funds approved to KDOC for distribution in FY94 (includes $240,261 federal drug grant funds) | = | $12,857,208 |
| June 1993 - Original amount allotted to local programs by KDOC for FY94 | = | $12,242,563 |

| | |
|---|---|
| $12,857,208 | Total Funds Available |
| -$12,242,563 | Total Allotted to Local Programs |
| $ 614,645 | Reserve |

Proposed Purpose of Reserve:

| | |
|---|---|
| $ 350,000 | Appeal Process and Unanticipated Growth |
| +$ 264,645 | Develop and Implement Statewide Community Corrections Database |
| $ 614,645 | Total |

Actual Use of Reserve:

| | |
|---|---|
| $ 18,087 | Appeal Restorations at 1st Stage |
| +$ 492,957 | Appeal Restorations at 2nd Stage |
| $ 511,044 | Total Funds Distributed from Reserve (August, 1993) |

Remaining Funds:

| | |
|---|---|
| $ 614,645 | Total of Reserve |
| -$ 511,044 | Total Funds Distributed on Appeal |
| $ 103,601 | Remaining Funds - September, 1993 (One appeal for $22,500 remains at Stage 3 with decision pending by Secretary of Corrections) |

Funds remaining upon the resolution of the last appeal will be utilized as necessary for unanticipated program growth.



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# KANSAS DEPARTMENT OF CORRECTIONS
# COMMUNITY AND FIELD SERVICES

## Unexpended Community Corrections Grant Funds - Fiscal Year 1993

Estimated Total - Unexpended Funds, FY 1993 = $832,226.00

The $832,226 will be used to reduce state grant payments that will be made in January of 1994, thereby freeing up $832,226 in state funds. It is proposed that the state funds be used as follows:

- $300,000 - Development of community corrections database
  - to improve offender tracking
  - to improve access to information
  - to provide for more accurate, up-to-date information
  - to improve the user's ability to create and generate statistical reports
  - to improve case statistical reporting and improve fiscal decisions based upon more accurate population projections

(Community corrections programs currently utilize a personal computer based system. This initiative would give community corrections direct access to the KDOC mainframe computer.)

- $532,226 - Financing the FY 1995 community corrections programs

Note: The Department's FY 1995 budget submission assumed that carryover funds of $700,000 (FY93 unexpended funds) would be available because that was the best estimate at the time the budget was prepared.



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September 29, 1993

# KANSAS DEPARTMENT OF CORRECTIONS
# COMMUNITY AND FIELD SERVICES

## FY95 Budget

A Level

Total Request = $11,372,289

At this level, funding for juvenile intensive supervision and adult and juvenile residential services would be discontinued.

B Level

Total Request = $14,859,611

This amount provides for continuation of the current program and includes the anticipated impact of sentencing guidelines. No new programs or enhancements at this level.

C Level

Total Request = $17,171,965

(Based upon local programs' requests.)



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# KANSAS DEPARTMENT OF CORRECTIONS
# COMMUNITY AND FIELD SERVICES

## Average Daily Populations (ADP)
## Community Corrections Programs

FY 1989

| | | |
|---|---|---|
| Adult Intensive Supervision | = | 1,539 |
| Adult Residential Services | = | 133 |
| Juvenile Intensive Supervision | = | 180 |
| Total ADP - All Programs | = | 1,852 |

FY 1990

| | | |
|---|---|---|
| Adult Intensive Supervision | = | 1,474 |
| Adult Residential Services | = | 136 |
| Juvenile Intensive Supervision | = | 82 |
| Total ADP - All Programs | = | 1,692 |

FY 1991

| | | |
|---|---|---|
| Adult Intensive Supervision | = | 2,080 |
| Adult Residential Services | = | 148 |
| Juvenile Intensive Supervision | = | 123 |
| Adult Day Reporting | = | 12 |
| Total ADP - All Programs | = | 2,363 |

FY 1992

| | | |
|---|---|---|
| Adult Intensive Supervision | = | 2,569 |
| Adult Residential Services | = | 100 |
| Juvenile Intensive Supervision | = | 148 |
| Adult Day Reporting | = | 55 |
| Juvenile Residential Services | = | 12 |
| Total ADP - All Programs | = | 2,884 |

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FY 1993

| | | |
|---|---|---|
| Adult Intensive Supervision | = | 2,948 |
| Adult Residential Services | = | 81 |
| Juvenile Intensive Supervision | = | 130 |
| Adult Day Reporting | = | 115 |
| Juvenile Residential Services | = | 10 |
| Total ADP - All Programs | = | 3,284 |

FY 1994 - Projected

| | | |
|---|---|---|
| Adult Intensive Supervision | = | 3,343 |
| Adult Residential Services | = | 76 |
| Juvenile Intensive Supervision | = | 75.8 |
| Adult Day Reporting | = | 159 |
| Juvenile Residential Services | = | 9 |
| Total Projected ADP - All Programs | = | 3,662.8 |

FY 1995 - Projected

A Level

| | | |
|---|---|---|
| Adult Intensive Supervision | = | 4,084 |
| Adult Day Reporting | = | 230 |
| Total Projected ADP - All Programs | = | 4,314 |

B Level

| | | |
|---|---|---|
| Adult Intensive Supervision | = | 4,008 |
| Adult Residential Services | = | 103 |
| Juvenile Intensive Supervision | = | 98 |
| Adult Day Reporting | = | 203 |
| Juvenile Residential Services | = | 12 |
| Total Projected ADP - All Programs | = | 4,424 |

C Level

| | | |
|---|---|---|
| Adult Intensive Supervision | = | 4,042 |
| Adult Residential Services | = | 103 |
| Juvenile Intensive Supervision | = | 201 |
| Adult Day Reporting | = | 281 |
| Juvenile Residential Services | = | 12 |
| Total Projected ADP - All Programs | = | 4,639 |

# MEMORANDUM

**Kansas Legislative Research Department**

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September 29, 1993

To: House Committee on Appropriations; Senate Committee on Ways and Means

From: Tim Colton, Fiscal Analyst and Laura Howard, Senior Fiscal Analyst

Re: Mental Retardation Issues

## I. INTRODUCTION

Developmental disabilities are severe, disabling conditions that arise in infancy or childhood, persist indefinitely, and cause serious problems in language, learning, mobility, and capacity for independent living. These disabilities often result from damage to the brain structure or functioning, such as epilepsy, cerebral palsy, multiple sclerosis, or autism.

Mental retardation is classified as a developmental disability. People with mental retardation mature at a below-average rate and have IQs of 70 or below. Increasingly, the relevance of IQ scores alone has been called into question, and professionals often rely on other aspects of a person's capabilities to determine whether that person has mental retardation. Approximately 2.5 percent of the population have an IQ of 70 or below, but only about 1 percent is considered retarded, since even a person with an IQ of 70 or below is not diagnosed as retarded unless social and personal functioning are so seriously deficient that special protection and services are needed. There are four levels of mental retardation: mild, moderate, severe, and profound.

- **Mild Retardation.** People with mild retardation constitute 80 percent of all persons with mental retardation. They are, in many ways, similar to people without retardation and are not usually identified as retarded until they enter school. They differ primarily in rate and degree of intellectual development. Persons with mild retardation are not considered developmentally disabled unless they have a secondary handicap.

- **Moderate Retardation.** People with moderate retardation (10-15 percent of all people with mental retardation) can learn to speak in sentences, but have difficulty conforming to social conventions. They are not likely to pass second grade and require supervision as adults.

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Joint Senate Ways & Means
and House Appropriations Cmtes

Attachment 3

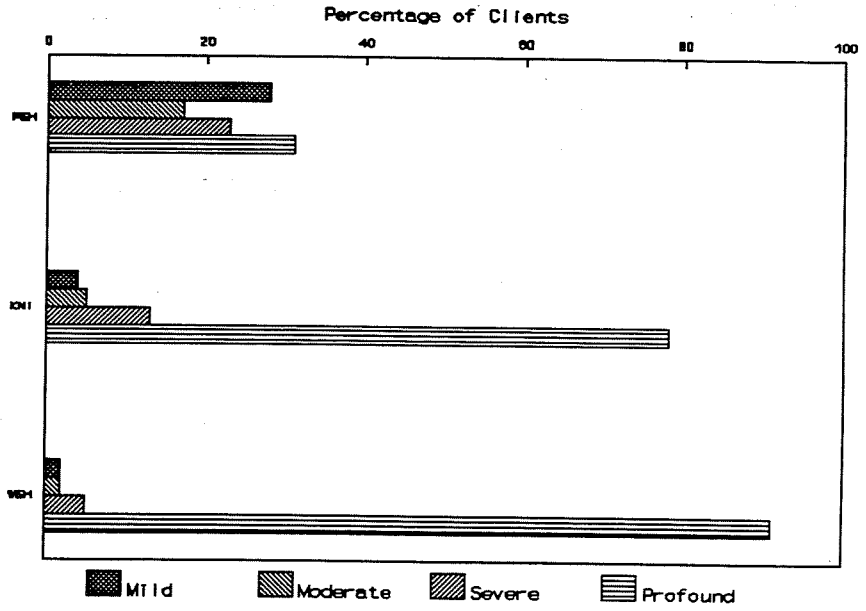
- **Severe Retardation.** People with severe retardation are able to learn some speech and elementary hygiene. They account for about 7 percent of people with retardation.

- **Profound Retardation.** People with profound retardation (1 percent of people with mental retardation) have limited sensory awareness and mobility and require constant supervision.

## II. INSTITUTIONAL OVERVIEW

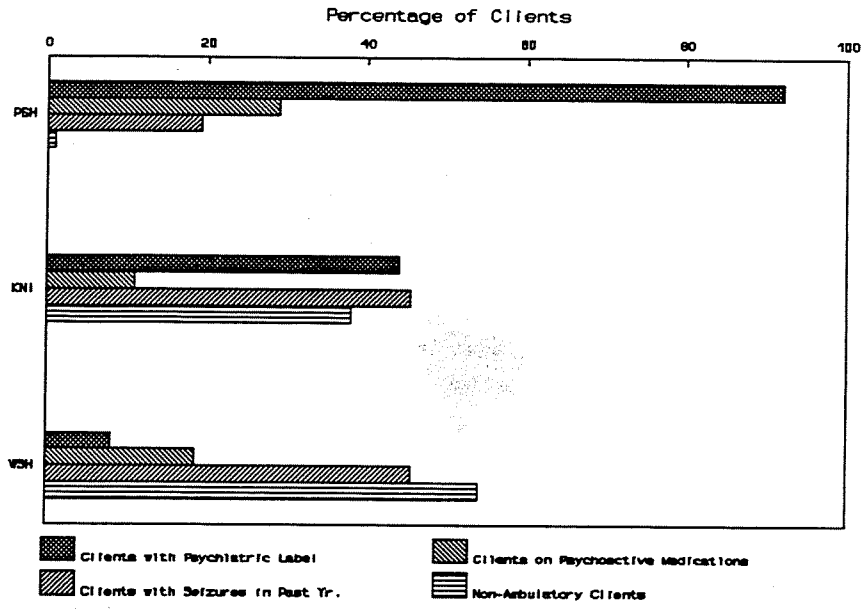
Kansas has three institutions for people with mental retardation and developmental disabilities -- Kansas Neurological Institute, Parsons State Hospital and Training Center, and Winfield State Hospital and Training Center. In FY 1992 the institutions served approximately 950 clients (average daily census), down 110 from the approximately 1,060 clients served at the beginning of calendar year 1989.

**State Mental Retardation Institutions**
**Level of Client Mental Retardation**




In addition to mental retardation, many of the clients at the institutions have severe sensory and motor disabilities, behavior problems, chronic health conditions and severe communication disorders.

**State Mental Retardation Institutions**
**Other Client Demographic Data**

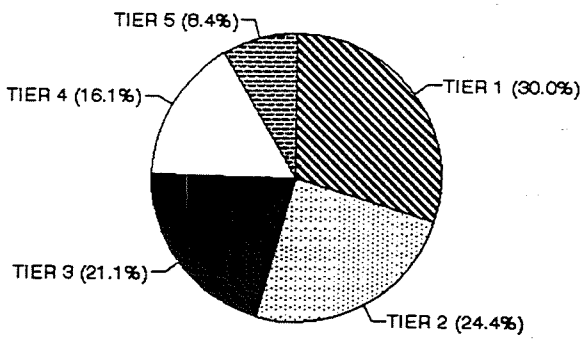



Many states are adopting the federal definition of developmental disabilities based on functional abilities. A person with developmental disabilities must have substantial difficulties in three of the following areas: self-care, understanding and use of language, mobility, self-direction, capacity for independent living, and economic self-sufficiency. For example, under the federal definition, a person with cerebral palsy, is not developmentally disabled until a chronic condition affects major areas of that person's life.

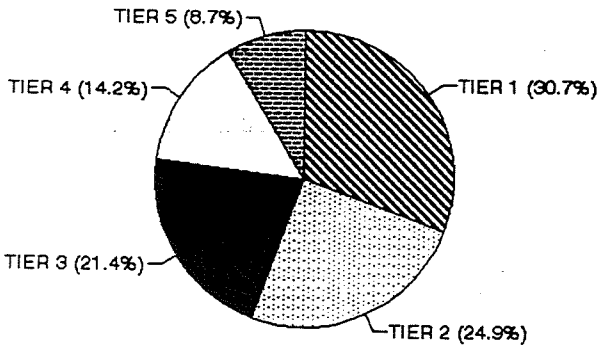
The following graphic compares client characteristics at each hospital based upon the Developmental Disabilities Profile (DDP). The DDP is a five-tiered profile of characteristics which measure the disability of an individual based upon indices for adaptive behavior, maladaptive behavior, and health needs. The adaptive behavior index measures an individual's ability in areas of self-care and daily-living skills. The maladaptive behavior index shows forms of maladaptive behavior exhibited by an individual. The health index shows an individual's health needs. Based upon the DDP, a person in Tier 1 would exhibit the most-severe disabilities, while a person in Tier 5 would show the least-severe disabilities.

# DISTRIBUTION OF DDP TIERS WITHIN EACH STATE MR FACILITY

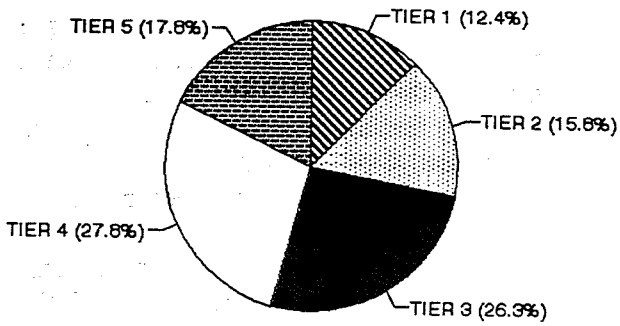
## ALL STATE MR FACILITIES



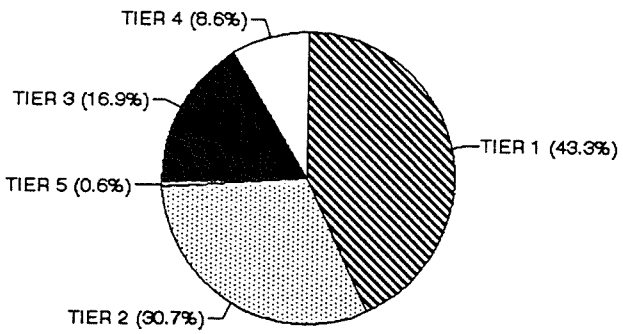

## KNI




## PSH&TC




## WSH&TC




| |
|---|
| Tier 1=Most-Severe Disabilities |
| Tier 5=Least-Severe Disabilities |

Source: SRS

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**Funding**

The mental retardation institutions are financed from four primary sources, *i.e.*, the State General Fund (SGF), Title XIX (federal Medicaid) funds, institutional fee funds, and federal Chapter I education funds. Title XIX and institutional fee funds are described briefly below.

**Title XIX Funds.** To receive Title XIX funding, the institutions must comply with federal standards, and be certified annually for receipt of such funding. These certification inspections have, in the recent past, been problematic at all three institutions. Certification problems and threatened loss of Medicaid funding prompted the state to add 486 new FTE positions at the three institutions between FY 1985 and FY 1989. However, the Department of Social and Rehabilitation Services (SRS) has reported no major problems in this area at any of the institutions during FY 1992 and FY 1993.

Daily rates are developed annually for each institution for reimbursement for clients eligible for Medicaid funding. Nearly all clients at the mental retardation institutions are Title XIX eligible. Of the total Title XIX rate for the institutions for FY 1994, the Title XIX program will pay approximately 59 percent and the state 41 percent. The state portion appears as part of the SGF appropriation for each institution.

**Fee Funds.** Each of the institutions has a fee fund for miscellaneous revenues received by the institution. The largest source of revenue to the fee funds is reimbursement for the care of clients. In addition, revenue received from building and land rent, sale of meals to visitors and staff, and other items is also credited to the fee funds. At the MR institutions, revenue for the care of residents generally consists of Social Security payments, insurance payments and -- to a very small extent -- private payments. SRS charges a maximum of $100 per month to families and guardians.

## III. COMMUNITY OVERVIEW

Mentally retarded and developmentally disabled clients receive services in other settings apart from the three state institutions. Clients receive services through community mental retardation centers, and in small and large intermediate care facilities for the mentally retarded (ICFs-MR).

**Community Mental Retardation Centers**

K.S.A. 19-4001 *et seq.*, authorizes the establishment of community facilities for the mentally retarded by the board of county commissioners of any county or by the boards of more than one county working jointly. With certain exceptions, each county or group of counties establishing a facility for the mentally retarded is required to establish a mental retardation governing board. Counties may also establish such boards for the purpose of contracting with a nonprofit corporation to provide services for the mentally retarded. Statutes specifically authorize the Boards of County Commissioners in Sedgwick and Johnson counties to serve as these required boards. The Secretary of SRS is authorized to approve the establishment of facilities for the mentally retarded.

Community facilities for the mentally retarded are authorized to render directly, or through contracts with nonprofit corporations the following services: pre-school, day care, work activity, sheltered workshops, sheltered domiciles, parent and community education, clinical services, rehabilitation services, in-service training for students, and consulting and referral services.

There are 27 recognized nonprofit community mental retardation centers (CMRCs), which along with their affiliates, serve approximately 4,244 people in a variety of residential, day, or support services. The centers serve persons in designated geographic areas of the state. The centers receive a variety of funding from state, federal, and local sources. In addition, counties are authorized to levy up to 2 mills (K.S.A. 79-1947) for mental retardation services or contracts. County mill levies are estimated to produce revenue of $10.2 million in FY 1994, which is equivalent to the FY 1993 amount, and an increase of approximately $350,000 from FY 1992.

**ICF-MR Facilities**

Intermediate care facilities for persons with mental retardation or related conditions must serve at least four persons per facility, and are required to provide continuous active treatment in residential and day programs in compliance with federal regulations. There are currently ten large-bed (17 beds or more) private for-profit ICF-MR facilities serving approximately 650 people. SRS has stated that it intends to close all large bed ICF-MR facilities by the year 2000. There are also 36 small (16 beds or less) ICF-MR facilities, the majority of which are operated by CMRCs or their affiliates, or church affiliated not-for-profit agencies. Small ICF-MR facilities serve approximately 300 persons. Funding for ICF-MR facilities is through the Medicaid program in the SRS medical assistance budget. Since FY 1991, the Legislature has included proviso language in the SRS appropriations bill authorizing the Secretary to refuse to enter into contracts with ICF-MR facilities, effectively limiting the growth of these facilities. However, no mechanism currently exists to require downsizing at these facilities. Approved FY 1994 funding for ICFs-MR totals $37.1 million, of which approximately $15.2 million is from state funds. $22.0 million of this amount is for ten large-bed facilities; the remaining $15 million is for small-bed facilities.

**Financing Community Services**

There are a variety of funding sources available to finance non-ICF-MR community services to persons with mental retardation and developmental disabilities. Community services for the mentally retarded and developmentally disabled are funded from local funds, private sector funds, SGF dollars, and state and federal matching funds. Most of the funds distributed by the state are granted to community mental retardation centers either on a formula basis or on behalf of agreements to serve a specific number of clients. In recent years, the state has attempted to maximize Medicaid funding on behalf of MR/DD clients through use of the Home and Community Based Services (HCBS) Medicaid waiver and other Medicaid options. The following summarizes the major categories of support granted by the state from both state and federal funding sources.

**Non-Medicaid Grants**

**State Aid to Community Mental Retardation Centers.** State aid to CMRCs is distributed on a population formula basis pursuant to the provisions of K.S.A. 65-4411. State aid is not tied to specific consumers and is designed to provide basic core support to the centers. In combination with other funds including county mill levies, client fees, production income, and other miscellaneous grants, an estimated 2,300 persons receive services through this funding source. CMRCs also use this funding as the match for federal Medicaid funds for targeted case management. The approved budget for FY 1994 includes $5,963,173 from the SGF for state formula aid, the same amount as in FY 1992 and FY 1993.

**Community and Day Living Grants.** The state uses a portion of the Social Service Block Grant and some SGF as a part of the consolidated grant to CMRCs to fund services to a specified number of people. The approved budget for FY 1994 includes $10.4 million in this category, including $9.0 million from the Social Service Block Grant and $1.4 million from the SGF. These funds help to support approximately 550 persons.

**Special Purpose Grants.** SGF dollars are awarded to CMRCs and their affiliates to provide specific units of service to persons with developmental disabilities. These grants provide family support services, adult day, and residential services. These funds provide a source of funding for services for persons who are mentally retarded or developmentally disabled and unserved, and who are not eligible for services under the HCBS Medicaid waiver. Since 1984, these funds have been used to place individuals from state hospitals into the community. However, beginning in FY 1991, the HCBS waiver has replaced special purpose grants for these deinstitutionalization efforts. The approved budget for special purpose grants for FY 1994 (including autism and alternate care grants) totals $16.5 million. However, the agency has undertaken an initiative to maximize Medicaid funding, resulting in a shift from special purpose funds to the HCBS-MR waiver. This is more fully discussed in a later section of this memorandum.

**Vocational Rehabilitation Match.** Beginning in FY 1992, SGF dollars have been appropriated in the mental retardation services budget to match federal vocational rehabilitation funds on an 80 percent federal matching basis to provide supported employment and supported living services. Funding of approximately $400,000 from the SGF supports approximately 75 clients on an annual basis. Because this funding is time-limited the clients are shifted to special purpose grants for ongoing support.

**Family Subsidy.** There are several smaller grants funded through the Division of Mental Health and Retardation Services including a family subsidy. This subsidy was first approved by the 1991 Legislature for FY 1992. Funding of $1.0 million from the SGF was approved for FY 1994. Funding is directed to families who have members living with them who have severe-developmental disabilities. Families are eligible to receive $200 per month for the care of a disabled person in the community.

**Medicaid Funding**

**Home and Community-Based Services (HCBS) Waiver.** The HCBS Medicaid waiver for the mentally retarded and developmentally disabled allows states to cover certain home and community-based support services to Medicaid-eligible persons who otherwise would be served in an institutional setting at an equal or higher cost. A separate waiver for the MR/DD population was

approved beginning in FY 1991. Funding is at the Medicaid match rate; the current federal financial participation rate in Kansas is 59 percent. The waiver has become the primary funding source for the movement of clients from state institutions to the community. The approved budget for FY 1993 assumed the placement of 108 clients from state hospitals and 108 from the community waiting list. This included 24 clients from state hospitals remaining to be placed from FY 1992. All 108 placements from the community waiting list were made in FY 1993, and 60 placements were made from state hospitals, including 12 in June. For FY 1994, the approved HCBS-MR budget assumes the placement of 235 clients from the community waiting list, and 84 new clients from state hospitals, in addition to any clients unplaced at the close of FY 1993. Thus, to meet the census and placement targets, a total of 132 clients need to be placed from the state hospitals in FY 1994.

**Targeted Case Management.** SRS received approval in October, 1992, to include targeted case management as a Medicaid service. Funds at the local level, including state aid, provide the match for these federal funds for service coordination. Approximately $3.5 million in federal funds was budgeted for targeted case management both in FY 1993 and FY 1994.

## IV. TRANSITION FROM INSTITUTIONAL MODEL TO COMMUNITY MODEL

### Question of Closure and Consolidation

The issue of downsizing and closing mental retardation institutions in Kansas is not a new one. In addition to KNI, Parsons, and Winfield, Kansas had a fourth mental retardation institution, Norton State Hospital, until the closing of that institution on October 1, 1988. An FY 1989 Research Department memorandum noted: "the Legislature has budgeted reductions in overall institutional populations in recent years, in an attempt to serve certain clients in a more appropriate environment in the community and to provide higher staffing ratios for the clients remaining at the institutions." The memorandum noted further that in spite of client movement into community settings, costs for operating the institutions did not decrease proportionately. The memorandum stated "it is impossible to decrease costs proportional (sic) to client movement unless major portions of a hospital are closed, due to the fixed nature of many costs at the institutions."

The process of reducing the number of clients with mental retardation and developmental disabilities at the state's mental retardation institutions continued in 1990, when the Kansas Legislature ordered SRS, Division of Mental Health and Retardation Services (MHRS) to implement the movement of 50 clients from the state hospitals into community settings. The process continued in 1991, and in 1992, a subcommittee of the House Appropriations Committee, in its report on the budgets of SRS and the MR/MH institutions, suggested further reductions in census at all three mental retardation hospitals.

In response to the mandate of the 1990 Legislature and suggestions made during the 1991 Legislative Session, SRS/MHRS drew up a plan for census reduction at all three MR hospitals. The plan called for the following end-of-year censuses at the state mental retardation hospitals.

**End-of-Year Census FY 1991-FY 1994**

| | FY 1991 | FY 1992 | FY 1993 | FY 1994 |
|---|---|---|---|---|
| KNI | 333 | 310 | 282 | 247 |
| Parsons | 270 | 270 | 242 | 235 |
| Winfield | 362 | 332 | 304 | 269 |

Reductions in staff were planned at all three institutions in tandem with reductions in census, as the following table shows.

**FTE Position Limitation FY 1991-FY 1994**

| | FY 1991 | FY 1992 | FY 1993* | FY 1994* |
|---|---|---|---|---|
| KNI | 879.5 | 862.5 | 852.5 | 815.5 |
| Parsons | 563.0 | 563.0 | 563.0 | 535.0 |
| Winfield | 1,002.5 | 992.5 | 872.5 | 862.5 |

* The FTE position limitations reflect reductions carried out during the course of the previous fiscal year.

The Subcommittee wrote that it had also heard testimony from hospital superintendents to the effect that, based on the record of clients who have moved into the community as part of the Community Integration Demonstration Project, many parents and family members would greet the return of their loved ones from institutions into the community. The Subcommittee expressed its opinion that, if client movement were to continue and were to be accelerated -- as made possible by the HCBS waiver -- the State of Kansas would no longer need three MR hospitals.

The Subcommittee noted that the 1991 interim Task Force on SRS recommended the closure of one of the state's MR hospitals.

The Subcommittee wrote that, "[i]n light of these factors, it is the opinion of the Subcommittee that the time has come to build up the community-care system for people with mental retardation and developmental disabilities, and to consolidate the number of state MR institutions from three to two. This will, of course, entail the closing of one of the state's MR institutions. The Subcommittee believes that SRS/MHRS is in the best position to ascertain which institution it would be most appropriate to close. The process of determining which hospital to close should be driven by what is best for the system's clients and their families, keeping in mind that it has been the experience of both families and professional caregivers that community settings are generally more positive than institutional ones. The agency should also consider the following factors, among others:

- The impact that the hospital's closing would have on the hospital's clients and their families.

- The availability of appropriate community-care settings and supports in the service area of each institution.

- The effect of closing an institution on the institution's staff, their families, and the institution's host community.

- The efficiency of the institution's operation.

- Employee availability and labor costs.

- The ability of the institution's home community to deal with the economic consequences of closure as determined by a financial-impact study; the community's general economic health, long-term labor trends in the community, and employment alternatives for workers at the institution are among the factors that should be considered in this regard. In studying this factor, the finding of the Ad Hoc Committee that two jobs would be created for every client placed into the community should be kept in mind.

- The savings to the State of Kansas that would be generated by closing the institution. (It is the understanding of the Subcommittee that savings realized from the downsizing and closing of the institution would be used to augment community-care programs for people with mental retardation and developmental disabilities.)

- The state of the institution's physical plant, and future capital costs that would be incurred by the state if the institution were kept open."

The Subcommittee concluded that, "in coming to the decision on which institution to close, SRS/MHRS should work in close consultation with a recognized outside expert."

The Subcommittee recommended that the pace of client movement from the institutions continue at the same pace as at present, *i.e.*, approximately 84 clients a year. This Subcommittee noted that this would allow for the closing of the chosen hospital in about four years' time.

The Subcommittee recommended that the agency make a decision on which institution to close, and formulate a plan for client movement and consolidation, and present these in a report to the Kansas Legislature by January 1, 1993. The Subcommittee recommended that the plan be included in the agency's and SRS' FY 1994 budget requests.

The Subcommittee's report was approved by the House Committee on Appropriations and by the House of Representatives as a whole. However, during the Conference Committee on the appropriations bill that funded the state mental retardation institutions (1992 S.B. 507), the conferees on the part of the Senate expressed disagreement with the conclusions made by the House Subcommittee. A proviso was inserted into the bill that made any closing of an MR institution subject to the approval of the 1993 Kansas Legislature.

## V. 1993 SESSION ACTIVITY

At the beginning of the 1993 Legislative Session, SRS presented a report to the House Appropriations Subcommittee for Mental Retardation Institutions which, essentially, recommended that Winfield State Hospital and Training Center be targeted for closure. After extensive and controversial hearings, the House Subcommittee disagreed with the agency recommendation, and chose, with the concurrence of the full House Appropriations Committee, the Kansas Neurological Institute for closure.

A bill ordering the Secretary of SRS to close KNI when the combined population of all three mental retardation hospitals reached 500 clients was introduced and referred to the House Committee of the Whole. The bill, however, was never debated in the House, and was eventually removed from General Orders and referred to the House Appropriations Committee.

The question of hospital closure and consolidation was not discussed by the Senate Subcommittee during the 1993 Session.

During the 1993 Session, the House Appropriations and Senate Ways and Means subcommittees considering the budgets of the state mental retardation hospitals also considered issues relating to the funding of community-based services. The Committees heard testimony regarding the pace of client movement from the institutions to the community, and certain perceived "bottlenecks" affecting the pace of such movement, such as start-up funding and cash flow. Conferees also identified issues pertaining to medical and therapeutic services available to clients in the community, staff training, and quality assurance.

The Subcommittees also heard testimony regarding the waiting list for community services. SRS maintains a list of persons reported by community mental retardation agencies as waiting for community services. These lists exclude children aged 16 and younger waiting for adult services. The **primary** waiting list, indicating those clients who would accept services immediately if they were available, currently consists of 550 persons. The **secondary** waiting list includes 492 persons. Some of the individuals on the waiting list need residential services, while others need some type of day services; others need both types of services. The Senate Subcommittee expressed concern during the 1993 Session regarding the criteria for inclusion on the waiting list and the validity of the waiting list data.

H.B. 2047, the SRS appropriations bill, included provisions for the placement of clients from state institutions and from the community waiting list in community settings, as well as recommendations designed to address the community "bottleneck." Several items recommended by the Legislature were vetoed by the Governor and reinserted during the Omnibus Session in House Sub. for S.B. 437, the Omnibus appropriations bill. The following summarizes the major community services recommendations for FY 1994.

## Client Placements – FY 1994

The approved FY 1994 budget, taking into account state hospital placement shortfalls from FY 1993, assumes placement of 310 clients from the community waiting list and the movement of 132 clients from state hospitals to the community in FY 1994. The following summarizes the detailed client placement recommendations:

- o funding through the HCBS-MR waiver to serve 235 clients on the community waiting list;
- o funding through vocational rehabilitation services for 75 new clients on the community waiting list;
- o funding through the HCBS-MR waiver for the placement of 84 clients from state hospitals to the community in FY 1994. (Since 48 planned placements were not made in FY 1993, the total number to be placed in FY 1994 is 132.)

## Initiatives to Facilitate Movement to the Community

The following initiatives were recommended by the Legislature to facilitate the placement of clients from state institutions to the community:

- o **MR/DD Provider Revolving Fund.** A transfer of $500,000 was made from an existing fund to the MR/DD Provider Revolving Fund to provide short-term loans to providers to alleviate cash flow concerns arising as a result of increased reliance on Medicaid billing for program funding. The agency has prepared draft regulations which are being reviewed by SRS legal staff. Temporary and permanent regulations should be submitted during August, 1993.
- o **One-Time Placement Costs.** The 1993 Legislature approved the expenditure of $100,000 from the SRS Contingency Fund in FY 1993, and $325,000 from the SGF in FY 1994 for one-time costs associated with the placement of clients from state hospitals into community settings. SRS has developed a plan for the distribution of start-up funds in FY 1994. The amount of funding to be disbursed per placement from an institution will depend upon whether the client is placed prior to February 1, 1994, and whether the client is moving to an individual community setting or a congregate community residential setting. Payments per client will range from $1,000 to $3,200.
- o **Training.** A total of $500,000 from the SGF was approved in FY 1994 for training community mental retardation center staff.

- **Quality Assurance.** Funding for 3.0 FTE new quality assurance field staff was approved for the last half of FY 1994, bringing the total quality assurance staff to 9.0 FTE.

## Proviso

During consideration of H.B. 2047 during the 1993 Session, the House inserted a proviso directing SRS to begin planning for consolidation from three to two state MR/DD hospitals. The proviso further said that a state institution for the mentally retarded should be closed at a point in time at which the Secretary of SRS determined that the combined census at the institutions had reached a point where it is no longer necessary to maintain three institutions, and that such closure should not take place prior to June 30, 1997. The Senate deleted this proviso and recommended an interim study of the MR/DD service delivery system. During conference consideration, the following proviso was added to the bill:

"And provided further, That the Secretary of Social and Rehabilitation Services shall:

- Develop definitions of the criteria for the inclusion of people with mental retardation and developmental disabilities on waiting lists for community services; that based on such definitions, the Secretary shall carry out an assessment to identify the number of people with MR/DD on waiting lists and the level of services that such persons require;

- That savings from FY 1994 state MR/DD institutions' budgets and/or private ICF/MR facility budgets that result from clients leaving these facilities shall be budgeted in FY 1995 to meet the critical needs of clients in community settings;

- That the Secretary shall develop criteria for identifying the number of people with MR/DD who receive services in state MR/DD institutions who might be appropriately served in community settings;

- That the Secretary shall identify the number of people with MR/DD who receive services in community settings who might be more appropriately served in a state MR/DD institution;

- That the Secretary shall develop a profile of characteristics of clients with MR/DD who receive services in private, large-bed ICFs-MR who might be more appropriately served in community settings;

- The Secretary shall report such information to an appropriate interim committee which shall be established by the Legislative Coordinating Council for the 1993 Legislative interim, and shall update such information in a report presented to the 1994 Legislature by February 1, 1994."

## Community Placement of Clients with MR/DD

During 1991, multiyear goals were developed for the placement of clients with mental retardation and developmental disabilities (MR/DD) from the three state mental retardation institutions into community care settings. The goals were formulated by a committee consisting of the superintendents of the three state MR/DD institutions, SRS/MHRS staff, and leaders of four CMRCs.

The following table compares the average daily census upon which the Governor's FY 1993 budget recommendations were based to the actual FY 1993 average daily census.

### FY 1993 Average Daily Census

| Hospital | Budgeted ADC -- FY 1993 | Actual ADC -- FY 1993 | Shortfall |
|---|---|---|---|
| KNI | 296.0 | 311.0 | 15.0 |
| Parsons | 256.0 | 258.4 | 2.4 |
| Winfield | 320.0 | 326.0 | 6.0 |

The following table compares the institutions' target end-of-year census for FY 1993 to the actual institutional census on June 30, 1993.

### FY 1993 End-of-Year Census

| Hospital | Target End-of-Year Census -- FY 1993 | Actual Census June 30, 1993 | Shortfall |
|---|---|---|---|
| KNI | 282 | 301 | 19 |
| Parsons | 242 | 255 | 13 |
| Winfield | 304 | 320 | 16 |

The following table shows the number of clients who will have to move out of the institutions during the course of FY 1994 if the FY 1994 end-of-year target census set for each institution is to be reached.

**FY 1994 Placement Goals**

| Hospital | Actual Census June 30, 1993 | Target End-of-Year Census -- FY 1994 | Balance To Be Placed |
|---|---|---|---|
| KNI | 301 | 247 | 54 |
| Parsons | 255 | 235 | 20 |
| Winfield | 320 | 269 | 51 |

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**Client-Placement Methodology**

Movement of clients from institutions to the community is done on a voluntary basis and only with the consent of the client, or the client's family or legal guardian. The process of placing clients with mental retardation and/or developmental disabilities from state institutions has, essentially, four parts, *i.e.*:

- Referral of a client for placement, development of a personal plan for the client, and forwarding of the personal plan to a community provider. Each of the state MR institutions is responsible for maintaining a referral list with at least 1.5 clients for every placement that is needed to meet the institution's population goal. This is done in order to have "back-up" clients ready in case problems develop during another client's placement process. ***This step occurs at the institutions.***
- Development of a support plan and a cost proposal for the implementation of the plan. ***This is done by the community provider.***
- Review and, if appropriate, approval of the support plan and cost proposal by ***SRS/MHRS Central Office.***
- Arrangements for the client to move from the institution into the community-care setting. This involves finding roommates for the client, hiring staff and making other living arrangements. ***The client will move in the immediate future.***

## VI. CURRENT STATUS AND OTHER ISSUES

**Education Pilot Projects.** The 1993 Legislature heard testimony regarding proposed pilot projects relating to special education services for children with special needs. Both the House Appropriations and Senate Ways and Means committees endorsed this pilot project. The recommended pilot projects would be designed to address the educational services and supports for family and community life for children currently living in state institutions. The subcommittees recommended that this project be undertaken with the Department of Education as the lead agency.

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The Department of Education reported on July 30, 1993 that it has taken no action on this recommendation.

**Refinancing Initiative.** During the 1993 Omnibus Session, the Legislature recommended the deletion from the SRS budget of $500,000 (SGF) in special purpose grants. It was recommended that the agency seek to shift clients currently served from state funded special purpose grants to the HCBS-MR waiver to take advantage of available federal funding. The agency testified at that time that current limits on the number of waiver participants would make such action difficult. The Legislature recommended that the agency seek to amend its waiver to accomplish this purpose and predicated the reduction of $500,000 on approval of an expanded waiver effective January 1, 1994. The Governor vetoed this lapse with the stated intent of providing the agency with "greater flexibility in shifting additional clients to the Medicaid program." The Governor stated her anticipation that "this shift will produce savings of $500,000 or more from the current FY 1994 approved budget, and that this savings will be reflected in [her] FY 1995 budget document." The Governor also directed that the agency not expend $500,000 which was also restored by the veto which had been originally appropriated for medical and therapeutic services.

Subsequent to the session, through further analysis of the current approved waiver, the agency learned that the number of clients who could be served in the final year of the current waiver (FY 1994) could be increased by 190 persons. Thus, without further expansion of the waiver, 190 clients could be shifted from special purpose grants to the waiver. The agency's plan to shift clients includes several components:

- increasing the current HCBS-MR waiver rates to exceed special purpose grant amounts to prevent provider loss of funds through shifting of clients from special purpose grants; and

- adding a requirement that agencies arrange for and include in their services medical and therapeutic evaluations and instruction of and oversight of direct care staff in carrying out appropriate therapeutic interventions not otherwise covered by the Medicaid card.

Based on this plan, the agency would shift 190 persons from special purpose grants to the waiver, and would provide $1.0 million in SGF savings which could be reduced from the budget. This is in addition to the $500,000 in medical and therapeutic funding which could also be reduced from the budget.

Additionally, the agency has proposed the reallocation of the $500,000 from the SGF approved for training between Medicaid and special purpose grants. A total of $302,376 would be added to the Medicaid General Fund base in order to annualize provider staff training. This allows HCBS-MR per diem rates for residential services to be increased by $2.30 per day and prevocational per diem rates to be increased by $1.60 per day. The remainder ($197,624) would be retained in special purpose grants and would increase the average rate by approximately $1 per day.

In addition to SGF savings, the agency indicates the following benefits of this refinancing plan: annualization of provider staff training and the elimination of future requests for training funds; client access to appropriate medical and therapeutic intervention without establishing a new program or creating a new entitlement; and a higher base of community services from which to begin

negotiations with the Health Care Financing Administration (HCFA) for a new waiver to begin in FY 1995.

**Community Placement Pilot Project.** During the 1993 Legislative Session, both the House and Senate subcommittees heard testimony regarding problems encountered in aiding the movement of clients with developmental disabilities from institutional into community settings. Two major problems attested to by conferees addressing the subcommittees were the fact that CMRCs were already working at or near capacity in creating placement settings for institutional and waiting-list clients, and a shortage of funding for start-up costs to develop community-placement settings.

In order to address the latter problem, the House Subcommittee recommended, with the concurrence of the Senate Subcommittee, the addition of funding for community-placement start-up costs in both FY 1993 and FY 1994.

In order to break what was termed a "bottleneck in the movement of institutional clients into community settings," the Senate Subcommittee recommended that each of the state's MR institutions develop community placement settings apart from those being developed by CMRCs. The development of community placement settings by the state institutions was to be a pilot project involving as many as ten clients per hospital. While the Senate Subcommittee felt that the pilot project should be carried out using, for the most part, the hospitals' existing resources, it also recommended that the hospitals have access to the start-up funding added by the House Subcommittee to the SRS-Community Mental Retardation budget. According to the Senate Subcommittee, once the placement settings were developed, they should be spun off to existing community providers. Hospital superintendents were told to report back to the 1994 Legislature on the results of the pilot project.

SRS' Division of Mental Health and Retardation Services reported on August 3, 1993, that it had done nothing to carry out the recommendation of the Senate Subcommittee.

3-18

## THE MENTAL RETARDATION/DEVELOPMENTAL DISABILITIES SYSTEM

| | Actual FY 1992 | | | Estimated FY 1993 | | | Estimated FY 1994 | | |
|---|---|---|---|---|---|---|---|---|---|
| | SGF | All Funds | Clients[a] | SGF | All Funds | Clients[a] | SGF | All Funds | Clients[a] |
| Category | | | | | | | | | |
| State Hospitals | $ 32,512,043 | $ 73,438,566 | 950 | $ 31,298,875 | $ 71,703,351 | 872 | $ 28,257,235 | $ 71,252,045 | 787 |
| ICFs-MR | 13,770,105 | 33,390,168 | 939 | 14,902,897 | 35,910,595 | 939 | 15,209,783 | 37,097,031 | 939 |
| Community Services: | | | | | | | | | |
| State Aid | 5,963,771 | 5,963,771 | 2,387 [b] | 5,963,174 | 5,963,174 | 2,077 [b] | 5,963,173 | 5,963,173 | 2,077[b] |
| HCBS-MR | 3,563,613 | 8,723,195 | 864 | 7,754,836 | 18,627,352 | 1,058 | 15,947,606 | 39,072,905 | 1,615 |
| Special Purpose Grants | 13,187,990 | 13,187,990 | 620 | 15,417,083 | 15,417,083 | 966 | 12,830,016 | 12,830,016 | 851 |
| Social Service Block Grant | 1,161,956 | 10,282,790 | 550 | 1,261,106 | 10,348,790 | 550 | 1,447,668 | 10,441,106 | 550 |
| Vocational Rehab. Match | 399,320 | 1,597,280 | 75 | 395,326 | 1,581,304 | 75 | 395,326 | 1,581,304 | 75 |
| Family Subsidy | 429,927 | 429,927 | 250 | 792,000 | 792,000 | 330 | 1,000,000 | 1,000,000 | 500 |
| Targeted Case Management (Federal Match) | – | – | – [c] | – | 2,000,000 | – [c] | – | 3,500,000 | –[c] |
| One-time Placement | – | – | – [c] | – | 100,000 | – [c] | 325,000 | 325,000 | –[c] |
| County Mill Levy | – | 9,881,402 | – | – | 10,231,341 | – | – | 10,231,341 | – |
| Subtotal - Community | $ 24,706,577 | $ 50,066,355 | 4,746 | $ 31,583,525 | $ 65,061,044 | 5,056 | $ 37,908,789 | $ 84,944,845 | 5,668 |
| GRAND TOTAL | $ 70,988,725 | $ 156,895,089 | 6,635 | $ 77,785,297 | $ 172,674,990 | 6,867 | $ 81,375,807 | $ 193,293,921 | 7,394 |

**Notes:**

a) Number of clients at state institutions is average daily census; number of clients in community is FTE. Thus, since some clients only receive part-time services, more persons are actually served.

b) State aid dollars are not tied to a specific number of clients; the estimate reflects clients served through state aid, county mill levy, production income and other local and private funds.

c) The number of clients served by targeted case management and the one-time placement funding would duplicate other categories on this table.

93-7027/lh

# AN ANALYSIS OF PROFILES OF INDIVIDUAL CHARACTERISTICS OF PERSONS WITH DEVELOPMENTAL DISABILITIES

## A Report To The Legislature Directed By House Bill 2047

July 7, 1993

Kansas Department of Social and Rehabilitation Services
Donna L. Whiteman, Secretary

SRS Mission Statement

"The Kansas Department of Social and Rehabilitation Services empowers individuals and families to achieve and sustain independence and to participate in the rights, responsibilities and benefits of full citizenship by creating conditions and opportunities for change, by advocating for human dignity and worth, and by providing care, safety and support in collaboration with others."

Joint Senate Ways + Means and House Appropriations Cmtes

9/29/93

attachment 4

# BACKGROUND

House Bill 2047 adopted by the Legislature and signed by the Governor included several provisos to be reported to committee(s) established by the Legislative Coordinating Council (LCC) for the 1993 legislative interim with an update to be reported to the 1994 legislature by February 1, 1994. The Secretary of the Kansas Department of Social and Rehabilitation Services was directed to accomplish the following:

- Develop criteria for identifying the number of people who are mentally retarded or otherwise developmentally disabled (MR/DD) who receive services in state MR/DD institutions who might be appropriately served in community settings,

- Identify the number of people who are mentally retarded or otherwise developmentally disabled (MR/DD) who currently receive services in community settings who might be more appropriately served in a state MR/DD institution, and;

- Develop a profile of characteristics of clients who are mentally retarded or otherwise developmentally disabled (MR/DD) who receive services in private, large-bed Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) and
  - Develop criteria for identifying the number of people who are mentally retarded or otherwise developmentally disabled (MR/DD) who receive services in private, large-bed ICFs/MR who might be more appropriately served in community settings.

These provisos suggest there may be a direct correlation between specific individual characteristics of persons with developmental disabilities which can be accurately and reliably measured and isolated to specific environments. The provisos also imply that various environments with the same labels are functionally equivalent.

4-2

The purpose of this report is to provide information on common characteristics of individuals served -insofar as possible -across different service environments currently operating in the MR/DD service system in Kansas. The results will then be analyzed for whether or not there are significant individual characteristics which correlate only to the specific service settings specified in the provisos of HB 2047. If no exclusive correlations occur a conclusion can be reached, variables other than individual characteristics are the primary predictors of where a person is served and, there is no basis on which to develop criteria which specifies an appropriate service setting based on identified characteristics. If such correlations do occur, additional assessment would need to be made in order to reconcile individual and family choice with the results.

# PROCEDURE

The information on individual characteristics is directly dependent on data already gathered in the MR/DD system data base. It must be noted the data have been collected over a period of time using various methods. The data have been gathered through the application of a functional assessment instrument called the Developmental Disabilities Profile (DDP). The DDP was developed in New York, has been vigorously tested on a large population of persons who are mentally retarded or developmentally disabled, and has been demonstrated to be valid and reliable. The results obtained from application of the DDP to large populations can be used with as much confidence as can be obtained using any general screening instrument. Reliability and validity do become more variable when the DDP is relied on to compare characteristics individual to individual, but the cost of applying a more structured and formalized instrument to all persons to obtain individual comparisons would be prohibitive.

Development and application of the DDP in Kansas was initially funded by the Kansas Planning Council on Developmental Disabilities (KPCDD) for the express purpose of assessing individuals served in ICFs/MR and establishing an eligibility base which would then apply to the HCBS/MR waiver. A report was issued in 1990 describing the process.[1] Since then, obtaining a completed DDP on all persons served by, or applying for services in, the MR/DD system has been sporadic

due to lack of funds to pay assessors to conduct the screening(s). To date a variety of methods for obtaining a DDP score on individuals have been implemented in an effort to keep the data base as reliable and up to date as possible.

- SRS Area Office personnel provided initial screening for applicants seeking ICF/MR or HCBS/MR waiver eligibility until 7-1-91 at which time their responsibility was limited to providing re-screening to HCBS/MR recipients on an annual basis. At that time, Community Mental Retardation Center (CMRC) personnel began providing initial screening for applicants who applied for ICF/MR or HCBS/MR waiver services.

- Contract personnel funded by the KPCDD grant conducted initial screening of state MR institutions in 1989-1990. All subsequent screening or re-screening of state MR/DD institutional residents is now conducted by institutional staff.

- Contract personnel funded by the KPCDD grant conducted the initial screening of residents in large and small ICF/MR facilities in 1989-1990. Beginning July 1, 1992, private ICFs/MR were asked to assess their own clients on an annual basis. Concurrently, MR/DD services developed a contract with the Kansas University Affiliated Program (KUAP) to develop and implement a random DDP validation process across all community settings who were assessing their own clients.

- A partial DDP assessment of clients in community MR/DD services who were funded by sources other than Medicaid was begun in FY 1991 using contract staff but was not completed due to lack of funding.

- There is currently no formalized process for obtaining assessments on persons on community waiting lists for other than potential HCBS/MR waiver funding or ICF/MR placement.

4-4

This history is provided to explain not all persons who are currently served in all service settings of the MR/DD system have current (one year old or newer) DDPs or any DDP at all. However, a statistically significant representative sample of persons for each service setting designated in the provisos is available. In order to provide as much information as possible, this analysis will also provide available profile data on community waiting lists and recent placements from state MR institutions to community services as well as the statewide average. The distribution of available DDPs is as follows:

| CATEGORY | TOTAL NUMBER | DDPS AVAILABLE | % |
|---|---|---|---|
| All Categories Total | 7748 | 5090 | 66% |
| Community Waiting Lists | 866 | 292 | 34% |
| Community MR Settings | 4918 | 2876 | 59% |
| ICF/MR (17 or more beds) | 655 | 648 | 99% |
| ICF/MR (16 or less beds) | 321 | 297 | 93% |
| State MR Facilities | 902 | 891 | 99% |
| Recent Placements from MR Hospitals to the Community | 86 | 86 | 100% |

## CHARACTERISTICS

In addition to demographic information and descriptors which categorize various characteristics of individuals, the DDP provides Index Scores on Adaptive Behavior, Maladaptive Behavior, and Health needs. An exhaustive review and comparison of every characteristic or contributing component to the Adaptive, Maladaptive, or Health Indexes would be difficult to accomplish and not be more informative than selection of salient characteristics and components. An example of all the variables that could be reviewed is attached to this report as Appendix A. This analysis will

be based on salient components - those experts agree have the greatest influence on institutional placement - drawn from those variables as well as tiered groups based on the Adaptive, Maladaptive, and Health Indexes. The variables which will be examined have been grouped into the following categories for purposes of reporting:

| DEMOGRAPHICS | CHARACTERISTICS | INDEXES |
|---|---|---|
| Intellect | Assaultive | Tier 1 |
| Mobility | Destroys Property | Tier 2 |
| Presence of Seizures | Self-Injurious | Tier 3 |
| Direct Care Trained in Health Procedures | Sexual Misbehavior | Tier 4 |
| Receives Nurse Services | Anti-psychotic Medication(s) | Tier 5 |
| Receives Psychologist Services | Psychiatric Diagnosis | |
| Receives Psychiatrist Services | | |
| Receives Speech & Hearing Services | | |
| Receives Physical Therapy Services | | |
| Receives Occupational Therapy Services | | |

METHOD

The demographic(s), characteristics, and indexes will be compared on a percentage basis across six service categories plus a statewide average. The categories, as previously indicated, will be State MR Facilities, Large ICFs/MR, Small ICFs/MR, other Community Settings, the Community Waiting List, and Recent Placements from State MR Facilities to the Community. This approach will provide a basis for comparison proportional to the population of each service setting.

State MR Facilities are the state operated institutions: Kansas Neurological Institute (KNI), Winfield State Hospital and Training Center (WSH&TC), and Parsons State Hospital and Training Center (PSH&TC).

Large ICFs/MR are private agencies of 17 or more beds certified to participate in Medicaid funding for provision of active treatment programs to persons with mental retardation or related conditions. The corporate owners and agencies in Kansas are:

- Beverly Enterprises Kansas, Inc.
  - Golden West Skills Center, 53 beds, Goodland
  - Living Skills Center, 60 beds, St. Paul,
  - Parkview Learning Center, 54 beds, Macksville
- Focus Inc.
  - Focus Developmental Center, 81 beds, Winfield
- Hartford, Inc.
  - Hartford Manor, 50 beds, Hartford
- Hunter Care Centers
  - Friendship Manor Haven, 76 beds, Haven
  - Friendship Manor Medicine Lodge, 49 beds, Medicine Lodge
- Medicalodges Inc.
  - New Horizons Pittsburg, 82 beds, Pittsburg
  - New Horizons Valley Center, 100 beds, Valley Center
- Shields Adult Care Home, Inc
  - Shields Adult Care Home, 50 beds, Pittsburg

Small ICFs/MR are facilities of 16 beds or less. There are 36 of these facilities, the majority operated by Community Mental Retardation Centers (CMRCs) and church affiliated not-for-profit agencies with a few operated by for-profit corporations.

4-7

Community Settings are group homes, supported apartments, family homes, day programs etc. funded by county mill levy, special purpose grants, social service block grants, Title XIX HCBS/ MR waiver funds, and Vocational Rehabilitation.

Recent Placements To The Community are the people placed from the three State MR Facilities to Community Settings since February of 1992.

The Community Waiting List consists of those persons who have applied for services to a community agency and are receiving no services at this time.

# ANALYSIS

The initial variable(s) to be compared across service categories are those grouped under Demographics. These variables provide an overview of the level of intellectual functioning, the ability to walk, and the presence and type of seizure activity. These variables also reflect an assessment as to whether or not specially trained direct care staff or medical/therapeutic consultant staff are providing services to individuals within the service category analyzed. The assessment does not determine whether such services are needed and not provided or provided though not needed.

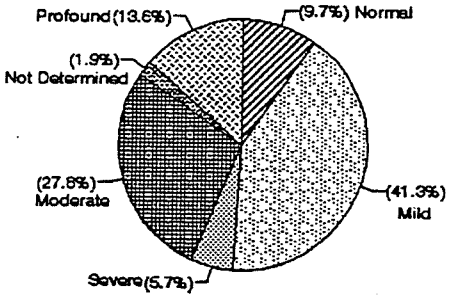
## INTELLECTUAL FUNCTIONING

As the graphs which follow demonstrate, no service category analyzed has a monopoly on a particular level of intellectual functioning. Residents of State MR Facilities constitute the highest percentage of persons who primarily fall into severe and profound levels of mental retardation. However, in terms of sheer numbers, more persons who fall into these two levels of intellect do not live in State MR Facilities than who do. Comparisons of Recent Placements to the Community from State MR facilities also indicate very little difference in percentages in these two levels of intellectual functioning.

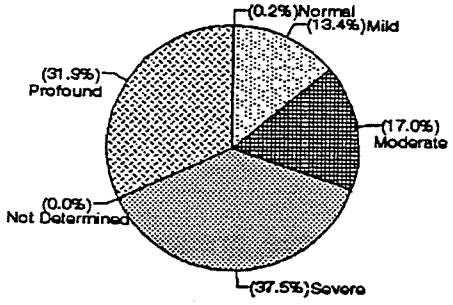
4-8

# DISTRIBUTION OF INTELLECTUAL FUNCTIONING

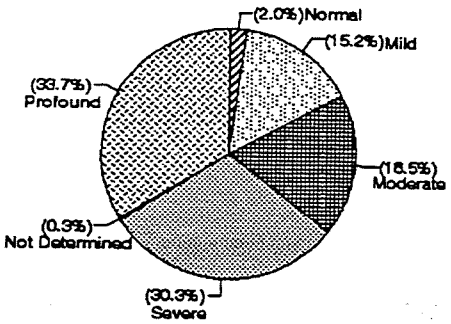
## Community Settings



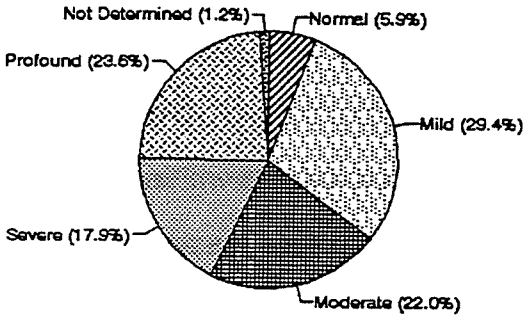

## Large ICFs/MR



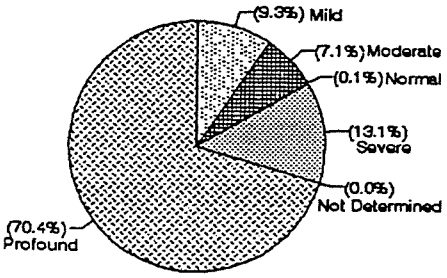

## Small ICFs/MR



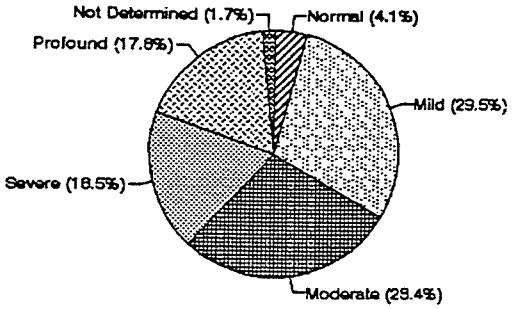

## All Categories



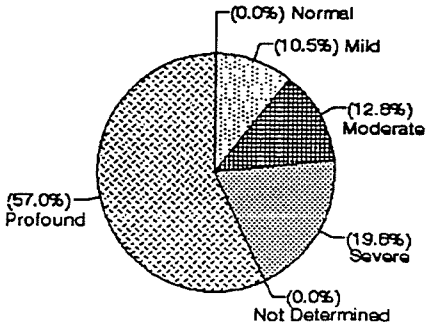

## State MR Facilities




## Waiting List




## Recent Placements to the Community*

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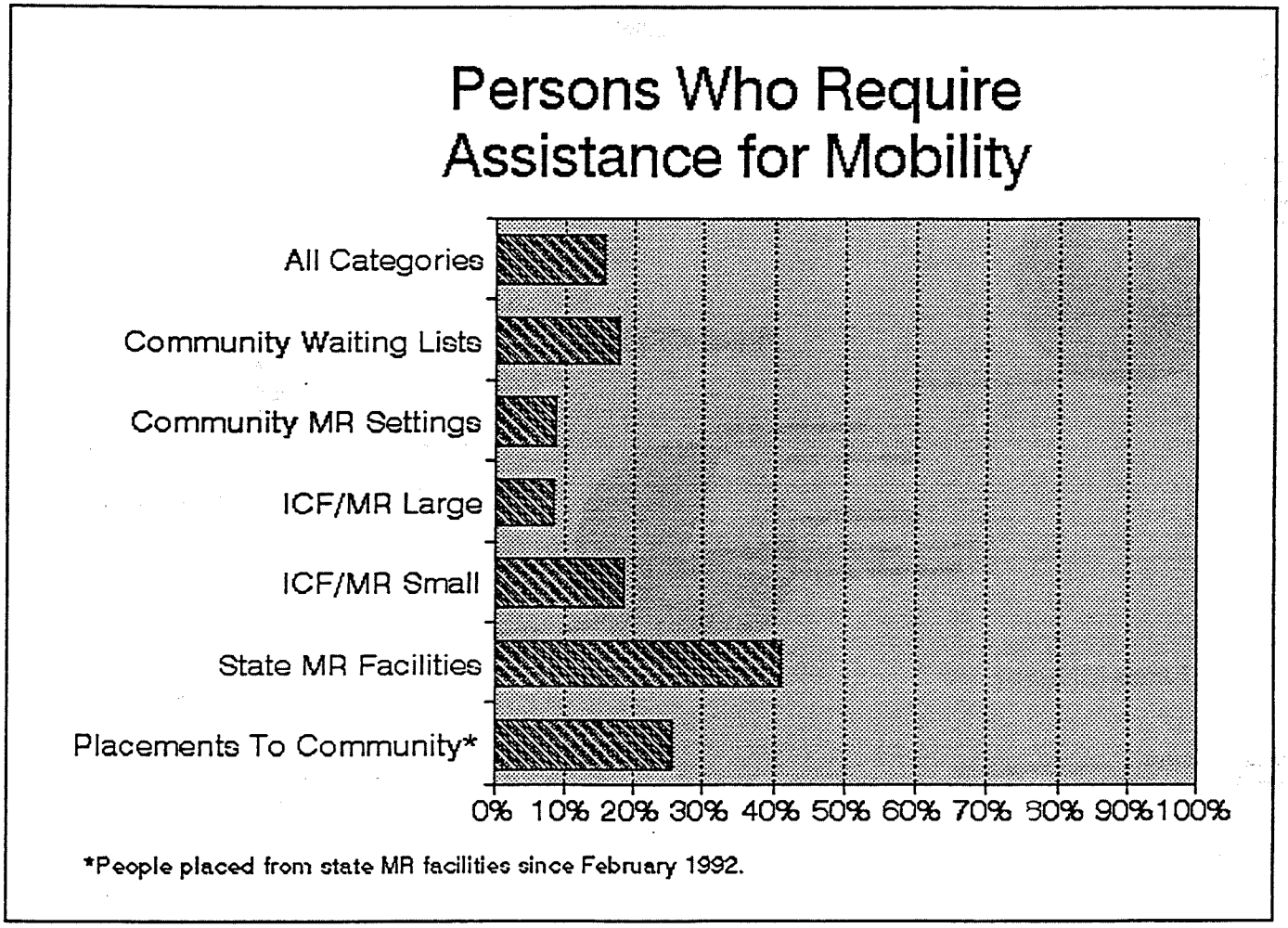
*People placed from state MR facilities since February 1992.

MOBILITY

Mobility is defined - for purposes of this study - as requiring assistance in walking or moving from place to place. An analysis of Mobility demonstrates a pattern similar to Intellectual Functioning. Although State MR Facilities demonstrate the highest population percentage on this variable, persons who require assistance in walking are present in significant numbers across all service categories.



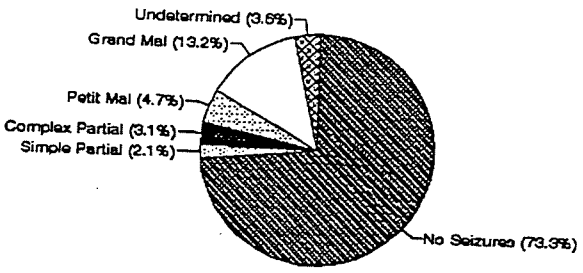

PRESENCE OF SEIZURES

This demographic is formed by including all persons who were subject to a seizure in the past year. The various charts identify the type of seizure activity which occurred. The data indicate the presence of seizures has not been an obstacle to placements from State MR Facilities to Community Settings - demonstrated by the chart Recent Placements to the Community. The charts also indicate the State MR Hospitals and Recent Placements to the Community data currently constitute the categories with a greater percentage of persons with seizures.

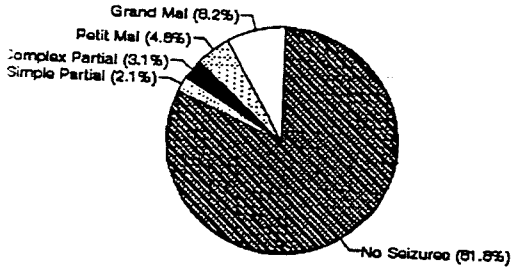
4-10

# SEIZURE ACTIVITY

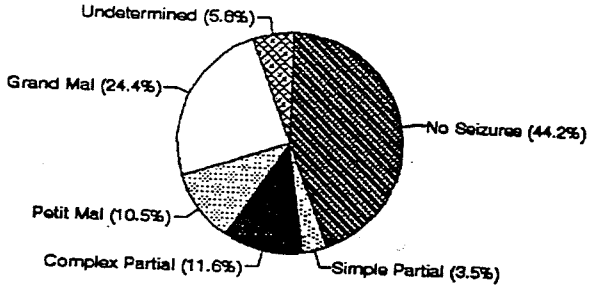
## All Categories




## Community MR Settings

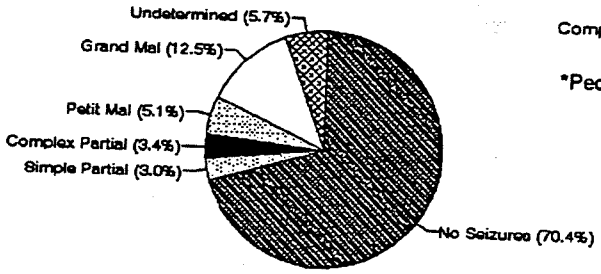



## Recent Placements to the Community*

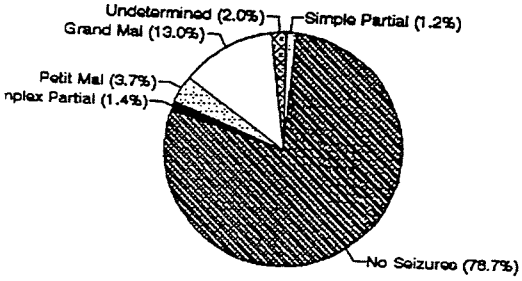



*People placed from state MR facilities since February 1992.

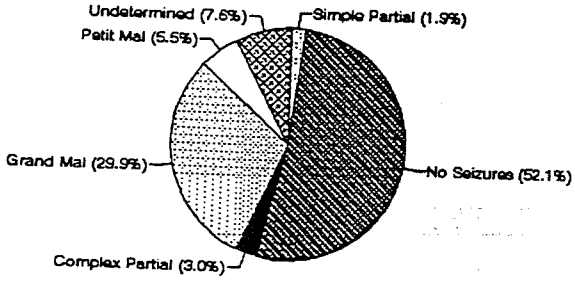
## Small ICFs/MR



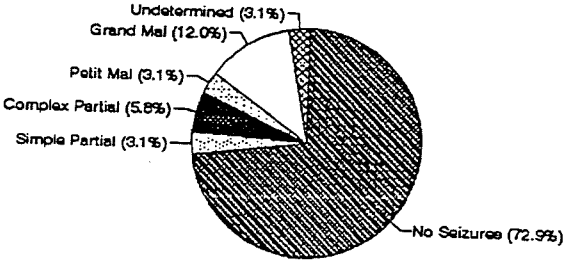

## Large ICFs/MR




## State MR Facilities




## Waiting List



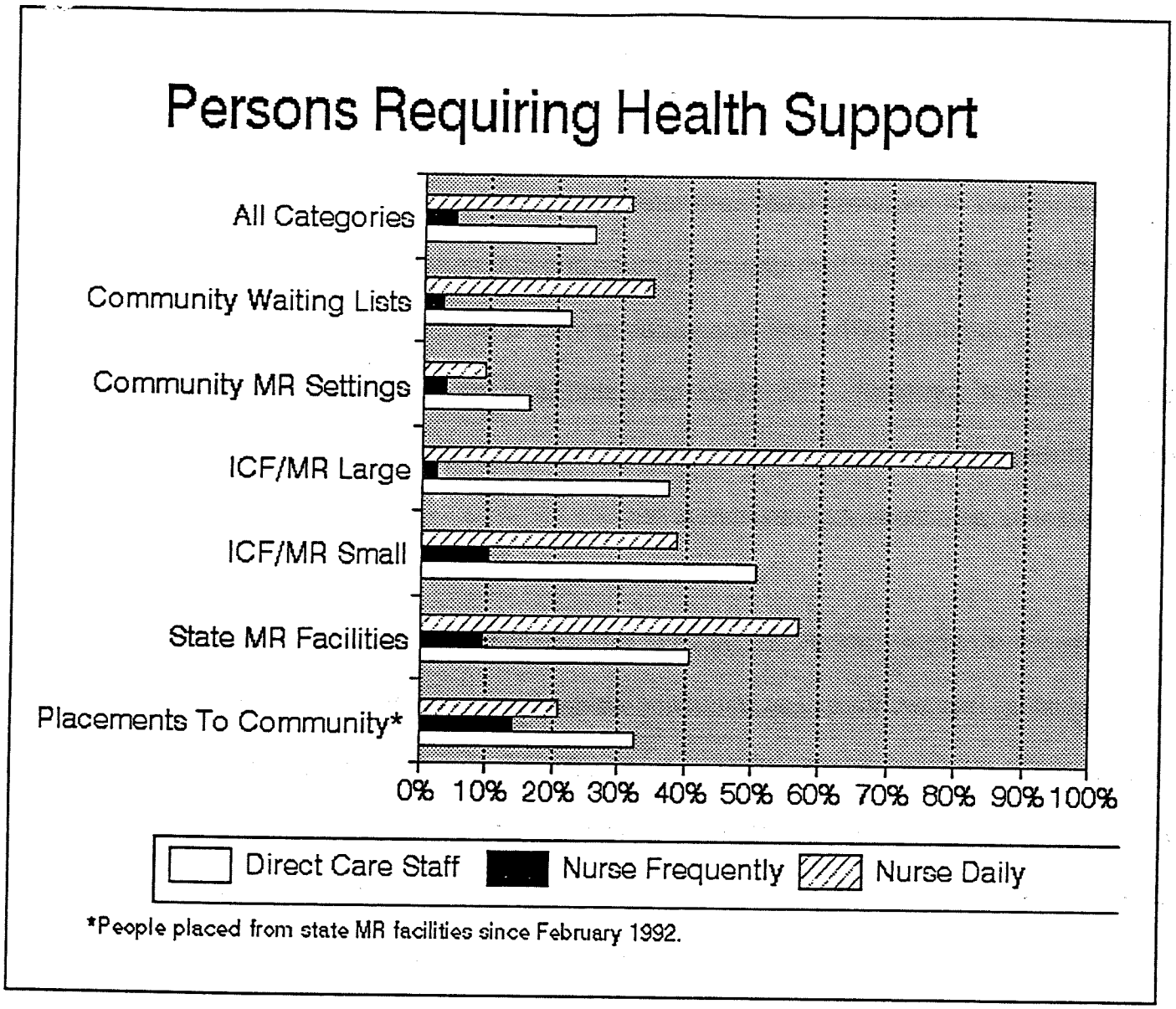

4-11

SUPPORTIVE HEALTH SERVICES

This variable combines two categories from the DDP. The demographics measured are those where the individual requires direct care staff to be trained in special health care procedures combined with an analysis of the frequency a nurse provides services. The measure of direct care staff trained in special health care procedures relates to the programming consequences of a person's medical condition. The direct care staff training may need to include, but is not necessarily limited to, changing sterile dressings, changing colostomy bags, suctioning care for a tracheostomy, and respirator assistance, etc.

The measures of nursing are divided into two sets - visits frequently (about three times a week) and daily visits. The two measures of nursing are not duplicative, therefore a person counted in one category is not counted in the other. However, the same person may require direct care staff trained in special health care procedures as well as frequent or daily visits from a nurse. The data indicate all service categories contain individuals who require direct care staff be trained in special health care procedures and who receive frequent or daily nursing services. The finding in the large ICFs/MR of an unexpected level of daily nursing may be due more to application of federal standards than needs of the individuals residing in these facilities. The data also indicate State MR Facilities and ICFs/MR contain a higher percentage of individuals who fall into these categories. There is, however, an indication that there will be an increasing demand on Community MR Settings as illustrated by the Community Waiting Lists and Placements to the Community. Finally, only sixteen persons across all service categories in the total MR/DD service system receive daily visits from a physician; three in State MR Facilities, five in Large ICFs/MR, seven served by Community MR Settings using the HCBS/MR waiver, and one on the Community Waiting List.

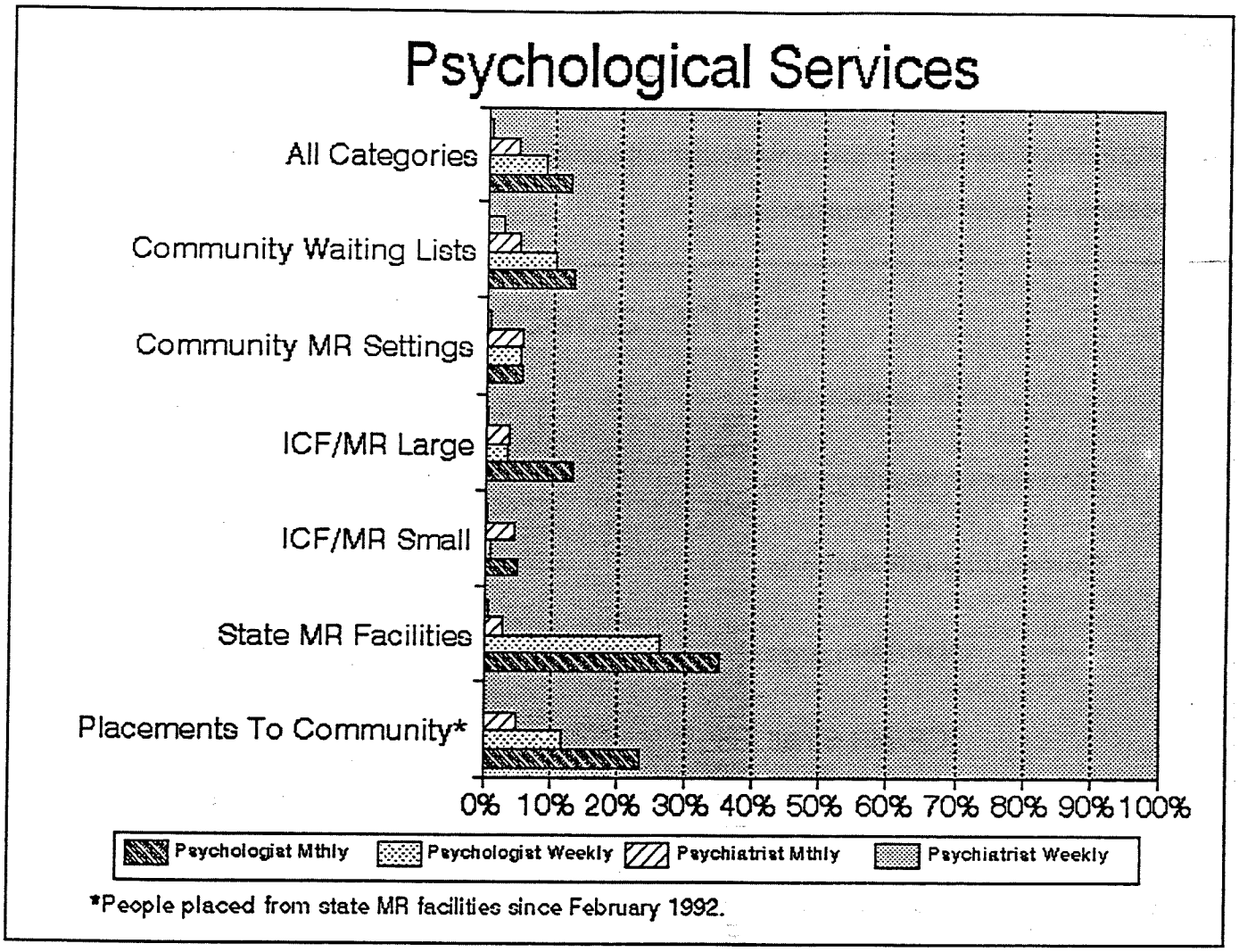
4-12




PSYCHOLOGICAL SERVICES

This variable looks at the frequency - on a monthly or weekly basis - an individual receives psychiatric or psychological services. As can be seen, the use of psychiatrists in the total MR/DD system is very small and is generally on a monthly basis. Psychologists provide services to a higher percentage of individuals in State MR Facilities and Recent Placements to the Community, particularly on a monthly basis. Although psychological services are provided across all service categories, the data from the Community Waiting Lists, Placements to the Community, and State MR Facilities indicate Community MR Settings must gear up as individuals demonstrating a need for these services constitute an increasing percentage of the individuals they serve.

4-13

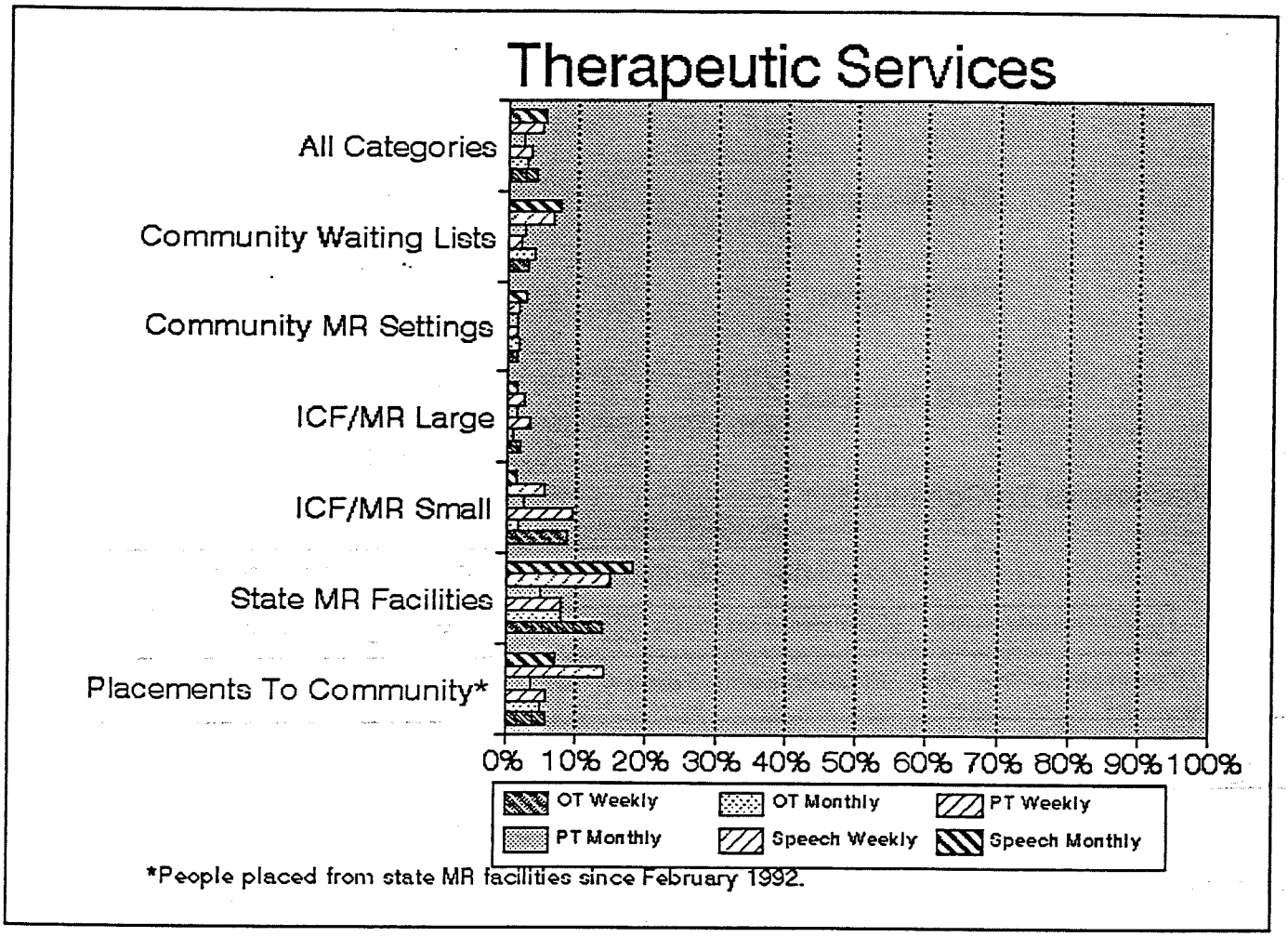



THERAPEUTIC SERVICES

The demographic variables analyzed as therapeutic services include any combination of Occupational Therapy, Physical Therapy, and Speech and Hearing services provided to individuals on a monthly, weekly or daily basis. Persons included in this demographic may be receiving any or all of the specified services. The frequencies of daily, weekly, and monthly were selected as valid overall indicators of the level of these activities. It must be reiterated that measures of these levels of activity are not necessarily indicators of whether or not persons are in need of these services or should receive these services.

As the graphs depicting these variables indicate, there is no major variability between service categories on any of the three therapies. As a percentage of population, Speech and Hearing Therapy appears to be the therapy received most frequently in State MR Facilities although less

than twenty percent of the persons assessed received this service. A view of these therapies systemwide indicates generally less than ten percent of the persons assessed with the DDP are receiving therapy services. Again, this data must be interpreted with caution as the DDP data does not necessarily relate to assessed needs.



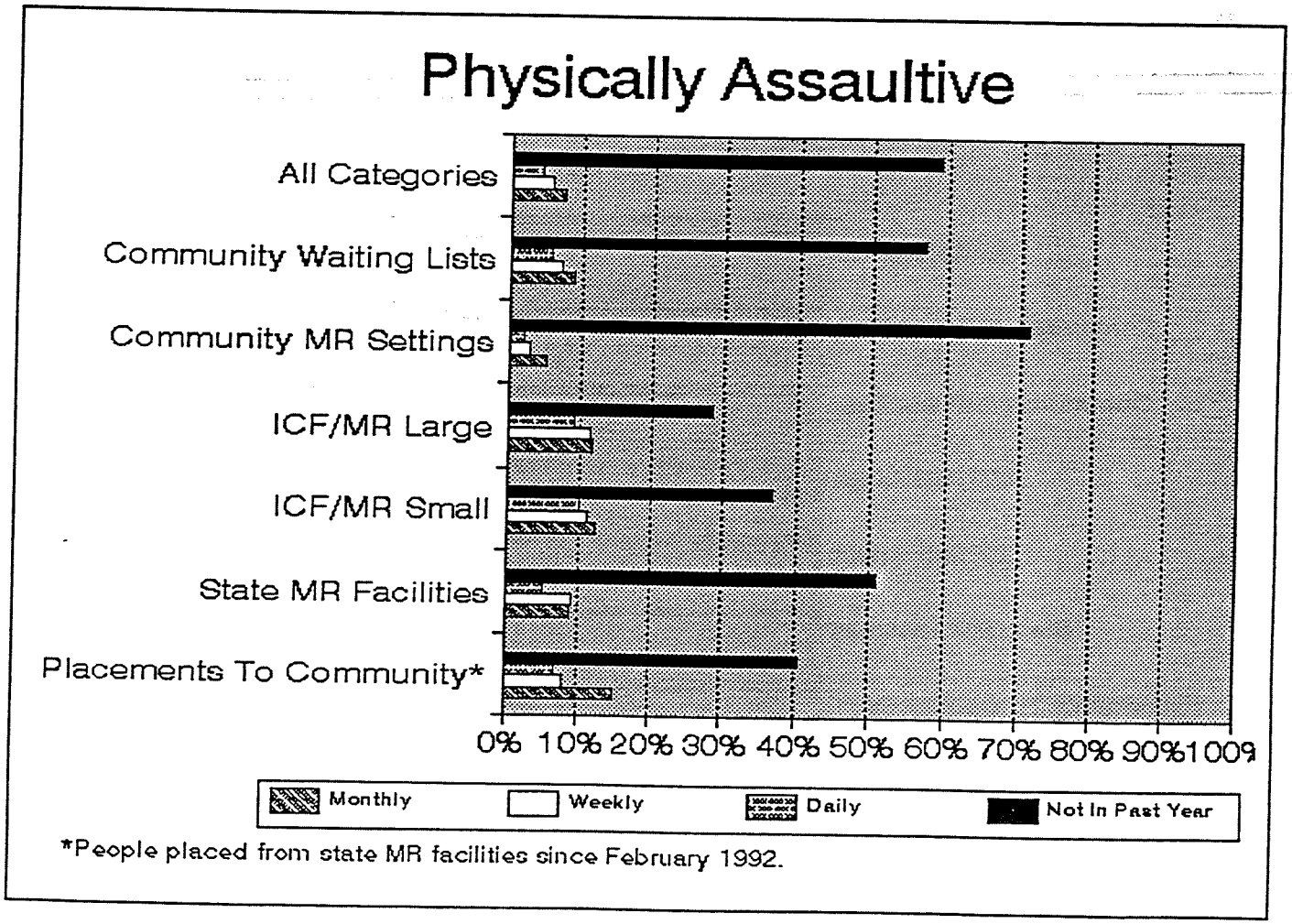

The next area of analysis covers selected characteristics in the behavior area which present the greatest barrier(s) to successful living in the community. These characteristics have been grouped for this analysis into two areas: Behavior, and the presence of a Psychiatric Diagnosis or medication regimen using antipsychotic or antidepressant drugs.

## BEHAVIOR DOMAIN

Four separate and distinctive characteristics were examined in the behavior domain. Each characteristic assessed whether or not an individual displayed the following on a daily, weekly, monthly, or not-in-the-last-year frequency: Damage of personal or others property, physical

assaults on others, intentional self-injury, or sexually inappropriate behavior. Again, the data indicate the behaviors measured are distributed across all service categories. Of interest is the data indicating that recent Placements to the Community contained a higher percentage of individuals who displayed property damage, sexually inappropriate and physically assaultive behavior than the percentage contained in the State MR Facilities population. Also, Community Waiting Lists and Large and Small ICFs/MR data indicate a greater percentage of individuals with physically assaultive behaviors when compared to the State MR Facilities. Finally, the data clearly indicate an overwhelming majority of persons in all the service categories did not demonstrate any of the identified behaviors in the last year. The following charts provide a graphic illustration of the measures in the behavior domain.

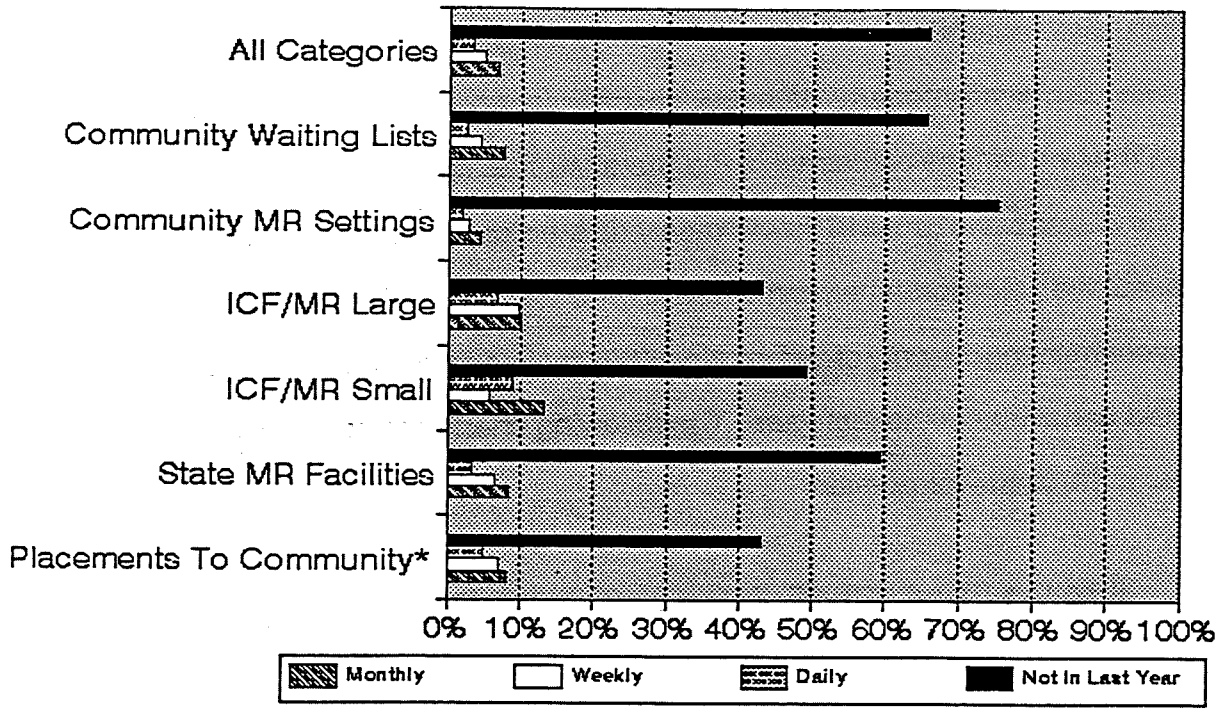
## MALADAPTIVE BEHAVIORS DISPLAYED





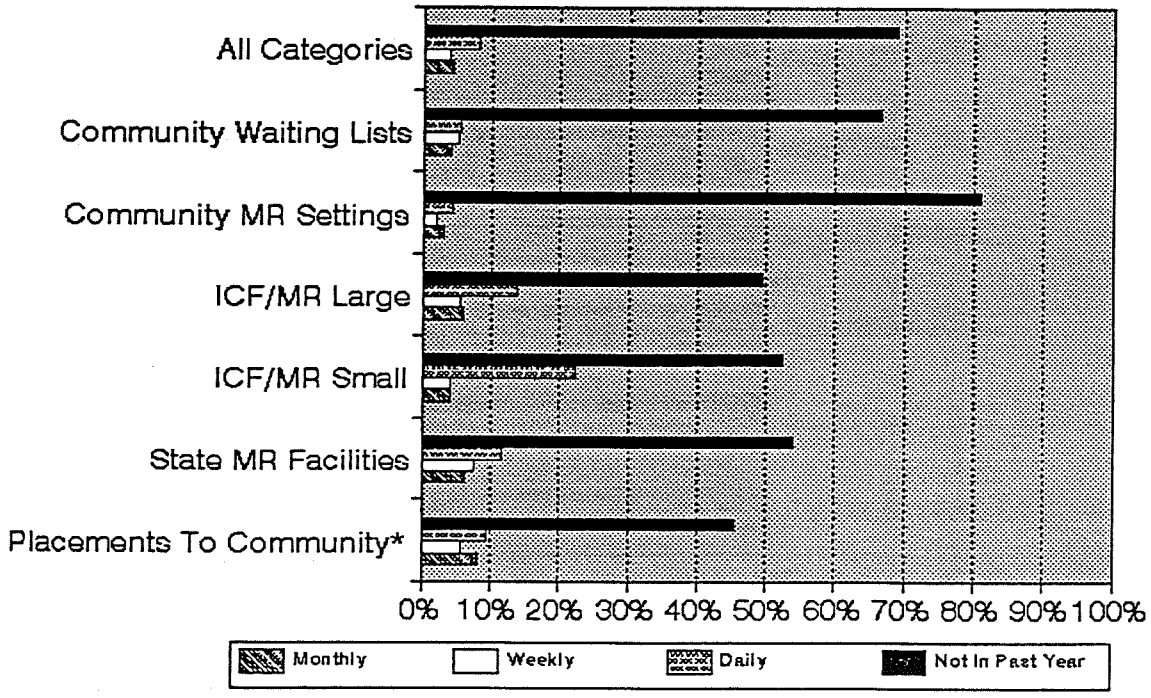

4-16

# Damages Property




*People placed from state MR facilities since February 1992.

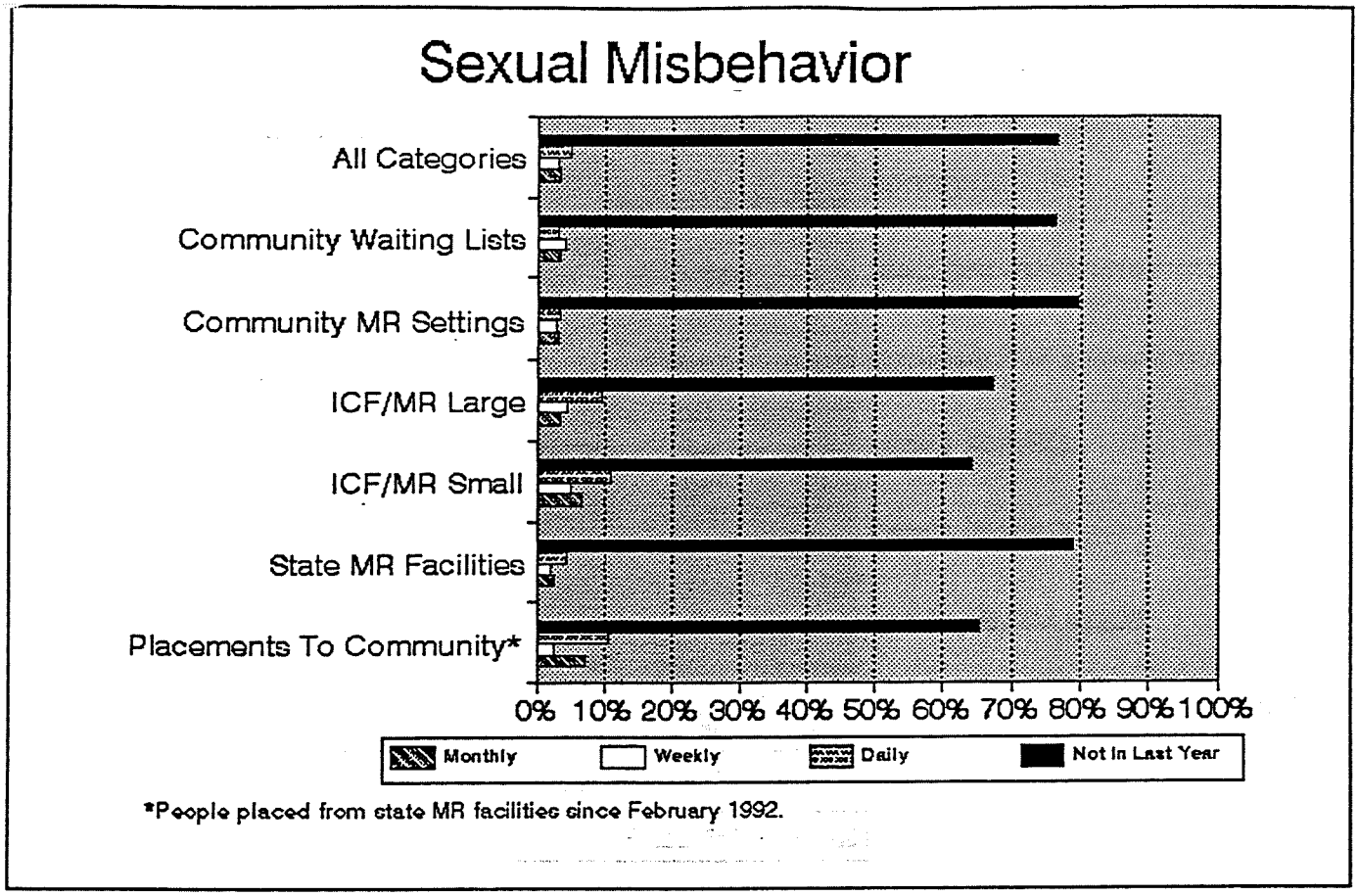
# Self-Injurious




*People placed from state MR facilities since February 1992.



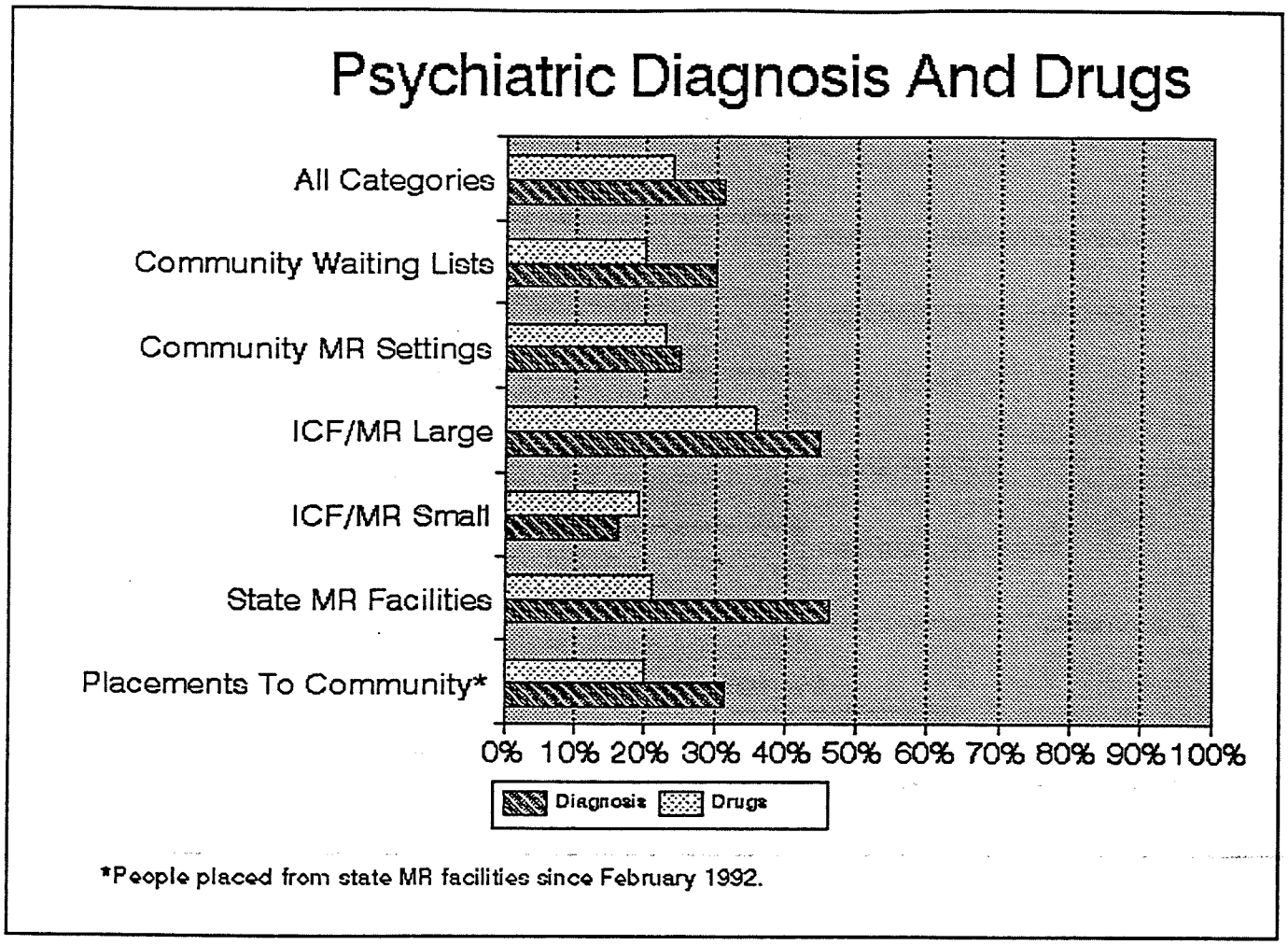
4-17




PSYCHIATRIC DIAGNOSIS/MEDICATIONS

The DDP records whether or not an individual has a formal psychiatric diagnosis as identified in the Diagnostic and Statistical Manual of Mental Disorders (DSM III) and/or is receiving on an ongoing basis antipsychotic or antidepressant prescription medications for behavior management (e.g., Thorazine, Mellaril, Lithium, etc.). The data indicate slightly over 30 percent of the individuals assessed across all service categories have a formal psychiatric diagnosis. The data also indicate the State MR Facilities appear to have the greatest success in titration of drug regimens.

4-18




INDEXES

As previously stated, the DDP provides Index Scores on Adaptive Behavior, Maladaptive Behavior, and Health needs. The adaptive behavior index combines all items which measure individual capability in self care and daily living skills. The maladaptive behavior index combines all items measuring maladaptive behavior displayed by an individual and the health index combines all items which measure health needs. An Index Score is arrived at electronically for each of the three indexes when the individual DDP items are entered onto a computer. The maximum possible scores for each index are 500 for Adaptive Behavior, 200 for Maladaptive Behavior, and 31 for Health. These maximums indicate the highest need or most severe disability, and were originally established by the state of New York in the development of the DDP.

4-19

When MR/DD Services sought to establish a tiered rate of reimbursement for services provided under the HCBS-MR waiver based on severity of disability, a large sample of DDP scores of persons served under the waiver, in state MR facilities, and large and small ICFs/MR were arrayed from high to low. Giving each index of adaptive, maladaptive, and health scores equal weight, the sample was divided into five equal groups. The resulting cut-off scores illustrating most severe in group one to least severe in group five are listed in the following chart:

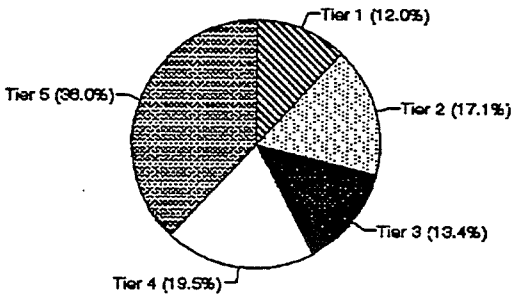
| Group | Adaptive Score | Maladaptive Score | Health Score |
|---|---|---|---|
| 1 | 455.56 - up | 135.20 - up | 15 - up |
| 2 | 406.57 - 455.55 | 117.33 - 135.19 | 12 - 14.99 |
| 3 | 355.47 - 406.56 | 98.00 - 117.32 | 9 - 11.99 |
| 4 | 274.90 - 355.46 | 65.33 - 97.99 | 8 - 8.99 |
| 5 | 00.00 - 274.89 | 00.00 - 65.32 | 0 - 7.99 |

For purposes of this analysis all the DDP scores from the seven service categories under study were assigned to one of the above five groups using the highest score attained on any of three indexes. Although the resultant tiers are no longer composed of equal numbers of individuals, analysis should yield an indication of the relative levels of severity of the populations in the service categories on a percentage basis. Charts illustrating the distribution of tiers in the various service categories are on the following page.

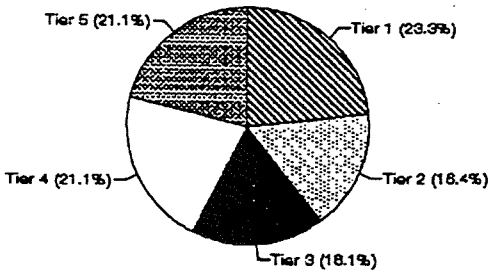
4-20

# DISTRIBUTION OF DDP TIERS BY CATEGORY

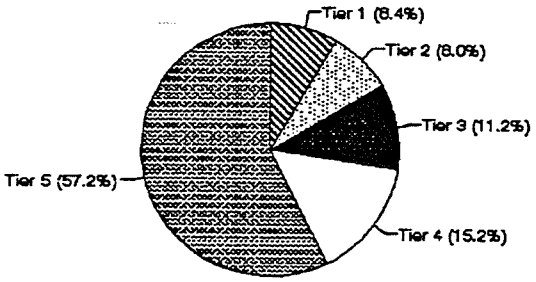
## Community Waiting List



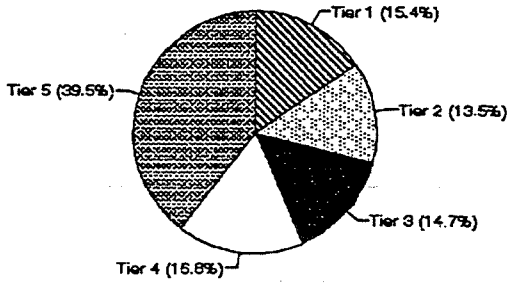

## Large ICFs/MR



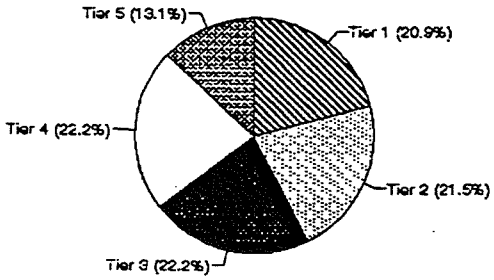

## Community Settings



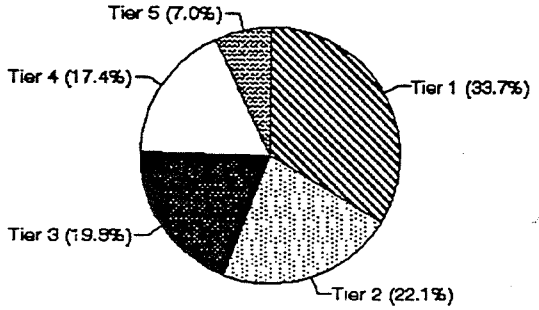

## All Categories




## Small ICFs/MR

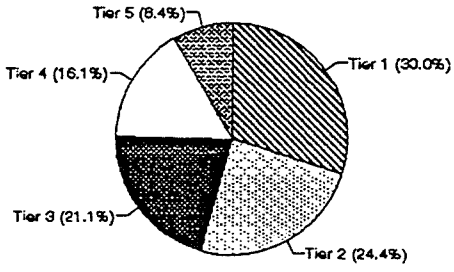



## Recent Placements to the Community*




*People placed from state MR facilities since February 1992.

## State MR Facilities




4/21

The data clearly indicate the State MR Facilities populations contain the highest percentage of difficult to serve clients (tier 1 & tier 2) followed by the large and small ICFs/MR when comparing service settings. However, in terms of actual numbers, Community Settings serve as many tier one and tier two individuals as do the State MR Facilities, but the percentage of population is lower due to the greater number of persons served in community settings. Overall, Community Settings, Large ICFs/MR, and the Community Waiting List contain the highest percentage of tier five individuals.

Of special interest is the data that shows Recent Placements to the Community - those placed since February 1992 - are a mirror image of the distribution of tiers in the State MR Facilities. This finding indicates Community Settings have not been accepting only the easiest to serve persons as individuals have been transferred nearer their home, and reinforces the position these placements have occurred based on choices exercised by families and guardians.

All tiers are represented across all service categories. This finding supports the previous findings which showed the selected demographics and characteristics were represented across all service categories.

# SUMMARY AND CONCLUSIONS

At the direction of the Legislature, this analysis was conducted to develop criteria which could be used to reliably differentiate between persons who might be appropriately served in community settings, persons who might be appropriately served in state MR/DD institutions, and persons who might be appropriately served in private ICFs/MR. The objective of the analysis was to isolate demographic and individual characteristics which would validly correlate with various service categories.

The findings indicate various degrees of variability between service categories when the data are compared on a proportional (percentage) basis. However, there is no apparent significant

variable, among those selected for review, which correlates with a specific type of service setting to the degree it could serve as criteria for designating appropriate service settings. All variables studied were present in significant - when compared in actual rather than percentage - numbers across all categories studied. The conclusion must be reached, based on current experience in Kansas, there are no individual characteristics which can be used to accurately determine in what service setting an individual should be placed.

This analysis did reveal significant information when comparing the categories of Recent Placements to the Community and State MR Facilities which deserves further discussion. That comparison indicates, since February 1992, there is no significant difference between institutional populations and persons transferred to community programs. This outcome was achieved by the Community Integration Demonstration (CID) project, a new methodology which was implemented to improve the process for moving individuals from the State MR Facilities into community programs.

Historically, State MR Facilities reported 20 to 50 percent of people transferred to community settings returned. The new process involves establishing a four-way partnership consisting of families, community agencies, State MR Facilities, and MH&RS. The purpose is to move individuals living in state MR hospitals into community integrated services of their choice - bypassing the traditional continuum of care based on severity of disability - by providing the individuals with appropriate supports and services thus preventing returns. The commitment is to move those individuals whose parents or guardians wanted them to live closer to home, regardless of severity of disability.

To date, over ninety-six percent (96%) of those persons placed through the CID project remain in their new home community. Preliminary data indicate the cost of serving the persons placed through the CID project is 45.3 % less than the average State MR Facility cost. The CID project was evaluated by an independent consultant who termed the Kansas Community Integration

4-23

Project "overall, ... a clear and exciting success" in a report issued in February 1993.[2] The report documents the commitment made through the CID project was successful to a degree never before achieved for a group of individuals exhibiting the same distribution of demographics and characteristics as State MR Facilities. This report is available through MH&RS.

In conclusion, this analysis and the success of the CID does not support the premise clients with certain characteristics must be served in specifically designed settings. They do suggest adoption of the principle of consumer and parent/guardian choice can be supported in any setting in the Kansas MR/DD service system.

4-24

# CITATIONS

(1) **Assessing Individuals in the Kansas Mental Retardation / Developmental Disability Service System with the Developmental Disabilities Profile**, A report prepared by the Kansas Department of Social and Rehabilitation Services, Mental Health and Retardation Services, June 1990.

(2) **Community Integration Demonstration Project Evaluation Report**, A product of Rucker, Powell & Associates, Ltd., Herington, Kansas, February, 1993.

4-25

# APPENDIX
# A

4-26

Mental Health and Retardation Services
Abstract of ICF's/MR Based on KUAP Project
Data as of April 1, 1993

| | Small Bed | Large Bed | Totals |
|---|---|---|---|
| Male | 154 | 341 | 495 |
| Female | 107 | 287 | 394 |
| Totals | 261 | 628 | 889 |
| | | | |
| Ages 4 and Under | 0 | 0 | 0 |
| Ages 5-10 | 0 | 0 | 0 |
| Ages 11-16 | 0 | 0 | 0 |
| Ages 17-18 | 2 | 2 | 4 |
| 19 and Over | 259 | 626 | 885 |
| Totals | 261 | 628 | 889 |
| | | | |
| Client's Residence | | | |
| Living Independently | 0 | 0 | 0 |
| Living with relatives. | 0 | 0 | 0 |
| OMRDD Certified Residence | 250 | 627 | 877 |
| Health Facility | 0 | 0 | 0 |
| Other | 11 | 1 | 12 |
| Totals | 261 | 628 | 889 |
| | | | |
| Day Programs | | | |
| None | 0 | 2 | 2 |
| OMRDD Cert. Program | 259 | 622 | 881 |
| School | 2 | 4 | 6 |
| Competitive Employment | 0 | 0 | 0 |
| Other | | | 0 |
| Totals | 261 | 628 | 889 |
| | | | |
| All developmental disabilities that apply to individuals. | | | |
| No Developmental Disability | 2 | 1 | 3 |
| Mental Retardation | 258 | 628 | 886 |
| Autism | 14 | 20 | 34 |
| Cerebral Palsy | 30 | 56 | 86 |
| Epilepsy/Seizure Disorder | 89 | 209 | 298 |
| Learning Disability | 1 | 12 | 13 |
| Other Neurological Impairments | 29 | 80 | 109 |
| Undetermined Developmental Disability | 8 | 4 | 12 |
| Totals | 431 | 1010 | 1441 |
| | | | |
| Primary developmental disability of individuals. | | | |
| No Developmental Disability | 0 | 1 | 1 |
| Mental Retardation | 256 | 626 | 882 |
| Autism | 0 | 1 | 1 |
| Cerebral Palsy | 3 | 0 | 3 |
| Epilepsy/Seizure Disorder | 1 | 0 | 1 |
| Learning Disability | 0 | 0 | 0 |
| Other Neurological Impairments | 1 | 0 | 1 |
| Undetermined Developmental Disability | 0 | 0 | 0 |
| Totals | 261 | 628 | 889 |

Mental Health and Retardation Services
Abstract of ICF's/MR Based on KUAP Project
Data as of April 1, 1993

| | Small Bed | Large Bed | | Totals |
|---|---|---|---|---|
| Individual's level of intellectual functioning | | | | |
| Normal or Above | 2 | 1 | | 3 |
| Mild retardation | 36 | 77 | | 113 |
| Moderate retardation | 38 | 107 | | 145 |
| Severe retardation | 94 | 238 | | 332 |
| Profound retardation | 90 | 205 | | 295 |
| Not determined at this time | 1 | 0 | | 1 |
| Totals | 261 | 628 | | 889 |
| Individuals who have a psychiatric diagnosis. | 48 | 250 | | 298 |
| Medical conditions. | | | | |
| Respiratory | 16 | 31 | | 47 |
| Cardiovascular | 28 | 105 | | 133 |
| Gastro-Intestinal | 73 | 162 | | 235 |
| Genito-Urinary | 23 | 51 | | 74 |
| Neoplastic Disease | 10 | 27 | | 37 |
| Neurological Diseases | 24 | 111 | 0 | 135 |
| Individuals who have a history of seizures. | 116 | 217 | | 333 |
| Type of seizures experienced in last twelve months. | | | | |
| No Seizures This Year | 46 | 122 | | 168 |
| Simple Partial | 21 | 13 | | 34 |
| Complex Partial | 18 | 32 | | 50 |
| Generalized-Absence (Petit Mal) | 24 | 26 | | 50 |
| Generalized-Tonic-Clonic (Grand Mal) | 43 | 80 | | 123 |
| Had Some type of Seizure | 10 | 7 | | 17 |
| Frequency of seizures in the past year that involved the loss of awareness and/or loss of consciousness. | | | | |
| None during past year | 25 | 18 | | 43 |
| Less than once a month | 30 | 64 | | 94 |
| About once a month | 16 | 22 | | 38 |
| About once a week | 11 | 15 | | 26 |
| Several times a week | 5 | 9 | | 14 |
| Once a day or more | 6 | 1 | | 7 |
| All types of prescription medications individual received on an ongoing basis | | | | |
| No Prescription Medication | 33 | 93 | | 126 |
| Antipsychotic/Antidepressant | 46 | 218 | | 264 |
| Antianxiety | 9 | 34 | | 43 |
| Anticonvulsant | 82 | 172 | | 254 |
| Diabetes Medication | 2 | 15 | | 17 |
| Other Maintenance Medications | 194 | 422 | | 616 |
| Individuals who receives ongoing Medication by injection. | 16 | 19 | | 35 |

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Mental Health and Retardation Services
Abstract of ICF's/MR Based on KUAP Project
Data as of April 1, 1993

| | Small Bed | Large Bed | Totals |
|---|---|---|---|
| Level of support received when taking medication. | | | |
| No Medications received at this program | 8 | 20 | 28 |
| Total support | 136 | 207 | 343 |
| Assistance | 96 | 322 | 418 |
| Supervision | 3 | 1 | 4 |
| Independent | 3 | 0 | 3 |
| Totals | 246 | 550 | 796 |
| Individual missed more than two weeks of programming due to medical conditions in the last year. | 34 | 56 | 90 |
| Individual was hospitalized for medical conditions in the last year. | 54 | 96 | 150 |
| Individual requires direct care staff to be trained in special health care procedures. | 93 | 195 | 288 |
| Individual requires a special diet planned by dietician, nutritionist, or nurse. | 148 | 327 | 475 |
| Level of hearing. | | | |
| Normal | 213 | 479 | 692 |
| Mild loss | 26 | 75 | 101 |
| Moderate loss | 5 | 26 | 31 |
| Severe loss | 6 | 23 | 29 |
| Profound loss | 8 | 15 | 23 |
| Undetermined | 3 | 10 | 13 |
| Totals | 261 | 628 | 889 |
| Level of vision. | | | |
| Fully sighted | 217 | 467 | 684 |
| Moderate impairment | 20 | 97 | 117 |
| Severe impairment | 8 | 24 | 32 |
| Light perception | 6 | 4 | 10 |
| Total blindness | 4 | 9 | 13 |
| Undetermined | 6 | 27 | 33 |
| Totals | 261 | 628 | 889 |
| Level of mobility. | | | |
| Walks independently | 174 | 437 | 611 |
| Walks independently but with difficulty | 33 | 82 | 115 |
| Walks independently with corrective device. | 24 | 48 | 72 |
| Walks only with assistance from another person | 10 | 32 | 42 |
| Can not walk. | 20 | 29 | 49 |
| Totals | 261 | 628 | 889 |

Mental Health and Retardation Services
Abstract of ICF's/MR Based on KUAP Project
Data as of April 1, 1993

| | Small Bed | Large Bed | Totals |
|---|---|---|---|
| Individuals who use a wheelchair. | 38 | 67 | 105 |
| Type of wheelchair mobility | | | |
| Can use wheelchair independently | 5 | 24 | 29 |
| Can use, needs assistance transferring. | 10 | 22 | 32 |
| Requires assistance transferring and moving. | 11 | 18 | 29 |
| No mobility | 12 | 4 | 16 |
| Totals | 38 | 68 | 106 |
| Can roll from back to stomach. | 242 | 590 | 832 |
| Can pull self to standing. | 232 | 570 | 802 |
| Can walk up and down stairs. | 149 | 317 | 466 |
| Can pick up a small object. | 249 | 605 | 854 |
| Can transfer an object from hand to hand. | 241 | 588 | 829 |
| Can mark with pencil. | 237 | 596 | 833 |
| Can turn pages of a book one at a time. | 205 | 480 | 685 |
| Can copy a circle from an example. | 120 | 291 | 411 |
| Can cut with scissors along a straight line. | 81 | 198 | 279 |
| Can sort objects by size. | 142 | 347 | 489 |
| Can correctly spell first and last name. | 78 | 145 | 223 |
| Can tell time to nearest five minutes. | 43 | 74 | 117 |
| Can distinguish between right and left. | 59 | 131 | 190 |
| Can count ten or more objects | 98 | 194 | 292 |
| Can understand simple functional signs. | 95 | 210 | 305 |
| Can do simple addition and subtraction of figures. | 26 | 81 | 107 |
| Can read and comprehend simple sentences. | 37 | 89 | 126 |
| Can read and comprehend newspaper or magazine articles. | 23 | 25 | 48 |
| Understands the meaning of "No". | 246 | 601 | 847 |
| Understands one-step directions. | 248 | 570 | 818 |
| Understands two-step directions. | 170 | 399 | 569 |
| Understands a joke or story. | 92 | 228 | 320 |
| Can indicates "Yes" of "No" response to a simple question. | 198 | 475 | 673 |
| Can asks simple questions. | 147 | 380 | 527 |
| Can relates experiences when asked. | 88 | 221 | 309 |
| Can tell a story, joke, or plot of a television show. | 46 | 131 | 177 |
| Can describe realistic plans in detail. | 26 | 65 | 91 |

Mental Health and Retardation Services
Abstract of ICF's/MR Based on KUAP Project
Data as of April 1, 1993

| | Small Bed | Large Bed | Totals |
|---|---|---|---|
| **Has tantrums or emotional outbursts.** | | | |
| Not this year | 50 | 101 | 151 |
| Occasionally | 34 | 122 | 156 |
| Monthly | 29 | 69 | 98 |
| Weekly | 39 | 85 | 124 |
| Frequently | 54 | 111 | 165 |
| Daily | 55 | 140 | 195 |
| Totals | 261 | 628 | 889 |
| **Damages own or others property.** | | | |
| Not this year | 131 | 297 | 428 |
| Occasionally | 49 | 145 | 194 |
| Monthly | 19 | 65 | 84 |
| Weekly | 19 | 57 | 76 |
| Frequently | 30 | 29 | 59 |
| Daily | 13 | 35 | 48 |
| Totals | 261 | 628 | 889 |
| **Physically Assaults others.** | | | |
| Not this year | 95 | 179 | 274 |
| Occasionally | 52 | 174 | 226 |
| Monthly | 31 | 84 | 115 |
| Weekly | 29 | 64 | 93 |
| Frequently | 38 | 75 | 113 |
| Daily | 16 | 52 | 68 |
| Totals | 261 | 628 | 889 |
| **Disrupts others activities.** | | | |
| Not this year | 65 | 164 | 229 |
| Occasionally | 27 | 103 | 130 |
| Monthly | 27 | 48 | 75 |
| Weekly | 25 | 54 | 79 |
| Frequently | 47 | 89 | 136 |
| Daily | 70 | 170 | 240 |
| Totals | 261 | 628 | 889 |
| **Is verbally or gesturally abusive.** | | | |
| Not this year | 119 | 271 | 390 |
| Occasionally | 24 | 95 | 119 |
| Monthly | 21 | 54 | 75 |
| Weekly | 26 | 55 | 81 |
| Frequently | 40 | 83 | 123 |
| Daily | 31 | 70 | 101 |
| Totals | 261 | 628 | 889 |

Mental Health and Retardation Services
Abstract of ICF's/MR Based on KUAP Project
Data as of April 1, 1993

| | Small Bed | Large Bed | Totals |
|---|---|---|---|
| Is self-injurious. | | | |
| Not this year | 131 | 336 | 467 |
| Occasionally | 32 | 101 | 133 |
| Monthly | 19 | 38 | 57 |
| Weekly | 12 | 28 | 40 |
| Frequently | 24 | 53 | 77 |
| Daily | 43 | 72 | 115 |
| Totals | 261 | 628 | 889 |
| Teases or harasses peers. | | | |
| Not this year | 130 | 311 | 441 |
| Occasionally | 25 | 102 | 127 |
| Monthly | 14 | 37 | 51 |
| Weekly | 15 | 43 | 58 |
| Frequently | 38 | 53 | 91 |
| Daily | 39 | 82 | 121 |
| Totals | 261 | 628 | 889 |
| Resists supervision. | | | |
| Not this year | 47 | 92 | 139 |
| Occasionally | 30 | 108 | 138 |
| Monthly | 16 | 55 | 71 |
| Weekly | 36 | 74 | 110 |
| Frequently | 54 | 106 | 160 |
| Daily | 78 | 193 | 271 |
| Totals | 261 | 628 | 889 |
| Runs or wanders away. | | | |
| Not this year | 157 | 340 | 497 |
| Occasionally | 27 | 72 | 99 |
| Monthly | 10 | 28 | 38 |
| Weekly | 18 | 37 | 55 |
| Frequently | 21 | 53 | 74 |
| Daily | 28 | 98 | 126 |
| Totals | 261 | 628 | 889 |
| Steals | | | |
| Not this year | 169 | 409 | 578 |
| Occasionally | 24 | 88 | 112 |
| Monthly | 12 | 28 | 40 |
| Weekly | 15 | 28 | 43 |
| Frequently | 21 | 37 | 58 |
| Daily | 20 | 38 | 58 |
| Totals | 261 | 628 | 889 |

Mental Health and Retardation Services
Abstract of ICF's/MR Based on KUAP Project
Data as of April 1, 1993

| | Small Bed | Large Bed | Totals |
|---|---|---|---|
| Eats inedible objects. | | | |
| Not this year | 218 | 580 | 798 |
| Occasionally | 12 | 23 | 35 |
| Monthly | 6 | 5 | 11 |
| Weekly | 11 | 3 | 14 |
| Frequently | 7 | 10 | 17 |
| Daily | 7 | 7 | 14 |
| Totals | 261 | 628 | 889 |
| Displays sexually inappropriate behavior. | | | |
| Not this year | 150 | 442 | 592 |
| Occasionally | 33 | 75 | 108 |
| Monthly | 17 | 27 | 44 |
| Weekly | 11 | 32 | 43 |
| Frequently | 18 | 22 | 40 |
| Daily | 32 | 30 | 62 |
| Totals | 261 | 628 | 889 |
| Smear feces. | | | |
| Not this year | 226 | 595 | 821 |
| Occasionally | 17 | 16 | 33 |
| Monthly | 7 | 2 | 9 |
| Weekly | 5 | 7 | 12 |
| Frequently | 4 | 6 | 10 |
| Daily | 2 | 2 | 4 |
| Totals | 261 | 628 | 889 |
| Behavior problems currently prevent this individual from moving to a less restrictive setting. | 155 | 383 | 538 |
| Specific behavioral programming or procedures are required. | 177 | 447 | 624 |
| Individual's environment must be carefully structured to avoid problems. | 139 | 444 | 583 |
| Because of behavior problems, staff must sometimes intervene physically with individual. | 159 | 395 | 554 |
| Because of behavior problems, a supervised "time-out" is needed at least once a week. | 16 | 135 | 151 |
| Because of behavior problems, individual requires one-on-one" for many activities. | 75 | 243 | 318 |

Mental Health and Retardation Services
Abstract of ICF's/MR Based on KUAP Project
Data as of April 1, 1993

| | Small Bed | Large Bed | Totals |
|---|---|---|---|
| Indication of how independently individual typically performs each of the following activities. | | | |
| Toileting/bowels. | | | |
| Total Support | 19 | 39 | 58 |
| Assistance | 52 | 99 | 151 |
| Supervision | 55 | 79 | 134 |
| Independently | 135 | 411 | 546 |
| Totals | 261 | 628 | 889 |
| Toileting/bladder. | | | |
| Total Support | 18 | 38 | 56 |
| Assistance | 43 | 94 | 137 |
| Supervision | 60 | 97 | 157 |
| Independently | 140 | 399 | 539 |
| Totals | 261 | 628 | 889 |
| Taking a shower/bath. | | | |
| Total Support | 42 | 59 | 101 |
| Assistance | 94 | 192 | 286 |
| Supervision | 76 | 262 | 338 |
| Independently | 49 | 115 | 164 |
| Totals | 261 | 628 | 889 |
| Brushing teeth/cleaning dentures. | | | |
| Total Support | 46 | 78 | 124 |
| Assistance | 71 | 172 | 243 |
| Supervision | 90 | 265 | 355 |
| Independently | 54 | 113 | 167 |
| Totals | 261 | 628 | 889 |
| Brushing/combing hair. | | | |
| Total Support | 52 | 68 | 120 |
| Assistance | 79 | 159 | 238 |
| Supervision | 74 | 254 | 328 |
| Independently | 56 | 147 | 203 |
| Totals | 261 | 628 | 889 |
| Selecting clothes appropriate to weather. | | | |
| Total Support | 72 | 74 | 146 |
| Assistance | 53 | 150 | 203 |
| Supervision | 81 | 230 | 311 |
| Independently | 55 | 174 | 229 |
| Totals | 261 | 628 | 889 |
| Putting on clothes. | | | |
| Total Support | 26 | 42 | 68 |
| Assistance | 58 | 119 | 177 |
| Supervision | 70 | 99 | 169 |
| Independently | 107 | 368 | 475 |
| Totals | 261 | 628 | 889 |

Mental Health and Retardation Services
Abstract of ICF's/MR Based on KUAP Project
Data as of April 1, 1993

| | Small Bed | Large Bed | Totals |
|---|---|---|---|
| **Undressing self.** | | | |
| Total Support | 17 | 35 | 52 |
| Assistance | 33 | 86 | 119 |
| Supervision | 50 | 62 | 112 |
| Independently | 161 | 445 | 606 |
| Totals | 261 | 628 | 889 |
| **Drinking from a cup or glass.** | | | |
| Total Support | 6 | 6 | 12 |
| Assistance | 15 | 32 | 47 |
| Supervision | 14 | 35 | 49 |
| Independently | 226 | 555 | 781 |
| Totals | 261 | 628 | 889 |
| **Chewing and swallowing food.** | | | |
| Total Support | 2 | 6 | 8 |
| Assistance | 13 | 114 | 127 |
| Supervision | 34 | 49 | 83 |
| Independently | 212 | 459 | 671 |
| Totals | 261 | 628 | 889 |
| **Feeding self.** | | | |
| Total Support | 5 | 9 | 14 |
| Assistance | 27 | 107 | 134 |
| Supervision | 33 | 55 | 88 |
| Independently | 196 | 457 | 653 |
| Totals | 261 | 628 | 889 |
| **Making bed.** | | | |
| Total Support | 74 | 158 | 232 |
| Assistance | 57 | 172 | 229 |
| Supervision | 61 | 118 | 179 |
| Independently | 69 | 180 | 249 |
| Totals | 261 | 628 | 889 |
| **Cleaning room.** | | | |
| Total Support | 67 | 159 | 226 |
| Assistance | 82 | 193 | 275 |
| Supervision | 86 | 175 | 261 |
| Independently | 26 | 101 | 127 |
| Totals | 261 | 628 | 889 |
| **Do laundry.** | | | |
| Total Support | 74 | 340 | 414 |
| Assistance | 86 | 162 | 248 |
| Supervision | 82 | 96 | 178 |
| Independently | 19 | 30 | 49 |
| Totals | 261 | 628 | 889 |

Mental Health and Retardation Services
Abstract of ICF's/MR Based on KUAP Project
Data as of April 1, 1993

| | Small Bed | Large Bed | Totals |
|---|---|---|---|
| Using telephone. | | | |
| Total Support | 153 | 340 | 493 |
| Assistance | 70 | 184 | 254 |
| Supervision | 28 | 73 | 101 |
| Independently | 10 | 31 | 41 |
| Totals | 261 | 628 | 889 |
| Shopping for a simple meal. | | | |
| Total Support | 172 | 341 | 513 |
| Assistance | 55 | 192 | 247 |
| Supervision | 30 | 75 | 105 |
| Independently | 4 | 20 | 24 |
| Totals | 261 | 628 | 889 |
| Preparing foods that do not require cooking. | | | |
| Total Support | 121 | 307 | 428 |
| Assistance | 74 | 178 | 252 |
| Supervision | 44 | 95 | 139 |
| Independently | 22 | 48 | 70 |
| Totals | 261 | 628 | 889 |
| Using stove or microwave. | | | |
| Total Support | 152 | 390 | 542 |
| Assistance | 72 | 162 | 234 |
| Supervision | 28 | 65 | 93 |
| Independently | 9 | 11 | 20 |
| Totals | 261 | 628 | 889 |
| Crossing street in residential neighborhood. | | | |
| Total Support | 140 | 282 | 422 |
| Assistance | 39 | 174 | 213 |
| Supervision | 58 | 126 | 184 |
| Independently | 24 | 46 | 70 |
| Totals | 261 | 628 | 889 |
| Using Public Transportation for a simple direct trip. | | | |
| Total Support | 201 | 520 | 721 |
| Assistance | 45 | 91 | 136 |
| Supervision | 13 | 11 | 24 |
| Independently | 2 | 6 | 8 |
| Totals | 261 | 628 | 889 |
| Managing own money. | | | |
| Total Support | 211 | 345 | 556 |
| Assistance | 38 | 260 | 298 |
| Supervision | 9 | 22 | 31 |
| Independently | 3 | 1 | 4 |
| Totals | 261 | 628 | 889 |

Mental Health and Retardation Services
Abstract of ICF's/MR Based on KUAP Project
Data as of April 1, 1993

| | Small Bed | Large Bed | Totals |
|---|---|---|---|
| The frequency individuals receive services from the following clinical specialist. | | | |
| Psychologist | | | |
| Not this year | 62 | 19 | 81 |
| Occasionally | 144 | 445 | 589 |
| Monthly | 46 | 97 | 143 |
| Weekly | 9 | 17 | 26 |
| Frequently | 0 | 2 | 2 |
| Daily | 0 | 48 | 48 |
| Totals | 261 | 628 | 889 |
| Psychiatrist. | | | |
| Not this year | 182 | 582 | 764 |
| Occasionally | 71 | 39 | 110 |
| Monthly | 8 | 5 | 13 |
| Weekly | 0 | 2 | 2 |
| Frequently | 0 | 0 | 0 |
| Daily | 0 | 0 | 0 |
| Totals | 261 | 628 | 889 |
| Speech and Hearing Pathologist. | | | |
| Not this year | 28 | 67 | 95 |
| Occasionally | 226 | 468 | 694 |
| Monthly | 6 | 1 | 7 |
| Weekly | 1 | 3 | 4 |
| Frequently | 0 | 89 | 89 |
| Daily | 0 | 0 | 0 |
| Totals | 261 | 628 | 889 |
| Physical Therapist. | | | |
| Not this year | 38 | 184 | 222 |
| Occasionally | 175 | 306 | 481 |
| Monthly | 14 | 1 | 15 |
| Weekly | 3 | 9 | 12 |
| Frequently | 29 | 104 | 133 |
| Daily | 2 | 24 | 26 |
| Totals | 261 | 628 | 889 |
| Occupational Therapist. | | | |
| Not this year | 43 | 158 | 201 |
| Occasionally | 182 | 406 | 588 |
| Monthly | 7 | 0 | 7 |
| Weekly | 2 | 2 | 4 |
| Frequently | 26 | 60 | 86 |
| Daily | 1 | 2 | 3 |
| Totals | 261 | 628 | 889 |

Mental Health and Retardation Services
Abstract of ICF's/MR Based on KUAP Project
Data as of April 1, 1993

| | Small Bed | Large Bed | | Totals |
|---|---|---|---|---|
| Physician | | | | |
| Not this year | 2 | 1 | 0 | 3 |
| Occasionally | 211 | 511 | | 722 |
| Monthly | 46 | 111 | | 157 |
| Weekly | 2 | 4 | | 6 |
| Frequently | 0 | 1 | | 1 |
| Daily | 0 | 0 | | 0 |
| Totals | 261 | 628 | | 889 |
| Nurse | | | | |
| Not this year | 0 | 0 | | 0 |
| Occasionally | 29 | 19 | | 48 |
| Monthly | 42 | 9 | | 51 |
| Weekly | 27 | 6 | | 33 |
| Frequently | 51 | 14 | | 65 |
| Daily | 112 | 580 | | 692 |
| Totals | 261 | 628 | | 889 |
| Social Worker | | | | |
| Not this year | 77 | 1 | | 78 |
| Occasionally | 96 | 156 | | 252 |
| Monthly | 23 | 42 | | 65 |
| Weekly | 42 | 34 | | 76 |
| Frequently | 13 | 241 | | 254 |
| Daily | 10 | 154 | | 164 |
| Totals | 261 | 628 | | 889 |
| Most recent IOC determination. | 257 | 620 | | 877 |
| Hepatitis B Carrier. | 6 | 22 | | 28 |
| Eating disorder. | 13 | 25 | | 38 |
| Hypnotic/Sedative. | 6 | 6 | | 12 |
| Other medication for behavior management. | 52 | 67 | | 119 |
| County of Origin | | | | |
| Allen | 2 | 3 | | 5 |
| Anderson | 1 | 0 | | 1 |
| Atchison | 2 | 1 | | 3 |
| Barber | 0 | 12 | | 12 |
| Barton | 7 | 8 | | 15 |
| Bourbon | 0 | 2 | | 2 |
| Brown | 3 | 2 | | 5 |
| Butler | 2 | 8 | | 10 |
| Chase | 1 | 1 | | 2 |

Mental Health and Retardation Services
Abstract of ICF's/MR Based on KUAP Project
Data as of April 1, 1993

| | Small Bed | Large Bed | Totals |
|---|---|---|---|
| Chautauqua | 0 | 1 | 1 |
| Cherokee | 0 | 6 | 6 |
| Cheyenne | 0 | 1 | 1 |
| Clark | 0 | 1 | 1 |
| Clay | 0 | 0 | 0 |
| Cloud | 2 | 0 | 2 |
| Coffey | 1 | 10 | 11 |
| Comanche | 0 | 0 | 0 |
| Cowley | 6 | 14 | 20 |
| Crawford | 1 | 45 | 46 |
| Decature | 0 | 1 | 1 |
| Dickinson | 0 | 4 | 4 |
| Doniphan | 3 | 0 | 3 |
| Douglas | 8 | 7 | 15 |
| Edwards | 0 | 1 | 1 |
| Elk | 0 | 1 | 1 |
| Ellis | 1 | 4 | 5 |
| Ellsworth | 10 | 0 | 10 |
| Finney | 0 | 5 | 5 |
| Ford | 2 | 8 | 10 |
| Franklin | 2 | 1 | 3 |
| Geary | 0 | 4 | 4 |
| Gove | 0 | 0 | 0 |
| Graham | 0 | 0 | 0 |
| Grant | 0 | 0 | 0 |
| Gray | 0 | 1 | 1 |
| Greeley | 0 | 1 | 1 |
| Greenwood | 0 | 1 | 1 |
| Hamilton | 0 | 0 | 0 |
| Harper | 1 | 3 | 4 |
| Harvey | 2 | 7 | 9 |
| Haskell | 0 | 1 | 1 |
| Hodgeman | 0 | 3 | 3 |
| Jackson | 5 | 1 | 6 |
| Jefferson | 3 | 1 | 4 |
| Jewell | 1 | 0 | 1 |
| Johnson | 37 | 34 | 71 |
| Kearny | 0 | 0 | 0 |
| Kingman | 0 | 3 | 3 |
| Kiowa | 0 | 0 | 0 |
| Labette | 11 | 10 | 21 |
| Lane | 0 | 1 | 1 |
| Leavenworth | 3 | 6 | 9 |
| Lincoln | 1 | 2 | 3 |
| Linn | 0 | 2 | 2 |
| Logan | 0 | 1 | 1 |
| Lyon | 10 | 7 | 17 |
| Marion | 5 | 1 | 6 |
| Marshall | 0 | 1 | 1 |
| McPherson | 6 | 3 | 9 |
| Meade | 0 | 0 | 0 |
| Miami | 9 | 3 | 12 |
| Mitchell | 1 | 0 | 1 |
| Montgomery | 0 | 9 | 9 |
| Morris | 0 | 1 | 1 |

Mental Health and Retardation Services
Abstract of ICF's/MR Based on KUAP Project
Data as of April 1, 1993

| | Small Bed | Large Bed | Totals |
|---|---|---|---|
| Morton | 0 | 0 | 0 |
| Nemaha | 1 | 0 | 1 |
| Neosho | 1 | 6 | 7 |
| Ness | 0 | 1 | 1 |
| Norton | 0 | 1 | 1 |
| Osage | 2 | 3 | 5 |
| Osborne | 1 | 0 | 1 |
| Ottawa | 0 | 3 | 3 |
| Out Of State | 15 | 55 | 70 |
| Pawnee | 0 | 1 | 1 |
| Phillips | 0 | 1 | 1 |
| Pottawatomie | 0 | 2 | 2 |
| Pratt | 0 | 1 | 1 |
| Rawlins | 0 | 0 | 0 |
| Reno | 4 | 37 | 41 |
| Republic | 0 | 0 | 0 |
| Rice | 2 | 2 | 4 |
| Riley | 0 | 4 | 4 |
| Rooks | 0 | 2 | 2 |
| Rush | 0 | 2 | 2 |
| Russell | 1 | 0 | 1 |
| Saline | 1 | 12 | 13 |
| Scott | 1 | 0 | 1 |
| Sedgwick | 11 | 132 | 143 |
| Seward | 0 | 1 | 1 |
| Shawnee | 37 | 16 | 53 |
| Sheridan | 0 | 1 | 1 |
| Sherman | 0 | 2 | 2 |
| Smith | 1 | 0 | 1 |
| Stafford | 2 | 8 | 10 |
| Stanton | 0 | 0 | 0 |
| Stevens | 0 | 0 | 0 |
| Sumner | 0 | 2 | 2 |
| Thomas | 1 | 2 | 3 |
| Trego | 1 | 1 | 2 |
| Unknown | 15 | 46 | 61 |
| Wabaunsee | 0 | 1 | 1 |
| Wallace | 0 | 0 | 0 |
| Washington | 0 | 2 | 2 |
| Wichita | 1 | 1 | 2 |
| Wilson | 0 | 5 | 5 |
| Woodson | 0 | 2 | 2 |
| Wyandotte | 14 | 19 | 33 |
| Totals | 261 | 628 | 889 |

# A PRELIMINARY REPORT ON KANSANS WHO ARE MENTALLY RETARDED OR OTHERWISE DEVELOPMENTALLY DISABLED WAITING FOR COMMUNITY SERVICES

AUGUST 2, 1993

Kansas Department of Social and Rehabilitation Services
Donna L. Whiteman, Secretary

SRS Mission Statement

"The Kansas Department of Social and Rehabilitation Services empowers individuals and families to achieve and sustain independence and to participate in the rights, responsibilities and benefits of full citizenship by creating conditions and opportunities for change, by advocating for human dignity and worth, and by providing care, safety and support in collaboration with others."

9/29/93

Joint Senate Ways + Means and House Appropriations Comm

Attachment 5

House Bill 2047 directed the Secretary of Social and Rehabilitation Services to develop criteria for inclusion of people with mental retardation and developmental disabilities on waiting lists for community services. It also directed the Secretary to carry out an assessment to identify the level of services such people require. The following is a preliminary report to the interim legislative committees regarding those provisos.

## Introduction:

Social and Rehabilitation Services (SRS) through the Commission of Mental Health and Retardation Services (MH&RS) provides funding for services to individuals who are mentally retarded or otherwise developmentally disabled. In order to be eligible for these funds an individual must:

- Have an IQ of 70 or below; OR
- Have another disabling condition like autism or cerebral palsy; AND
- The disability must:
  * be manifested before the age of 22; AND
  * be likely to continue indefinitely; AND
  * result in substantial limitations in three or more life functioning areas: AND
  * reflect a life long need for interdisciplinary services

Individuals who are disabled and do not meet these eligibility criteria are expected to obtain funding for their needed services from another source.

Kansans who are mentally retarded or otherwise developmentally disabled (MR/DD) receive a wide variety of services such as:

Community Vocational

Community Residential

Institutions such as:
* Private ICFs/MR
* State MR Hospitals
* Private Children's Institutions

Day Habilitation

Education

Family Support such as:
* Respite
* In-home Support
* Subsidy

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These services are provided to an estimated **11,446** individuals in Kansas. An approximation of how many individuals and families are served by each service setting is detailed in Table A below:

| TABLE A | |
|---|---|
| ESTIMATED NUMBER SERVED & UNSERVED | |
| Community Mental Retardation Agencies | 4,849 |
| State MR/DD Hospitals | 864 |
| Private ICFs/MR | 933 |
| Family Subsidy | 416 |
| School* | 4,384 |
| Total Served | 11,446 |
| MRI Estimate of Incidence of MR/DD | 15,000 |
| Estimate of Unserved | 3,554 |
| *Does not include children whose families receive Subsidy | |

In 1989 Midwest Research Institute (MRI), using a grant awarded by the Kansas Planning Council on Developmental Disabilities Services, estimated there are approximately 15,000 individuals who are MR/DD in Kansas. Of these, approximately 4,800 are between the ages of six and 17. When these estimates are compared in Table A with the number of people served, it is clear not all individuals who are MR/DD receive services in Kansas. What happens to the individuals who are not being served? First, not everyone who is MR/DD needs formal services. Many individuals receive adequate support from family, friends and the local community and, therefore, do not request formal services. However, many other individuals and their families do need and want formal services and since they are not entitled to services they must wait for resources to become available to receive them.

## The Waiting List:

Most often people who are MR/DD and their families in need of services apply to local private non-profit MR/DD agencies. These agencies use a combination of federal, state, county, local

and private resources to provide services in their local area. Individuals who do not receive services due to insufficient resources are placed on a waiting list. Community MR/DD provider agencies report to SRS/MH&RS the number of people waiting for services. The compilation of the numbers of people waiting for services reported by all agencies constitutes the statewide waiting list.

An individual must provide a minimum amount of information including the social security number, date of birth, name of the agency, date of application, general type of service requested and whether or not the need for the service is immediate in order to be included on the waiting list. Other demographic information may be collected and included for each individual but this additional information is not required to be counted as waiting for services.

Individuals and their families are asked, "If services were available today would you accept them?". Persons answering this question "yes" are placed on the primary or immediate waiting list. Those answering "no" are placed on a secondary waiting list.

SRS/MH&RS takes these raw data and eliminates possible duplicate applications to agencies, people who are already served in another setting such as state MR/DD hospitals or private ICFs/MR and obvious inappropriate requests such as young children applying for adult services. The result is a list of unduplicated unserved individuals waiting for community MR/DD services. A summary of the numbers of individuals currently on the primary/immediate waiting list is shown below.

TABLE B

NUMBER OF PEOPLE REPORTED REQUESTING IMMEDIATE SERVICES

| | Unserved | Duplicates | In ICFs/MR | Total Reported |
|---|---|---|---|---|
| Day Services Only | 133 | 4 | 32 | 169 |
| Residential Services Only | 305 | 11 | 111 | 427 |
| Day and Residential | 127 | 69 | 91 | 287 |
| Subtotal | 565 | 84 | 234 | 883 |
| Support Services | 12 | 2 | 3 | 17 |
| Preschool | 32 | 0 | 0 | 32 |
| TOTAL | 609 | 86 | 237 | 932 |

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## The Developmental Disability Profile:

The waiting list enumerates approximately how many individuals are waiting for community MR/DD services and generally the type of services for which they are waiting. It does not, however, describe the severity of the disability of individuals waiting for these services. Individuals who are MR/DD present a wide range of severity of disabilities requiring a equally wide range of resources to serve them. Therefore, it is helpful to know, at least in general terms, the severity of disabilities of individuals reported as waiting for services in order to adequately plan resources to meet their needs.

While severity of the disability of individuals is not included in the waiting list some of this information is available through another data source. A Developmental Disability Profile (DDP) is completed for everyone requesting ICF/MR or HCBS/MR services. New York developed the DDP, and extensively tested it, finding it very valid and reliable. The DDP was selected for ICF/MR and HCBS/MR eligibility determination because of its validity, reliability, brevity and ease of administration.

DDP data are available for nearly half of the individuals listed as waiting for immediate services. Given the size of this sample, it can be assumed it is representative of the people who are waiting for services with one proviso. Most of the DDP data are from applications for ICF/MR and HCBS/ MR services. These services are specifically designed for individuals who are generally more severely disabled. As a result it is possible the individuals with DDP scores are more disabled than the average person on the statewide waiting list. Never-the-less, the information from the waiting list can be combined with the information from the DDP to provide some general estimate of the resources necessary to meet the needs of the individuals waiting for immediate services.

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## DDP Tiers:

In the last year SRS/MH&RS has started reimbursing the cost of some services on the HCBS/MR waiver based on the relative severity of the individuals served. Reimbursement for services provided to individuals who are more severely disabled are higher than for those who are relatively less severely disabled. This was done by placing individuals who were eligible for HCBS/MR waiver funding into five equal groups based on DDP domain scores. Each of these groups were assigned reimbursement rates based on cost data assumptions developed by the accounting firm of Deloitte and Touche. This produced five tiered reimbursement rates. The tiers and the corresponding reimbursement rates are listed below. Based on nearly a year of experience SRS/ MH&RS believes these rates, on the average, provide adequate funding for serving individuals whose services are funded by the HCBS/MR waiver.

TABLE C

| HCBS/MR TIERED REIMBURSEMENT RATES | | | STATE MR HOSPITAL RATES | |
|---|---|---|---|---|
| HCBS/MR Tier | Residential | Day* | | Budgeted* Per Diem |
| Tier 1 | $113.04 | $74.36 | WSH&TC | $267.02 |
| Tier 2 | $94.44 | $55.75 | KNI | $256.24 |
| Tier 3 | $68.61 | $45.26 | PSH&TC | $213.29 |
| Tier 4 | $44.73 | $34.03 | AVERAGE | $247.35 |
| Tier 5 | $33.74 | $29.30 | | |
| *Day Services are provided and paid for approximately 250 days per year. | | | *Based on most recent budgeted figures and budgeted census. | |

## Combining the Waiting List with HCBS/MR DDP Tiers:

Generalizing the DDP data for the whole waiting list provides an estimate of how many people are waiting for services in each tier. Assuming the cost to serve these individuals equates with HCBS/MR tiered rates, it can be estimated, how much funding would be necessary to meet the needs of individuals on the waiting list. Based on this information, approximately $11,600,000 would be needed to fund services to everyone community MR/DD agencies report are currently requesting immediate services. The detail for this calculation is shown as follows:

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| TABLE D | | | | | |
|---|---|---|---|---|---|
| PERCENT OF WAITING LIST ON EACH TIER | | | | | |
| GENERALIZED FROM DDP DATA | | | | | |
| Service Requested | Tier 1 | Tier 2 | Tier 3 | Tier 4 | Tier 5 |
| Day Services Only | 11% | 21% | 21% | 32% | 14% |
| Residential Only | 11% | 15% | 19% | 28% | 28% |
| Day and Residential | 16% | 19% | 19% | 22% | 24% |

| TABLE E | | | | | | |
|---|---|---|---|---|---|---|
| ESTIMATED COST OF SERVICES | | | | | | |
| BASED ON PERCENT OF WAITING LIST IN EACH TIER | | | | | | |
| Service Requested | Tier 1 | Tier 2 | Tier 3 | Tier 4 | Tier 5 | TOTAL |
| Day Service Only | $244,775 | $350,347 | $284,425 | $325,871 | $122,752 | $1,328,170 |
| Residential Only | $1,245,834 | $1,419,327 | $1,306,099 | $1,254,851 | $946,539 | $6,172,650 |
| Day and Residential | $1,094,529 | $1,051,279 | $789,579 | $624,475 | $538,767 | $4,098,629 |
| TOTAL | $2,585,138 | $2,820,953 | $2,380,104 | $2,205,197 | $1,608,058 | $11,599,449 |

## Problems with the Waiting List Process and Recommended Actions:

The waiting list data provides estimates regarding who community MR/DD agencies report are currently requesting services and the DDP can be used to estimate the annual cost of services. However, there are problems with the current approach for compiling the waiting list which should be addressed in order to more accurately reflect the need for services.

First, the waiting list should vary throughout the year and over several years. Its numbers increase as individuals who are MR/DD graduate from school and request adult services or when individuals no longer get sufficient support from family, friends and community. Waiting List numbers decrease when new people are added to services or individuals leave service for whatever reason.

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In spite of vigorous efforts on the part of Kansas to expand services, the waiting list has not declined appreciably in the last several years. The data from MRI indicates as many as 3,554 people who are MR/DD and their families are unserved in Kansas. The current process, however, may not provide valid predictors of who, among these individuals, will need immediate services and the approximate cost of these services. If the waiting list is to maintain its credibility as a measure of future need, more research must be done to better predict future waiting list needs. In particular, new more comprehensive research must be done to determine how many individuals graduating from special education will need MR/DD services. Schools are now required by federal law and regulation to do transition planning from school to adulthood for people who are MR/DD. MH&RS will work closely with the Board of Education to closely examine these transitional plans to better predict the effect of special education graduations on the waiting list.

Second, community MR/DD agencies do not use the same process when accepting a referral for services. Some have extremely in-depth application processes to accept people for the waiting list. Others accept individuals for the waiting list with very minimal information. This makes it difficult to determine if all of the individuals reported to SRS/MH&RS are always appropriate for, and in need of, community MR/DD services. SRS/MH&RS will establish a uniform referral process for the waiting list to alleviate this problem.

In addition, community MR/DD agencies sometimes serve a broad range of individuals with a variety of disabilities. Many of these individuals do not meet the definition of MR/DD described earlier. The current process of compiling statewide waiting list information does not adequately determine whether an individual is MR/DD or not according to SRS/MH&RS policy. SRS/MH&RS will address this by establishing a more valid process for inclusion on the compiled waiting list.

Third, the current community MR/DD waiting list includes almost exclusively individuals requesting out of home adult services or developmental preschool services. It does not

currently provide information regarding people who need, and are waiting for, support services such as respite, subsidy, in-home support, special equipment, home modifications, etc. Families who have children or young adults who are MR/DD living at home often need support services but do not want the child to be served out of the home. Special education services alone do not meet these needs. Therefore, efforts need to be made to add requests for these services to the waiting list.

## Conclusion:

Kansas provides a large variety of services for people who are MR/DD and their families. Despite these efforts, reliable independent incidence studies report as many as 3,554 individuals who are MR/DD are unserved in Kansas. Some of these people will not need services; others do and have requested them. Lists of people with immediate needs for services are reported by community MR/DD agencies and compiled by SRS/MH&RS. Current available data estimates the cost of providing these people with immediate services at $11,600,000 per year.

These estimates assume the information provided through the current waiting list process is accurate. Problems do exist with the methodology for compiling the waiting list. Research needs to be done to better understand the dynamics involved in the lack of changes in the waiting list. A set of statewide standards will be developed and implemented for inclusion of individuals on the waiting list. These standards will include a determination regarding whether individuals meet SRS/MH&RS MR/DD eligibility for funding. Requests for family support services need to be compiled with the waiting list data. MH&RS will continue addressing these concerns between now and February 1, 1994 when an updated report will be provided to the legislature.

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STATE OF KANSAS
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
MENTAL HEALTH AND RETARDATION SERVICES

SUBJECT: Eligibility for MR/DD Services

DATE: July 1, 1992 EFFECTIVE: July 1, 1992

NUMBER: MRDD 92-1

POLICY: It shall be the policy of MH&RS that all recipients of services funded by the MR/DD division of MH&RS shall meet the definitions of mental retardation or other developmental disability outlined below.

**Mental retardation** means significantly sub-average intellectual functioning as evidenced by an IQ score of 70 or below on a standardized measure of intelligence. Other developmental disability means a condition such as autism, cerebral palsy, epilepsy, or other similar physical or mental impairment. In addition, **mental retardation and otherwise developmentally disabled** is evidenced by a severe, chronic disability which:

1. is attributable to a mental or physical impairment or a combination of mental and physical impairments, AND

2. is manifest before the age of 22, AND

3. is likely to continue indefinitely, AND

4. results in substantial functional limitations in any three or more of the following areas of life functioning:

   a. self-care,

   b. understanding and the use of language,

   c. learning and adapting,

   d. mobility,

   e. self-direction in setting goals and undertaking activities to accomplish those goals,

   f. living independently,

   g. economic self-sufficiency, AND

5. reflects a need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are lifelong, or extended in duration and are individually planned and coordinated, AND

6. does not include individuals who are solely severely emotionally disturbed or seriously and persistently mentally ill or have disabilities solely as a result of infirmities of aging.

**For children under the age of six,** developmental disability means a severe, chronic disability which:

1. is attributable to a mental or physical impairment or a combination of mental and physical impairments, AND

2. is likely to continue indefinitely, AND

3. results in at least **three developmental delays** as measured by qualified professionals using appropriate diagnostic instruments or procedures, AND

4. reflects a need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are lifelong, or extended in duration and are individually planned and coordinated, AND

5. does not include individuals who are solely severely emotionally disturbed or seriously and persistently mentally ill.

PROCEDURES:

1. MR/DD service providers shall ensure that all persons served with MH&RS/MR/DD funds meet one of the above definitions.

2. MR/DD service providers may use the Eligibility Determination Instrument (Adult or Children's version) to verify that a person does meet one of the above definitions.

3. In order to receive ICF/MR or HCBS/MR services, persons must meet additional eligibility criteria outlined in MH&RS Policy HCBS/MR 90-1 and the HCBS/MR Handbook.

4. If there is disagreement between an MR/DD service provider and MH&RS/MR/DD, the Eligibility Determination Instrument (Adult or Children's version) will be completed by a third party.

5. Persons shall have the right to a reconsideration of the eligibility determination by requesting such, in writing, from MH&RS/MR/DD.

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6. If, upon reconsideration, the determination is unchanged, persons shall have the right to an appeal, which must be filed within 30 days by writing:

Administrative Hearings Section
Credit Union One Bldg.
610 W. 10th, 2nd Floor
Topeka, KS 66612.

Darrin Hirsch
Director of MR/DD Programs

Director of Community MR/DD Programs

# ASSURING CONSUMER AND FAMILY INVOLVEMENT IN THE PROVISION OF SERVICES

AUGUST 24, 1993

Kansas Department of Social and Rehabilitation Services
Donna L. Whiteman, Secretary

SRS Mission Statement

"The Kansas Department of Social and Rehabilitation Services empowers individuals and families to achieve and sustain independence and to participate in the rights, responsibilities and benefits of full citizenship by creating conditions and opportunities for change, by advocating for human dignity and worth, and by providing care, safety and support in collaboration with others."

9/29/93

Joint Senate Ways & Means and House Appropriations Cmtes

Attachment 6

# QUALITY ENHANCEMENT PROGRAM
# MENTAL RETARDATION/DEVELOPMENTAL DISABILITIES SERVICES

## DEFINITION

A quality enhancement program determines the needs, wants, and desires of individuals, families, and advocates and measures quality of life indicators to determine whether services are being provided consistent with these needs, wants, and desires. Where services are insufficient, a quality enhancement program facilitates continuous improvement of the service system to meet the identified needs, wants, and desires of its customers.

## PRINCIPLES

The MR/DD quality enhancement program is being designed in partnership between individuals and their families and the organizations or individuals who serve them. The program will focus on highlighting and building upon the strengths in the current system of services while addressing and identifying needs as defined by the consumer.

The following principles have been adopted to accomplish this goal, and they will apply to all components of the program:

**CONSUMER DRIVEN:**

The MR/DD service system must be responsive to its consumers--individuals with developmental disabilities in need of or receiving services. For this reason, the consumers, families, and advocates will take the leadership role in shaping every aspect of the system in cooperation with the community agencies and the state.

**LOCALLY DEVELOPED:**

Using the MR/DD quality enhancement program and the successes within the MR/DD service system in Kansas as a foundation, services and supports consistent with the unique needs and preferences of the consumers in each local area will be developed and implemented.

6-2

**DATA BASED:**

The program will utilize objective data based methods of identifying consumer specific quality of life indicators and measuring provider responsiveness to them.

**OUTCOME MEASURES:**

Emphasis will be placed on outcomes in evaluating the achievement of the individuals' desired lifestyles.

**CONTINUOUS RESPONSIVENESS:**

The MR/DD service system will evolve in response to the ever changing needs and aspirations of the consumers.

## PURPOSE AND MISSION

The purpose and direction of the quality enhancement program was defined through the following mission statement developed using recommendations from consumers, families, advocates, and providers of services and supports:

THE MISSION OF THE MENTAL RETARDATION/DEVELOPMENTAL DISABILITIES SERVICES QUALITY ENHANCEMENT PROGRAM IS TO AID OUR CUSTOMERS--CONSUMERS, FAMILIES, PROVIDERS OF SERVICES AND SUPPORTS, AND THE COMMUNITY AT LARGE--IN THE DEVELOPMENT OF A CONTINUOUSLY RESPONSIVE, CONSUMER DRIVEN SYSTEM THAT MEASURES QUALITY OF LIFE INDICATORS AND FACILITATES THE ACHIEVEMENT OF EACH INDIVIDUAL'S DESIRED LIFESTYLE.

Ultimately, the quality enhancement program will support and enable the MR/DD service system to:

* Empower consumers,
* Meet the expectations of consumers,
* Allow consumers to shape the ways in which services and supports are developed and provided, and

* Ensure each individual is receiving the quality service and supports necessary to facilitate the achievement of his/her desired lifestyle.

## QUALITY OF LIFE INDICATORS

Services and supports will be assessed based on the four quality of life indicators which measure conformance with the mission of the quality enhancement program. Recognizing each individual's needs, interests, and preferences plays a major role in any definition of quality of life. The indicators will be used as a framework to assess the responsiveness of the service system to meet the individual needs and aspirations of each consumer. These indicators are listed below with examples to further explain what they include:

### MEMBERSHIP AND PARTICIPATION IN THE COMMUNITY:

* Individuals live, work, and recreate in typical communities.
* Individuals participate in and contribute to the life of their community in individual ways.
* Individuals have real relationships with their families, friends, neighbors, and co-workers.
* Individuals spend time with their families, friends, neighbors, and co-workers.
* Individuals participate in a variety of activities outside their home.

### SELF-DETERMINATION:

* Individuals have control over selecting their own services, choosing where and with whom they live, work, and spend time, and determining their goals for the future.
* Individuals make legitimate choices about all aspects of their lives and those choices are respected. Individuals are provided a broad base of experience and knowledge to draw from in order to make legitimate choices.
* Individuals are supported in such a way to maintain the critical individual balance between risk and protection.

6-4

**EQUALITY AND FULL CITIZENSHIP:**

* Individuals exercise their rights and their rights are not limited without due process.
* Individuals are respected and their opinions are taken seriously and acted upon.
* Individuals are provided privacy and security.
* Individuals are recognized for their abilities.

**SATISFACTION OF BASIC NEEDS:**

* Individuals are safe.
* Individuals enjoy optimal health.
* Individuals are free from abuse, neglect, and exploitation.
* Individuals experience personal well being.

A balance among all of the quality of life indicators must be attained if the achievement of individuals' desired lifestyles are to become reality. Like anyone else, individuals with developmental disabilities need the people who know and care about them to participate in making important decisions about their lives. Also, they must take into consideration, as we all do, the limitations placed on their range of available options due to circumstances and resources.

## SUMMARY

No two individuals have identical ideas of what constitutes quality services, but the important values in determining whether a quality lifestyle is achieved are no different for a person with developmental disabilities than for anyone else. The quality of life indicators were developed based on the values important to all of us in achieving a quality lifestyle.

MR/DD Services is adopting this quality enhancement system as opposed to using exclusively regulatory surveys and/or national professional standards to monitor services. This allows the assessment of services to be measured by the desired outcome--the achievement of each individual's desired lifestyle--as opposed to services being assessed by minimum health, safety, and professional standards.

There are valuable aspects of regulatory surveys and professional standards; however, quality enhancement takes service assessment a step further by stressing the importance of meeting the expectations of the consumers. By empowering consumers to take the leadership role in shaping the way services and supports are developed and provided, the ultimate goal of providing the quality services and supports necessary to facilitate the achievement of each individual's desired lifestyle can be realized.

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

**Mental Health & Retardation Services**
**Fifth Floor North**
**(913) 296-3561**
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September 20, 1993

The Honorable Rochelle Chronister
Representative, District 13
Route 2, Box 321A
Neodesha, KS 66757

Dear Representative Chronister:

At the last Legislative Budget Committee meeting you asked how many school age children were in the process of placement from state Mental Retardation Hospitals to community services. Thank you for your patience as we researched the answer.

Currently there are ten (10) children aged 19 or less in processing. Eight (8) of these children have had Essential Lifestyle Plans developed by the MR Hospital which have been forwarded to Community Mental Retardation Centers (CMRCs). The CMRCs are working with child placing agencies and the natural family to find appropriate family settings. The MR Hospitals are still developing Essential Lifestyle Plans for two of the children. The children's ages are:

19 years old - 3 children
18 years old - 1 child
17 years old - 1 child
12 years old - 2 children
10 years old - 1 child
7 years old - 2 children

If I can be of further service please contact me at (913) 296-3561.

Sincerely,

Darvin Hirsch

Darvin Hirsch, Ed.D.
Director of MR/DD Services

DH:eb

cc: Secretary Whiteman
Commissioner Vega

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

9/29/93
Joint Senate Ways & Means
and House Appropriations Cmtes

Attachment 7