Provision of Nursing Home Services to Oklahoma Residents who have Mental Retardation: 1992 through 1996

Brief Report Number 15
Of a Series on the Well Being of People with
Developmental Disabilities in Oklahoma

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April, 2000

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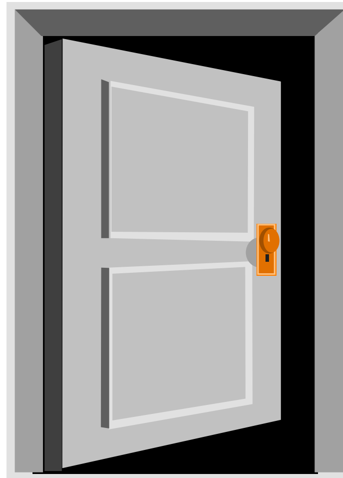
Acknowledgement

Data have been obtained through a cooperative agreement with the Oklahoma State University Department of Sociology's Developmental Disabilities Quality Assurance Research Project. Since 1989, the Sociology Department at O.S.U. has conducted yearly independent assessments of consumer outcomes for approximately 3700 individuals receiving services from the Oklahoma Department of Human Services Developmental Disabilities Services Division.



"In 1990, these people were surrounded by walls.
In 1994, they're surrounded by doors."

The quotation above is from David Loconto, a graduate student at Oklahoma State University. When he wrote this in 1995, Mr. Loconto was studying the well-being of people who moved from Hissom to community. He personally visited more than 200 Hissom class members in 1995.

Executive Summary

Survey data from 1992, 1994, and 1996 were compared to assess whether improvement was evident in service planning and service provision for persons who have mental retardation and who live in Oklahoma Nursing Homes. The following information was gleaned:

1. Most persons have written program plans (98.2%).
   This is a massive improvement over 1992, when only 24.3% had written plans.
2. Actual service hours increased by slightly over 100% over the four year time period.
3. The percentage of persons receiving no services declined from 19.5% to just 5.4%. Similarly, the percentage of persons receiving less than 20 hours service per month declined from 38.6% to 16.0%.
4. Relative to persons who live in ICF/MR Programs and Supported Living Arrangements, persons in Nursing Homes have more written goals, but receive lesser amounts of service.

Introduction

Nursing Homes have been a relatively common service alternative for persons with mental retardation. According to Amado, Lakin, and Menke (1990), almost 46,000 Americans with mental retardation lived in Nursing Homes in 1987. This figure had been relatively constant for the previous decade, indicating that Nursing Homes have long served as an option for providing services to persons with mental retardation.

It has been suggested (Mitchell and Braddock, 1990)) that some states, in attempting to limit and/or decrease the population of state developmental centers for persons with mental retardation, have inadvertently contributed to the high utilization of nursing homes for persons with mental retardation. The utilization of nursing homes for persons with mental retardation varies from state to state, with Mitchell and Braddock (1990) reporting that one state expended over 20% of its mental retardation budget for nursing home services. In 1996, approximately 29.2% of the persons receiving residential services in the Oklahoma mental retardation system were living in nursing homes.

In spite of their apparent widespread use, Nursing Homes are generally not viewed as acceptable alternatives for persons with mental retardation. This is largely because that while Nursing Homes provide medical, nursing, and other

personal care services, they are generally unable to meet the social, recreational, and habilitative needs of younger, healthy persons. Such individuals need aggressive and continuous programs of teaching and treatment in order to assist and enable them to achieve their own potential for independence, productivity, and integration, services that would significantly impact the financial costs of nursing home services.

Because of concerns about the general quality of care in nursing homes and concerns about inappropriate nursing home placements (Institute of Medicine, 1986), the United States Congress enacted the Omnibus Budget Reconciliation Act of 1987 (OBRA; P.L. 100-203). OBRA set forth a policy of nursing home reforms in which states were required to take affirmative actions to prevent or to terminate inappropriate placements of persons in Nursing Homes. Specifically, the law targeted persons with mental retardation, other related conditions, and persons with mental illness.

OBRA required two major reforms (Seltzer, 1990). First, states were required to initiate a screening process to prevent inappropriate admissions to Nursing Homes. This preadmission screening process, or PAS, was designed to ensure that persons with disabilities entered Nursing Homes only if their advanced age and/or medical care needs required the type of 24 hour nursing care that

Nursing Homes are designed to provide. Second, states were required to conduct an Annual Resident Review (ARR) for all persons living in Nursing Homes. This Annual Nursing Review was designed to determine whether each individual needed active habilitative services or whether he/she needed Nursing Home type services. The expectation was that individuals who were determined to be in need of habilitative services would receive them, whether in the Nursing Home or in an alternative placement. Mitchell and Braddock (1990) reported that two most common approaches used by states to gain compliance with OBRA were to provide active treatment in the nursing home and/or to move individuals from nursing homes to various community living arrangements.

The purpose of this study was to attempt to answer two basic questions about services provided to Oklahoma citizens who have mental retardation and who live in nursing home facilities. These two questions were:

1. To what extent have services improved since 1992 in nursing homes that serve Oklahoma citizens who have mental retardation?
2. How do mental retardation services provided in nursing homes compare with services provided in other residential alternatives?

Methods

Subjects

The primary subjects for this investigation were Oklahoma citizens who had mental retardation and who lived in Oklahoma Nursing Homes in 1992, 1994, and/or 1996. There were 907 such individuals in 1992, 1122 such individuals in 1994, and 957 such individuals in 1996. Demographic summary regarding these individuals appears below in Table 1.

Table 1
Demographic Summary

	1992	**1994**	**1996**
Number of Persons	907	1122	957
Percent Male	46.2%	43.8%	44.5%
Mean Year of Birth	1940.7	1935.7	1936.1
Level of Mental Retardation			
Without Mental Retardation	4.6%	5.6%	7.3%
Mild Mental Retardation	7.8%	6.9%	8.6%
Moderate Mental Retardation	12.9%	8.5%	9.1%
Severe Mental Retardation	16.8%	16.3%	15.3%
Profound Mental Retardation	8.6%	7.6%	6.7%
Unclassified	49.3%	55.1%	53.0%

Instrumentation

Oklahoma administers the Developmental Disabilities Quality Assurance Questionnaire (DDQAQ; Oklahoma State University, 1991) for all consumers within its service system on an annual basis. This assessment is administered by interviewers contracted by the state, and it includes major sections on adaptive behavior, use of medication, family contact, challenging behavior, service planning, and consumer satisfaction. In this particular study, the sections on service planning and family contact were of primary consideration.

Have Mental Retardation Services Improved in Oklahoma Nursing Homes?

To address the first question, we adopted a cross-sectional approach, comparing data that were collected in 1992, 1994, and 1996. Using this snapshot-like approach, we were able to compare overall performance on a number of key indicators at three different points in time. Three key indicators were considered: The Individual Habilitation Plan, Service Provision, and Family Contact. Each will be discussed below.

Results

Individual Habilitation Plan - The Individual Habilitation Plan (IHP) is the document that identifies and describes the types and amounts of needed service for individuals with mental retardation. This document often has slightly different names (Individual Program Plan, Individual Service Plan, etc.), however, the purpose is consistent across names. Every person who has mental retardation and who is receiving habilitative services is expected to have some sort of formal service plan. In 1992, only 24.6% of the persons with mental retardation who lived in Nursing Homes actually had any sort of written IHP. This figure increased dramatically by the 1994 data collection, when 91.8% of the persons with mental retardation who lived in Nursing Homes had written IHPs. In 1996, the comparable value was 98.2%. The magnitude of this improvement is noteworthy, and it obviously represents an increased commitment to the service planning process.

It is also apparent that the complexity of the written IHPs increased over this time period. In 1992, the average written IHP contained 5.6 goals. By 1996, this value increased to 7.7 goals per written IHP. It should be noted that these values are corrected by the number of written IHPs, such that the 1992 data are based on just the 220 individuals who actually had written IHPs.

Table 2 below presents the percentage of nursing home residents who had IHP goals within key programmatic areas.

Table 2
Percentage of Nursing Home Residents with Key IHP Goals

Skill Area	1992	1994	1996
Workskills	1.0%	0%	-----
Recreation	11.1%	22.9%	42.3%
Self Care Skills	17.1%	40.3%	53.9%
Communication	14.4%	33.3%	47.3%
Community Skills	8.2%	16.9%	26.5%
Challenging Behavior	9.5%	27.8%	32.5%
Social Skills	9.5%	11.1%	18.6%
Job Getting Skills	1.0%	-----	-----
Job Keeping Skills	1.0%	-----	-----
Citizenship Skills	0%	0%	0%
Domestic Activity	------	1.0%	6.3%
Sensorimotor Skills	------	30.3%	37.2%
Other	8.6%	51.0%	76.8%

NOTE: **------** indicates that data were not specifically collected for this goal area, and that goals of this type were included as "OTHER".

Actual Service Provision - The IHP is merely a plan to deliver services, and while our data do suggest a growing complexity of plans, the key measure of interest must be the actual provision of services. In 1992, the monthly average number of service hours provided to nursing home residents was 64.3. This increased to 111.6 in 1994 and 131.8 in 1996. The amount of services provided actually doubled over the four-year period. At the same time, the number of

individuals who were reported as receiving no services declined. In 1992, 19.5% of the persons with mental retardation who lived in nursing homes were reported to receive no services other than maintenance. This figure declined to 4.7% in 1994 and 5.4% in 1996. Similarly, the number of persons who were reported to receive less than 20 hours of service per month declined from 38.6% in 1992 to 16.6% in 1994 and 16.0% in 1996. Table 3 below summarizes these data.

Table 3
Hours of Service Delivery in Nursing Homes

	1992	**1994**	**1996**
Mean Service Hours / Month	64.3	111.6	131.8
Percent with No Service Hours	19.5%	4.7%	5.4%
Percent with ≤ 20 Hours/ Month	38.6%	16.6%	16.0%

There were shifts evident with respect to provision of specific services. Habilitation Training Hours increased markedly from 5.8 hours per person per month in the 1992 survey to 31.3 hours in 1994 and 79.1 hours per person per month in 1996. Similarly, the number of individuals who were involved in Sheltered, Supported, or Competitive Employment increased from 15 in 1992 to 34 in 1994 and 44 in 1996. Interestingly, the actual number of hours devoted to vocational services remained relatively constant during this time (3.7 in 1992 and 4.0 in both 1994 and 1996), perhaps reflecting the fact that only a very small number of individuals were involved in vocational programming in any year.

Family Contact - There were three questions in the annual survey that asked about contact with family members. To some extent, these numbers are limited by the age of the persons who live in nursing homes. With an average age approaching 60, it is reasonable to expect that many parents have died. The three family contact questions can be added together to create a scale. This scale ranges from a value of 0 to 18. Higher scores on this scale indicate greater levels of family contact. The family contact score in 1992 was 7.8. In 1994, it was 6.9, and in 1996, it was 7.7. Family contact was essentially unchanged during this time period.

How do Oklahoma Nursing Homes Compare with Current Alternatives?

The above data clearly suggest that there has been considerable improvement with regard to service provision for persons with mental retardation who live in Oklahoma Nursing Homes. It is reasonable to ask how the most recent data compare with data collected in other types of residential programs that serve persons with mental retardation. We elected to compare the Nursing Home data with similar data that were collected in ICF/MR programs and Supported Living Arrangements. We selected ICF/MR programs as an alternative because these programs do have a strong medical focus in common with Nursing Homes. Supported Living Arrangements were selected because they are the fastest growing residential alternative in Oklahoma, serving just 5.6% of the service population in

1992 and 16.8% of the service population in 1996. These three residential alternatives were compared with respect to IHP goals, Service Hours, and Family Contact. We also examined adaptive behavior as a means of identifying the relative skill levels of the persons living in the three different residential alternatives. We also present a summary of an earlier study that compared service provision for persons who either stayed in nursing homes or moved to the community.

IHP Goals - The highest average number of habilitative goals was found in IHPs written for persons who live in Nursing Homes, where the typical IHP contained 7.72 goals. The typical IHP from ICF/MR Programs contained 5.98 goals, while the typical IHP from the Supported Living Programs contained only 3.34 goals.

Service Provision - In contrast with the above data regarding service planning, data on service provision reveal greater levels of actual service provision occurring in ICF/MR Programs and Supported Living Arrangements. The average resident of an ICF/MR Program received 206.9 hours of services per month, and the average resident of a Supported Living Arrangement received 197.0 hours of

service per month. These values were not statistically distinguishable, but both were significantly greater than the 131.8 hours of service provided per month to residents of Nursing Homes.

Adaptive Skills - Comparison of adaptive behavior scale scores indicated that persons who lived in Nursing Homes had significantly less skills than persons living in either ICF/MR Programs or Supported Living Arrangements. We explored the possibility that our Nursing Home data were spuriously deflated by persons whose minimal adaptive skills precluded even the most minimal habilitative involvement. To do this, we compared the number of hours of services for nursing home residents whose adaptive behavior skills fell within each of the four quartiles of the adaptive behavior variable. We actually found that the persons with the greatest limitations in adaptive behavior received the greatest number of hours of service, thus refuting the hypothesis regarding service provision to lowest functioning individuals.

Family Contact - Family contact was greatest in the Supported Living Arrangements, where an average score of 10.49 was reported. Lower scores, indicating lesser family contact, were reported in ICF/MR programs (8.45) and Nursing Homes (7.74).

Matched Sample Comparison of Nursing Home and Community Placement

In an earlier study conducted by the Center for Outcome Analysis (Spreat and Conroy, 1996), a matched sample longitudinal design was used to compare the outcomes for individuals with mental retardation who were either retained in nursing homes or transferred to Supported Living Arrangements in the community. Persons who moved from nursing homes to community residences experienced increased performance in adaptive behavior skills, while persons who remained in nursing homes regressed. Individual Habilitation Plans became nearly universal in both environments, but those plans prepared in the community were more focused on vocational type goals. Hours of service also increased in both environments, with the greatest increases being observed in Habilitation Training. Nursing services dropped to near zero levels in community based programs.

Discussion

The above reported data support the contention that the provision of services for persons with mental retardation who live in Oklahoma Nursing Homes has improved over the past several years. Almost all persons (98.2%) now have written Individual Habilitation Plans, whereas only 24.3% had such plans in 1992. The number of goals per IHP has increased from 5.6 to 7.7. More importantly, the average number of service hours provided each month has essentially doubled over the four-year time span. With this improvement, the percentage of persons receiving no services declined from 19.5% to 5.4%. It is evident that there has been considerable improvement with respect to service planning and service provision for persons with mental retardation who currently live in Oklahoma Nursing Homes.

In spite of the positive news regarding improvement within the Oklahoma Nursing Home environments, it must be recognized that the typical Nursing Home resident receives fewer hours of service than peers in either ICF/MR Programs or Supported Living Arrangements, in spite of the fact that the community based IHPs have significantly fewer written goals. This general finding was also supported by a separate study that compared service patterns for persons who were discharged from Nursing Homes with a matched sample of individuals who remained within

Nursing Homes. In sum, it would appear that much has been accomplished over the past few years in Oklahoma Nursing Homes. It also appears that the Nursing Home environments continue to lag behind other residential alternatives, and it does not appear that resident functioning level is an adequate explanation of this difference.

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