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H.B. 283 Oversight Committee Report

An evaluation and recommendations concerning statutory and administrative amendments by the Ohio Departments of Aging, Health and Mental Health enacted to improve the care and treatment of Residential State Supplement recipients and individuals residing in adult care facilities with a focus on those facilities serving persons with mental illness.

July 1, 2002

Prepared for
Joan Lawrence, Director of Aging
Nick Baird, Director of Health
Michael Hogan, Director of Mental Health
And the General Assembly

Acknowledgments

This study was conducted at the request of the Directors of the Ohio Departments of Aging, Health and Mental Health in accordance with Section 68.04 of the Ohio Revised Code. Brenda Lovenshimer, RSS Clinical Manager, Ohio Department of Aging; Roy Croy, Bureau Chief of Community Health Care Facilities and Services, Ohio Department of Health and Charles Ashe, Chief of Licensure and Certification, Ohio Department of Mental Health, coordinated the effort and provided technical assistance and support to the committee.

Enclosed is the report of the H.B. 283 Oversight Committee. We gratefully acknowledge the contributions from members of the H.B. 283 Oversight Committee, listed below. We appreciate the group's willingness to share experiences and expertise about these complex and interdependent issues. We would like to particularly thank Sande Johnson and Meg Teaford, Ohio Department of Aging's evaluation staff, for taking the lead on the development of the constituent surveys. A very special thanks goes to Lesley Wilson Schaab, Ohio Department of Health, for taking on the task of primary drafter of this report. Thanks also to Margaret Lewis and Stephen Kotev, Ohio Commission on Dispute Resolution and Conflict Management, for facilitating our discussions.

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EXECUTIVE SUMMARY

In 1999, a work group representing the Ohio Departments of Aging, Health, and Mental Health, agreed that changes were needed to improve their ability to assure quality of resident care in Adult Care Facilities (ACFs) and accessibility to specialized services needed by residents diagnosed with mental illnesses. Specifically, the Department of Aging (ODA) needed a means to certify quality of care provided to clients receiving Residential State Supplement (RSS), many of whom are diagnosed with mental illness and are residing in ACFs. The Department of Mental Health (ODMH) needed to improve the ability to assure quality, availability and accessibility of mental health care services. And the Department of Health (ODH) needed to address concerns regarding ACF operator and staff training in ACFs, ensuring that residents are appropriately placed in ACFs and that the resident needs are met.

As the inter-departmental workgroup identified specific policy issues and solutions requiring statutory change, they collaborated on language necessary to bring about the results envisioned. This inter-departmental effort resulted in statutory changes jointly proposed by the Departments of Aging, Health and Mental Health, and adopted as part of amended substitute House Bill 283 in July 1999(hereinafter referred to as H.B. 283). Subsequent to this action, rules were developed, adopted and implemented to carry out the intent of the legislation.

Following implementation of administrative rules and in accordance with Section 68.04 of H.B. 283, the Directors of the Ohio Departments of Aging, Health and Mental Health were required to convene a representative group of entities impacted by these actions, to evaluate implementation of H.B. 283. To this end, the H.B. 283 Oversight Committee (Committee) began meeting in April, 2001, considered anecdotal and empirical information and arrived at certain conclusions, which include the following.

MAJOR FINDINGS

Based upon consideration of various sources of information, described in Section II of this report, the Committee reached consensus that, as the result of administrative rules adopted and implemented by authority of provisions of H.B. 283:

- the coordination of services for persons with mental illness who reside in ACFs appears to be improving;

- while it is believed that the quality of care may be improving, it is not possible, without further study and the development of measurement tools, to, at this time definitively make that assertion;

- the new requirements are making it easier to utilize the process to match appropriateness between prospective residents and ACFs;

- overall communication among ACF operators, the mental health system and PASSPORT Administrative Agencies (administer the RSS program) has improved;

- in areas where implementation of certain rules appeared problematic, increased resources for various types of training may resolve most difficulties; and

- the number of RSS clients over age 60, residing in ACFs did not increase, as anticipated.

In addition to these major findings, the Committee agreed that two other concepts greatly impact data gathered and shaped discussions covering every topic presented in this report: diversity and the lack of resources and funding.

Diversity

There was recognition within the Committee that Ohio is a diverse state of rural and urban areas with varying levels of availability, accessibility and efficacy of local services. In this context, the committee noted that successful implementation of rules reflects this diversity and some areas have experienced varying degrees of difficulty in implementing all portions of the new rules.

Lack of Resources and Funding

During discussion of rule topics, data findings and anecdotal information, it was clear that every aspect of the care continuum concerning the Committee was negatively impacted by lack of funding and resources. Central to this concern is the deleterious impact of poor funding on quality and availability of appropriate care. For example, representatives of ODA cited a lack of funding and resources to expand the number of RSS slots (placement opportunities) beyond the current 2800 available. As of March 2002, there were 1,520 individuals on the RSS waiting list. Please see page 20 for more detailed information on slots, waiting list and the RSS program.

ODH representatives and ACF operators noted the new regulations dramatically increase training requirements for staff in ACFs serving people with mental illness. However, few resources were provided for the production and distribution of approved training materials; no funding has been provided to cover the additional cost for training for staff; and there are no plans to increase care reimbursement for ACFs that meet all training requirements. In addition, the reimbursement rates for ACF operators result in low wages and high turnover for staff, resulting in a continuing need for repeat training opportunities.

ODMH representatives pointed out that, after initial statewide training opportunities, few resources were devoted to the training of mental health boards and agencies on the implementation of the new rules. A general lack of funding has resulted in low wages and high turnover among mental health case managers (often entry level workers) in the agencies. Those workers who were trained were often no longer working at the agencies, and the training of new workers on these specific rules has been inconsistent. The lack of funding also precluded ODMH from adequately tracking operations of all mental health boards and agencies to assure compliance with new regulations.

The Committee agreed that ODA, ODH and ODMH should collaborate on the development of a core curriculum on the care needed by ACF residents with mental illness. Such collaboration would be an effective way to assure consistent training content for ACF operators and their staff, ODH surveyors, RSS staff, staff of mental health boards and agencies and all others involved in the placement, housing and care of persons in ACFs, particularly those diagnosed with mental illness. At the time of this writing, however, there is no funding available for the production or distribution of such materials.

The Committee agreed that ACFs save the state millions of dollars each year by providing homes for thousands of individuals who otherwise would live in costlier facilities. Unfortunately, lack of adequate funding for these operators has already forced some out of business. Without additional resources and funding directed toward community-based programs and services, training, and reimbursement to facility operators, we will expect fewer ACFs to survive and expect quality of care to deteriorate.

Finally, while the Committee agreed that the intent of the new regulations was and remains valid, lack of funding and resources prevents all entities involved from providing optimal service and quality of care.

GENERAL RECOMMENDATIONS

Throughout discussions pertaining to the rules analyzed in this report, the committee returned to ideas that could not be associated with one specific rule or recommendation. These observations are listed here.

- ODA should re-examine what they want the RSS Program to achieve.

- The influx of mentally ill ACF residents from other states negatively impacts the ability of some Ohio mental health boards to accurately plan and fund services to optimally meet their community needs. This situation, while not experienced statewide, is a significant burden and irritant to affected boards and communities.

- Although the rules prescribe a collaborative process between the resident, ACF operator and mental health agency for developing the resident's Mental Health Plan For Care (MHPFC), many ACF residents are not routinely included in the formulation of the plan. Mental health agencies and ACF operators should assure that residents are involved and participate, within the mental and physical capacity of each resident to do so, in developing and updating their MHPFC.

- While ACF operators and RSS staff must strictly abide by the rules, there is little accountability demanded for mental health boards and agencies.

- Additional study is needed on client outcomes pertaining to the implementation of these rules.

- Additional study is needed on the high turnover rate of MH case managers and ACF staff.

- ODA, ODH and ODMH should continue to evaluate implementation of these rules and to collaborate on changes necessary to effectively reach the intent of the rules.

- ODA, ODMH and ODJFS should consider the reimbursement for ACF operators to provide an optimal environment for their residents.

- ODMH should ensure that whoever answers the telephones listed in the MHPFC crisis plan is adequately trained to understand the nature of the ACF and to effectively respond to the situation.

- ODA, ODH and ODMH should explore development and consistent application of measurement tools for client outcomes.

- ODA, ODH and ODMH should share information and patterns or trends of operational practice to track the impact of these rules.

Following significant discussion, the Committee also endorsed the following recommendations. Background information and discussion points relating to these recommendations may be found in Section III of this report.

- ODA should identify ways to address RSS access to the population age 60 and older especially to those individuals who do not have system-oriented advocates.

- ODA should re-examine the RSS enrollment priority and explore a first-come first-serve system for RSS.

- ODA should continue to monitor implementation of OAC 173-35-051 Determination of Facility Appropriateness.

- Increased resources need to be directed to RSS to meet demand (eliminate waiting list).

- ODH should evaluate these rules in the context of citations, relevant trends and the efficacy of specified training hours and develop responses to problematic areas.

- ODA, ODH and ODMH should coordinate an effort to develop a core curriculum acceptable to all departments to meet the intent of enhanced training standards for ACFs accepting residents with mental illness.

- ODA, ODH, and ODMH should coordinate the distribution of training materials developed in response to the recommendation stated above.

- ODH should explore the cost impact for ACF operators to secure training and advocate for funding as needed. To this end, the Ohio General Assembly should earmark ACF civil money penalties (CMPs) use for future ACF training.

- ODH should explore better means to enforce the ACF regulations and apply remedies as appropriate.

- ODH should investigate other disincentives to facility noncompliance beyond those sanctions currently provided for in the ACF statute and rules (civil money penalties and suspension of admissions). With few exceptions, ACFs may avoid actual imposition of allowable sanctions by subsequent actions to become compliant; therefore, even serious infractions are essentially excused and the possible deterrent effect of the sanction is lost.

- Request the Attorney General re-evaluate the interpretation of the rule as it applies to repeat violations to place more emphasis on historical non-compliance.

- ODMH needs to provide on-going training and monitoring of mental health boards and agencies to ensure consistent application of all current regulations.

- ODMH should establish means necessary to monitor consistent application and use of the MHPFC and monitor resident outcome.

- ODMH and ODH should provide and coordinate training for ACF operators, mental health case managers, ODH surveyors, resident advocates and others involved in the MHPFC to assure knowledge and modification of the MHPFC, as needed. Training should have consistent content and should be presented at a level appropriate for the audience. The training should include the value of the plan and that it needs to be individualized and implemented collaboratively.

- ODMH and ODH should clarify the intent of the MHPFC crisis plan, discourage use of a reference to "911" for this purpose whenever possible; and encourage inclusion in the crisis plan of appropriate entities capable of immediately responding to a mental health emergency.

- ODMH and ODH should coordinate distribution of the “ACF MH orientation videotape” to all ACFs serving residents with mental illness.

- ODMH should develop a process to monitor mental health agencies regarding proper implementation of these rules.

- ODMH should recommend inclusion of a monitoring mechanism as part of the community plans submitted by mental health Boards.

- ODMH needs to provide training to mental health boards and agencies on proper incident reporting and investigations.

- Mental health agencies and boards need to better communicate with operators about availability, and methods of training, as well as possible sources of financial assistance for training costs.

- NAMI Ohio is suggested as a source of appropriate training assistance.

CONCLUSIONS

The Committee concludes that through H.B. 283, the Ohio Legislature succeeded in enabling fundamental changes that restructure the system of referrals, placement and the general environments with the ACF level of care. While the Committee agreed that the intent of the new regulations was and remains valid, lack of funding and resources prevents all entities involved from providing optimal service and quality of care. Therefore, to maintain the intent of this purpose, the legislature needs to consider and address the deleterious impact of cuts in funding and resources on the entities mandated to carry out these changes.

More specific information leading to this conclusion is provided in the report, which follows.

SECTION I: FINDINGS OF THE H.B. 283 OVERSIGHT COMMITTEE

Compiled in accordance with Section 68.04 of H.B. 283 requiring, "Not later then July 1, 2001, the Directors of Mental Health, Health and Aging shall convene a group of key relevant constituencies to evaluate the implementation of Sections 173.35, 340.03, 340.091, 3722.01, 3722.011, 3722.10, 3722.15, 3722.16, 3722.18, and 5119.61 of the Revised Code, as amended or enacted by this act. The group shall report its findings and recommendations to the directors and General Assembly not later than July 1, 2002."

SYNOPSIS

In April 2001, the Oversight Committee convened its first meeting to consider the implementation of rules developed and adopted in accordance with provisions of the Ohio Revised Code, noted in the preceding paragraph. The Committee was made up of individual Adult Care Facility (ACF) operators and representatives of organizations with an interest in ACFs and their residents. Participation on the group was at the invitation of the Ohio Departments of Aging (ODA), Health (ODH) or Mental Health (ODMH).

The Committee met monthly to consider the legislative intent of the aforementioned H.B. 283 provisions and to explore means to measure the efficacy of related administrative rules promulgated by the ODA, ODH and ODMH. The Committee also received assistance from facilitators from the Ohio Commission on Dispute Resolution and Conflict Management.

BACKGROUND OF COMMITTEE CONCERNS

In November 1990, one result of the enactment of Amended Substitute House Bill 253 was the transfer of licensure authority over certain facilities from ODMH to ODH. Specifically, HB 253 gave ODH jurisdiction over all facilities (except those specifically excluded from statute) that provide personal care services to three or more adults, regardless of the nature of the residents' disabilities. Before this time, ODMH licensed facilities that provided personal care services to one or more persons with mental illnesses or severe mental disabilities. Consequently, with the enactment of HB 253, facilities providing personal care services to three or more persons with mental illnesses or severe mental disabilities were transferred to ODH for licensure.

Another provision of HB 253 required ACFs to obtain an "affiliation agreement" from their local mental health board as a condition of licensing. ODMH and many of their constituents considered affiliation agreements the key to continuity and quality in the community-based mental health care system.

While ODH and ODMH were addressing issues relating to the facility licensing transition and affiliation agreements, changes in another program were made which would impact all three

department. In 1993, ODA assumed responsibility for administering the Residential State Supplement (RSS) program. This program provides a cash supplement (state funds) to Medicaid eligible aged, blind or disabled adults who have increased needs due to a medical condition that is not severe enough to require institutionalization. The cash payment is used together with the individual's personal income to pay for an alternative living arrangement to institutional care and for the individual's personal needs. Eligible individuals may reside in the following types of living arrangements:

- Adult Foster Homes (1 to 2 beds certified by an Area Agency on Aging);
- Adult Care Facility (3 to 16 beds, licensed by ODH);
- Residential Care Facility (17 or more beds, licensed by ODH);
- Community Alternative Homes (3 to 5 beds serving individuals who have AIDS, licensed by ODH);
- Mental Health Residential Facilities and Apartments (1 to 2 beds, certified by ODMH and approved by the ADAMHS Board).

The RSS program currently serves a population that consists of a majority of persons under the age of sixty who have mental illness. Additionally, the majority of RSS recipients reside in ACFs licensed by ODH. ODA administers the RSS program through 13 PASSPORT Administrative Agencies (PAAs). The PAAs determine eligibility and provide case management services to all RSS recipients.

In the years that followed, affected ACFs, mental health providers and state agencies began reporting problematic aspects of implementation of the legislation. Further, the Ohio Departments of Aging, Health and Mental Health and various provider groups began identifying specific and serious gaps in services, coordination of referrals and quality of care. As a result, an increasing number of affected parties questioned if the legislation and related rules truly met the needs of ACF residents, particularly those diagnosed with mental illnesses.

After almost a decade of problematic and awkward implementation, the Taft Administration directed ODA, ODH and ODMH to use whatever means necessary to resolve identified gaps, improve the environment and services for ACF residents (particularly those with mental illness), and to improve communication between all parties involved with the resident's placement and care. As a result, an inter-departmental work group began an unprecedented cooperative mission to identify and utilize legislative and/or administrative means to:

- Improve staff training and preparedness to improve quality of care in ACFs

- Improve the availability, accessibility and quality of services to ACF residents, especially those with mental illness

- Improve appropriateness of ACF placements

- Improve coordination and communication between ACFs, mental health providers, local agencies and state agencies.

During discussions within the inter-departmental work group, issues affecting specific departments and their operations were also identified, as follows.

Ohio Department of Aging

- Needed a means to certify quality and provision of care for residents receiving Residential State Supplement (RSS);

- Needed means to assure appropriate placement of RSS clients in facilities prepared to meet specific resident needs.

Ohio Department of Health

- Needed to assure appropriate initial placement of ACF residents in facilities best suited for individual resident needs;

- Needed means to assure appropriate operator and staff orientation and training to meet the needs of residents, especially those diagnosed with mental illness.

Ohio Department of Mental Health

- Needed to improve the ability to assure quality, availability and accessibility of mental health care services in the community setting;

- Needed to increase communication between local mental health boards, mental health agencies and ACF operators.

- Needed to assure local mental health boards maintain responsibility for their clients placed in facilities outside the board's own service area.

As the inter-departmental group discussed possible remedies for these concerns and issues, it became clear that new legislation would be necessary to enable the structural changes needed to accomplish the charge given to the state agencies. As a result, the group drafted legislative language addressing the issues and providing for the envisioned rule changes. The draft language was forwarded jointly by ODA, ODH and ODMH directors for inclusion in HB 283, which was signed into effect July 1, 1999.

Amended Substitute House Bill 283

This legislation provided the legislative authority needed for the coordinated, structural, and programmatic changes envisioned by the inter-departmental work group. To this end, HB 283 required development and implementation of administrative rules by the three state agencies to address identified concerns and issues; and required the formation of an evaluation committee to monitor administrative rule implementation. The impact on the three state departments and their subsequent operations can be summarized in the following manner.

Impact on ODA

Amended statute and rules to:

- Change the program enrollment priority to favor individuals in community settings, in order to make RSS an alternative to the 60+ population and an alternative to nursing home placement. Previously this was the lowest priority; consequently, individuals residing in the community rarely had access to RSS.

- Establish a mechanism to assure placement meets individual's needs by: establishing new eligibility criteria; establishing a process referring individuals with mental illness to local mental health systems for recommendations on facility appropriateness; and establishing objective criteria for making the placement determination.

Impact on ODH

Amended statute and authorized new rules or rule amendments to:

- Enhance licensing standards for ACF operations and staff training. This provision represented a major change to address the growing need to assure caregivers had appropriate training to meet the needs of residents, particularly those diagnosed with mental illnesses.

- Establish procedures for ACF operators to follow regarding referrals, placement and care needs of prospective residents, particularly those diagnosed with mental illness. Provisions included acquiring a Mental Health Plan For Care (MHPFC) prior to admitting a mentally ill individual to clearly delineate a prospective resident's needs and to enhance communication between ACF operators, MH boards and agencies, and residents.

Impact on ODMH

Amended statute and authorized new rules or rule amendments to:

- Expand authority of mental health boards and agencies to enter ACFs serving individuals with mental illness, provide skilled services in an ACF, or investigate a complaint constituting immediate threat to a resident with mental illness;

- Prescribe referral process to encourage greater communication between mental health boards, agencies and ACF operators and ODMH.

- Develop an individualized MHPFC for each resident with mentally illness residing in an ACF and utilizing publicly funded mental health services. This would allow mental health agencies to provide sufficient information about clients and their needs to provide for an optimal living environment, with care-givers appropriately informed to respond to the individual's needs. This provision represented a major change in the placement and care of residents with mentally illness, who previously were placed in ACFs with only a general affiliation agreement between the ACF and a mental health board in place, which did not address needs of specific individuals.

In order to develop the administrative rules, the three state agencies identified key constituents to represent various interests concerned with ACFs and their residents. This group became the H.B. 283 Oversight Committee and began meeting in September 1999. As a result of this committee's efforts, rule amendments were drafted and proposed by ODA, ODH and ODMH between the months of March and June 2000. Rules proposed by ODA became effective July 1, 2000; the ODMH Rule 5122-31-01 became effective August 1, 2000; and the ODH and ODMH 5122-31-02 rule amendments became effective October 15, 2000.

Soon after the rules became effective, staff of the three state agencies began discussing logistics of convening the Oversight Committee to evaluate the new rules, which had been implemented. Staff within each department nominated individuals to represent constituencies affected by the rules. Staff also reached agreement on the division of responsibilities associated with the needs of the Oversight Committee; while Section 68.04 of H.B. 283 mandated the Committee, no funding was attached. Consequently, any expenses associated with the Committee would have to be absorbed by the state agencies.

The Committee began meeting in April 2001 and considered questions, such as:

- What was to be accomplished by implementing legislation and related rules by the three state departments; and has it been accomplished?

- Has the change in enrollment priority to individuals from community settings made the RSS program more accessible to seniors?

- Is the quality of care and services for persons with mental illness residing in ACFs improved as a result in changes in regulations?

- Have new resident rights issues come to light since implementation of these rules?

To discuss and answer these questions, the Committee considered anecdotal evidence provided by group members and a community housing report provided by NAMI Ohio (National Alliance for the Mentally Ill).

State agencies also provided relevant data, including ODA monthly reports describing RSS waiting lists, implementation of mental health placement recommendations and information on placements, by living arrangement. ODH supplied reports on ACF deficiencies and surveyor observations.

Additionally, the Committee requested empirical data relating to specific elements of administrative rules. To this end, ODA, ODH and ODMH, in cooperation with the Committee, developed questionnaires, which were distributed to a sample of appropriate constituents determined by each state agency.

A synopsis of these findings is included in the next section of this report.

SECTION II: SURVEY FINDINGS

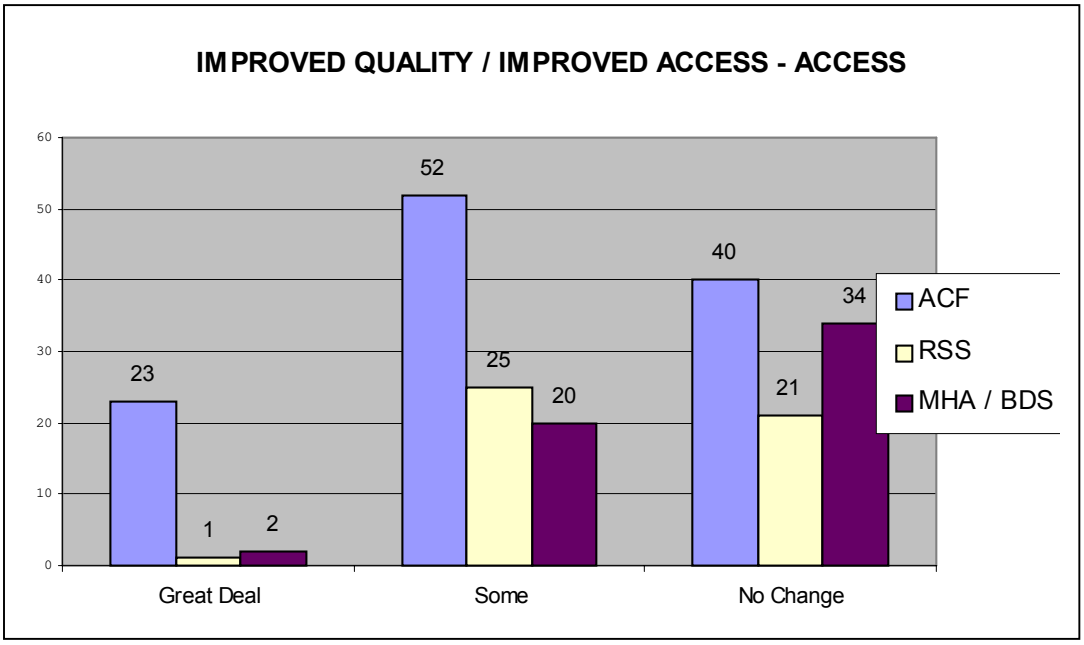
Each of the three state agencies developed a sample of relevant constituencies to receive surveys with certain questions common to all three groups of respondents; additionally, there were questions tailored specifically to the respondents within a department's sample.

The sample developed by each department reflected the diversity of the state and included a balance of urban and rural operations; large, medium and small operations and a balance of geographically distributed respondents.

As described in Section I, ODA distributed and received a total of 52 responses from various staff person in all 13 PAAs, where RSS programs are administered. ODH sent surveys to 250 geographically diverse ACF operators and received responses from 118, for a return rate of just under 50%. ODMH sent out 108 surveys: 58 to selected mental health agencies and 50 to selected mental health boards. Almost half of each group surveyed responded including 38 of the 50 board areas and all urban counties but one. Additionally it should be noted that 3 of the 12 non-responding board areas do not have ACFs serving residents with mental illness.

In response to questions asking if the new regulations had improved access to MH services, most ACF operators felt there was some or a great deal of improvement, which was a similar response to the PAA respondents, indicated here by "RSS". Slightly more than half the MH respondents did not perceive much change in improved access to MH services as a result of new regulations.

GRAPH 1



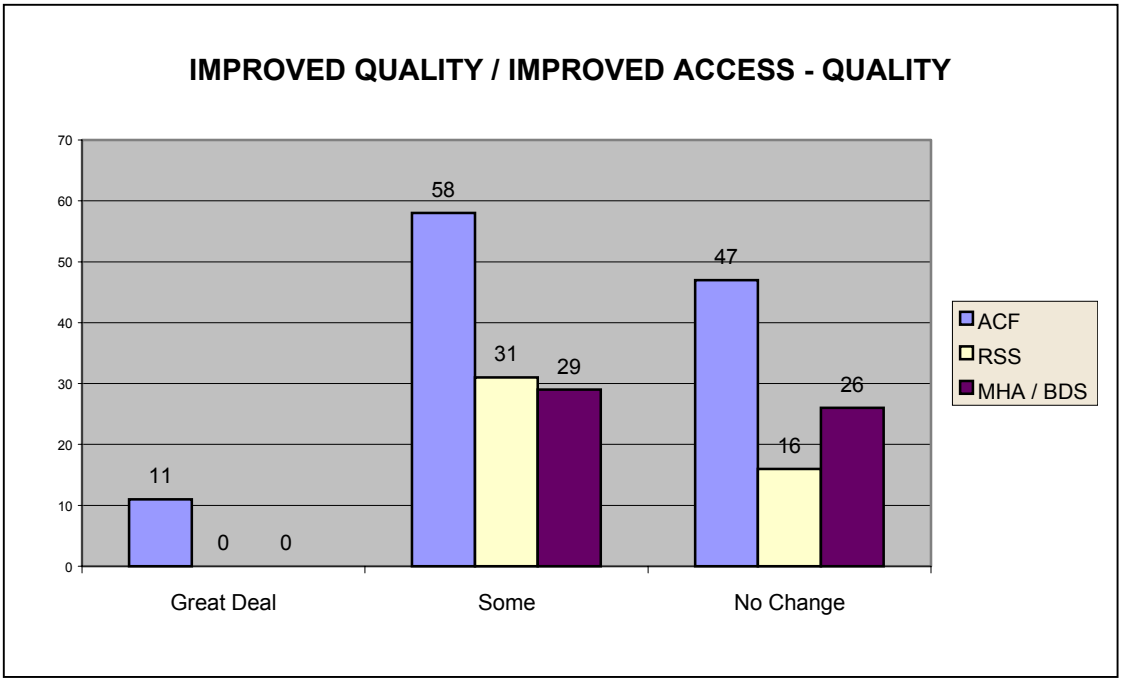
Source of all Graphs: ODA *PAA Survey, ODH Operator Survey, ODMH MH Agency/Board Survey, 2002*

When asked if the new regulations improved the quality of services to residents, the majority of respondents, particularly ACF operators, responded affirmatively. As indicated in Graph 2, the majority of operators said new regulations improved quality "some" or "a great deal". The

majority of RSS staff and MH agency and board respondents also noted "some" improvement in quality.

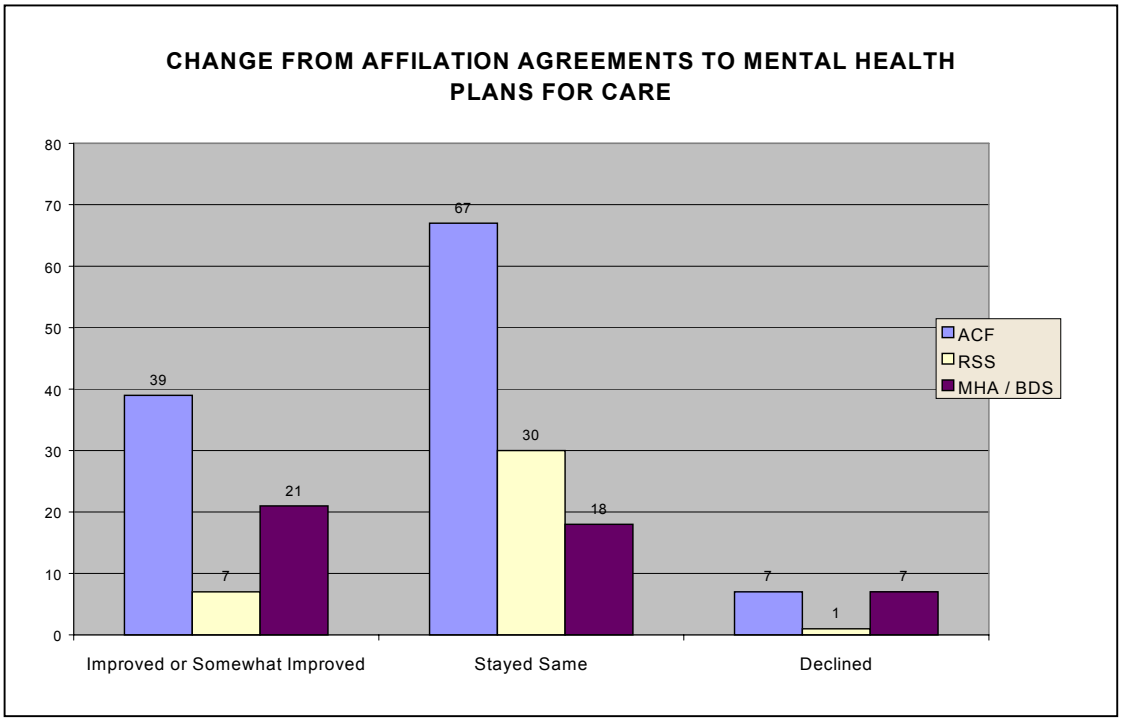
It should be noted, that some respondents commented that the rules had been implemented for a limited amount of time when these questions were considered and the surveys were completed. These respondents suggested that further changes might be observed, as all involved became more familiar with the rules and their implementation.

GRAPH 2



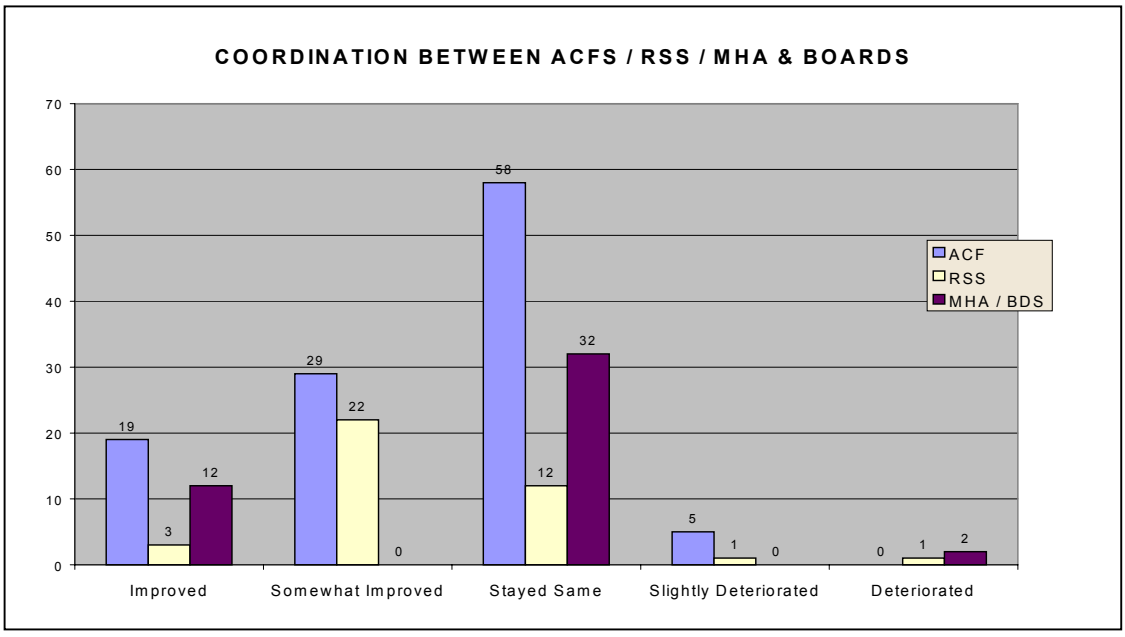
Graph 3 illustrates that the majority of respondents considered the change from affiliation agreements to individual MHPFC to provide “some” improvement in assuring mental health services for clients. Among ACF operators, the majority said the change constitutes "some" or "a great deal" of improvement in assuring mental health services for residents. Some respondents from all surveyed stated that changing from affiliation agreements to MHPFC made "no change" regarding assurance of mental health services. The Committee thought this may reflect the diversity among MH boards and agencies and the level of cooperation among respondents which may have existed prior to the new regulations. Following discussion of these findings, the committee concluded this information might validate the usefulness of the new regulations.

GRAPH 3



Similar to these findings, Graph 4 illustrates a measure of coordination between ACFs, MH boards and agencies and RSS, as reported by those entities. It is significant to note that in some areas of the state, the level of coordination was already acceptable. The new regulations, however, appear to be having a positive effect on statewide coordination levels.

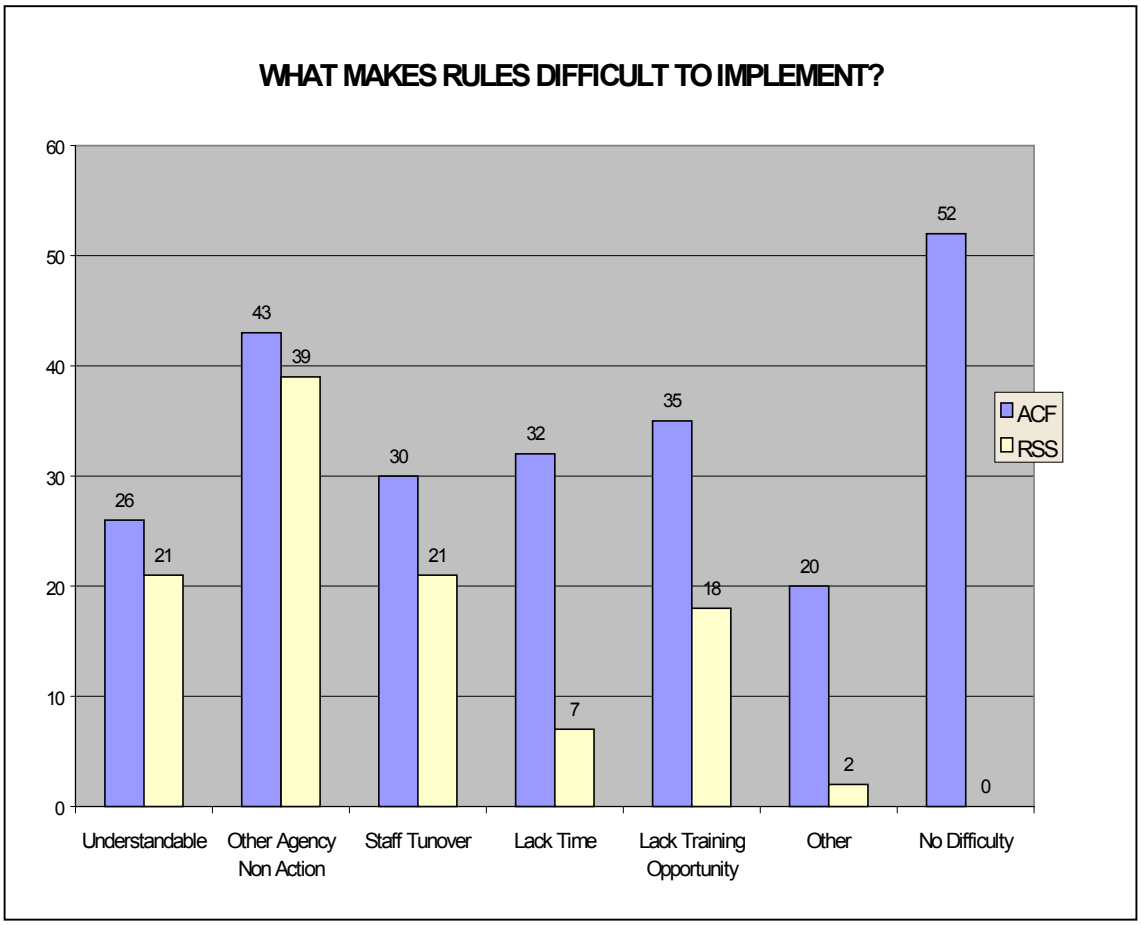
GRAPH 4



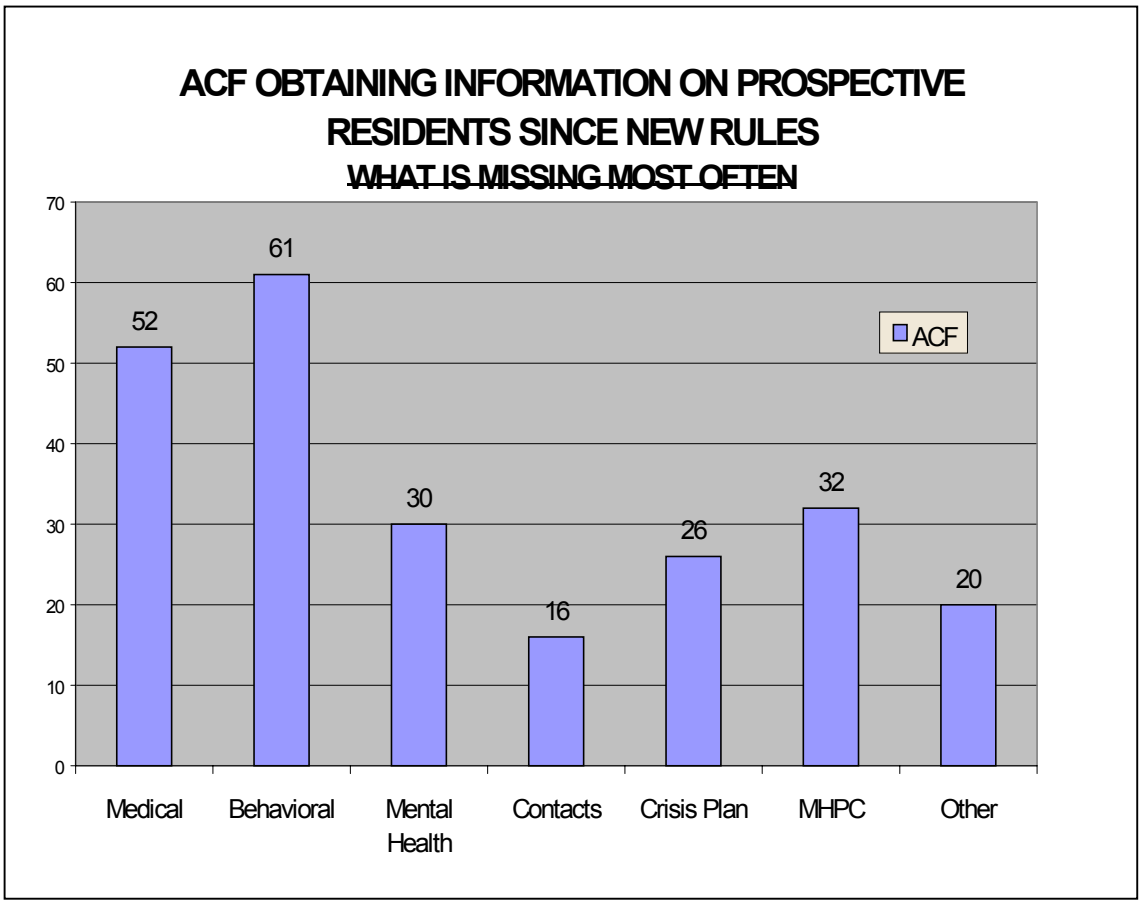
In spite of the encouraging information derived from the surveys, data confirmed a widespread problem interfering with implementation of the new regulations: on-going education of all entities involved on what the regulations require and when and how this requirement must be met. An example of this may be seen in Graph 5. When asked what makes the rules difficult to implement, ACF operators and RSS staff cited inaction by other agencies as a significant problem. Anecdotal information confirmed that primarily because of staff turnover and the lack of on-going training, some MH agency case managers do not know what a MHPFC should contain, or when it must be provided. This conclusion is further shown in Graph 6, which illustrates what pieces of required information is most often missing from MHPFC, when they are provided for prospective residents.

In addition to these problems, lack of training was cited as a reason some ACF operators were unsure who was responsible for developing MHPFC and the importance of including information on: medications and medication interactions; special instructions for the care of certain individuals; and specific emergency contacts in the event of weekend or evening crises.

GRAPH 5



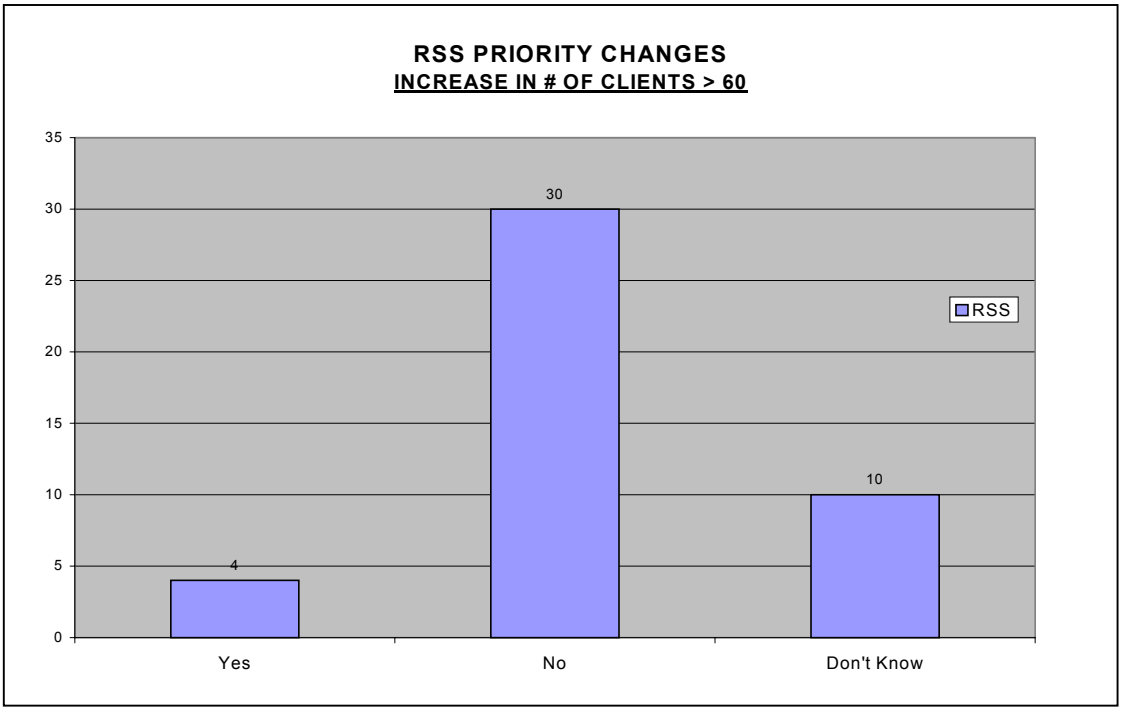
GRAPH 6



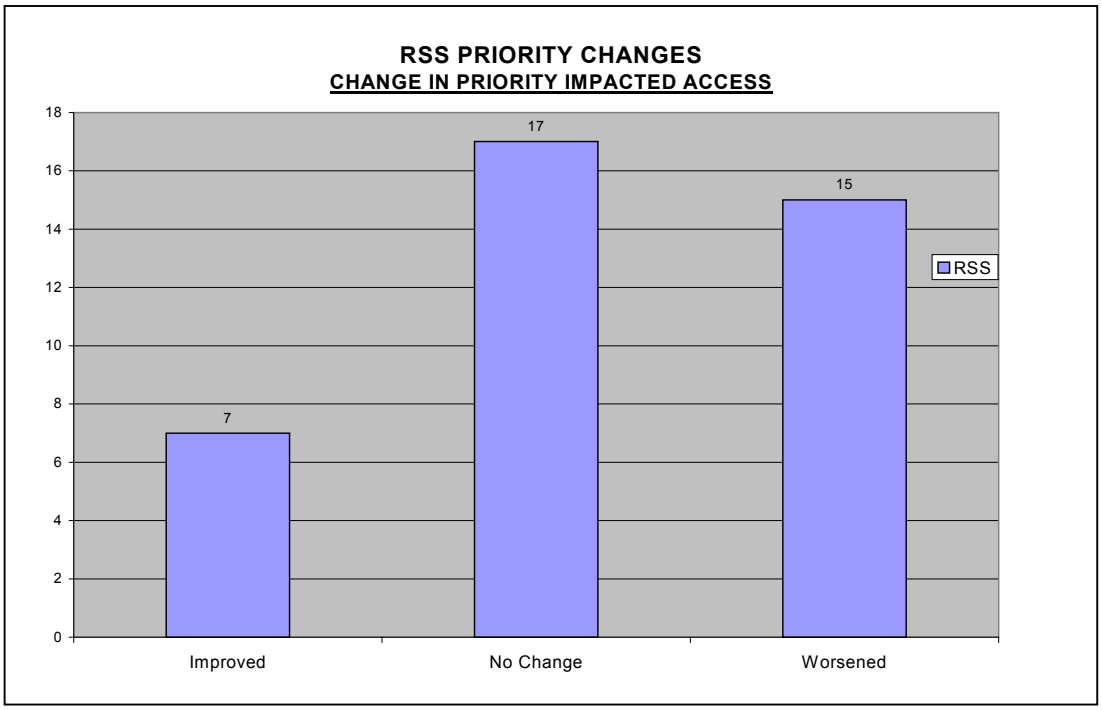
Another major question considered by the Committee pertained to the impact of the new regulations on the RSS program. As noted in Section I, the new regulations changed enrollment priority to favor individuals in community settings, in hopes of making RSS a viable alternative to the over-60 population and provide an alternative to nursing home placement. Prior to this time, individuals residing in the community rarely had access to RSS because priority had been given to those residing in facilities. With the change in priority implemented via the new regulations, staff within the program was asked about the changes they had observed and if the changes seemed to meet the intended purpose.

Perhaps most significantly, the new regulation did not increase the number of RSS clients over age 60 (please refer to Graph 7.) Further, as seen in Graph 8, the new enrollment priority system did not change the situation in most areas, as desired. In fact, they actually worsened the number of placements for persons over age 60 in some areas.

GRAPH 7



GRAPH 8



Following their study of empirical data, the Committee reviewed the new rules in the context of all information provided. Further, the Committee considered the rules against evaluation tools, including appropriateness (if applicable), accessibility, quality improvement and availability (definitions of these terms are provided in the glossary).

During this phase of the Committee's work, each agency gave a brief overview of a specific rule promulgated by that department. The Committee then evaluated the rule and whether it had achieved its purpose.

The Committee’s findings and recommendations are compiled in Section III of this report.

SECTION III: RECOMMENDATIONS

ODA RULES

Rule: 173-35-03 – Registration for RSS enrollment and RSS Caseload Allocation

Intent of the Rule:

To give priority for RSS slots to people age 60 and older, residing in the community.

Discussion

The RSS program currently has 2800 slots, in which more than 3200 clients are served each year. (The difference in the number of slots to the number of persons served accommodates deaths, admissions to nursing homes, or other circumstances for a client to leave the program.) While the rule increased community referrals, the intent for older people to have greater access to ACF placements did not happen as assumed. Due to the demand for RSS and limited funding, individuals interested in RSS are placed on a waiting list. As of April 30, 2002, the waiting list contained 1, 520 individuals. Consequently, while the new regulations have increased access to all individuals in the community, the majority of RSS residents residing in ACFs continue to be less than 60 years of age, with mental illness. As of August 2001, 74% of the waiting list was under the age of 60 and that pattern continues.

During Committee discussions it was noted that some persons age 60 or older do not wish to live with younger residents with mental illness and there are not enough RSS slots to meet all community-based care needs. Other information discussed includes the assertion by ACF representatives that for financial reasons, they do not want to admit potential RSS clients into their homes, without knowing if the individual will receive RSS since the enrollment priority has been changed. Also, ODA monthly reports indicate an increasing number of RSS clients are residing in Residential Care Facilities (RCFs). This may be attributed to these housing options being attractive to persons age 60 and older, as well as the fact that some parts of the state do not have many ACFs. It was also been noted that individuals with system-oriented advocates (for example, case managers, social workers, discharge planners, etc.) have greater access to RSS because they have help in accessing available community resources and programs.

Recommendations

Based upon group discussion and factual information, the Committee recommends the following actions.

- ODA should identify ways to address RSS access to the population age 60 and older especially to those individuals who do not have system-oriented advocates.

- ODA should re-examine the intent of the rule and explore a first-come first-serve system of priority for RSS slots.

- Increased resources need to be directed to RSS to meet demand (eliminate waiting list).

Rule: 173-35-051 – Determination of Facility Appropriateness

Intent of the Rule:

To establish a process between RSS and MH reviewing agencies for matching clients to available, appropriate housing. The process sets timelines for such decisions at ten working days and includes prescribed criteria for denials. This process applies to all RSS applicants regardless of the type of living arrangement.

Implementation of this rule has provided access to care services, increased levels of communication and has enhanced the ability of agencies to work more efficiently to match clients with mental health and personal care needs with appropriate receiving facilities.

Discussion

When this rule was developed, there was an identified need for timely coordination between referring agencies. Further, the new regulations attempted to address the fact that some "matches" were being denied without a reasonable, verifiable and objective reason being stated.

Implementation of this rule has provided access to care services, increased levels of communication and has enhanced the ability of agencies to work more efficiently to match clients with mental health and personal care needs with appropriate receiving facilities.

Recommendation

- ODA should continue to monitor implementation of this rule.

ODMH RULES

Rule: 5122-31-01 – Mental Health Board/Mental Health Agency Procedures for Residential State Supplement (RSS) Placement for Persons with Mental Illness

Intent of the Rule:

This rule mirrors ODA Rule 173-35-01, establishing a process between RSS and MH reviewing agencies for matching clients to available, appropriate housing. The process sets timelines for such decisions at ten working days and includes a prescribed process in the case a match denial.

Discussion

As previously stated, implementation of this rule has provided access to care services, increased levels of communication and has enhanced the ability of agencies to work more efficiently to match clients with appropriate receiving facilities. However, concern remains for gaps in communication and coordination of information with out-of-county mental health boards. Specifically, some receiving counties are not properly notified by referring boards when an individual in need of services is being placed in another county. In some instances, proper information has not been received on a timely basis. While these problems are believed to stem from a lack of awareness or misunderstanding of the new regulations, such gaps undermine the efficiency envisioned in the original intent.

Recommendations

- ODMH should develop a process to monitor mental health agencies regarding proper implementation of this rule.

- ODMH should recommend inclusion of a monitoring mechanism as part of the community plans submitted by mental health boards.

Rule: 5122-31-02 – Mental Health Board/ Mental Health Agency Accountability Rule Regarding ACF Placements for Persons Diagnosed with Mental Illness

Intent of the Rule:

This rule is complex and contains several specific elements intended to address the need for better coordination between mental health boards in different counties regarding resident placement, continuity of care, including complaint investigation and related actions. To this end, the rule sets forth the specific process and responsibilities of mental health boards and mental health agencies regarding placement referrals and coordination of care for individuals with mental illness residing in ACF's. Following placements, this

rule authorizes boards and agencies to investigate issues of neglect or abuse and requires the reporting of incidents to the three involved state agencies as well as the Ohio Legal Rights Service and the State Long Term Care Ombudsman.

The rule also contains the elements required in individualized MHPFC and prescribes the role of mental health agencies in working with ACF operators and residents to develop the plans for care and the updates of these plans. If there is non-compliance or a situation changes or is not appropriate, the rule also applies to finding another placement.

Discussion

For the sake of clarity, the Committee divided the discussion into several parts to cover the various elements of the rule. It should also be noted, that these discussions apply to the implementation of similar rules promulgated by other agencies.

Mental Health Plan for Care Discussion

When this portion of the rule was developed, it was acknowledged that a general agreement between an ACF operation and a mental health board failed to address specific needs of individuals receiving mental health services. ACF operators reported they often did not know the true extent of care needs required for certain individuals prior to their placement; and too often, it was immediately apparent that the placement had been inappropriate. In some circumstances, operators reported difficulty in obtaining mental health services from local boards and agencies, after accepting a resident referred from another mental health board's jurisdiction. Local boards of mental health complained they frequently were unaware a new client had been placed in their board's jurisdiction, until the resident wanted publicly-funded services or was in a crisis situation. Resident advocates were concerned for individuals who were being placed in facilities that could not meet the resident's needs, residents who had little contact or no meaningful contact with their case manager, and for residents who were not receiving the treatment services they needed.

The remedy to these problems was a completely new approach to community mental health referral and care centered on an individualized document, the mental health plan for care. This document was intended to assure optimal placement in a facility, where ACF operators, prospective residents and the mental health agency all know and agree to specific care needs of prospective residents, prior to their admission. Additionally, MHPFC were intended to assure that local mental health boards and agencies are aware of an individual likely to utilize publicly funded mental health services in their jurisdiction.

Progress has been observed in the implementation of this rule. Yet, some ACF operators report they have not been receiving MHPFC or the MHPFC was not performed on a timely basis and/or did not include all the information or the signatures required by law. It has also been reported that mental health case managers, ACF operators and residents are not working together, as the regulations require, to develop an individualized plan for

care. Rather, operators sometimes receive a completed "boilerplate" document, for which they have had no input. Further, the MHPFC was to be a dynamic document, which would change with a resident's treatment and progress. However, operators have reported difficulty receiving accurate updates on MHPFC, particularly for medication changes.

During the Committee's review, it became apparent there is significant confusion regarding the purpose, scope and timing of the MHPFC. Also, there is confusion about the difference between the MHPFC and Individual Service Plans, which concern clinical treatment information used by clinicians in mental health agencies. While some confusion may be attributed to a "learning curve" and the relatively short time the new regulations have been in effect, staff turnover within mental health agencies exacerbates this problem.

From the perspective of mental health agencies, there are many expectations put on case managers and in this context, the MHPFC and related updates appear to be burdensome. While the Committee acknowledges greater demands on case managers, there also is recognition of increased accountability by all entities utilizing public funds. It also acknowledged that in the event of a poor outcome in a mental health crisis situation, an untimely or incomplete MHPFC or updates could potentially become a liability problem for the board or agency.

Incidents Investigation & Reporting Discussion

This portion of the rule was intended to address problems caused when there was apparent need to investigate alleged problems in an ACF, on behalf of a individual with mentally illness, and a mental health board or other advocate lacked authority to take such action. Additionally, mental health advocates were concerned that ACF operators were not adequately reporting incidents to authorities that could take appropriate action.

During discussion of implementation of this regulation, the Committee observed it was not clear what incidents should be reported, and to whom. Further, it would be difficult to clarify the regulation without excluding, by reference, situations that should be reported. Also, in some instances when abuse or neglect was reported, it was not routinely reported to all entities prescribed in the rule. For example, during one such discussion the Ohio Legal Rights Service representative noted receiving reports from only one county mental health board and the State Long Term Care Ombudsman had received no reports at the time of the discussion.

Access to Mental Health Training Discussion

The original intent of this rule was to ensure that in ACFs accepting persons diagnosed with mental illness the staff would be adequately trained to care for these residents. While mental health agencies and boards and reviewing agencies are not mandated to provide specialized training to ACF operators, they are to provide access to the training they do offer.

Implementation progress on this regulation has been uneven across the state. In some areas, various entities, particularly the RSS staff, have provided extensive resources to help ACF operators fulfill this requirement. In some parts of the state, this requirement has caused significant hardship for operators for several reasons: sending staff to training causes a financial burden on the ACF operator who must pay for the training session, staff time and replacement staff to provide care while others are being trained; the training has not been provided at a level understood by non-nursing or non-medical personnel; and sometimes training is scheduled during times that conflict with staff schedules.

The Committee noted that the intent of the regulation remains important. However, there are steps that should be taken to lessen the burden of implementation. Steps could include coordination among state agencies to produce and distribute videotapes with appropriate training and information deemed important. State agencies should also re-evaluate the six hour training requirement and consider other means to measure optimal levels of training. Also, mental health agencies need to better communicate with operators about availability, and methods of training, as well as possible sources of financial assistance for training costs. Finally, NAMI Ohio was suggested as a source of appropriate training assistance.

Effective Placements for ACF's In and Out of County Discussion

This rule was intended to address coordination problems caused when residents would cross county lines to live in an ACF and receive publicly funded mental health services. Often the "receiving county" mental health board would have an established budget for service provision and an influx of residents would disrupt this plan and sometimes result in a lack of available mental health services. To improve coordination and communication among mental health boards, the rule prescribes the process a "referring" board must use to notify another of a new resident. The rule also prescribes how the "referring" agency should contact the receiving agency to assure continuity of care.

It has been reported that not all boards are aware or understand this rule and may not notify other boards, as required. Also, with jurisdiction only for Ohio, the rule could not address a very significant problem of persons coming from other states to reside in Ohio ACFs and receive services from Ohio mental health agencies.

Recommendations

- ODMH needs to provide on-going training and monitoring of mental health boards and agencies to ensure consistent application of all current regulations.

- ODMH should establish means necessary to monitor consistent application and use of the MHPFC and monitor resident outcome.

- ODMH and ODH should provide and coordinate training for ACF operators, mental health case managers, ODH surveyors, resident advocates and others involved in the MHPFC to assure knowledge and modification of the MHPFC, as needed. Training

should have consistent content and should be presented at a level appropriate for the audience. The training should include the value of the plan and that it needs to be individualized and implemented collaboratively.

- ODMH and ODH should clarify the intent of the MHPFC crisis plan, discourage use of a reference to "911" for this purpose whenever possible; and encourage inclusion in the crisis plan of appropriate entities capable of immediately responding to a mental health emergency.

- ODMH should ensure that whoever answers the telephones listed in the MHPFC crisis plan is adequately trained to understand the nature of the ACF and to effectively respond to the situation.

- ODMH needs to provide training to mental health boards and agencies on proper incident reporting and investigations.

- ODA, ODH, and ODMH should coordinate the distribution of training materials developed in response to the recommendation stated above.

- ODMH and ODH should coordinate distribution of the "ACF MH orientation videotape" to all ACFs serving residents with mental illness.

- Mental health agencies and boards need to better communicate with operators about availability, and methods of training, as well as possible sources of financial assistance for training costs.

- NAMI Ohio is suggested as a source of appropriate training assistance.

ODH Rules

The process of reviewing the following rules required significant discussions, which encompassed the impact and intent of several rules. It should be noted that ODH amended a total of 11 rules as a result of implementing H.B. 283 statutory changes; however, 8 of those rules contained only technical amendments. When asked if they felt it was necessary to evaluate the remaining eight ODH rules, the committee agreed that the major concerns had been considered during the analysis of the following.

3701-20-141, Additional staffing requirements.

Intent of the Rule:

The intent of this rule was to enhance personnel standards in ACFs accepting residents with mental illness into their homes.

During the development of this rule, concern was expressed that some ACF operators and staff do not understand symptoms manifested by individuals with mental illness. Symptoms of impending crisis and the interaction of psychotropic medications and heat, were frequently cited examples justifying additional training requirements for ACFs accepting mentally ill clients

.

Discussion

Please refer to related Access to Mental Health Training discussion, for MH rule 5122-31-02.

Recommendations

- ODH should evaluate this rule in the context of citations, relevant trends and the efficacy of specified training hours and develop responses to problematic areas.

- ODH should explore the cost impact for operators to secure training and advocate for funding as needed. To this end, the Ohio General Assembly should earmark ACF civil money penalties (CMPs) use for future ACF training.

- ODH and ODMH should coordinate distribution of the "ACF MH orientation videotape" to all ACFs serving residents with mental illness.

- ODA, ODH and ODMH should coordinate an effort to develop a core curriculum acceptable to all departments to meet the intent of enhance training standards for ACFs accepting residents with mental illness.

- ODA, ODH and ODMH should also re-evaluate the six hour training requirement and consider other means to measure optimal levels of training.

3701-20-18, Resident Assessments; mental health plan for care.

The Committee divided the discussion into several parts to cover the various elements of the rule-- health assessments and mental health plans for care (MHPFC).

Intent of Health Assessments Rule:

The intent of this regulation was to ensure updated, accurate information is provided for all ACF residents, particularly those with mental illnesses. To this end, the rule also provides for assessments to be done at the request of an ACF operator, at times other than the resident's annual assessment.

Health Assessment Discussion

At the time of this report, this rule is too new to evaluate. While it is considered to be a necessary regulation, many aspects of obtaining a health assessment are beyond the

control of the affected parties. Also, because of numerous factors to be considered, client outcome and available health assessments cannot be correlated.

Intent of MHPFC Rule:

This regulation mirrors the ODMH Rule 5122-31-02 regarding the MHPFC sections specifying the elements required in a MHPFC and prescribes the role of the ACF operators in working with mental health agencies and residents to develop MHPFC and the updates of these plans

Mental Health Plan for Care Discussion

Please refer to related "*Mental Health Plan for Care Discussion"* for Mental Health rule 5122-31-02 on pages 23 and 24.

Recommendations

In addition to the recommendations found in the rule analysis, the Committee noted the following.

- ODA, ODH and ODMH should continue to share information and patterns or trends of operational practices in tracking the impact of these rules.

- ODH and ODMH should provide and coordinate training for ACF operators, mental health case managers, ODH surveyors, resident advocates and others involved in the MHPFC to assure knowledge and modification of the MHPFC, as needed. Training should have consistent content and should be presented at a level appropriate for the audience. The training should include the value of the plan and that it needs to be individualized and implemented collaboratively.

- ODH and ODMH should clarify the intent of a crisis plan, discourage use of a reference to "911" for this purpose whenever possible; and encourage inclusion in the crisis plan of appropriate entities capable of immediately responding to a mental health emergency.

3701-20-26, Imposition of civil penalties

Intent of the Rule:

In accordance with law, this rule prescribes the penalties, which may be assigned to ACFs for failure to comply with the rules.

Discussion

Penalties are rarely imposed because, by law, operators are offered the opportunity to correct problems, The Attorney General's strict interpretation of operators' repeat

violations makes it unlikely that significant penalties will be imposed. Additionally, there is no parallel rule for mental health agencies or other entities involved in ACF placement. As a result, ACF operators are the only entities penalized for non-compliance with rules.

Recommendations

- Request the Attorney General re-evaluate the interpretation of the rule as it applies to repeat violations to place more emphasis on historical non-compliance.

- ODH should investigate other disincentives to facility noncompliance beyond those sanctions currently provided for in the ACF statute and rules (civil money penalties and suspension of admissions). With few exceptions, ACFs may avoid actual imposition of allowable sanctions by subsequent actions to become compliant; therefore, even serious infractions are essentially excused and the possible deterrent effect of the sanction is lost.

- ODH should explore better means to enforce the ACF regulations and apply remedies as appropriate.

Additional Information Needed:

For additional information, please contact:

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GLOSSARY

ACF – Adult Care Facility

MH - Mental health

MHPFC - Mental Health Plan for Care

NAMI - National Alliance for the Mentally Ill

ODA – Ohio Department of Aging

ODH - Ohio Department of Health

ODJFS - Ohio Department of Jobs and Family Services

ODMH - Ohio Department of Mental Health

PAA - PASSPORT Administrative Agency

RSS – Residential State Supplement

DEFINITIONS

ACCEPTABILITY - The degree to which an individual is willing to obtain or utilize available services.

ACCESSIBILITY - The degree to which an individual can obtain or utilize available services.

APPROPRIATENESS - The degree to which a given service or referral meets the needs of an individual.

QUALITY IMPROVEMENT - A process through which intended outcomes of services are enhanced.

APPENDICES

CONTENTS

NAMI Ohio ACF Position Paper

Sample Mental Health Plan for Care

Compilation of Survey Results: ACF Operator Survey; PAA Survey; MH Boards and Agencies Survey

Where NAMI Ohio Stands

Adult Care Facilities Position Paper

INTRODUCTION

It has been over twenty years since the community mental health system was established in Ohio. Many of us strongly believe that persons with severe mental illness can have full and meaningful lives in the community if the appropriate support services, including housing, are available and accessible.

During the past year, NAMI Ohio has received complaints about certain adult care facilities in the state that are substandard and not appropriate for anyone in which to live let alone a person with mental illness. This sparked the NAMI Ohio Board to appoint a committee to study the issues and develop a position paper. The committee consisted of family members, providers, ADAMHS Board staff, ODMH staff and NAMI staff.

Adults with severe mental illness live in an array of community housing options. Most of them live independently or with their families. Others, who need more support, may live in Adult Family homes (2 to 5 beds), Adult Group Homes (6 to 16 beds), Residential Care Facilities (more than 16 beds). These homes are licensed by the Ohio Department of Health. There are also Mental Health Residential facilities and apartments that are licensed or inspected by the Ohio Department of Mental Health or the local ADAMHS Board. It was decided early on that the Committee would concentrate on the Adult Care Facilities (2 to 16 beds). Rules governing these homes were changed last July and went into effect in October 2000. It was important to find out if the changes helped or hindered our mentally ill family members.

The Committee took time to educate itself about the new rules. A Committee member did an extensive review and presented the various issues at one of the Committee meetings. It was learned that there are 811 adult care facilities in Ohio with a total number of 5,722 beds licensed by the Department of Health. Of that number, 476 homes or 58.7% have residents diagnosed with a mental illness.

The Committee also made the decision to visit several homes throughout the state to see "first hand" the conditions of these adult care facilities. Surveys were developed for both the home operators and residents so that the surveyors would collect the same information.

Twelve homes (8 in urban counties and 4 in rural counties) were visited during April 2001. Several issues were noted:

- Funding for the residents' care varied. Some received Residential State Supplement Program (2,800 slots throughout the state) while others relied on only SSI. The variance of funding presented problems to some of the privately owned homes. Agency owned homes usually had a subsidy from the local ADAMHS Board.

- Number of staff varied depending on the size of the facility and the available funding resources.

- The required Mental Health Plans for Care were in place for persons with a mental illness. They are reviewed annually and in one case are reviewed quarterly. However, in two of the homes the Plans did not have any diagnosis information.

- The ongoing relationship with the local public mental health system varied greatly. In some cases, case managers had some contact with residents. In others, the only contact was when a resident was in crisis and needed intervention services. Some of the homes, especially those that contracted with the local ADAMHS Board, used the local system as well as other resources in the community, e.g. sheltered workshop.
  Private mental health providers, not related to the ADAMHS Board systems, were used in some facilities.

- The physical conditions of some of the facilities were deplorable. There was some question as to how they could have passed any type of survey conducted by the Department of Health. Also questioned was the type of sanctions that might be imposed on a facility and if there is a follow-through by the Department of Health.

- Although the rules specify the type of training required for the Home Operators, there was question as to how much information workers really had about mental illness. It is recognized that it is difficult for workers to have time off for in-service training especially if the facility has minimum staff. However, it is imperative that those who are in close contact with persons with mental illness have knowledge about symptoms, behavioral characteristics, and appropriate treatment.

During the time that the Committee was making site visits and studying the new rules, a state Committee was formed in accordance with Section 68.04 of the Ohio Revised Code. This section calls for the Directors of Mental Health, Health and Aging to convene a group of key relevant constituencies to evaluate the implementation of the new rules governing adult care facilities. This group is to report its findings and recommendations to the directors and General Assembly no later than July 1, 2002. NAMI Ohio was asked to participate and one of the Committee members is serving on this Committee.

HOUSING POSITION

NAMI Ohio believes that safe, decent, healthy and affordable housing in the community should be available for all persons with a severe mental illness. For some of our loved ones who are unable to live independently, supported living arrangements may be necessary. These types of arrangements may be adult care facilities licensed by the Department of Health.

To assure that adult care facilities meet the needs of those with mental illness and provide quality care, we believe that:

1. **Adequate training be given to facility staff (home operators and others) which would include the understanding of mental illness, management of persons with mental illness, medication and side effects, the recovery model, and crisis intervention techniques. This would also include adequate training on the medical needs of the resident.**

Action Steps:

- The Ohio Department of Mental Health and the Department of Health should develop a training curriculum for adult care facility staff. Every adult care facility should be required to implement the curriculum with their staff within the next 24 months. Various strategies could be used such as videotapes, readings, and meetings with local mental health professionals.

- Every adult care facility should be required to have the services of visiting nurses who would examine the physical conditions of each resident and make appropriate referrals.

2. **The staff/resident ratio should be specified in the Rules, especially during the day hours, based on the size of the adult care facility and the functioning level of the residents.**

Action Step:

- The state Committee that is currently functioning in accordance with Section 68.04 of the Ohio Revised Code should develop staff residency ratios for adult care facilities that protect the residents. These ratios will be incorporated into state statutes and rules.

3. The local ADAMHS Board or local mental health provider should visit the local adult care facilities in its catchment area at least twice a year. We realize that the Ohio Department of Health surveys and licenses the facilities but we think that more frequent visits would help with relationships with Home Operators as well as determining if persons with mental illness are receiving adequate care. Reports should also be sent to the out-of-county Board if there are individuals living in the facilities that come from other counties.

Action Step:

- Immediate action should be taken by the Ohio Department of Mental Health to eliminate any barriers that currently exist that prohibit the local mental health system from visiting these facilities. Local ADAMHS/CMH Boards should visit these facilities at least twice a year to monitor the quality of care being provided.

4. **The Mental Health Plans for Care, as required by law, should include specific areas regarding the mental illness such as diagnosis, and suggested treatment strategies. The Home Operator should review them at least quarterly and the Case Manager assigned to the person should be responsible to insure the plan is followed. In addition, it would be helpful for one Case Manager to be assigned to a facility/facilities. This would help with communications between the Home Operator and the Case Manager and may improve the quality of care to the residents.**

Action Step:

- Adult care facility providers should be fined or de-certified if the Mental Health Plans for Care are not developed and followed. Case managers assigned to these adult care facilities should be given the responsibility to monitor these plans. Mental Health Plans for Care should include types of social/recreational and/or vocational training that the individual would need to improve the quality of life.

5. **Adult care facilities that have persons receiving only SSI benefits should receive some type of subsidy from the home ADAMHS Board. There is quite a discrepancy of funding between RSS benefits and SSI. It makes it difficult for the Home Operators to manage and provide adequate staff for the facilities. In addition, the amount of spending money that persons have available varies significantly.**

Action Steps:

- The Ohio Department of Mental Health should provide additional funding to those ADAMHS/CMH Boards that have a significant number of persons with serious mental illness in adult care facilities. The funds would equalize per diem rates for those who are not in the Residential State Supplement program (RSS).

- The ADAMHS/CMH Boards or local agencies should monitor the social activities, recreation and/or vocational training provided to persons with mental illness living in adult care facilities. Home operators should be encouraged to plan activities and use community resources.

6. **It is a tragic reality that many of these residents spend all of their money in the first few days of the month and then become dependant upon predators for the remainder of the month. A payee program should be implemented for those who have a mental illness. It would assure that persons would have spending money throughout the month. There are several model programs that are established throughout the state.**

Action Step:

- Every resident of an adult care facility in the State of Ohio must have the opportunity to join a payee program. Regional payee programs should be developed and funded by the Ohio Department of Mental Health. An aggressive marketing campaign should take place to enroll as many adult care facility residents as possible.

7. **It is apparent to NAMI Ohio that some of the current adult care facilities provide substandard care. We are concerned about the residents' safety, nutrition, social interaction, cleanliness and their overall quality of life. We are also aware that these individuals have few or no alternatives for housing. Hopefully, improvements can be made so that no resident has to be displaced.**

Action Step:

- During the next twelve (12) months, the Ohio Department of Health should develop specific procedures to be used for inspecting adult care facilities. There should be strict enforcement of the existing rules. Home operators should be sanctioned if deficiencies are found. Follow-up procedures should be developed for those who have been sanctioned.

This NAMI Ohio Position Paper on adult care facilities will be distributed to the legislature, the Governor, the Ohio Department of Mental Health, the Ohio Department of Health, the Ohio Department of Aging, local ADAMHS/CMH Boards and to the NAMI Ohio membership (10,000) who will be asked to support this advocacy effort. We believe that this is a critical situation and action must be taken immediately.

NAMI Ohio, the State's Voice on Mental Illness, is a grassroots organization comprised of person with severe mental illness, their families and others committed to educating, supporting and advocating on issues of mental illness.

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S A M PL E

MENTAL HEALTH PLAN FOR CARE

(OAC 5122-31-02 and OAC 3701-20-18)

NAME OF CONSUMER: John Doe **SOCIAL SECURITY NUMBER:** 555-55-5555

AGE: 64 **DATE of BIRTH:** February 14, 1938

CURRENT RESIDENCE: Golden Days Care Facility

RESIDENCE ADDRESS: 4562 Quiet Lane, Anytown, Ohio 43XXX

CONSUMER'S PREVIOUS ADDRESS: We Care Home III, Littletown, OH

REFERRING AGENCY: Acme Tri-county Behavioral Health **AGENCY NUMBER**: 35XX

AGENCY ADDRESS: 27 Wellsburg Pike, Householder, Ohio 43XXX

CASE MANAGER or CSP WORKER: Florence Carefor

AGENCY TEAM LEADER or SUPERVISOR: William Stans

CONSUMER'S GUARDIAN or NOK: Ivan Foxx, Esq, Guardian

GUARDIAN or NOK ADDRESS: 33 S. Pointe St., Suite 200, Bainbridge, Ohio

CONSUMER'S REPRESENTATIVE PAYEE ADVISOR: None

ADVANCED DIRECTIVES: NO X YES____ DESCRIBE BELOW OR ATTACH ADVANCED DIRECTIVES COPY

_____

_____

_____

HAS RESIDENT EVER BEEN CONVICTED OF A CRIME: NO____ YES X DESCRIBE BELOW AND INCLUDE ANY INFORMATION THAT HOME OPERATOR SHOULD KNOW OR ANY INTERVENTIONS RECOMMENDED TO ASSIST RESIDENT TO ADAPT TO NEW RESIDENCE.

Convicted in 1999 for possession of drugs. No history of any violent crimes. Client has been clean since participating in drug rehab program. Likely to not require any specific surveillance by home operator.

ADDITIONAL INFORMATION ABOUT RESIDENT OR PAST CARE OR RESIDENCIES THAT MAY ASSIST HOME OPERATOR IN PREPARING FOR AND PROVIDING OPTIMAL CARE FOR THIS RESIDENT:

While no history of violent crime, client does have history of aggressive behavior in group living environments.

History of polysubstance abuse, without any recent (since 1999) problems.

EMERGENCY CONTACT PROCEDURES:

REGULAR AGENCY BUSINESS HOURS (8:00 a.m. to 5:00 p.m., M-F):

- Contact Case Management Office at (937) XXX-XXXX
- Ask for assigned case manager
- If unavailable, ask for team leader or supervisor
- If there is no answer at case management office or no staff are available, hang up and call the crisis hotline at (XXX) XXX-XXXX

AFTER AGENCY BUSINESS HOURS, WEEKENDS, and HOLIDAYS:

- Contact the crisis hotline at (XXX) XXX-XXXX

ALL EMERGENCY MEDICAL ISSUES AND LEGAL ISSUES SHOULD BE HANDLED BY CONTACTING THE APPROPRIATE AUTHORITIES.

CONSUMER'S CURRENT MEDICATIONS, MOST COMMON SIDE EFFECTS, OR POSSIBLE ADVERSE REACTIONS:

MEDICATION	***SIDE EFFECT/AR***
Zoloft, 100 mg daily	Nervousness, dizziness, constipation
Zyprexa, 10 mg po	Agitation, insomnia, constipation
Glucotrol XL 10 mg AM po	Diarrhea, nausea & vomiting, anorexia
Depakote 500mg po bid	Nausea & vomiting, itching, depression

REQUIRED ASSISTANCE WITH ACTIVITIES OF DAILY LIVING (Complete only where needed):

NEED	***PROMPT or SERVICE***	***RESPONSIBLE PARTY***
Hygiene	Bathing, nails, hair	Home operator
Medications	Require daily meds reminder	Home operator/staff
Nutrition	Follow low fat/low sugar diet	Home operator/staff
Scheduling of Appointments	Coordination	CM coordinate with home staff And staff assist resident w/ preparation
Budgeting/Finances	Payee services	Home operator
Personal Activities Transport	Prompt to always provide advance notice/request	Home operator/staff
Medical Appointment Transport	Transportation to and back	Agency case management
Psychiatric Appointment Transport	Transportation to and back	Agency case management

CONSUMER'S COMMENTS:

_____
_____
_____
_____

HOME OPERATOR'S COMMENTS:

_____
_____
_____
_____

AGENCY REPRESENTATIVE: _____ DATE: _____

HOME OPERATOR: _____ DATE: _____

CONSUMER: _____ DATE: _____

HB 283 SURVEY RESPONSES

ADULT CARE FACILITY OPERATORS

Section A: Overview of the Rules

1. Overall, are the new rules helping to improve the quality of services for clients?

A great deal	**11**
Some improvement	**58**
No change	**47**
No answer	**2**

2. Are the new rules helping to assure that clients have access to appropriate mental health services?

A great deal	**23**
Some improvement	**52**
No change	**40**
No answer	**2**
Other	**1**

Section B: Mechanics of rule implementation

3. Have you been able to implement all of the new rules?

Most of them	**87**
Some of them	**17**
Few of them	**10**
No answer	**3**
Other	**1**

4. Which of the following have made implementing the new rules difficult?

The rules are not easy to understand	**26**
Other agencies have not provided the needed services	**43**
Staff turnover	**30**
Lack of time	**32**
Lack of adequate training opportunities	**35**
Other	**20**
Have had no difficulty	**32**
No answer	**3**

5. **For which rules do you need more clarification?**

Documentation	**28**
Crisis plan	**19**
Mental health plan for care	**32**
Reporting significant changes or incidents	**22**
Resident rights	**2**
Other	**8**
Do not need any clarification	**52**
No answer	**5**

Section C: Training requirements

6. **Have the increased training requirements improved the care you and your staff are able to provide to clients in your facility?**

A great deal	**22**
Some improvement	**48**
No change	**46**
No answer	**1**
Other	**1**

7. **Which four of the following make it most difficult to meet this new training requirement?**

Time	**78**
Staff turnover	**38**
Too few training opportunities	**59**
Available training is too technical for people to understand	**15**
Training methods no appropriate for topic	**29**
Lack of training specific to care of persons w/mental illness	**55**
Lack of training on personal care needs of older adults	**15**
Other	**5**
No answer	**24**

8. **Please list three topics you and/or your staff need training on to continue to provide services to clients? Please be specific. (Please see Addendum)**

9. **How has getting information about prospective clients prior to admission changed since the implementation of the new rules?**

Improved	**32**
No change	**70**
Deteriorated	**12**
No answer	**1**
Other	**3**

10. **How many times have you admitted a client with mental illness without going through the process within the last twelve months?**

Zero (0)	**97**
One (1)	**8**
Two (2)	**8**
Three or more (3+)	**5**

11. **How frequently within the last twelve months have you felt pressured to accept a new client without the necessary paper work?**

Rarely	**34**
Occasionally	**18**
Frequently	**14**
Not applicable	**48**
No answer	**3**
Other	**1**

12. **If you have felt pressured, identify who or what agency has been involved.**

Mental health agency	**17**
Mental health board	**4**
RSS case manager	**3**
Crisis center	**7**
MH case manager	**18**
Other	**15**
Not applicable: have not felt pressured	**66**
No answer	**11**

13. **Please identify what admission information is most often missing.**

Medical/health information	**52**
Contact person(s)	**16**
Behavioral health information	**61**
Crisis plan information	**26**
Mental health plan for care	**32**
Mental health information	**30**
None	**4**
No answer	**20**
Other	**2**

14. Have you found later that the information you received prior to admission was incomplete or incorrect?

All information was complete	**31**
Some information was incomplete or incorrect	**70**
Most information was incomplete or incorrect	**4**
No answer	**10**
Other	**0**

15. How frequently within the last twelve months have you been concerned that you are admitting a client whose personal care needs might exceed your capacity to care for them?

Rarely	**70**
Occasionally	**20**
Frequently	**3**
No answer	**13**
None	**1**
Never	**1**
Not applicable	**1**
Other	**12**

16. How frequently within the last twelve months have you been concerned that you are admitting a client whose mental health needs might exceed your capacity to care for them?

Rarely	**77**
Occasionally	**19**
Frequently	**2**
No answer	**11**
None	**4**
Other	**5**

17. The new RSS rules changed the way priority placements are done. How has this affected the characteristics of clients in your home?

No changes	**55**
More clients w/MI, funded by RSS have been admitted	**9**
More clients 60 years + have been admitted	**3**
Fewer clients 60 years + have been admitted	**10**
More clients have been discharged to nursing homes	**5**
Other changes	**19**
Not applicable to my ACF	**18**
No Answer	**9**

Section D: Mental Health Services and Mental Health Plan for Care

18. Has the change from affiliation agreements to plans for care improved/been more useful in assuring mental health services for clients?

Yes	**39**
Stayed about the same	**67**
Declined	**7**
No answer	**4**
Other	**1**

19. Which of the following contributes to the development of a mental health plan for care for your clients?

Mental health agency staff	**96**
Operator	**62**
Client's family	**33**
Mental health board representative	**18**
RSS case manager	**42**
Client	**64**
Physician	**44**
Other	**7**
No answer	**7**

20. How helpful/active is the local mental health agency with developing the mental health plans for care?

Helpful/active	**48**
Somewhat helpful/active	**40**
Not very helpful/active	**24**
No answer	**4**
Other	**2**

21. How timely is the local mental health agency with developing the mental health plans for care?

Timely	**51**
Somewhat timely	**41**
Consistently not timely	**20**
No Answer	**5**
Other	**1**

22. How complete is the information provided by the local mental health agency for the mental health plans for care?

All required information is provided	**67**
Some information is missing	**31**
Information is very incomplete	**8**
No answer	**9**
Other	**3**

Section E: Crisis plan component of the mental health plan for care

23. How complete is the information provided by the local mental health agency for the crisis plan?

All required information is provided	**73**
Some information is missing	**13**
Information is very incomplete	**15**
No answer	**13**
Other	**4**

24. In the past year, when a client had an emergency that required you to refer to his/her mental health crisis plan, whom did you usually contact?

Mental health therapist	**26**
Hospital	**25**
Mental health hotline	**40**
Other	**35**
Not applicable	**34**
No answer	**3**
Other	**3**

25. Consider situations when a client who was experiencing a mental health crisis needed access to services in the community. How available were the services listed in his/her mental health plan for care?

Weekday 9-5	**Good 72**	**Fair 17**	**Poor 6**	**No Answer 23**
Weekdays evenings/overnights	**Good 41**	**Fair 27**	**Poor 24**	**No Answer 26**
Weekends/holidays	**Good 33**	**Fair 21**	**Poor 35**	**No Answer 29**

Section F: Reporting changes in status, condition and incidents

26. When you report either a change in status or condition and/or incidents, what kind of responses are you getting, for example, from a case manager?

Good response	**69**
Late response	**16**
No response	**8**
Acknowledgement of info only	**13**
No situation requiring such reporting	**19**
Other	**4**
No answer	**2**

27. Has the addition of the RSS case manager to the list of persons to call improved communication and coordination of services?

Yes	**54**
Some improvement	**25**
No improvement	**17**
Do not RSS in my facility	**14**
No answer	**7**
Other	**1**

28. How would you rate the understanding of new rules by the local mental health boards or agencies?

Good	**29**
Acceptable	**60**
Unacceptable	**17**
No answer	**10**
Other	**2**

29. Since the implementation of the new rules, how has the responsiveness of/ assistance from the local mental health agency changed?

Improved	**19**
Somewhat improved	**29**
Stayed the same	**58**
Slightly deteriorated	**5**
Deteriorated	**0**
No answer	**7**

30. Have you had unresolved situations with the local mental health agency about which you contacted the local mental health board?

Yes	**15**
No	**86**
Was not aware of this option	**8**
Does not apply to my situation	**5**
No answer	**4**

Section H: Consumer/client access to mental health services

31. In the last twelve months, have you admitted persons with mental health needs who wanted but could not access mental health services through the local mental health agency?

Yes	**10**
No	**88**
Not applicable	**16**
No answer	**4**

32. If so, how helpful was the local mental health agency with the appropriate assessment or referral?

Helpful	**24**
Somewhat helpful	**12**
Not very helpful	**11**
Not applicable	**42**
No answer	**28**
Other	**1**

33. How helpful is the local mental health agency when you request an assessment when/if you observe deterioration in a client's condition who had not previously been identified as having a mental health problem?

Helpful	**31**
Not very helpful	**6**
Do not respond to request	**2**
Have never requested an assessment	**66**
No answer	**10**
Other	**3**

34. How helpful is the local mental health agency when you request an assessment when you observe deterioration in a client's condition who had previously been identified as having a mental health problem?

Helpful	**48**
Not very helpful	**16**
Do not respond to request	**4**
Have never requested an assessment	**41**
No answer	**7**
Other	**2**

ADDENDUM: ACF OPERATOR SURVEY RESPONSE

QUESTION 8

1. Diet and special diets
2. Mental health clients
3. Documentation
4. Special diets & where to obtain dieting when doctors do not give you information needed on diet they prescribe.
5. Medical conditions, ie. Epilepsy, diabetes, etc
6. Mental health plan
7. Understanding
8. Special diets- nutrition
9. HIV and Older Adults
10. HIV
11. Understanding mental illness
12. Update on medication
13. I would like more input from case managers
14. None - things are going well.
15. Meds
16. Living with older clients
17. Mental health issues
18. How to discuss with doctors if it seems medications aren't effective.
19. Defusing agitated residents.
20. We're OK, thanks.
21. Menus for special care, ex. Diabetes
22. Don't need more training; need to be free to implement what we have (training).
23. Behavior identification- when/how interferes with household
24. The administrative part that is required
25. Tracking the system for liaisons to help ASAP, get needed service
26. Meetings with consumers to advise them of what is right/wrong. Consumer input is needed to determine how best to develop rules and application.
27. Documentation
28. How to get difficult client (MHMR) to clean themselves and surroundings
29. Side effects from medication
30. Medications and what they do.
31. Working with mental health agencies and CM's
32. Crisis intervention

33. Documentation
34. Mental health training
35. Borderline personality disorder
36. Training at local mental health clinic
37. Mental illness
38. New rules - what does it mean?
39. Client behavior
40. We need classes on how to run our homes on the little bit of income we get and still meet all the standards the state expects us to meet.
41. New medications & side effects
42. First Aid
43. Medication side effects
44. Crisis management
45. CPR and Basic First Aid to keep up with license procedure.
46. Mental health issues
47. Aggressive behavior
48. Medications
49. Medications - effect- side effects
50. More S/W help
51. Verbal interventions
52. Caring for mentally ill
53. Caring for client with multi diagnosis
54. Dealing in death - losing someone who has been with you a long time
55. Infection control
56. Training that you require should just be on VCR tapes & sent to all AFH homes then we could test ourselves & employees & you could send us our certificate; then we could be done with it.
57. Long term effects
58. None
59. Orientation tape provided free to each caregiver
60. Long term effects psych. Drugs have on body (organs)

61. None different
62. Personal care needs
63. Emotion & illness
64. Medications and diagnosis
65. Conflict resolution between agency providing MH & staff that works with client daily.
66. Psychiatric disorder symptoms
67. None
68. At this time I can't say anything is needed.
69. Diet (DM, low salt)
70. More training about the medicine
71. Communication between agency/home
72. More activities outside the facility
73. Personal care services
74. Schizophrenia topics: how to motivate clients, deal with clients, etc.
75. Mental health plan
76. Behavioral modification

RSS Survey (HB 283)
Questions for PAA and AAA Staff Involved with RSS

Section A: Overview of the rules

1. Overall, are the new rules helping to improve the quality of services for RSS clients?

a great deal	0
some improvement	31
no change	16
no response	5

2. Are the new rules helping to assure that RSS clients have access to appropriate mental health services?

a great deal	1
some improvement	25
no change	21
no response	5

Section B: Mechanics of rule implementation

3. Have the RSS providers been able to implement all of the new rules?

most of them	14
some of them	23
few of them	7
no response/don't know	8

4. Which of the following have made implementing the new rules difficult for RSS operators? **Check all that apply**:

the rules are not easy to understand	21
other agencies have not provided the needed services	39
staff turnover	21
lack of time	7
lack of adequate training opportunities	18
have had no difficulty	0
other; **see Appendix Implementation Q4**	6

5. For which rules do RSS providers need more clarification? **Check all that apply**:

Documentation	25
crisis plan	17
mental health plan for care	33
reporting significant changes or incidents	38
priority ranking	18
residents rights	19
do not need any clarifications	1
other, **see Appendix Clarification Q5**	6

Section C: Training requirements

6. Have the increased training requirements improved the care RSS clients receive in ACFs?

a great deal	0
some improvement	27
no change	20
no response	5

7. Which **four** of the following make it most difficult for ACF providers to meet this new training requirement?

time	38
staff turnover	23
too few training opportunities	21
available training is too technical for people to understand	8
training methods are not appropriate for topic; e.g., lectures	6
lack of training specific to the care of persons with mental illness	26
lack of training on the personal care needs of older adults	7
other, **see Appendix Training Q7**	12
No response	6

8. Please list **three** topics that you feel providers need training on to continue to provide services to clients. Please be specific:

   see Appendix Training Suggestion Q8

Section D: Appropriateness of placement of RSS clients in ACFs

9. How many recommendations for appropriateness of placement did you request during: * *Numbers are estimates

PAA	**7/1/00 – 6/30/01**	**7/1/01 – 12/31/01**
1	120	33
2	76	17
3	8	1
4	136	18
5	159	20
6	135	23
7	321	50
8	23	10
9	150	25
10A	250	75
10B	210	13
11	246	66
CSS	24	7
Totals	1858	358

10. How often do mental health agencies request additional information from you in order to complete their placement recommendations?

rarely	31
sometimes	7
frequently	1
not applicable	5
no response	8

11. Is the mental health agency completing the recommendations within the 10-day time frame?

yes	4
mostly yes	26
no	1
mostly no	8
no response	13

12. How many of your recommendations for placement were found to be **inappropriate** for:

PAA	**7/1/00 – 6/30/01**	**7/1/01 – 12/31/01**
1	0	0
2	0	0
3	0	0
4	1	1
5	1	0
6	1	0
7	1	0
8	0	0
9	1	2
10A	<20	<10
10B	0	0
11	1	0
CSS	0	0

13. Why were your recommendations for placement found to be inappropriate? **Check all that apply**:

client was too high functioning for this level of care	0
client was too low functioning	1
client was too aggressive	4
client had serious medical/health care needs	1
other, **see Appendix Inappropriate Q13**	5

Section E: Mental health plan for care

14. Has the change from affiliation agreements to mental health plans for care improved/been more useful in assuring those services for clients?

yes	7
stayed about the same	30
declined	1
no response	14

15. How **helpful/active** is the local mental health agency with developing the mental health plans for care?

helpful/active	3
somewhat helpful/active	19
not very helpful/active	13
don't know/no contact with agencies about the MH plan for care	8
no response	9

16. How **timely** is the local mental health agency with developing the mental health plans for care?

timely	2
somewhat timely	19
consistently not timely	11
don't know/no contact with agencies about the MH plan for care	11
no response	9

17. Have you had to delay placement of an RSS client with mental illness because the mental health plan for care was not completed?

frequently	0
occasionally	11
rarely	26
no response	15

18. If you have delayed placement of clients, on average, how long was the delay?

a few days	9
a week	4
a few weeks	7
not applicable	19
no response	13

19. If you have referred an RSS client for mental health services, how cooperative was the local mental health agency?

cooperative	9
somewhat cooperative	16
not very cooperative	4
uncooperative	4
no response	20

20. If you have requested reassessment of an RSS client currently receiving mental health services, how cooperative was the mental health agency?

cooperative	7
somewhat cooperative	9
not very cooperative	6
not cooperative	1
no response	29

Section F: Crisis plan component of the mental health plan for care

21. How **complete** is the information provided by the local mental health agency for the crisis plan?

all required information is provided	13
some information is missing	11
information is very incomplete	5
only 911 is listed for the crisis plan	1
no response	22

What information is most often missing? **See Appendix Crisis Plan Missing Info Q21**

22. Consider situations when an RSS client who was experiencing a mental health crisis needed to access services in your community. How available were the services listed in his/her mental health plan for care?

weekdays 9 to 5	Good - 10	Fair - 16	Poor - 4	no response – 22
weekdays during evenings/overnights	Good - 4	Fair - 12	Poor - 12	no response - 24
weekends/holidays	Good - 5	Fair - 12	Poor - 12	no response - 24

Section G: Reporting changes in status, condition and incidents

23. Has the addition of the **RSS** case manager to the list of persons to call, improved communication and coordination of services?

yes	4
some improvement	16
no improvement	7
am not contacted as required	11
no response	14

Section H: Coordination with mental health agencies

24. Since the implementation of the new rules, how has your relationship with mental health boards and local mental health agencies changed? **Check one**:

improved	3
somewhat improved	22
stayed the same	12
slightly deteriorated	1
deteriorated	1
no response	13

25. Overall, how would you rate the understanding of new rules by the local mental health boards or agencies?

good	2
fair	17
poor	21
no response	12

Section I: Waiting list priorities

26. Has your site experienced an increase in the number of clients over age 60 accessing the RSS program as a result of the change in priorities?

yes	4
no	30
don't know	10
no response	8

27. Has your site had clients who were already placed in a certified home, leave the facility and move to a nursing facility because they could not access a RSS slot?

yes	9
no	16
don't know	18
no response	9

PAA	**Approx. #****
1	?
2	?
3	0
4	25
5	?
6	0
7	18
8	0
9	?
10A	<10
10B	Unknown
11	?
CSS	0

**

= estimate/actual; 0 = none known; ? = don't know if this has happened; Unknown = yes, it has occurred but don't know how often.

28. Overall, how do you feel that the change in priority for enrollment has impacted access to the RSS program?

improved	7
no change	17
worsened	15
no response	13

Comments:

See Appendix Comments

Primary Role	#of Respondents
RSS Case Manager	30
RSS Supervisor/Admin.	13
Housing	3
Quality Assurance	3
Ombudsman	1
Trainer	1
Unknown	1
TOTAL	**52**

RSS Survey - Implementation Difficulties Q4

Other Obstacles to Implementing rule amendments for ACFs

- ACF operators complain about lack cooperation of MH agencies
- RSS enrollment priority status hinders operators to take a person without RSS
- ACF did not have the RSS rules until 1/16/02
- staff turnover at MH agencies and ACFs
- lack of effort by MH agencies
- Some have had difficulty obtaining copy of MHPFC
- MH not assisting owners with new rules

RSS Survey - Rule Clarification Q5

Rules ACF Operators need more clarification on (rules not listed in survey

- ACF required documentation
- MH Appropriateness Review
- admission requirements
- process for clients with MI who are not in publicly funded MH system
- RSS rules on client discharge/moves/transfers including notification requirements

RSS Survey - Training Comments Q7

Other Reasons Training is Difficult for ACF operators

- difficult for rural providers to make it
- operators need to find replacement coverage – costly
- apathy of owner
- apathy on part of some of the home operators regarding training
- No MH Training available in our area
- Providers won't attend because they are illiterate
- limited staff availability and no one to cover facility
- cost of trainings
- lack of interest by lot of managers or home owners
- location of trainings
- Not difficult to meet

RSS Survey - Training Suggestions For ACF Operators Q8

Record keeping and documentation - 18

dealing w/ difficult clients/behavior management – 12 responses

resident's rights – 12 responses

crisis intervention/de-escalation techniques – 12 responses

MH training – 10 responses

maintaining and handling financial records – 8 responses

medication management; including psychotropic and client non-compliance – 8 responses

reporting significant changes – 4 responses

understanding the roles of the RSS and MH case mangers - 4 responses

treating clients with respect/individuality and encouraging client autonomy – 4 responses

MHPFC – 3 responses

Non-TV home activities, how to arrange outside activities; especially religious – 3 response

MH Forensic system and other community MH agencies/services – 2 responses

importance of making sure client gets to appointments/ interaction with doctors – 2 responses

dietary/meal issues – 2 responses

provider rights when discharging a client from the ACF- 2 responses

resident agreements – 1 response

improving the quality of the home environment – 1 response

ODH rules clarification – 1 response

the importance of documentation as it relates to survey process – 1 response

RSS rules w/ testing – 1 response

client benefits management – 1 response

best practices – 1 response

how to operate an efficient business – 1 response

confidentiality – 1 response

MH referral form process – 1 response

MRDD Care Plans – 1 response

RSS Survey – Placement Recommendations Inappropriate Q13

- MH would not allow client to go
- Home requested unable to handle client's behavior
- Pedophile
- client needed more supervision than the ACF provided
- MH Reviewing Agency felt client inappropriate

RSS Survey – MHPFC Crisis Information Missing Q21

- MH CMs name and treatment goals
- missing altogether, out of date or incomplete
- most of the ones I have seen only list 911
- directions on how to de-escalate clients
- Dealing with police
- everything is missing in x county; the other counties are good
- MH CM's supervisor
- plan of action
- crisis plans in general
- depends on the county
- very vague, blanks filed in, not very structured
- who can be reached after hours

RSS Survey – General Comments

- Providers tell me that RSS CMs are the most reliable.
- Majority of MH CM have been very timely and helpful; however, large range of variation
- I was not involved in RSS prior to 6/01 so am unable to make comparisons
- New requirements have made it harder for elder clients to access the RSS program. MH Boards have developed several ways to get MH clients into the community in order to access RSS. X County MH Board will not use Adult Foster Homes because they don't have affiliation agreements even when clients chose these settings.
- 1st come 1st serve; suggest reserving a certain number of slots for the PAAs discretionary use
- X MH Board refuses to place MH consumers in foster care homes. We have much concern regarding the Social Security clients "Personal Needs Allowance" disparity. Waiting list changes has had major impact on ACFs. Clients accepted in ACFs prior to rule changes will probably never access RSS due to limited slots.
- There is nothing in place to encourage MH community service providers to notify ACFoperators of CM staff changes. When problems arise operators have no real recourse but to call the MH board for follow-up and support. This can be lengthy and/or dangerous.
- providers often express anger over the priority changes - some are discharging
- Reconsider waiting list priorities. Our site remains at 2/3 <60 and 1/3 60+.
- Agencies are manipulating the waiting list. Relationships/cooperation good in other counties except X county.
- Direct-care staff need to attend training sessions geared specially toward care of the MI/elderly. Home operators that currently receive training are not always directly involved in caring for the residents. Some sort of testing should be done to evaluate participants understanding of training. Change RSS waiting list - 1st come 1st serve
- priority should be 1st come 1st serve. We have ongoing problems with X county who have the majority of our clients.
- x county has been poor relationship to start and it has deteriorated further
- We proceed with placement to support the consumer - (don't delay for MHPFC)
- Problems are county specific – one county has MH recommendations outstanding over 1 year. Rules should include language prohibiting enrollment of clients with documented behaviors that are a threat to self or others.
- Q 18 - 20 no response because situations have not occurred/site has no experience
- All clients have been in MH system prior to rule changes, we haven't seen a MHPFC and no emergencies since new rules (Q 18 - 20)

RSS Survey – General Comments Continued

- "1st Come 1st Serve" would be helpful. Site is seeing large # of inappropriate referrals - mostly involved w/ criminal justice system. Access to list #2 (not residing in the community but elsewhere) is very rare.
- I feel the priority system/list is backwards. There will always be a waiting list for the community so why not help the homes already serving clients?
- Multiple complains about priorities, but the fact is with the size of the list - someone will always be waiting/last unless more slots are made available
- MH system needs to be accountable - providing appropriate training when requested and the lack of awareness that the rules even changed. Staff turnover in MH centers affect this, but in my opinion should not be an excuse.
- x county MH doesn't understand MH PFC - providers have a hard time getting them. X county operators were completing MH PFC and had clients sign them. Bottomline is services are only as good as the individual MH CM, turnover very high and little accountability.
- MH CMs are difficult to reach (often no voice mail) it takes several days/weeks to contact MH agencies for information on clients they have referred
- I wish we do 1st come 1st serve for the waiting list. I think MH CMs learned about RSS in 2000. With these rule changes we are seeing even more unstable clients (just out of prison, severely MI, homeless, etc).
- MHPFC - although most MH agencies will visit the client, they are unwilling to change the MHPFC to meet the client's needs. Also, most MH CMs are not aware of the rules changes.
- Regarding residents having to move to a NF because they can't access RSS (Q 27) - don't know the exact number but it has affected a few.
- Waiting list should be first come-first serve without priorities. X county usually does not complete referrals within 10 days
- waiting list rules need to be changed to avoid manipulation
- X CMHB still using Affiliation agreements.
- X board's is excellent! Most MH PFC are done the day of placement and not before. Home operators are refusing to take clients w/o RSS because of change in waiting list. This makes it difficult for MH that cannot delay placement.
- New employee - could not respond to some questions

HB 283 Survey Responses
Mental Health Boards and Agencies

1. Are the new rules helping to assure that consumers living in ACFs have greater access to mental health care?

Response	***Boards***	***Agencies***	***Total***
A great deal	**1**	**0**	**1**
Some Improvement	**7**	**12**	**19**
No Change	**13**	**21**	**34**

2. Overall, are the new rules helping to improve the quality of services for consumers living in ACFs?

Response	**Boards**	**Agencies**	**Total**
A great deal	**0**	**0**	**0**
Some improvement	**8**	**19**	**27**
No change	**12**	**14**	**26**

3. Since the implementation of the new rules, how has your relationship with RSS program staff changed?

Response	**Boards**	**Agencies**	**Total**
Improved	**5**	**6**	**11**
Stayed the same	**12**	**18**	**30**
Deteriorated	**1**	**2**	**3**
Not Applicable	**2**	**6**	**8**

4. Since the implementation of the new rules, how has your relationship with ACF operators changed?

Response	**Boards**	**Agencies**	**Total**
Improved	**3**	**10**	**13**
Stayed the same	**14**	**20**	**34**
Deteriorated	**1**	**0**	**1**
Not Applicable	**3**	**4**	**7**

5. Has the change from affiliation agreements to plans for care improved/been more useful in assuring services for consumers in ACFs?

Response	**Boards**	**Agencies**	**Total**
Improved	**1**	**3**	**4**
Somewhat improved	**5**	**15**	**20**
Stayed the same	**7**	**10**	**17**
Slightly deteriorated	**1**	**1**	**2**
Deteriorated	**3**	**2**	**5**
Not Applicable	**4**	**4**	**8**

Questions 6 through 8 for MH Agency staff only

6. How many consumers did you refer to Adult Care Facilities (ACFs) in your home county Board service area?
    a. Between July 1, 2000 through June 30, 2001
    b. Between July 1, 2001 through December 30, 2001

7. Of those, how many had a mental health plan for care developed prior to admission?
    a. Between July 1, 2000 through June 30, 2001
    b. Between July 1, 2001 through December 30, 2001

8. How many consumers did you refer to ACFs outside your home county Board Service Area
    a. Between July 1, 2000 through June 30, 2001
    b. Between July 1, 2001 through December 30, 2001

Questions 9 through 23 are for Mental Health Boards and Agencies staff only:

9. Of those consumers mentioned in question 8, for how many did you contact the receiving board?
    a. Between July 1, 2000 through June 30, 2001
    b. Between July 1, 2001 through December 30, 2001

10. For how many did you contact the receiving agency?
    a. Between July 1, 2000 through June 30, 2001
    b. Between July 1, 2001 through December 30, 2001

11. How many consumers in facilities in your area come from other Board areas?
    a. Between July 1, 2000 through June 30, 2001
    b. Between July 1, 2001 through December 30, 2001

12. For how many of those (in question 11) were you contacted beforehand?
    a. Between July 1, 2000 through June 30, 2001
    b. Between July 1, 2001 through December 30, 2001

13. Of those individuals you referred to an ACF, how many had a mental health plan for care completed prior to placement?
    a. Between July 1, 2000 through June 30, 2001
    b. Between July 1, 2001 through December 30, 2001

14. How many requests for a mental health plan for care have you received?
    a. Between July 1, 2000 through June 30, 2001
    b. Between July 1, 2001 through December 30, 2001

15. Of those, how many have been completed?
    a. Between July 1, 2000 through June 30, 2001
    b. Between July 1, 2001 through December 30, 2001

16. Please describe three barriers to completing the plan for care **prior to** placement:

Agency Responses:

All the people placed here have been current agency clients and all already had plans of care.
We have found no barriers at this time.
We have not experienced any major barriers. It might be because of size. We have had no RSS reviews and and 2 care plans with residents already residing in ACR prior to rules becoming effective.
None that we have experienced so fare. We have trained our after hours emergency staff to complete form in case of emergency placement in ACF.
Operators won't cooperate.
Out of county placements.
No notification
No placements made. One was started, but was withdrawn.
No opportunity for ACF collaboration.
Care managers unaware of their role.
Case managers unfamiliar with clients.
Lack of timely notification by RSS staff.
Accessing consumer
Don't know the agencies/services available, appropriateness of services, etc.
Out of county placements
Knowledge of consumer needs and desires is lacking, not dynamic just updated once a year.
Time crunch if plan is urgent
Immediacy of placement
Out of county placements because of distances involved are problematic.
Client may be placed from a nursing home or hospital setting without adequate advance notice.
Occasional refusal by client to cooperate in completion of plan
No problems
Do not always know client well enough
Client is in hospital/jail/treatment center- coordination
Scheduling conflicts

Agency Responses continued:

Emergency Placements – biggest problem
Lack of knowledge of facility staff and resources
Insufficient info of how a person will adapt to environment
Insufficient knowledge of community resources
Discharges from hospital without notice
Occasionally the time frame is short for scheduling meeting between 3 parties involved
Lack of client information
No fact to face contact/assessment
Client lack of involvement
Emergency movement

Board Responses

As clinical specialist at the Board, I do not get information prior to a plan of care being completed. Agency concerns are around a lack of face to face contact
Lack of cooperation between agencies. Case manager didn't follow instructions, operator didn't request.
Not enough openings to meet various levels of care..
Sometimes time is factor, but plans done by time of placement
None because mental health agency staff plan for own clients prior to placement and rarely receive an out of county referral for group home placement
Difficult getting information if a person is not part of this agency
Lack of understanding of expectations
Coordination of various parties is very difficult
No one seems to understand what is required
Lots of confusion
Most referrals are fairly well known; can be completed soon after, if not before
Clients were in jail, went right from court to facility – arrangements not definite until last minute
Encouraging participation from resident
Gathering of some information
Individual responsibility clear, no one designated to be in the lead
Often we are just getting to know this person who is new to our county and cannot know all their wants and needs upfront
Facility does not contact agency
Little knowledge of client and his history
Unscrupulous operators purposefully concealing information

17. If your staff received training on the new rules, how would rate their overall understanding of the changes in the new rules?

Response	Boards	Agencies	Total
Good Understanding	**7**	**8**	**15**
Generally Understood	**9**	**14**	**23**
Somewhat unsure	**2**	**2**	**4**
Not sure	**3**	**2**	**5**
Agency did not offer training	**1**	**3**	**4**

18. Describe your staff's training activities for ACF operators regarding the new rules:

Response	**Boards**	**Agencies**	**Total**
Provided Training to operators	**9**	**7**	**16**
Not our role; another agency doing it	**1**	**5**	**6**
Did not know we should be doing this	**1**	**5**	**6**
Have had no requests for training	**6**	**10**	**16**
Other	**3**	**2**	**5**
No ACF facilities in our area	**1**	**3**	**4**

19. How well do ACF operators understand the new rules?

Response	**Boards**	**Agencies**	**Total**
Good Understanding	**0**	**4**	**4**
Fair Understanding	**9**	**9**	**18**
Still some uncertainty	**10**	**12**	**22**
Other	**1**	**3**	**4**

20. How well does your staff understand what information is required in the mental health plan for care?

Response	Boards	Agencies	Total
Good Understanding	9	15	24
Generally understand	9	12	21
Somewhat unsure	2	1	3
Not sure	o	2	2

21. How helpful are the ACF providers in developing the mental health plans for care?

Response	Boards	Agencies	Total
Very helpful	3	5	8
Helpful	3	11	14
Somewhat helpful	5	5	10
Not at all helpful	4	2	6
Varies widely among providers	7	6	13

22. How well do the ACF providers follow through with their responsibilities on the mental health plans for care?

Response	Boards	Agencies	Total
Very Well	6	4	10
Well	8	7	15
Not very well	2	4	6
Poorly	1	4	5
Varies widely among providers	4	6	10

23. How often have you found that ACF operators in your area admit people with mental illness without a mental health plan for care?

Response	Boards	Agencies	Total
Rarely	10	7	17
Occasionally	7	8	15
Frequently	4	5	9

24. Within the last 12 months, have ACF operators asked you to provide services to people characterized as one or more of the following? **Check all that apply:**

Response	Boards	Agencies	Total
Not admitted according to the new rules	**2**	**3**	**5**
Having no diagnosis of mental illness	**3**	**3**	**6**
Unwilling to accept services	**0**	**2**	**2**
Not appropriate for services	**2**	**4**	**6**
Other	**3**	**2**	**5**
This has not happened in our area	**16**	**13**	**29**

Please go to Question 30, at the end of the survey, for an area where you may write additional comments related to this survey.

Questions 25 through 29 are for Board contracted RSS review agencies only:

25. How many RSS reviews have you conducted?
    a. Between July 1, 2000 through June 30, 2001
    b. Between July 1, 2001 through December 30, 2001

26. How many of the RSS reviews are you able to complete within the 10 day time frame required by the new rules?
    a. Almost all (90% or more)
    b. The majority of them (75%-89%)
    c. Most of them (50%-74%)
    d. Some of them (fewer than 50%)

27. What are three **most significant** barriers to the timely completion of the RSS reviews?

Agency Responses

Scheduling the visit within ten days from receipt of referral when we already have our schedules booked for that time frame
Making sure the client is available when we are
Other work to do
One ACF is out in the country and I will try to accumulate several before I go out to save time
No barriers at this time
I have not had problems with their completion
Cannot respond, no RSS in this county
Getting info from providers
None
No facilities, none requested
Initial year volume
Lack of case manager cooperation
Lack of home operator understanding
Treating agency not making contact
Placing of others in our county and not following guidelines
Accessing clients in hospitals, accessing staff from home, trying to complete with all parties present
RSS reviews are a priority and unless we receive a delayed request for completion of paperwork from RSS, we have been able to complete the reviews in a timely fashion.
Contacting other agencies
Questions re: form
Sometimes need 2+ hours and already have full schedules
Less time from being faxed to me receiving
Completing assessment and returning – 15 days would be better
The quantity of reviews combined with the quantity of plans for care
No significant barriers
Getting word back on whether a person is actually going I home or not
Connecting with ACF operator
Essentially the same as for question 16
Health Department response re: questions with facility

Board Responses

Occasionally schedule conflicts
No assigned MH case manager
On occasion, receive several for outlying group homes
Getting information from homes where we do not give services
Did not receive referral in time
Constraints of staff time due to caseload demands
Accessing clients from a hospital setting
Getting all team members together to discuss plan for customer
Accessing home staff in a timely manner

28. How many of the recommendations for placement in an ACF were found to be inappropriate?
    a. Between July 1, 2000 through June 30, 2001
    b. Between July 1, 2001 through December 30, 2001

29. Why were they found to be inappropriate? **Check all that apply**
    a. Person was too high functioning for this level of care
    b. Person was too low functioning for this level of care
    c. Person was too aggressive
    d. Person has too severe physical illness(es)
    e. Other; please explain_____

30. Finally, if you have other concerns or suggestions about the new requirements, please write your comments in the space below.

Agency Responses

We are not notified as to what RSS homes are in our area and if mental health clients are there. In Butler County, we are in constant contact with the ACF owners/operators and they always request our approval/input regarding new mental health admissions.

Overall, we feel that the new forms are easy to understand and provide ACF operators with a brief synopsis of the consumer in an easy to read format that assists them in dealing with crisis. Affiliation agreements seemed to have more teeth. Most group home operators are cooperative, but some totally disregard the rules. Sorry for inexact numbers, but we were not directed to keep them.

(The following is from one agency)

This agency does not provide primary case management services. Therefore, it does not make direct referrals to ACFs. The agency does operate four ACFs and provides community services to a number of mental health consumers. It straddles the fence between mental health provider and ACF operator. I may be a rather unique perspective.

This agency has noticed no difference in access to mental health care as a result of revised rules. There has been no concerted effort to reach out to home operators to advise them of the process or the options. Home operators see no benefit since they see no improvement in the quality of mental health care provided by local agencies to those clients who have been linked. By in large, the local mental health agencies do not appear to be aware of the revised rules, let alone their role in implementation.

This agency has also received a questionnaire from the Ohio Department of Health. The questionnaire's comment section is attached to this narrative and may provide some insight into the issues surrounding coordination of efforts. The short answer is that there has been little if any systems effort to establish coordination.

Board Responses

Although the Board would like to perform its duties around these new requirements, having not been included in the loop we cannot easily track referrals and/or plans of care. RSS referrals go directly to the MH agency. Plans of Care are developerd and not always faxed to the Board. MH agencies and ACF providers decide who needs training. RSS referring agency and MH agency have not always agreed on appropriateness of placement.

I assume you want ot know if Board in other area were contacted if we placed a Portage County resident in and ACF in a different Board area. One consumer was place in a Summit Co. ACF. This individual continues to receive services from a Portage County agency, so no need to contact the Summit Co. Board.

Our agency staff provide the training. One ACF operator called the Board for the training. I called the agency to provide the training.

According to agency staff, the ACF providers are helpful

Providers seem to have some difficulty with plans. Many are not able to participate in planning, but agency is conscientious about trying to work with less able providers. The largest area of concern is other Board areas reluctance to serve, or pay for service, for their clients when placed out of county. They attempt to evade responsibility by not negotiating up front.

Tracking system for collecting data needed to answer the majority of questions has not been developed/used.
The ACFs in our county have not vacancies and are not interested in admitting people with mental illness.
Currently, it is unclear who is accountable for ensuring plans of care are done and who should maintain a database of referrals/admissions and related information. Could there be a mechanism put in place to do this?
We are a small, rural county with few ACFs of which two are operated by a certified agency.
We have established plans for all residents, including those who were already living in the ACFs prior to the new requirements.
Plans for care are not always completed.
Often residents are inappropriately placed and the local Board and MH agency are expected to meet their needs. Additionally, referring county will not accept the resident back, citing no facility for them.

Responses to ODH

This company specializes in housing individuals with severe and persistent mental illness (SPMI). All of this company's 36 ACF beds are contracted to the local ADAMHS Board. In addition to all residents meeting the OMDH definition of SPMI, each resident must be receiving services from an ADAMHS-funded Community Support Agency. Therefore, this company has no experience in attempting to link a previously unserved resident with the mental health system. Although all of this company's residents are linked to mental health services, they do encounter difficulties in securing services from their case managers, also called Community Support Specialists. Merely mandating linkage has not been sufficient to ensure that the residents receive needed services

The mental health agencies in this county have not displayed awareness of ODMH's rules concerning their responsibilities under the rules. The agencies have taken the position that implementation is the exclusive responsibility of the home operators. Home operators have found that they are being cited in inspections for issues that should be the responsibility to the primary mental health agencies and staff.

This company has a licensed staff member who is able to provide some of the required training internally. However, that individual has a number of other responsibilities that make it difficult to keep up with the amount of training required by the rules. Staff turnover contributes to the difficulty in of providing timely training in some required areas.

The local ADAMHS Board conducted a series of workshops on the Mental Health Plan for Care; however, for the most part, the home operators have been left on their own to arrange training. No one has stepped forward to institute a training regime that would assist providers meet the training requirements; it is difficult to see how small providers are managing to comply with no outside assistance.

Long waiting lists for RSS in some areas
Out of county providers do not consult, provide MH plans, or follow procedures
I contacted Mike Schroeder 1/25/02 for clarification of ACF. Mr. Schroeder was extremely helpful. I was told ACF referred to home with 2 to 16 residents. I would like better training with more clarified information to assure that we are complying to all expectations.
We have about 12-15 being placed and have had no troubles. Plan of care is good in the sense it provides good summary of consumer for group home much needed information.
It is often unreasonable to have a plan of care completed immediately after discharge from the hospital. At times clients are admitted to the hospital without the ACF operator knowing or the mental health provider.
Without evidence of mental health treatment history, how can we determine who needs to have a mental health plan of care? In other words, if we are not already involved with the client, how can know to assess and complete a plan of care?
These plans of care are duplicative of the comprehensive RSS paperwork that is completed by LSW's and RN's.

Miscellaneous comments, by Question #

Boards Comments

1. We already had a strong dialogue due to our local affiliation agreement with ACFs
5. Not clear who is responsible for what
5. Agency doing plans of care prior to change
5. We still have people coming from other areas with no assessment or plan for care in place and the ACF accepts them.
6. The ACFs in our county have not vacancies and do not take people with mental illness
9. Contact though Buckeye Family
10. Contact through Buckeye Family
11. Data not available
12. Data not available
12. The home county pays for services at our local agency
13. Data not available
13. Board does not refer to ACFs. This is an agency function
13. Unknown
14. Unable to determine: no system for keeping this data
15. Unable to determine: no system for keeping this data
15. Data not available
17. Training was unclear
18. Operators, board staff, and agency staff attended department sponsored training at NBHC.
18. Most operators belong to a coalition and get training through it in Cuyahoga Co.
18. Developed care plan conjointly
19. Unknown
23. No ACF admissions in our area
24. Information not available
24. Sometimes a private organization calls the MHS or the Board's enrollment center to refer a person for services
29. No mental illness

Agencies Comments

1. No ACFs in our area
3. No relationship prior to new rules; however, have developed excellent rapport with RSS staff
3. Stayed the same, but good relationship – no history of problem
4. No relationship/limited before. Have had some negative reactions to my presence with several ACF operators
5. Often can not produce plan for care. Don't know what it means, in some cases.
5. Although, in Franklin Co., we continue to do affiliation agreements as well
5. No ceiling rates and not limits on spending money without affiliation agreements
6. We have not ACFs in our home county.
9. Was not aware of rule
10. Was not aware of rule
14. None, we do before admission
15. All our residents for our county have RSPs
18. Distributed changes to staff

Agencies Comments Continued

18. Office of Aging – RSS is doing it. Provided training for seven boarding home operators re: mental health issues only
18. 3 different trainings about 30 people each time
19. Varies dependent upon ACF operator
19. Varies among providers
23. No ACFs in our area
23. Unknown. We have no way to track the way to make ACF operators do anything
24. Unknown. How to track?
24. In need of services and have never had case manager assigned. I have referred several to job programs, mental health case management
24. Dumping from others counties without consult
25. No ACFs in our area
29. Lack of services from other Boards
29. External environment of ACF inappropriate for consumers with severe alcohol/drug problems – proximity to bars

Distribution of MH Boards and Agencies Survey Responses

County/Board Area	Board	Agency
Adams/Lawrence/Scioto		
Allen/Auglaize/Hardin		
Ashtabula		x
Belmont/Harrison/Monroe		
Clark/Greene/Madison	x	x
Columbiana		x
Cuyahoga	x	
Erie/Ottawa	x	x
Fayette/Ross/Pike/Pickaway/Highland		
Franklin		x
Geauga		x
Guernsey/Coshocton/Muskingum/Noble/	x	
Hamilton		
Hancock	x	
Huron	x	x
Athens/Hocking/Vinton		x
Jefferson	x	
Lake	x	
Licking/Knox		
Logan/Champaign		x
Lorain	x	x
Lucas		
Mahoning		xx
Putnam		x
Gallia/Jackson/Meigs		
Miami/Darke/Shelby		x
Delaware/Morrow		
Seneca/Sandusky/Wyandot		x
Stark	x	
Summit	x	x
Trumbull		
Tuscarawas/Carroll		x
Union		
Warren/Clinton		x
Wood		
Wayne/Holmes	x	x
Richland		
Fairfield		x
Marion	x	
Defiance/Fulton/Henry/Williams		
Clermont	x	
Huron	x	x
Medina	x	x
Portage	x	x
Washington	x	
Montgomery	x	x
Preble	x	
Brown		x
Butler		x
Van Wert/Mercer/Paulding	x	
Ashland	x	x
Unknown	x	