Iowa Association of Community Providers

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Residential Care Facilities: Role, Impact and Recommendations

Background Information:

Licensed Residential Care Facilities (RCFs) provide an integral service in the continuum of care for persons with mental illness and other disabilities. The services provided in RCFs are varied and inconsistently defined. In the past, many RCFs were "County Homes" and primarily served indigent elderly persons and persons with intellectual disabilities. Today almost all the RCFs in Iowa are privately run facilities, with the exception of a few which are still managed by counties. The majority of individuals served in RCFs have a diagnosis of mental illness.

The 2010 General Assembly directed the Iowa Developmental Disabilities Council to complete a study of RCFs in Iowa. This study provided an overview of three types of RCFs that are regulated by Iowa Administrative Code 481:

- RCF-Chapter 57; residential care for the general population
- RCF/ID-Chapter 63; residential care for the intellectually disabled
- RCF/PMI-Chapter 62; residential care for the mentally ill

The study's findings were based on 128 responses from RCFs (out of 188 RCFs). In FY 2010, 2,891 clients were served at this level of care. The majority of the admissions (71%) were voluntary and 28% were involuntary (court ordered placement for services in the RCF). Mental illness was reported as the diagnosis for 1,126 clients, intellectual disability diagnosis for 535 clients and dementia for 263 clients. Unspecified dual diagnosis was identified for 459 clients. Since this study was conducted, many facilities have closed. This has significantly reduced the number of available RCF beds.

Sources of Referral

RCFs are not all long-term care facilities or institutions. Some are five bed homes and some have more than one hundred beds. The majority of referrals to the RCF level of care come from the acute care system such as inpatient hospital settings or the state Mental Health Institutes. The acuity level of the individuals served in the RCFs has increased significantly. Most are referred after only 3-5 days on the acute inpatient units. This level of care in the continuum provides the level of supervision and structure needed to assist individuals in transitioning from acute care settings to the community as they continue in their recovery process. This function had previously been the responsibility of the state-run mental health institutes.

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Services

Many RCFs provide a variety of services to individuals with severe and persistent mental illness. For most clients, discharge planning begins the day of admission. RCFs with a treatment/outcome orientation focus on shorter length of stays, and emphasize transition to the community when the client is ready. Treatment decisions include everyone associated with the person, such as family, case managers, medical staff, etc. Treatment-based approaches emphasize:

- Reduced length of stays
- Decreased recidivism
- Symptom reduction and/or stabilization
- Increased opportunities for success in the community through skill development in the areas of:
    a. Symptom management/coping techniques
    b. Illness and medication education
    c. Medication management (learning to self manage their medications)
    d. Crisis interventions skills
    e. Developing natural supports
    f. Community inclusion/integration opportunities

The services provided to implement the treatment-based approach are focused on the individual needs of each person served. RCFs arrange for and provide access to a wide variety of services in order to address multiple and often complicated diagnoses. These services may include:

- Psychiatry
- ARNP with psychiatric certification
- Individual counseling
- Occupational and physical therapy
- Family practice to address medical needs
- Nutritional counseling
- Skill development

Funding

Funding is an issue for many of the individuals RCFs serve. Many of the individuals RCFs receive and admit to their facilities do not have Medicaid. RCF staff assist residents in applying for Social Security. It may take a year or more before the individual is eligible for Social Security benefits. Historically the county of legal settlement through the county mental health management plan has been the source of funding to ensure that the individual's needs are met. That responsibility will shift to the newly developed county regions based upon the region's operational guidelines. Individuals who are eligible to receive services under the HCBS waiver programs and Habilitation services are able to access those funding streams in some, but not all, RCFs.

RCFs currently struggle to be paid for the costs of the service. State Supplemental Assistance at its current rate does not meet the room and board costs of RCFs. Some RCFs offer a variety of waiver services in their facilities, but some do not qualify to offer waiver services due to size and demographic composition (larger than 16 beds, majority of persons served have an MI diagnosis). Services in non-Medicaid eligible facilities are funded solely by county dollars. The reimbursement rates from Medicaid for facilities that are eligible for participation in the program are based on cost reports and often the rates do not meet the costs. Some counties have paid for non-Medicaid covered services within these facilities, but some will not. The inconsistency in service payments as well as inadequate funding for the services provided has significantly imperiled this system of care, which places the service recipient and others at increased risk.

Gaps in the Continuum of Care

Sub-acute level of care has been identified as a gap in the continuum of care for people with mental illness. RCFs are currently filling this gap. DHS Director Palmer has stated that RCFs are already filling this gap. He has further stated RCFs should continue to be explored as an option in meeting this need.

Conclusion

RCFs have provided a vital link in the healthcare continuum for persons with mental illness and other disabilities. The missions of most RCFs are aligned with the principles articulated in the Olmstead decision. They focus on skill acquisition that enables persons with disabilities to quickly return to their community of choice. Typically, RCFs encourage and assist individuals to actively participate in service planning. RCFs can and do play an important role in the disability services system. They provide a transition to individuals with mental illness coming from acute care back in to their community of choice. Eliminating a link in the mental health care continuum has proven to place individuals at an increased risk of hospitalization, incarceration, homelessness and suicide.

The intent of the MH/DS Redesign is to improve the service system to this population. The number one goal as we move the system forward is to improve the quality of life for Iowans experiencing the challenges of mental illness and disabilities. In implementing the MH/DS Redesign, we have a moral obligation to ensure those responsible for the process **'Do No Harm.'**

Recommendations:

1. State leaders must ensure individuals continue to have **access** to high quality services, in spite of any and all transition of the larger service system.

2. Individual plans should drive the transition from acute care to community-based treatment services. We MUST focus on the person, not the payer. Individuals should not suffer due to a decision to change funding streams.

3. The principals of Olmstead and the ADA should drive systems change. Adherence to the federal law prohibiting Medicaid from funding 16+ bed facilities does not negate the obligation to treat those who are required to move from their homes with the utmost respect, dignity and compassion.

4. Iowa received $60 million to assist in rebalancing services from institutional to community-based. The most appropriate use of these funds appears to be an investment in the development of sub-acute services as the transition from acute care to community. Iowa leaders prefer serving people individually rather than in congregate settings; therefore leaders must also commit to make the investment in funding toward that vision.

5. Evaluate and re-write current regulations to support services and desired outcomes.