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JOINT SENATE/ASSEMBLY
LEGISLATIVE HEARING ON THE 2002 –2003 BUDGET

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Good Afternoon. Thank you for this opportunity to comment on the Governor's budget.

My name is Antonia Lasicki and I am the Executive Director of the Association for Community Living, or ACL. ACL represents 120 not-for-profit community mental health agencies from across the state that provide an array of mental health services to severely and persistently mentally ill adults. I'm here, however, to focus on how this budget impacts the *residential* services provided to the over 20,000 consumers we serve.

During times of budget crises in the eighties and the nineties, community mental health providers were told to tighten their belts. They did. During times of unprecedented surpluses in the later nineties, they were told that they couldn't get meaningful increases because if they got them, everyone would have to get them, and that would be just too expensive, even for NY. So I really have only one thing to say about the Governor's budget. It completely ignores the entire community mental health system, parts of which have been allowed to deteriorate badly, while simultaneously rewarding one sector of health care workers. The Governor has promised that he will come up with the \$1.8 billion dollars that would be needed if the Federal Government does not increase the Federal share of Medicaid to 53%. Clearly, it's never been about the money. Frankly, I am here to express our frustration, and to explain why NOW MORE THAN EVER, the community mental health residential providers need a meaningful increase.

This budget leaves the most difficult work to the least qualified and lowest paid workers.

LICENSED COMMUNITY RESIDENCE PROGRAMS

First, let me tell you why the work is the most difficult. Unlike the consumers who the community residence program was designed to serve – nearly twenty years ago - today's consumers have multiple diagnoses. Start with paranoid schizophrenia, bi-polar disorder, major depression, or schizoaffective disorder and couple that with impulse control problems, and sometimes mental retardation. Add to that consumers with substance addictions, with complicating medical conditions, for example, diabetes, seizure disorders, HIV/AIDS, cardiac conditions, cancer, chronic dental problems, high cholesterol, and hypertension, and then add to that, very complex medication regimens.

Add to that all the medical follow-up that we have to arrange, and the documentation that we have to keep. Add aging related problems like osteoporosis, and arthritis. Add to that the non-compliance issues that we experience with the court-ordered Kendra's law population. Add the documentation related to Medicaid Billing, the documentation related to the regulations, the documentation related to OSHA, the handling of medical waste, and the documentation and handling of dozens and dozens of medications and prescriptions. For psychiatric rehabilitation, the main purpose of the program, the staff have to complete a functional assessment on each consumer, and then write a service plan based on that functional assessment, and then develop goals and objectives based on the service plan and then document every time they work on a goal or an objective, and then translate that into a note that will pass muster for Medicaid billing. Add to that the responsibility to keep the houses clean, to shop for food, to cook nutritious meals, to encourage community integration, to transport, or arrange to transport, consumers to AA/NA meetings, to clinics, doctor's appointments, Day Treatment, and jobs. Add to this the need for staff to know crisis intervention and prevention, suicide prevention, CPR, first aid, and Psychiatric Rehabilitation principles.

OASAS residential programs have certified alcoholism counselors and multiple staff on duty. OMRDD residential programs have nursing oversight, medication certified staff, input from a psychologist, and multiple staff on duty.

Our staff, in contrast, work alone, and usually have only a high school diploma. There are no medication certification requirements even though a staff person might be supervising insulin injections. There is no nursing oversight, even though we might be supervising eighty medications on a shift. And it's twenty-four hours a day, seven days a week. Every shift has to be covered. No consumer can be left unsupervised while at a community residence site. As long as there is one consumer in a house, one staff person has to be there. But agencies are reimbursed \$16,000/per year upstate and \$18,000/year downstate for direct care positions. Turnover is at an all time high. Staff vacancies remain vacant for months. Agencies cannot fill the positions, and they tell me that they are hiring people they never would have hired five years ago. Managers often work all day and then have to cover empty shifts in the evening, on the overnight or on the weekends. Other direct care staff work unbelievable numbers of overtime hours.

I recently heard that a residence in central NY had one Full Time staff person hired out of the required seven and a half. In the Hudson Valley there is one that went through four managers in six months and had two staff hired out of the required seven and a half. I recently heard that in the Bronx a forty-eight bed CR that is supposed to have four staff on the evening shift is lucky to have one staff on any given evening.

We care for consumers who have a variety of behavioral problems related to their illnesses, which require more staff and more sophisticated staff. For example, there is a disorder where a person drinks too much water, throws their electrolytes out of balance, and has a heart attack. This has happened in a residence – the client died in the bathroom – for want of a second staff person to monitor him. Some consumers wolf their food, and choke. This has happened in a residence – the consumer died – for want of a second staff

person. Most consumers smoke and therefore, use matches. One residence caught fire and burned because the one staff person on duty decided to evacuate the residents first and put out the couch fire later, a judgment call. If there were two staff, they could have saved both the house and the people. In each of these instances two staff on duty would have avoided catastrophe. We need adequate salaries to insure that we can hire qualified staff, and we need additional staff.

However, instead of responding to the increased needs of the programs the Licensed Community residence budget was cut approximately 6% in 1995. Only 5.1% of those cuts were restored through COLA's. We are, in effect, behind *in real dollars from* where we were at the beginning of 1995. Add inflation and we're behind nearly 30%.

SUPPORTED HOUSING

Supported Housing is the least restrictive program model in the residential continuum and was developed as a vehicle to provide permanent housing for consumers. The state, or the counties, provide a per bed/per year stipend dependent on region. There have been some increases in the state beds since the program started, but there have been no increases to beds funded through Reinvestment. In some areas, particularly, NYC, Long Island, Westchester County, Rockland and Dutchess Counties, the stipend doesn't even cover the rent. Some case managers have caseloads of 20-40 consumers, rather than 15. These programs provide 2 – 4 staff visits in an apartment per month, however, we are being asked to use these apartments for more and more challenging consumers.

KENDRA'S LAW

After Kendra's Law was enacted, OMH added language to residential provider contracts creating a contractual obligation to give priority to "high risk, high need" consumers. Many of our providers are already serving a highly complex and difficult population, particularly because of the substance addictions, medical conditions, MR diagnoses, and complicated medication regimens. However, the contract language "high risk, high need" adds another element. We are now obligated to give priority to those who, by OMH definition, suffer from an enduring sense of danger to self or others. Many of our providers are perfectly willing to work with these consumers, however, they simply do not have the resources, and they do not think that the traditional residential and rehabilitative continuum of care, as it is designed now, can serve the very complex needs of these consumers. We have many ideas for models of housing and rehabilitation that could, and have tried to advance these ideas with no result.

ADMINISTRATION AND OVERHEAD

Agencies are shrinking their administrative shares to cover increasing costs for staff, health insurance, oil, food, and supplies. However, we work in a highly regulated field, and need a reasonable administrative share to insure that we are in compliance with OMH state regulations, state and federal Medicaid mandates, National Labor Relations Board rulings, the Driver Privacy Protection Act, The Pregnancy Protection Act, The Fair Labor Standards Act, the Family and Medical Leave Act, Occupational Safety and Health

Administration rules, Disability rules, Workers Compensation rules, HIPAA rules, Corporate Compliance mandates, Generally Accepted Accounting Principles, – I can go on and on. Many agencies are at or below 10-13% administrative share. Typical administrative costs for foundations that merely give away money is 20%. Decreasing administrative costs further is just not an option.

In summary - our staff turnover rates are 50% - we are burning out our middle managers, and our administration and overhead share has gone as low as it can go.

- The licensed Community Residence program needs a one-time increase of 30% to its Medicaid rate. The total cost would be \$34 million, and the state share would be \$17 million, a small price compared to the recent multi-billion dollar deal.
- The legislature passed Kendra's Law but provided no increased funding for providers. Additional resources must be made available directly to providers in any program that is expected to serve Kendra's Law court-ordered consumers, and "high risk, high need" consumers, and unless these resources are forthcoming, residences should be exempt from Kendra's Law placements and "high risk, high need" obligations.
- OMH has historically taken the position that all persons with severe mental illness are capable of recovery. Although we agree, we also believe that progress for some will be a long-term, or a life-long process. We believe that some consumers need permanent long-term care that can be provided in the community with the proper supports that are increased or decreased depending on need.
- Supported Housing stipends need to be sufficient, and based on cost. They need to cover rents, staff transportation, 1:15 staff ratio, office, telephone and an administrative share. Reinvestment beds should be brought up to the level of the state funded beds, and the Long Island rates should equal the NY City rates.
- Admission decisions are best made by agency staff. Single point of entry systems in counties must be made with provider input, and must not compromise an agency's ultimate authority over admission decisions.

ACL had Robert Kuttner, a nationally recognized economist, address our workforce crisis at our 2000 conference. His opening remark went something like this. "Do you really think you'd have a workforce crisis if you paid \$14.00/hour?"

Thank you for this opportunity to testify, and I'll answer any questions you might have.