

# Willowbrook: From Institution to the Community

A Fiscal and Programmatic Review  
of Selected Community Residences  
in New York City



New York State  
Commission on Quality of Care  
for the Mentally Disabled

August 1982

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*Chairman*

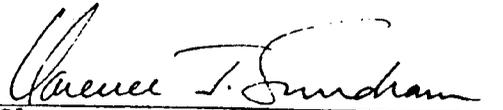
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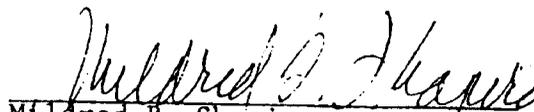


## PREFACE

In accordance with its statutory responsibility to oversee the quality of care and the expenditure of public funds in programs serving persons with mental disabilities, and in response to a specific request from the New York State Senate Committee on Mental Hygiene and Addiction Control, the Commission initiated a programmatic and fiscal review of 24 community residential programs serving individuals with severe and profound developmental disabilities in the New York City area in the winter of 1981. This report contains the findings, conclusions, and recommendations of this review.

The findings, conclusions, and recommendations contained in this report represent the unanimous opinion of the Commission and have been shared with the Office of Mental Retardation and Developmental Disabilities. The Office's response, contained in Appendix D, indicates agreement with the report's findings and conclusions and support of its recommendations.

  
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## ACKNOWLEDGMENTS

This report represents the contributions of many people involved with providing services to the developmentally disabled in community programs in the New York City metropolitan area. The staff members of the residences we visited deserve special mention for taking the time to show us their programs and answer our questions. The administrators of the voluntary agencies and the Borough Developmental Services offices are also to be commended for their willingness to participate and to contribute to our study. Central Office staff from the Office of Mental Retardation and Developmental Disabilities were very helpful in accessing the detailed fiscal and staffing information we required. Finally, special mention must be given the staff of the New York City County Service Group office for their ongoing cooperation and assistance.



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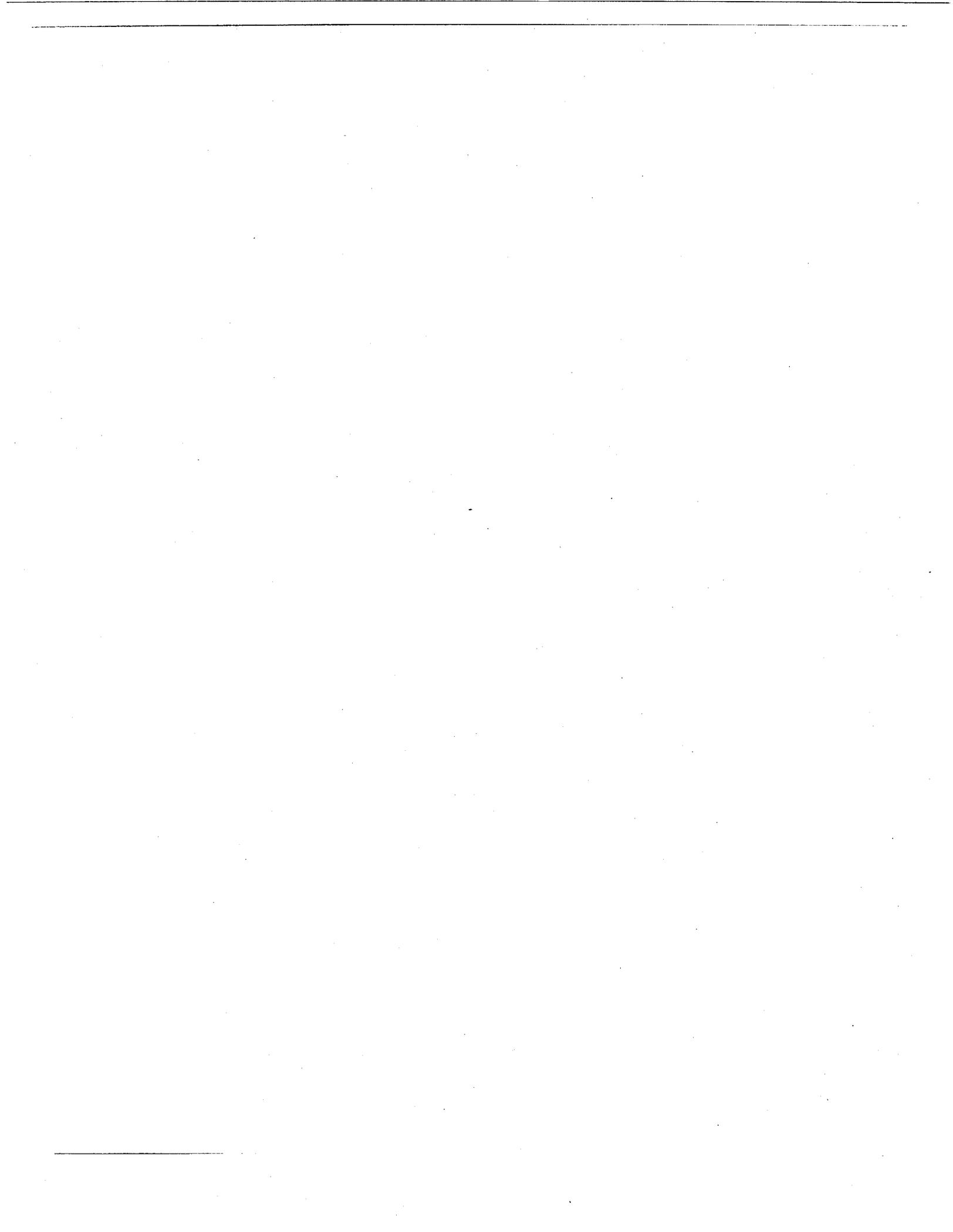
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## TABLE OF CONTENTS

	Page
Executive Summary	xiii
Chapter I Overview of the Study	1
Chapter II Looking Inside: The Residents, the Living Conditions and the Care and Treatment Programs	8
Chapter III The Care Givers: An Examination of Selected Staffing Issues	37
Chapter IV The Costs of Care: An Examination of the Fiscal Expenditures of the Facilities	59
Chapter V Conclusions and Recommendations	75
Appendix A: Methodology for Determining Number of Deficits Per Client in the Sampled Residences	87
Appendix B: Report of Follow-up Findings of Six Residence Sites Included in the Commission's Review	91
Appendix C: Reported Costs for Developmental Centers in the New York City Metropolitan Area for Fiscal Year 1979-80	101
Appendix D: Response to the Commission's Report from the Office of Mental Retardation and Developmental Disabilities	107



LIST OF TABLES AND FIGURES

	Page
Table 1: Residences in Study's Sample by Number and Percent by Type and Auspices, New York City, 1981	5
Table 2: Mean and Range of Functional Deficits Per Client Per Residence, by Type and Auspices of Residence, New York City, 1981	11
Table 3: Percent of Residences, by Housekeeping Status, by Type and Auspices, New York City, 1981	18
Table 4: Percent of Residences, by Attributes Indicative of a Homelike, Normalizing Setting, by Type and Auspices, New York City, 1981	19
Table 5: Percent of Clients, by Type of Day Program, by Type and Auspices New York City, 1981	24
Table 6: Percent of Residences, by Type and Frequency of Services Offered, by type and Auspices, New York City, 1981	25
Table 7: Percent of Residences, by Availability of Up-to-date Quarterly Client Assessments and Treatment Plans, by Type and Auspices, New York City, 1981	32
Table 8: Percent of Residences, by Degree to Which Identified Client Needs Are Addressed and Cited Barriers, by Type and Auspices, New York City, 1981	33
Table 9: Overall and Categorical Staff to Client Ratios by Type and Auspices of Residence	41
Table 10: Residences Overall Staff to Client Ratios by Residence, Type/Size and Average Level of Disability of Clients Living in the Residence	42

Continued



	Page
Table 11: Residences in the Study's Sample by Level of Client Disability and Overall/Categorical Staff to Client Ratios	46
Table 12: Reported Utilization of Clinical Staff in Sampled Residences by Voluntary Agency or BDSO Sponsor and by Percentage of Time Spent on Direct Services to Residents, Evaluation and Assessment, and Consultation and In-Service Training	53
Table 13: Entry Level Salaries of Direct Care Staff Members by Sponsoring Voluntary Agency/BDSO and Auspices	56
Table 14: Costs of Developmental Centers New York City, FY 1979-80	64
Table 15: Comparative Costs of Developmental Centers and Community Residential Programs, New York City, FY 1979-80	65
Table 16: Residences' Annual Per Client Costs by Type and Auspices of Residence and Level of Disability of Clients Served	69
Table 17: Individual Residences Annual Per Client Costs	73
Table B-1: Deficiencies Cited and Follow up Findings by Commission Staff of Six Selected Residence Sites	93
Figure 1: Residences Staff-to-Client Ratios by Level of Client Disability and Size of Residence	44
Figure 2: Residences Annual Per Client Costs by Level of Client Visability and Size of Residence	71



## EXECUTIVE SUMMARY

In the past decade, spurred by Governor Hugh L. Carey's decision to sign the Willowbrook Consent Decree,\* New York State has been in the forefront of a national movement to reduce reliance upon large institutions as the primary mode of providing residential care and services for developmentally disabled persons. In that decade, the population of the State's institutions for the mentally retarded, or developmental centers, has dropped from over 25,000 to 12,830. In addition, a significant number of mentally retarded and developmentally disabled persons, who once would have been admitted to institutions, have been placed in residential alternatives in the community.

The urgent need to establish a large number of community residential facilities to meet the requirements of the Willowbrook Consent Decree for removing class members\*\* from institutions, and to provide community-based residential alternatives to institutions for hundreds of other developmentally disabled citizens living in upstate communities, has also altered the traditional separation of roles between the State and voluntary agencies. Concerned

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\*On April 22, 1975 Governor Hugh L. Carey signed the Willowbrook Consent Decree which required the State of New York to place Willowbrook class members in the least restrictive residential setting appropriate to their needs. The decree further specified that the State must reduce the inpatient census of Staten Island Developmental Center, then called Willowbrook, from its 1975 census of 2,761 to 250 by April 1981. N.Y. Ass'n. for Retarded Children v. Carey, 393 F. Supp. 715 (E.D.N.Y. 1975).

\*\*Persons who are included in the class action lawsuit which led to the signing of the Willowbrook Consent Decree.

over the job security of a significant segment of its institutional work force as the population of institutions decreased, and in an attempt to comply with the compelling court imposed deadlines for achieving community placements of class members, the State decided to commence direct operation of community residential programs. This alteration of roles, whereby the State--while retaining control over the planning, licensing, funding and regulatory processes--competes with voluntary agencies in an arena that was traditionally their exclusive domain, has not been without controversy.

The most intense controversy, however, has focused upon the removal from institutions of the most severely disabled residents. Today, approximately 3,000 persons with profound and severe developmental disabilities reside in communities across the State, in a variety of residential settings of varying types and sizes, operated by voluntary agencies or by the State itself, through its Office of Mental Retardation and Developmental Disabilities (OMRDD). Over 30 percent of these placements are in New York City where, as a result of the Willowbrook Consent Decree, placement efforts have had the highest priority.

While the efforts to provide homelike residential settings in the community for developmentally disabled citizens are increasingly gaining general acceptance, some parents, providers, legislators, and other voices in the community-at-large have raised questions concerning the programmatic and fiscal viability of small, discrete community residential facilities for the multiple and specialized treatment and care needs of severely and profoundly developmentally disabled individuals. Reservations have especially been expressed over the appropriateness and fiscal advisability of placing severely and profoundly

disabled individuals in two- and three-bed apartments\* and the State's role in operating community residences.

In response to these questions, and at the specific request of the New York State Senate Committee on Mental Hygiene and Addiction Control, the Commission undertook this study of the services and costs of a variety of community residential facilities serving severely and profoundly developmentally disabled persons in the New York metropolitan area. This review was based on a stratified sample of 24 community residential facilities, 9 of which were operated by the State and the remaining 15 by 5 different voluntary agencies. Of the 24 facilities in the sample, one-half were group residences serving 6 to 15 clients, and the other half were apartment residences serving 2 to 3 clients. The 24 facilities provided services for 160 male and female clients, ranging in age from 13 to 65, 74 percent of whom were diagnosed as severely or profoundly retarded. Seventy-three percent were also members of the Willowbrook Class, who had previously resided in an institution. All but four of the remaining clients had previously lived with their families.

In the course of this study, Commission staff made site visits to each of the residences, interviewed the senior staff, assessed the general living conditions, and reviewed client records. Follow-up interviews were conducted with senior staff of the voluntary agency or State Borough Developmental Services Office (BDSO) of OMRDD responsible for monitoring community residential programs. Cost and staffing level data were obtained for fiscal year 1979-80.

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\*These apartment residences were established in response to an order of the Federal District Court in the course of its continuing supervision of the implementation of the Willowbrook Consent Decree. N.Y. Ass'n. for Retarded Children v. Carey, E.D.N.Y. Dk. Nos. 72 (iv. 356/357, October 22, 1979) (unreported).

The findings, conclusions, and recommendations of this review reported herein reflect the unanimous views of the Commission. In preparing this report, a conscientious effort was made to base our conclusions on the findings of the review of the sampled 24 residences. At the same time, it must be acknowledged that the conclusions are likely to have been influenced by the findings of numerous site visits, conducted as part of the Commission's ongoing oversight responsibility, to community-based and developmental center programs across the State serving persons with developmental disabilities. This may be a weakness if one thinks solely of the scientific rigor of the study. It is a strength to the extent that it provides a base of experience and a frame of reference for the observations, conclusions and recommendations stemming therefrom.

The overall findings and conclusions of this report follow. First, small community-based residences can provide safe, attractive, comfortable and homelike environments capable of addressing the identified care and treatment needs of severely and profoundly developmentally disabled persons. In fact, the majority of the residences in our sample did provide such care and treatment.

- The vast majority of these programs afforded their residents the opportunity to enjoy community life and to participate in normalizing activities such as the use of public transportation, shopping, attending theater and dining in restaurants.
- These programs provided personalized, individual care for their residents.
- All residents had annual medical examinations and annual assessments performed.
- All residences offered habilitative training in activities of daily living on-site weekly, and 22 of the 24 residences offered recreational opportunities on-site at least once a week.

- Twenty-one of the 24 residences offered a range of specialized services on-site, including speech therapy, nursing services, physician services, and/or psychological services.
- All but one of the 160 clients in the sample attended a day program outside the residence for at least five hours each weekday.

Second, these community residential programs delivered more personalized, individual care for their residents at comparable, and, on the average, lower costs than the cost of care provided in State developmental centers in the New York City metropolitan area.

- While annual per client costs of care for facilities in our sample ranged from \$16,892 in one voluntary agency group residence to \$57,600 in a State-operated apartment residence, the average annual per client cost among these residences was \$28,639 for fiscal year 1979-80, exclusive of day program costs.
- At the same time, the adjusted average annual per client cost for comparable services in developmental centers in the New York City area was approximately \$37,024.\*

However, the review also indicated that a majority of the apartment residences in the sample, and all but one of the visited State-operated apartments, reported higher annual per client costs than the comparable adjusted average annual per client cost of developmental centers in the New York City area.

Third, while the overall quality of life in the majority of community residences in the sample compares favorably with the institutions they replace, there are

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\*To achieve comparability between developmental centers' costs, which included day program costs as reported by OMRDD, \$13,425 was deducted from average annual per client costs in the centers; reflecting the State annual reimbursement rate for annual day programming services and the approximate average per client costs for ancillary medical and dental expenses, also not included in the reported community residences' costs.

significant differences among community residential programs based largely on the auspices of operation (State versus voluntary agency), and on the size of the residence (apartment versus group residence).

More specifically, the study indicates clearly that State-operated residences serve a more severely disabled population than do the voluntary-operated residences, and within each auspices, the apartments serve more disabled residents than do the group residences. (For example, all of the non-ambulatory clients in this sample resided in apartments.) Concomitantly, the State-operated residences have higher staff-to-client ratios than their voluntary agency counterparts, and the apartments are more richly staffed than group homes. State-operated programs also cost more: the median per year cost per client for the State-operated residences was \$43,093 compared with \$27,876 for voluntary-agency-operated residences.\* And apartment residences cost most of all. For the most disabled clients, apartments overall cost 60 percent more per client than group residences serving clients with a comparable level of disability.

Aside from the richer staffing of State programs, State employees in entry level direct care positions were generally better paid and entitled to a richer employee benefit package than their colleagues in the voluntary sector.

Fourth, by virtually every indicator of performance utilized in this study, the voluntary-operated residences

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\*Readers should note that the reported higher median costs of State-operated residences is largely reflective of the more disabled clients being served in State versus voluntary agency programs in the study's sample, as well as the higher proportion of high cost apartments versus group residences in State-operated sampled residences. While two-thirds of the sampled State residences were apartments, only 40 percent of the sampled voluntary agency residences were apartments.

were superior to the State-run programs in the New York City metropolitan area. For example:

- Although serving a more disabled population, State-operated residences, particularly apartment residences, tended to offer fewer types of services on-site to their residents than voluntary-agency-operated residences, e.g., 80 percent of the voluntary agency residences offered nursing services on-site at least weekly compared to one-third of State-operated residences and, notably, only one of the State-operated apartment residences, offered these services (Report, Chapter II, pp. 23-28).
- Voluntary-agency-operated residences provided medical and dental services outside the residence much more frequently than State-operated residences (87 percent versus 56 percent) (Report, Chapter II, p. 28).
- State-operated residences, particularly apartment residences, had significantly greater deficiencies than did their voluntary agency counterparts in the availability for all clients of updated quarterly treatment plans (22 percent versus 60 percent) and client assessments (0 percent versus 93 percent). In fact, in four of the six State-run apartments, such quarterly plans and assessments were not present for any clients in the apartment and in two BDSOs no client assessments and treatment plans were available on site, but were located at the BDSO several miles away (Report, Chapter II, pp. 28-35).
- Significantly fewer State-operated residences were addressing the identified needs of all clients than voluntary-agency-operated residences (11 percent versus 80 percent) (Report, Chapter II, pp. 33-34).
- Of the nine residences in which the absence of client-appropriate decorations and leisure time activities was noted, six were State-operated, representing two-thirds of the study's sampled State-run residences (Report, Chapter II, pp. 16, 19-21).

It is evident that the State-operated community residences in the New York City area, which are relatively new entities compared with the voluntary-agency-operated residences, are not providing the same standard of care we have come to expect of the voluntary agencies. While some have questioned the very propriety of the State's embarking upon the mission of operating community residences, the Commission's site visits to State-operated community residences outside the New York metropolitan area have demonstrated the State's capability to operate quality community residential programs. In these site visits, which have been made to over 60 State-operated upstate residences in the past two years, the Commission has been generally impressed by the quality of care provided, the compliance with State regulatory standards, and the homelike environments maintained by State employees.

At the same time, the Commission recognizes a critical and immediate need for the Office of Mental Retardation and Developmental Disabilities to reexamine their recruitment, training and retraining efforts for employees in community residences in the New York City metropolitan area, particularly in providing a sound orientation to the philosophy of community living for the mentally retarded. The support and supervision offered to such employees also requires reexamination, particularly in small apartments which place multiple and varied demands upon the few available employees. It is essential that OMRDD recognize that the proliferation of State-operated community residential programs in a multitude of small sites, while programmatically sound and beneficial to the residents, places added supervisory responsibilities upon it to assure the quality of the programs being developed.

Fifth, our review of the sampled apartments failed to identify any aspect of care and treatment of severely and

profoundly developmentally disabled persons that could not be provided at least as effectively, if not more so, in a group residence. In fact, in almost all areas reviewed, apartment residences, and particularly State-operated apartments, were rated less adequate than group residences, despite their significantly richer staffing ratios and higher costs. Median staff-to-client ratios for the sampled apartment residences were higher by 30 percent to over 60 percent than those of sampled group residences serving clients with comparable levels of disability. Similarly, comparison of median per client costs for apartments and group residences serving clients with comparable levels of disability indicated that apartment residence care ranged from 21 percent to 60 percent more costly than the group residence care for similar clients. Among the indicators of the less adequate care by sampled apartment residences versus group residences are:

- Apartment residences tended to offer fewer types of specialized treatment services, including speech therapy, nursing services, physician services, and psychological services, and, when offered, to provide them less frequently than group residences (Report, Chapter II, pp. 23-28).
- Significantly fewer of the sampled apartment residences offered their residents recreational opportunities outside of the residence than the sampled group residences (17 percent versus 50 percent) (Report, Chapter II, pp. 25-28).
- Significantly more apartment residences in the sample, particularly State-operated apartments, failed to address the identified treatment needs of at least one-half of their clients than group residences (33 percent versus 0 percent) (Report, Chapter II, pp. 33-34).
- Of the seven residences where clients did not have clothing conforming to community standards, five were apartment residences (Report, Chapter II, p. 20).

Based on these findings, the Commission believes that the use of apartment residences for severely and profoundly disabled persons is programmatically and fiscally misguided and should be discontinued. Commission staff reviewing these apartment residences in the New York City area could cite no advantage of these small units over the larger group residences and repeatedly observed that the apartment modality placed greater and more stressful demands on direct care staff.

Sixth, it is abundantly clear that, given the rapidity with which the community residential program has grown and developed under the pressures of the Willowbrook Consent Decree, the development of a regulatory framework has not kept pace. Program standards and cost control measures, where they exist, have not always been consistently applied, leading to unexplained idiosyncracies in staffing, staff utilization and funding of these programs. Furthermore, while much effort has been devoted to locating and establishing community residential programs, a few have been located in unsuitable areas and others, requiring maintenance and repairs, have been allowed to deteriorate for lack of a systemic mechanism to finance and effect such maintenance and repairs. For example:

- Although, in general, staffing and costs increased in relationship to the increasing level of disability of the clients and the decreasing size of the residence (reflecting diseconomies of scale), there are also significant variances in the level of staffing and costs not readily explainable based on any apparent treatment or programmatic consideration. Residences serving clients of similar disability levels had widely ranging staff-to-client ratios and costs, and some residences serving less disabled clients had higher costs than comparable residences serving more disabled clients:

- Two State-operated apartments serving clients of similar levels of disability had staff-to-client ratios of 1.91:1 and 3.58:1, respectively (Report, Chapter III, p. 45);
- Two voluntary-agency-operated apartment residences serving clients with comparable levels of disability reported widely variant annual per client costs of \$22,808 and \$40,074, respectively (Report, Chapter IV, p. 71);
- Two State-operated group residences, one serving considerably more disabled clients than the other, where the facility serving the more disabled clients reported annual per client costs of \$26,879 while the facility serving the less disabled clients reported annual per client costs of \$32,605 (Report, Chapter IV, p. 71);
- Of two State-operated apartments, both serving very disabled clients, the reported annual per client cost of the residence serving the less disabled clients was more than double the cost of the residence serving more disabled clients (\$52,871 versus \$22,089) (Report Chapter IV, p. 71).
- As a result of the differences in size, there are significant differences in job responsibilities and performance expectations of direct care staff assigned to apartments and group homes. Apartments' staff, serving the more disabled clients, had to be "generalists" who performed a variety of tasks, requiring them to prioritize tasks, balance responsibilities and schedule their time in a more sophisticated manner. Yet, they were generally afforded less regular, continuous supervision than staff in group homes because their small size did not warrant the assignment of a full-time manager (Report, Chapter III, pp. 47-49).
- There are also significant variations in the use of clinical staff among the residences surveyed which do not appear to be related to the disability level of the clients, size of the residence, or the auspices of operation (Report, Chapter III, pp. 49-53).

- Reported utilization of psychologists, speech therapists and occupational therapists for direct services to clients ranged from no utilization to one-third of their time;
  - Nursing staff time spent on client evaluations and assessments varied from a low of 15 percent of their time to a high of 65 percent;
  - Reported use of psychologists, speech therapists, and occupational therapists for in-service training and staff consultations ranged from one-third of their time to three-fourths of their time.
- The overall safety of the neighborhoods in which 4 of the 24 residences were located was also questionable as each was in a very run-down neighborhood, in the vicinity of many uninhabited buildings. Community services in these neighborhoods were scarce and public transportation, when available, was generally not used by staff or residents due to its alleged dangerousness. As a result, the residents of these facilities enjoyed few of the benefits of being part of the community (Report, Chapter II, pp. 15-16).
  - Although living conditions were generally found to be of high quality, 4 of the 24 residences had serious deficiencies in housekeeping and 2 had serious safety problems, including exposed heating fixtures and hot water pipes, plumbing problems and inadequate egress in case of fire or other emergency (Report, Chapter II, pp. 15-17).

The Commission concludes that as the community residential programs are becoming an increasingly important part of the State's service delivery system and, indeed, represent the future for most of the system, it is imperative that the regulatory framework within which they operate be further developed and strengthened. The State, through the Office of Mental Retardation and Developmental Disabilities,

must define and delineate its expectations both for its own programs and for those it licenses, and through its supervisory, quality assurance, cost control and regulatory mechanisms, must ensure consistent application of standards in order to achieve and maintain the high quality of care that this study demonstrates is attainable.

### Recommendations

Emanating from these conclusions, the Commission recommends certain specific regulatory, policy, and management initiatives to improve and ensure the continued viability of the community residential program for developmentally disabled people in the New York City metropolitan area. Implementation of these recommendations does not require additional new monies and, indeed, should provide the State OMRDD with mechanisms to ensure appropriate cost containment standards in the future.

1. The Commission strongly recommends that the Office of Mental Retardation and Developmental Disabilities continue to pursue its policy of developing community residential programs to serve persons with severe and profound developmental disabilities. The findings of this study clearly demonstrate that such programs can offer more personalized, individual care for their residents in attractive, homelike settings which provide a more normalizing living environment than institutional care, and at a comparable, and sometimes lower cost.
2. The Commission recommends that the Office of Mental Retardation and Developmental Disabilities closely review the performance of State-operated community residences in the New York metropolitan area with a view to identifying and correcting the factors that

have led to a poorer standard of performance than that of the voluntary-agency-operated residences. Among the specific factors that require attention, at a minimum, are the following:

- a. Clear standards for treatment and care services to be available to clients of State-operated residences, especially recreational opportunities outside the residences;
- b. Clear definition of performance expectations of all levels of staff in different roles;
- c. Staff recruitment, orientation, training and retraining for the specific jobs for which they are to be employed; and
- d. Provision of supervision for staff in accordance with their needs.

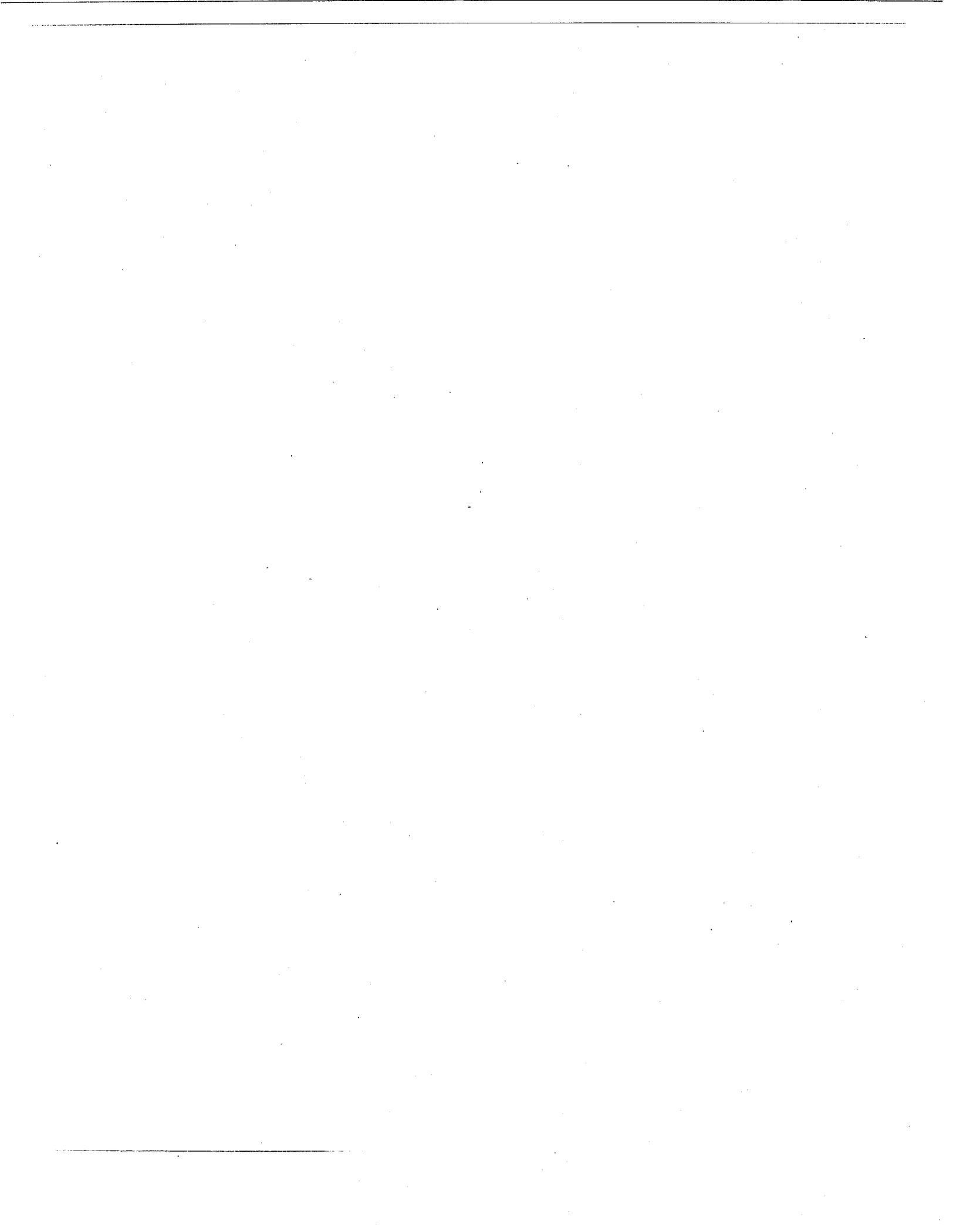
In this effort OMRDD may wish to study the experiences of both voluntary agencies with longstanding records of offering quality and normalizing residential programs and State-operated community residences outside the metropolitan New York area.

3. The Commission strongly recommends that the use of two- to three-bed apartment residences for the severely and profoundly developmentally disabled clients be discontinued as they are neither programmatically nor fiscally effective.
4. The Commission recommends that the Office of Mental Retardation and Developmental Disabilities further develop and strengthen the regulatory framework within which the community residential programs are developed and operated. Specifically:

- a. OMRDD should closely scrutinize proposed locations of community residences to assure that the neighborhoods are safe for staff and clients and are capable of providing a homelike and normalizing environment in which personal growth is possible.
- b. OMRDD should refine its methods of determining staffing and expenditure levels for community residential programs to ensure that there is a closer and more consistent relationship between the level of client needs and the staffing and expenditures of the program.
- c. OMRDD should discontinue its informal policy with certain voluntary agencies of allowing aggregate cost reporting for clusters of residences and require individual cost reporting for each residence. Such residence-specific cost reporting is essential to ensure OMRDD's capability to monitor effectively the costs of individual residences and to develop and implement equitable cost containment standards for community residences.
- d. OMRDD should work with the Division of the Budget and the Department of Social Services to develop comprehensive Medicaid rates for community-based ICF-MRs to cover day program, and residential care costs of these programs. The establishment of a comprehensive rate for these programs would greatly enhance the capability of OMRDD to account for total client care costs, to develop effective and equitable cost containment guidelines for these programs, and to preclude the inappropriate duplication of service provision to clients through their residential and day program.

- e. OMRDD should further define and delineate its expectations on staff utilization to achieve consistency in the availability of services to clients based upon their needs. Such an effort is particularly needed in developing uniform guidelines for appropriate and cost effective use of clinicians in these programs.
- f. Consistent with the previous recommendation, in developing guidelines for clinical staff utilization, special attention should be directed toward minimizing the paperwork responsibilities of clinical staff and maximizing their available time for activities directly related to client care and treatment. In this vein, OMRDD should seriously consider modification of present regulations for quarterly assessments and treatment plans for community residences serving adults, to require only semi-annual assessments and plans for clients after the first year of placement in the programs. Commission reviews of available client assessments and treatment plans in these residences suggest that such a modification would not sacrifice quality client care and indeed, may improve the quality of care by lessening the paperwork requirements imposed on clinical staff, increasing their available time for direct client care, therapy and treatment. Though such a modification would require a waiver from the U.S. Department of Health and Human Services, such a request appears especially timely in view of the federal government's articulated commitment to amend burdensome and non-productive regulations.

- g. OMRDD should require that such treatment plans and assessments be located in the residences (not the BDSO) where they will be accessible to direct care staff.
- h. Provision must be made, in funding community residential programs, for attending to reasonably foreseeable repairs and maintenance of the facilities. In addition, there should be a clear assignment of responsibility and clear procedures for promptly effecting necessary repairs, particularly of conditions that are potentially hazardous to the well-being of clients and staff.



## CHAPTER I

### Overview of the Study

Historically, persons with severe and profound developmental disabilities in New York State, like the rest of the nation, have been cared for either in public institutions or by their families. In the past decade, however, spurred by Governor Hugh L. Carey's decision to sign the Willowbrook Consent Decree,<sup>1</sup> New York has been in the forefront of a national movement to develop alternative residential opportunities in the community for these individuals. Today, approximately 3,000 individuals with profound and severe developmental disabilities reside in New York's communities in a variety of residential settings, ranging from moderate-sized residential facilities (50-100 beds) to the traditional hostel or community residence to the small community-based intermediate care facility for the mentally retarded (4-15 beds) to two- or three-bed supervised apartments.

Although the efforts to establish community residential alternatives for severely and profoundly developmentally disabled persons have been pursued statewide, these efforts, as a result of the Willowbrook Consent Decree, have been concentrated in the New York City metropolitan area. Over 30 percent of the existing community residential placements for severely and profoundly disabled persons are located in the five boroughs of New York City.

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<sup>1</sup>On April 22, 1975 Governor Hugh L. Carey signed the Willowbrook Consent Decree which required the State of New York to place Willowbrook class members in the least restrictive residential setting appropriate to their needs. The decree further specified that the State must reduce the inpatient census of Staten Island Developmental Center, then called Willowbrook, from its 1975 census of 2,761 to 250 by April 1981. N.Y. Ass'n. for Retarded Children v. Carey, 393 F. Supp. 715 (E.D.N.Y. 1975)

2.

The urgent need to establish a large number of community residential facilities to meet the requirements of the Consent Decree for removing class members<sup>2</sup> from institutions altered the traditional separation of roles between the State and voluntary agencies in the operation of institutional versus community residential care. Concerned over the job security of a significant segment of its institutional work force as the population of institutions decreased and in an attempt to comply with the compelling deadlines for achieving community placements, the State decided to commence direct operations of community residential programs. This alteration of roles, whereby the State--while retaining control over planning, licensing, funding, and regulatory processes--competes with voluntary agencies in an arena that was traditionally their exclusive domain, has not been without controversy. Currently the State Office of Mental Retardation and Developmental Disabilities (OMRDD), through its five local offices (BDSOs/ DDSOs)<sup>3</sup> in the New York City area operates 213 community residential facilities serving over 1,600 residents.

The aggressive promotion of community-based, homelike residential settings for the severely and profoundly disabled has been generally applauded. However, parents,

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<sup>2</sup>Persons who are included in the Class action lawsuit which led to the signing of the Willowbrook Consent Decree.

<sup>3</sup>In 1979 the OMRDD established 15 Developmental Disabilities Services Offices (DDSOs) upstate and five Borough Developmental Services Offices (BDSOs) in the New York City area to provide the framework for an integrated and balanced institutional and community service delivery system in each geographical area. In establishing the BDSOs/DDSOs the intent of OMRDD was to explicitly shift the focus of its service system for the developmentally disabled away from the institution as the hub of the system to the BDSO/DDSO located in the community.

legislators, service providers, and the community-at-large have questioned the programmatic and fiscal viability of the small two- to three-bed apartment modality for individuals with severe and profound developmental disabilities, as well as the State's direct operation of community residential programs.

This study, which reports the findings of a review of 24 community residential facilities serving severely and profoundly developmentally disabled persons in the New York metropolitan area, attempts to address some of these questions. Summarizing the findings of a six-month study conducted from January through June 1981, this report reviews the living conditions, client characteristics, treatment and program services, staffing levels, and annual per client costs of the 24 residences. Conducted in accordance with the Commission's broad statutory responsibility to ensure the quality of care and cost efficiency of programs serving the State's mentally disabled citizens, the study also responds to a specific request from the Senate Mental Hygiene and Addiction Control Committee of the State Legislature to examine the care costs of New York City community residence programs serving the developmentally disabled.

#### Methodology

The 24 residences selected for review represented a stratified sample of small community residential facilities serving residents with severe or profound functional disabilities. While all of the residences served individuals with at least one severe functional disability, the 160 residents included persons with a wide range of abilities and disabilities, some with considerable self-help skills, others nearly totally dependent.

4.

The sampled 24 community residences included 12 group residences serving 6-15 clients and 12 apartment residences serving 2-3 clients. Eleven of the 12 group residences and 7 of the 12 apartment residences were also certified as intermediate care facilities for the mentally retarded (ICF-MRs). Each of the six residences not certified as ICF-MRs has been surveyed for conversion to ICF-MR status and served clients similar to those in the ICF-MR residences. They were also presently funded at a level comparable to the ICF-MR residences of their class, i.e., group or apartment residence modality, included in the study's sample.

Nine of the 24 sampled residences were operated by the State OMRDD under the auspices of three Borough Developmental Services Offices. The remaining 15 sampled residences were operated by five different voluntary agencies in New York City. Table 1 describes the auspices and size of the residences included in the sample.

In the conduct of the Commission's review of the 24 sampled residences, site visits were made to each residence and interviews were held with the residence manager or assistant manager. In the course of the site visits, Commission staff, utilizing a uniform data collection instrument, assessed general living conditions and the presence of homelike environmental attributes in the residences and reviewed client records to determine the degree of compliance with State regulations for quarterly client assessments and treatment plans and to seek documentation that identified client needs were being addressed. The interviews with the residence manager or assistant manager were conducted based on a structured interview instrument which included an assessment of the functional abilities/disabilities of the clients in the residence, the program

Table 1. RESIDENCES IN STUDY'S SAMPLE BY NUMBER AND PERCENT BY TYPE AND AUSPICES, NEW YORK CITY, 1981

Sample data	Total (N=24)	Auspices							
		Type		Voluntary-agency-operated		State-operated			
		Group residences (N=12)	Apartment residences (N=12)	Total residences (N=15)	Group residences (N=9)	Apartment residences (N=6)	Total residences (N=9)	Group residences (N=3)	Apartment residences (N=6)
Number of residences in sample	24	12	12	15	9	6	9	3	6
Percent of sample	100.	50.	50.	63.	38.	25.	38.	13.	25.

NOTE: Detail may not add to total due to rounding.

6.

and treatment services offered by the residence, and a description of the staffing of the residence. As a follow-up to these site visits and interviews, telephone interviews were conducted with the voluntary agency/BDSO senior staff person monitoring the agency's/office's community residence programs. These follow-up interviews focused on obtaining more information about staff utilization, especially utilization of clinical staff, staff salaries, and other issues raised during the site visits and interviews with on-site management personnel.

Cost and staffing level data were also solicited for each residence in the study's sample. Voluntary agencies and BDSOs were asked to report the total costs of their residences in the study sample during fiscal year 1979-80. Staffing level data were obtained for the residences based on official agency/BDSO expenditure reports and, in a few cases where complete staffing information was not available from these reports, from documents submitted to the Commission by the New York City County Service Group of the OMRDD.

The findings of the Commission's review are discussed in Chapters II, III, and IV of this monograph. The review's findings pertaining to the residences' living conditions, clients' characteristics, program and treatment services, and treatment planning and client assessments are summarized in Chapter II. Staffing aspects of the residences, including staff-to-client ratios, utilization of staff, and staff salaries are explored in Chapter III. Chapter IV looks at the cost of care in the visited residences, analyzing annual per client costs and examining the relationship between the sampled residences' expenditures and the expenditures of the five State developmental centers in the New York City area. The conclusions and recommendations of the Commission's review are presented in Chapter V of the report.

It should be emphasized that the reported findings reflect the Commission's review of the 24 residences located in the New York City area. These findings do not reflect conditions in upstate OMRDD-operated community residence programs. In particular, it should be emphasized that the differences in the standards of care between voluntary agency and State-operated residences in these New York City residences have not been noted in the Commission's routine site visits to upstate residence programs for the developmentally disabled.

## CHAPTER II

### Looking Inside: The Residents, the Living Conditions and the Care and Treatment Programs

An essential aspect of the Commission's review was a general assessment of the residents' characteristics and the living conditions and care and treatment services offered by the 24 community residences. Though the Commission's "look inside" did not constitute a comprehensive needs assessment of the clients or a thorough program evaluation, it did allow for general observations of the quality of life and care afforded to the severely and profoundly disabled people living in these residences. These general observations are reported in this chapter in four subsections: (1) Client Characteristics; (2) Living Conditions; (3) Care and Treatment Services; and (4) Treatment Planning.

The reported observations are based on Commission staff findings during a two- to four-hour site visit of the residence, an in-depth interview with the residence manager or assistant manager, and a review of selected client records. All residences in the study's sample were visited by the same two Commission staff persons, who recorded their observations and findings on a written survey review instrument. A narrative site visit report was also prepared on each residence to allow the review specialists to record their general observations of the quality of life in the residence and any other significant information not specifically included in the survey review instrument.

Readers should note that the program services data presented in this chapter are based on interviews with the residence manager. The duration of the Commission's study did not allow for verification that program services purportedly offered were actually offered, an evaluation of the quality of offered services, or an assessment of the impact of offered services on client functioning.

### Client Characteristics

The clients of the 24 residences ranged in age from 13 to over 65. They included men and women who were profoundly, severely, and moderately retarded, many with substantial physical disabilities, and some who required nearly total care for their basic needs of eating, dressing, bathing and toileting. For three-fourths of the residents, their move to the community facility marked their departure from a State developmental center. Seventy-four percent were Willowbrook Class members.

The client profiles indicated that all residents had at least one serious functional disability and that most had at least three major functional deficits. Almost three-fourths (74 percent) of the 160 residents of the 24 residences were diagnosed as severely or profoundly retarded. Twenty-nine percent were physically disabled, e.g., non-ambulatory, hearing or vision impaired. Twenty percent had epilepsy and nine percent had cerebral palsy. Over half the clients needed help or total assistance in dressing. Approximately two-thirds of the residents had a significant communication deficit in expressive and/or receptive language. And, nearly one-third (31 percent) exhibited serious acting out or aggressive behavior.

At the same time, many residents also evinced substantial functional abilities, sometimes despite serious handicapping conditions. Many participated in meal preparation and housekeeping. Most enjoyed a variety of community recreational activities. Some assumed primary responsibility for their personal care needs. All but one of the clients left the residence for at least five hours daily to participate in some form of day programming.<sup>4</sup> Twenty percent

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<sup>4</sup>Transportation difficulties precluded this client's participation in day programming.

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of these clients were engaged in supervised work settings or sheltered workshops.

Using an established methodology of OMRDD and the client profile data collected by Commission staff, the average number of functional deficits per client in each of the 24 visited facilities was calculated. (See Appendix A for an explanation of this methodology.) These average deficits per client figures, which ranged from 1.50 to 8.00 deficits per client, highlighted the variation of abilities/disabilities of clients in the different residences. These figures also indicated that State-operated residences served more severely disabled persons than voluntary-agency-operated residences, and that apartment residences served more severely disabled persons than group residences. The average number of functional deficits per client in the visited facilities was 3.81, while the average number for residents in voluntary-agency-operated residences and in State-operated residences was 2.89 and 5.34, respectively. Similarly, the average number of deficits per client in apartments, 4.50, was significantly greater than the 3.12 average number of deficits per client in group residences. (See Table 2.)

In reviewing the above-noted data, it should be emphasized that, while auspices and type of residence correlated with the functional level of residents, all of the voluntary agencies and BDSOs in the study's sample served clients with a broad range of abilities and disabilities. It is also noteworthy that, while some residences served clients with similar disabilities and functional levels, many others served clients with a wide range of functional levels and disabilities. For example, of the 17 residents who could not walk independently, 6 lived in residences dedicated to persons with mobility difficulties, while the remaining 11 lived in residences for ambulatory and non-ambulatory

Table 2. MEAN AND RANGE OF FUNCTIONAL DEFICITS PER CLIENT  
 PER RESIDENCE, BY TYPE AND AUSPICES OF RESIDENCE  
 NEW YORK CITY, 1981

Statistic	Total (N=24)	Auspices						
		Type			State-operated			
		Voluntary-agency-operated			State-operated			
	Group residences (N=12)	Apartment residences (N=12)	Total residences (N=15)	Group residences (N=9)	Apartment residences (N=6)	Total residences (N=9)	Group residences (N=3)	Apartment residences (N=6)
Mean	3.81	3.12	4.50	2.89	2.85	2.95	3.92	6.06
Range	1.50- 8.00	1.79- 5.00	1.50- 8.00	1.50- 7.00	1.79- 5.00	1.50- 7.00	3.14- 4.90	4.67- 8.00

12.

clients. Similarly, approximately one-half of the hearing impaired clients lived in residences serving only hearing impaired individuals, while the other half lived in residences with people with normal hearing.

In summary, the 24 residences visited served individuals with a wide range of handicapping conditions, specific abilities and disabilities, and specialized care and treatment needs. The residents' profiles also indicated that, although the functioning levels of residents varied significantly both within and among residences, State-operated residences tended to serve more functionally disabled residents than voluntary-agency-operated residences and apartments tended to serve more severely disabled residents than group residences.

The summary statements, presented below, provide a profile of the 160 residents of the 24 visited residences.

1. A majority (52 percent) of the residents were 19 to 30 years of age. Only four (two percent) of the residents were over the age of 50 and only one resident was over 65. No residents were under the age of 13.
2. Almost three-fourths (74 percent) of the residents were diagnosed as severely or profoundly retarded. The remaining residents carried a diagnosis of moderate retardation.
3. The previous place of residence for three-fourths of the residents was a State developmental center. Almost all of these residents (116 of the 120) were also Willowbrook Class members. Of the 40 residents not previously residing in a State developmental center, almost all had previously lived with their families.
4. Over one-fourth (29 percent) of the residents were physically disabled, e.g., non-ambulatory, hearing or vision impaired.

5. Twenty percent of the residents had epilepsy, nine percent had cerebral palsy, three percent had a diagnosed neurological impairment, and one percent were autistic.
6. Almost all residents (93 percent) were able to feed themselves; however, only 59 percent were judged to have socially acceptable eating skills.
7. Over one-half (61 percent) of the residents needed help or total assistance in dressing.
8. Nearly all of the residents (91 percent) were fully toilet trained.
9. Approximately two-thirds of the residents had a significant communication deficit in expressive and/or receptive language. Only 29 percent of the residents used appropriate speech and 42 percent of the residents were not capable of even simple speech. Over one-half of the residents (58 percent) were capable of only simple understanding of oral language.
10. Nearly one-third (31 percent) of the residents had one or more serious behavior problems, e.g., self-abusive or assaultive behavior.
11. Residents of State-operated residences were significantly more disabled than residents of voluntary-agency-operated residences in almost all assessed areas of functioning. Specifically, more residents in State-operated than in voluntary-agency-operated residences were:

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<sup>5</sup> Many staff persons in the residences visited had difficulty indicating the receptive language ability of clients. Though this question was asked using a scale comparable to the NYS Office of Mental Retardation and Developmental Disabilities official needs assessment instrument, the reviewers question the reliability of this response across the facilities. Specifically, staff in different residences appeared to use different standards in indicating complex versus simple receptive language understanding ability for clients, making comparative ratings among clients unreliable.

14.

- diagnosed as profoundly retarded (77 versus 15 percent);
- physically disabled (52 versus 21 percent);
- hearing impaired (50 versus 18 percent) or visually impaired (31 versus 12 percent);
- lacking socially acceptable eating skills (70 versus 29 percent), unable to dress themselves (86 versus 51 percent), or only partially or not toilet trained (23 versus 4 percent); and
- exhibiting serious acting out or aggressive behavior (41 versus 27 percent).

12. Similarly, clients of apartments tended to be more disabled than clients of group residences.<sup>6</sup> Specifically, more apartment than group residence clients were:

- diagnosed as profoundly retarded (58 versus 26 percent);
- physically disabled (58 versus 21 percent);
- non-ambulatory (30 versus 0 percent);
- hearing impaired (36 versus 24 percent) or vision impaired (48 versus 9 percent);
- lacking socially acceptable eating skills (70 versus 33 percent), unable to dress themselves (63 versus 60 percent), or only partially or not toilet trained (27 versus 5 percent); and

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<sup>6</sup>It should be noted that the significant differences in the disability levels of residents of apartments and group residences are largely due to the substantially more disabled population serviced by State-operated apartments. While the sampled voluntary agency apartment residences tended to serve more disabled clients than voluntary group residences, the sampled State-operated apartments generally served a client population far more disabled than voluntary-agency-operated apartments and a population that was substantially more disabled than that served by either voluntary-agency-operated or State-operated group residences. (See Table 2.)

- exhibiting serious acting out or aggressive behaviors (52 versus 25 percent).

### Living Conditions

The 24 residences, located in a variety of New York's neighborhoods, including the Upper West Side, Spanish Harlem, Greenwich Village, Flatbush, and the South Bronx, generally offered their developmentally disabled residents a comfortable and attractive place to live. Sited in a range of buildings from renovated brownstones to modern apartment buildings to a former convent, almost all of the visited residences were spacious, affording clients ample living and recreational space and private or semi-private bedrooms. In many residences staff, sometimes with the assistance of residents, had made special efforts to decorate the residence with wall hangings, pictures, and murals to individualize the decor and arrangements of clients' bedrooms. In addition, the location of most of the residences in residential neighborhoods provided residents with a relatively safe environment and access to community services and public transportation.

There was also evidence in the vast majority of the residences visited of careful attention to ensuring a home-like, normalizing environment for the residents. In over 90 percent of the facilities residents had adequate privacy, when desired, freedom of movement throughout the house or apartment, and personal clothing and grooming supplies. Family dining arrangements were also the general rule.

There were, however, notable exceptions to the generally high quality of living conditions offered by the residences visited. In 4 of the 24 residences serious deficiencies in housekeeping were noted and in two residences, serious safety problems were apparent. The housekeeping deficiencies included extremely dirty bathrooms,

kitchens, and/or bedroom/living areas, while the safety problems ranged from serious plumbing problems to exposed heating fixtures and/or hot water pipes to inadequate egress in case of fire or other emergency.<sup>7</sup>

The overall safety of the neighborhood for 4 of the 24 residences was also questionable. Each of these residences was located in a very run-down neighborhood, in the vicinity of many uninhabited buildings. Community services in these neighborhoods were scarce and public transportation, when available, was generally not used by either staff or residents due to its alleged dangerousness. As a result, the residents of these facilities enjoyed few of the benefits of being a part of a neighborhood community.

Finally, although most of the residences visited had many attributes of a typical home with decorations and activities appropriate to the age and functional level of the residents, a majority of State-operated residences and a few voluntary agency residences were lacking these attributes. The absence of both client-appropriate decorations and leisure time activities was noted in nine residences. Notably, six of these nine residences were State-operated, representing two-thirds of the study's sampled State-operated residences. These residences stood in sharp contrast to the majority of facilities visited. They tended to have an institutional-like atmosphere with furniture often lined up against the walls, sparse decorations, and

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<sup>7</sup>In the case of these deficiencies, as with all serious deficiencies noted in this report, the Commission formally communicated with the responsible voluntary agency and/or OMRDD BDSO and is presently following up on their responses to ensure that appropriate corrective action has taken place. A summary report of the findings of this follow up (as of March 31, 1982) is included in Appendix B of this report.

few appropriate leisure time activities. The few wall decorations and client-oriented leisure time activities present in these residences were usually typical of a nursery school setting.

In summary, the Commission's review indicated that the majority of the 24 residences visited afforded their residents quality living conditions. The findings also revealed, however, that living conditions in 5 residences presented serious health and/or safety hazards to clients and that in six of the nine State-operated residences attributes indicative of homelike, normalizing settings were lacking.

The specific data findings of the Commission's review of the living conditions are presented below. (See Table 3 and Table 4.)

1. The overall housekeeping status was rated by Commission staff as "adequate" or "very good" in 88 percent of the residences visited. Thirty-eight percent of the residences evidenced "very good" housekeeping, while 13 percent evidenced "poor" housekeeping. The housekeeping status of the residences did not differ significantly by auspices or type of residence.
2. Almost 90 percent of the residences visited had at least 7 of the 11 assessed attributes indicative of a homelike, normalizing environment present, e.g., available client privacy, (96 percent); family dining arrangements (100 percent); personal clothing (100 percent); freedom of movement throughout the house (96 percent); comfortable furnishings (96 percent); and bathroom privacy (88 percent).
3. A majority of the residences visited had the remaining 4 of the 11 assessed attributes indicative of a homelike, normalizing environment present, e.g., age/functional level appropriate decorations (54 percent); age/functional level appropriate leisure time

Table 3. PERCENT OF RESIDENCES, BY HOUSEKEEPING STATUS, BY TYPE AND AUSPICES, NEW YORK CITY, 1981

Housekeeping status	Total (N=24)	Auspices								
		Type			Voluntary-agency-operated			State-operated		
		Group residences (N=12)	Apartment residences (N=12)	Total residences (N=15)	Group residences (N=9)	Apartment residences (N=6)	Total residences (N=9)	Group residences (N=3)	Apartment residences (N=6)	Total residences (N=9)
Total	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.
Very good	38.	42.	33.	33.	33.	44.	67.	33.	33.	33.
Adequate	50.	42.	53.	56.	33.	44.	0.	33.	33.	67.
Poor	13.	17.	13.	11.	33.	12.	33.	33.	12.	0.

NOTE: Detail may not add to total due to rounding.

Table 4. PERCENT OF RESIDENCES, BY ATTRIBUTES INDICATIVE OF A HOMELIKE, NORMALIZING SETTING, BY TYPE AND AUSPICES, NEW YORK CITY, 1981

Homelike attribute	Total (N=24)	Auspices									
		Type			Voluntary-agency-operated			State-operated			
		Group residences (N=12)	Apartment residences (N=12)	Total (N=15)	Group residences (N=9)	Apartment residences (N=6)	Total (N=9)	Group residences (N=3)	Apartment residences (N=6)	Total (N=9)	
Comfortable furnishings	96.	92.	100.	93.	89.	100.	89.	100.	89.	67.	100.
Available privacy for clients	96.	92.	100.	100.	100.	100.	89.	100.	100.	67.	100.
Family dining	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.
Bathroom privacy	88.	100.	75.	100.	100.	100.	100.	100.	67.	100.	50.
Client freedom of movement around the house	96.	100.	92.	100.	100.	100.	100.	100.	89.	100.	83.
Age/functional level appropriate decorations	54.	67.	42.	73.	78.	67.	22.	33.	17.		

(Continued)



activities/equipment (63 percent); clothing clean and conformed to community standards of age, sex, and season (71 percent); and rising, retiring, and mealtimes comparable to those in the community (79 percent).

4. The average number of assessed attributes indicative of a homelike, normalizing environment present in all residences was 8.92. For voluntary-agency-operated residences, the average number of attributes was 9.60 and for State-operated residences the average number of attributes was 7.77.
5. Significant differences were noted between State-operated and voluntary-agency-operated residences in the presence of certain attributes indicative of a homelike, normalizing environment. For example:
  - Only 2 of the 9 State residences (22 percent) had age/functional level appropriate decorations compared with 11 of the 15 voluntary-agency-operated residences (73 percent);
  - Only 3 of the 9 State residences (33 percent) had age/functional level appropriate leisure time activities/ equipment compared with 12 of the 15 voluntary agency residences (80 percent); and
  - Only four of the nine State residences (44 percent) had rising, retiring, and mealtimes which were comparable with those in the community compared with all of the voluntary agency residences (100 percent).
6. The group residences scored higher than the apartment residences in the presence of many of the attributes indicative of a homelike, normalizing environment. This difference, however, was largely accounted for by the absence of these attributes in State-operated apartments. Voluntary-agency-operated apartments overall scored as high as group residences, and slightly higher than State-operated group residences.

Care and Treatment Services

A variety of care and treatment services was offered to residents of the 24 community residences. According to interviews with staff, these services were offered in the residence, through the clients' day program, and through other providers outside the residence. Services ranged from basic personal care in toileting, dressing, and eating to habilitative training in the activities of daily living to specialized treatment services, such as nursing care, speech therapy and psychological evaluations.

On-site service provision for all residents focused on habilitative training in the activities of daily living (ADL) and recreational opportunities. A range of specialized services, including speech therapy, nursing services, physician services, and psychological services was also offered on-site. Day programs offered residents additional training in ADL skills, as well as vocational/occupational training. Still other services, primarily medical and dental care and recreation, were provided outside the residence, other than through day programs.

The length and nature of the Commission's review precluded an on-site monitoring of the delivery of services to clients or an evaluation of how residents benefited from receiving the services. The review did allow, however, for the identification of the range and type of services offered to clients on-site in each of the visited residences and for a general accounting of whether the offered services were consistent with the identified needs of clients as specified in their assessments and treatment plans. This section reports the study's findings pertaining to the range and type of services offered on-site, while the following section reports the findings relevant to the adequacy of service provision vis-à-vis the residents' assessed needs.

Commission staff found that the range and type of services offered varied considerably from residence to residence. In addition, it was noted that this variance was related in several significant areas of service provision to the auspices and type of the residence. Specifically, State-operated residences, especially State-operated apartments, tended to offer fewer types of services on-site to their residents than voluntary-agency-operated residences. For example, while 80 percent of the voluntary-agency-operated residences offered nursing services on-site at least weekly, only one-third of the State-operated residences, and notably only one of the State-operated apartments, provided this service on a weekly basis. Similarly, psychological services were provided on a weekly basis in nearly one-half (47 percent) of the voluntary-agency-operated residences, yet they were not offered in any of the State-operated residences on a weekly basis. The difference in service provision between State-operated and voluntary-agency-operated residences is perhaps most notable in view of the fact that residents of State-operated programs tended to have more physical and functional disabilities than clients in voluntary-agency-operated programs.

The specific findings of the study related to the types of programs and treatment services offered on-site by the 24 visited facilities are summarized below. (See Table 5 and Table 6.)

1. Twenty-one of the 24 residences (88 percent) offered clients a combination of services on-site, through day programming and through other outside providers. The remaining three residences, all State-operated apartments, did not offer any services to clients through outside providers other than day programs.

Table 5. PERCENT OF CLIENTS, BY TYPE OF DAY PROGRAM, BY TYPE AND AUSPICES, NEW YORK CITY, 1981

Type of day program	Total (N=160)	Auspices							
		Type		Voluntary-agency-operated				State-operated	
		Group residences (N=127)	Apartment residences (N=33)	Total residences (N=116)	Group residences (N=101)	Apartment residences (N=15)	Total residences (N=44)	Group residences (N=26)	Apartment residences (N=18)
Total	100.	100.	100.	100.	100.	100.	100.	100.	100.
Day treatment	46.	46.	49.	50.	45.	87.	36.	50.	17.
Day training	16.	17.	9.	13.	14.	7.	23.	31.	11.
School program	17.	11.	39.	9.	11.	0.	36.	19.	72.
Sheltered workshop/work activity center	21.	24.	3.	27.	29.	7.	5.	8.	0.
No day program	1.	1.	0.	1.	1.	0.	0.	0.	0.

NOTE: Detail may not add to total due to rounding.

Table 6. PERCENT OF RESIDENCES, BY FREQUENCY AND TYPE OF SERVICES OFFERED, BY TYPE AND AUSPICES, NEW YORK CITY, 1981

Service	Total (N=24)	Auspices										
		Type		Voluntary-agency-operated		State-operated						
		Group residences (N=12)	Apartment residences (N=12)	Total residences (N=15)	Group residences (N=9)	Apartment residences (N=6)	Total residences (N=9)	Group residences (N=3)	Apartment residences (N=6)			
OFFERED AT LEAST WEEKLY												
ADL skills	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.
Speech therapy	46.	50.	42.	47.	56.	44.	33.	33.	44.	33.	50.	50.
Physical therapy	4.	0.	8.	7.	0.	0.	17.	17.	0.	0.	0.	0.
Nursing services	63.	67.	50.	80.	78.	33.	83.	83.	33.	67.	17.	17.
Physician services	8.	17.	0.	7.	11.	11.	0.	0.	11.	33.	0.	0.
Psychological services	29.	42.	17.	47.	56.	0.	33.	33.	0.	0.	0.	0.
Recreation/socialization	92.	100.	83.	100.	100.	78.	100.	100.	100.	100.	67.	67.
Other	4.	8.	0.	7.	11.	0.	0.	0.	0.	0.	0.	0.

(Continued)

Table 6 (Continued)

Service	Total (N=24)	Auspices							
		Type		Voluntary-agency-operated			State-operated		
		Group residences (N=12)	Apartment residences (N=12)	Total residences (N=15)	Group residences (N=9)	Apartment residences (N=6)	Total residences (N=9)	Group residences (N=3)	Apartment residences (N=6)
OFFERED LESS OFTEN THAN WEEKLY									
Occupational/ vocational	8.	17.	0.	13.	22.	0.	0.	0.	0.
Speech therapy	4.	8.	0.	7.	11.	0.	0.	0.	0.
Physical therapy	4.	8.	0.	7.	11.	0.	0.	0.	0.
Nursing services	25.	17.	33.	20.	22.	17.	33.	0.	50.
Physician services	17.	17.	17.	13.	22.	0.	22.	0.	33
Psychological services	13.	8.	17.	13.	11.	17.	11.	0.	17.

2. All but one of the 160 clients in the sample attended some form of day programming at least five hours each weekday. Almost one-half (46 percent) attended day treatment programs; 21 percent attended sheltered workshops; 17 percent attended school programs; and 16 percent attended day training programs.
3. All residences visited offered clients training in ADL at least weekly on-site and all but two residences (both State-operated apartments) offered clients recreational services on-site at least weekly.
4. Eighty-eight percent of the residences offered nursing services on-site. Almost two-thirds of the facilities (63 percent) offered nursing services at least weekly on-site. All of the residences not offering nursing services were State-operated (one group residence and two apartment residences).
5. Speech therapy was offered on-site by 50 percent of the residences visited. All but one of these residences offered this service at least weekly. There was no significant difference in the provision of speech therapy by auspices or type of residence.
6. Psychological services, primarily evaluations, were offered by 42 percent of the residences on-site; however, only 29 percent of the residences provided this service at least weekly. In addition, of those residences offering psychological services at least weekly, all were operated by voluntary agencies. Only one State-operated residence (an apartment) provided any psychological services on-site and these were provided less often than weekly.
7. Physician services were offered on-site by one-fourth of the residences but in only two residences, one State-operated and one voluntary-operated, was a physician used on-site on a weekly basis.

8. Medical and dental services were the services most commonly provided outside the residence, other than through day programs. Although overall 70 percent of the residences provided these services outside the residence, they were much more frequently provided by voluntary-agency-operated residences than State-operated residences (87 percent versus 56 percent). It is also noteworthy that of the six residences not offering medical and dental services outside the residence, five of the six also provided no physician services on-site (four State-operated and one voluntary-agency-operated) and two of the six (both State-operated apartments) provided neither physician nor nursing services on-site.
9. Only 38 percent of the residences offered recreational services to clients outside the residence. Although the percentages of State-operated and voluntary-agency-operated residences offering recreational services for clients outside the residence were comparable (33 percent and 40 percent), significantly fewer apartments than group residences provided recreation outside the residence (17 percent versus 50 percent).

#### Treatment Planning

In conjunction with the Commission's examination of the types of services offered to residents on-site, staff also reviewed client records to determine if the required updated quarterly treatment plans and client assessments were available and to assess whether identified needs of residents as specified in such assessments were being addressed in accordance with the treatment plans. Staff also reviewed clients' records to determine if required annual assessments and annual medical examinations had been conducted.<sup>8</sup> This

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<sup>8</sup>Requirements for updated quarterly assessments and treatment plans, as well as annual assessments and medical examinations for residents of community residential facilities, including ICF-MRs, community residences, and apartments, are clearly specified in Department of Mental Hygiene regulations (14 NYCRR 681 and 686).

review entailed an examination of at least 40 percent of the clients' records in each group residence (6-15 beds) and an examination of all clients' records in each apartment. In addition, in the group residences where deficiencies were noted, additional records were reviewed to confirm the preliminary findings.

Commission staff found that annual assessments had been conducted for all residents and that documentation of annual medical examinations was present. Updated quarterly treatment plans on clients, however, were lacking on many clients in more than one-half of the residences and were not available for any clients in almost one-third of the visited residences (29 percent). Similarly, updated quarterly clients' assessments were not present for many clients in more than 40 percent of the visited residences and were lacking for all clients in approximately one-fifth of the sampled residences (21 percent).

Although deficiencies were cited in this area in both voluntary-agency-operated residences and State-operated residences, there were significantly more deficiencies noted in State-operated residences and, especially, in State-operated apartments. In four of the six State-operated apartments in the study's sample, updated quarterly plans and assessments were not present for any clients in the apartment.

The degree to which identified client needs were being addressed in accordance with available treatment plans varied considerably among residences.<sup>9</sup> The Commission's

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<sup>9</sup>In assessing the degree to which client needs were being addressed in accordance with treatment plans, Commission staff relied on the most recent client assessment and treatment plan available in his/her record. As noted above, for many clients updated quarterly assessments and treatment plans were not available.

review indicated that in 54 percent of the residences visited, the identified needs of all clients were being addressed, and that in an additional 29 percent of the residences the needs of most clients were addressed. In only 17 percent of the residences the identified needs of only some clients (fewer than one-half) were being addressed.

Significantly fewer State-operated residences were addressing the identified needs of all clients than voluntary-agency-operated residences (11 percent versus 80 percent). Apartments also addressed the identified needs of all clients less frequently than group residences, but this difference is largely reflective of deficiencies in State-operated apartments. While voluntary agency apartments did not score as high as voluntary agency group residences in this area, they did score considerably better than either State-operated group residences or apartments.

In residences where the identified needs of residents were not being addressed, facility management staff offered a variety of reasons for the lack of appropriate service provision. Among the barriers cited most often were the lack of available outside service providers or facility staff to provide these services, and/or the absence or inadequacy of treatment planning. Other reasons cited included the unavailability of transportation, lack of current client assessment data, and conflicts with the resident's day programming schedule.

Another significant finding of the Commission's review of selected client records was that in four of the nine State-operated residences, clients' quarterly assessments and treatment plans were not available on-site, but rather were located in the BDSO. In two of these residences, this situation (although it had persisted for at least four

months) was alleged to be temporary to allow clinical staff to update records. In the other two residences this situation was a permanent arrangement. Although the location of these records in the BDSO in all of these cases was reportedly arranged to allow their convenient access by clinical team members whose offices are also at the BDSO, it presented certain disadvantages to direct care staff in these residences who were primarily responsible for the day-to-day implementation of their residents' treatment plans.

The specific findings of the study related to updated client assessments and treatment plans and to the degree to which identified client needs were being addressed are summarized below. (See Table 7 and Table 8.)

1. Annual client assessments and documentation of annual medical examinations were available for clients in all the residences.
2. Updated quarterly treatment plans were available on all or most clients in over two-thirds (71 percent) of the residences sampled. Notably, however, updated quarterly plans were not available on any of the clients in almost one-third (29 percent) of the residences.
3. Updated quarterly assessments were available for all or most clients in 79 percent of the facilities visited. They were not available for any of the clients in 21 percent of the sampled residences.
4. Voluntary-agency-operated residences in the sample were in substantially greater compliance in having updated quarterly treatment plans and client assessments than the sampled State-operated residences. Specifically:

Table 7. PERCENT OF RESIDENCES, BY AVAILABILITY OF UP-TO-DATE  
 QUARTERLY CLIENT ASSESSMENTS AND TREATMENT PLANS, BY  
 TYPE AND AUSPICES, NEW YORK CITY, 1981

Quarterly updated client assessment and treatment plans	Total (N=24)	Auspices											
		Type			Voluntary-agency-operated			State-operated			Auspices		
		Group residences (N=12)	Apartment residences (N=12)	Total (N=15)	Group residences (N=9)	Apartment residences (N=6)	Total (N=9)	Group residences (N=3)	Apartment residences (N=6)	Total (N=9)	Group residences (N=3)	Apartment residences (N=6)	Total (N=9)
<b>CLIENT ASSESSMENT</b>													
Total	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.
All clients	58.	67.	93.	89.	100.	0.	100.	0.	0.	0.	0.	0.	0.
Most clients	21.	25.	7.	11.	0.	44.	67.	33.	33.	67.	33.	67.	67.
No clients	21.	8.	0.	0.	0.	56.	33.	67.	33.	67.	33.	67.	67.
<b>TREATMENT PLANS</b>													
Total	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.
All clients	46.	50.	60.	56.	67.	22.	33.	17.	33.	33.	17.	17.	17.
Most clients	25.	33.	27.	33.	17.	22.	33.	17.	33.	33.	17.	17.	17.
No clients	29.	17.	13.	11.	17.	56.	33.	67.	33.	67.	33.	67.	67.

NOTE: Detail may not add to total due to rounding.

Table 8. PERCENT OF RESIDENCES, BY DEGREE TO WHICH IDENTIFIED CLIENT NEEDS ARE ADDRESSED AND CITED BARRIERS, BY TYPE AND AUSPICES, NEW YORK CITY, 1981

Identified needs and barriers	Total (N=24)	Auspices												
		Type			Voluntary-agency-operated			State-operated						
		Group residences (N=12)	Apartment residences (N=12)	Total (N=15)	Group residences (N=9)	Apartment residences (N=6)	Total (N=9)	Group residences (N=3)	Apartment residences (N=6)	Total (N=9)				
CLIENT NEEDS ADDRESSED														
Total	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.	100.
All clients	54.	67.	80.	89.	67.	11.	0.	17.	33.	56.	100.	0.	17.	33.
Most clients	29.	33.	13.	11.	17.	56.	100.	33.	50.	33.	0.	50.	33.	50.
Some clients	17.	0.	7.	0.	17.	33.	0.	17.	33.	55.	33.	0.	67.	67.
BARRIERS TO ADDRESSING CLIENT NEEDS														
Unavailable outside service providers or facility staff	33.	17.	50.	20.	11.	33.	33.	55.	67.	67.	67.	67.	67.	67.
Treatment planning needed	21.	8.	33.	7.	0.	44.	33.	44.	50.	50.	50.	50.	50.	50.
Other	21.	17.	25.	13.	11.	33.	33.	33.	33.	33.	33.	33.	33.	33.

NOTE: Detail may not add to total due to rounding.

- Sixty percent of the voluntary-agency-operated residences, compared with only 22 percent of the State-operated residences, had updated quarterly treatment plans on all clients. And, only 13 percent of the voluntary-agency-operated residences, compared to over one-half (56 percent) of the State-operated residences, lacked such plans on all clients in the residence.
  - Ninety-three percent of the voluntary-agency-operated residences had updated quarterly client assessments on all clients in the residence. None of the State-operated residences had such assessments on all clients and 56 percent of the State-operated residences did not have such assessments on any clients in the residence.
5. Identified client needs were being addressed for all clients in approximately one-half (54 percent) of the residences reviewed. In another 29 percent of the residences visited, the identified needs of most clients were being addressed. In the remaining 17 percent of the sampled residences, the identified needs of only some (fewer than one-half) of the clients were being addressed.
  6. The identified needs of all clients were being addressed in significantly more voluntary-agency-operated residences than State-operated residences (80 percent versus 11 percent). Also, in significantly fewer voluntary-agency-operated residences than State-operated residences were the identified needs of only some (fewer than one-half) of the clients being addressed (7 percent versus 33 percent).
  7. Although the data also revealed substantial differences between group residences and apartments in terms of the presence of updated quarterly client assessments and in terms of their status in addressing identified client needs, these differences were

largely reflective of the deficiencies in State-operated apartments. More clearly, voluntary-agency-operated apartments scored considerably higher than either State-operated group residences or apartments and generally scored comparably with voluntary-agency-operated group residences in these areas.

8. Unavailability of outside service providers or residence staff was cited by residence managers most often as the reason why identified clients' needs were not being addressed. Thirty-three percent of all the sampled residences cited this reason. The need for treatment planning, cited by 21 percent of all residences, was another commonly cited reason. Other reasons cited included the unavailability of transportation, lack of current client needs assessment data, and conflicts with the client's day programming schedule.

#### Summary

The Commission's review of the clients' characteristics and their quality of life and program services indicated that the majority of clients were residing in comfortable, well-furnished homes and that, according to residence management staff, they were receiving a range of services in the facility, through their day programs and outside of the residence. The data also revealed that the services provided to clients were, in most cases, consistent with identified client needs as documented in updated treatment plans and client assessments.

The review indicated, however, that across most areas assessed--from environmental quality to level of specialized services to timeliness and completeness of treatment plans and client assessments to appropriateness of service provision--voluntary-agency-operated residences scored higher than State-operated residences. State-operated apartments, in particular, appeared to offer less programming and to be

substantially more deficient in the timeliness and completeness of quarterly client assessments and treatment plans. These differences between the apparent standard of care and treatment in voluntary-agency-operated residences and State-operated residences require further examination and correction.

Similarly, the deficiencies in the State-operated apartment residences, which in general served the most severely and profoundly disabled clients in the study's sample, require further examination. Though these deficiencies may in part be attributable to their State auspices, the particular deficiencies noted in these apartments, as well as the generally better conditions found in State-operated group residences, suggests that the programmatic difficulties of the State-operated apartments may also be attributable to the apartment modality--or, more specifically, the use of this modality for very severely disabled clients. More clearly, the types of deficiencies cited in these apartments, e.g., the limited range of offered services, lack of up-to-date client treatment plans and assessments, and failure to address identified client needs, may be more generally related to the State BDSO's difficulty in ensuring appropriate oversight and monitoring and adequate clinical teams to serve the scattered apartment sites.

### CHAPTER III

#### The Care Givers: An Examination of Selected Staffing Issues

The Commission's review of the "care givers" of the visited community residential facilities, though not a comprehensive assessment of staffing issues, revealed significant differences in the 24 residences' allocation, management, and remuneration of staff. While these noted differences were, in part, attributable to the disability level of the clients served and the size and/or auspices of the program, significant variance among residences' approaches to these staffing issues could not be readily explained based on any apparent programmatic or treatment consideration.

The Commission's review revealed that total staff-to-client ratios varied from less than one full-time staff person per client to almost four full-time staff per client. Perhaps more importantly, the data indicated that visited residences serving clients of comparable disability levels often had widely variant staff-to-client ratios. Significant differences were also noted among the residences in their utilization of staff, particularly in the job responsibilities of direct care and clinical staff. The size of the facility, in particular, affected the responsibilities of direct care staff. While the larger group residences could afford to hire staff to fulfill some housekeeping and food preparation duties, these staff persons were not available to the smaller apartment residences. As a result, direct care staff in apartment residences served more as "generalists" providing a full range of housekeeping functions, in addition to their care-giving and therapeutic responsibilities. Similarly, the proportion of clinical staff time spent on direct services to

residents, client assessments, and in-service training varied substantially among residences. And, the review of remuneration offered to direct care staff members indicated that State-operated residences generally paid more and offered better fringe benefits than voluntary-agency-operated residences.

The data in this chapter, which sustain the above, as well as other findings, are reported in three sections: (1) Staffing Levels; (2) Utilization of Staff; and (3) Staff Salaries. The findings are based on data from Commission staff on-site interviews with the residence manager or assistant manager, and telephone interviews with the voluntary agency or BDSO management staff person responsible for community residential programs. Specific staffing level data was obtained from the facility's 1980 expenditure reports to OMRDD and, in a few cases, where complete staffing data were not available from these reports, from documents submitted to the Commission by the New York City County Service Group of OMRDD. It should be emphasized that the staffing information reported in this chapter reflects what Commission staff were told by residence, agency or BDSO management and/or what was recorded in residences' official OMRDD expenditure reports or documents. It does not reflect an audit of actual staff present or a review of actual staff activities in the residences.

#### Staffing Levels

The 24 residences visited employed a variety of staff personnel, including administrative, supervisory, and clerical staff, a range of clinical professionals (nurses, psychologists, speech, physical and recreation therapists), direct care staff, and in many cases separate housekeeping, food preparation, and maintenance staff personnel. For the

purposes of this analysis the staff persons serving the residences were grouped into three categories: (1) administrative staff; (2) clinical staff; and (3) direct care staff. The administrative staff category includes all agency or BDSO supervisory personnel, as well as all clerical and business office support staff. The clinical category includes all professional clinicians assigned to the facility. And, the direct care staff category includes all on-site facility management staff, all paraprofessional staff providing personal care and treatment services for residents, and all housekeeping, food preparation and maintenance personnel.

The utilization of these categories allowed a uniform framework for comparison of staffing levels and patterns among residences. In this section these comparisons are often discussed in terms of the median staff-to-client ratio. This median, or midpoint, indicates that 50 percent of the residences in the sample had higher staff-to-client ratios and 50 percent had lower ratios. The median, rather than the more conventional average or mean, is employed since the calculation of the mean is skewed by the extreme highs or lows.

The comparisons of staffing levels revealed a variation in overall staff-to-client ratios among residences of 0.85:1 to 3.74:1, with a median staff-to-client ratio of 1.72:1 for all 24 residences. This substantial variance in staff-to-client ratios was largely reflective of the variance in direct care staff-to-client ratios. Direct care staff-to-client ratios ranged from 0.62:1 to 3.27:1, with a median ratio for all residences of 1.29:1. There was also significant variance in the administrative and clinical staff-to-client ratios. The median administrative staff-to-client ratio among residences was 0.11:1, but this ratio

varied from a low of 0.02:1 to a high of 0.25:1. Similarly, the median clinical staff-to-client ratio for all 24 residences was 0.18:1, and ranged from a low of 0.01:1 to a high of 0.54:1. (See Table 9.)

Further analysis of the reported variance in both overall and categorical staff-to-client ratios revealed that this variance was partially predictable by three variables: degree of resident disabilities, size of the residence, and auspices of the residence. Specifically, the data indicated that overall staff-to-client ratios increased with increasing level of disability of clients served, with decreasing size of the residence (reflecting diseconomies of scale), and to a lesser extent, with State versus voluntary agency operation of the residence.

Closer examination of the relationships of these variables to staff levels indicated that the level of disability of clients served accounted for the largest portion of the accountable variance in staff-to-client ratios. Median staff-to-client ratios consistently and significantly increased for all residences and all subgroups of residences by size or auspices as the clients served were more disabled. (See Table 10.) For example, residences serving clients with an average of 1.50 to 2.50 functional deficits had a median overall staff-to-client ratio of 1.25:1 compared with median overall staff-to-client ratios of 1.79:1 and 3.13:1 for residences serving clients with an average of 2.51 to 4.99 and 5.00 to 8.00 deficits, respectively. Comparable increases in the median staffing levels were also noted in group and apartment residences and State-operated and voluntary-agency-operated residences as the disability levels of the clients served by the facility increased.



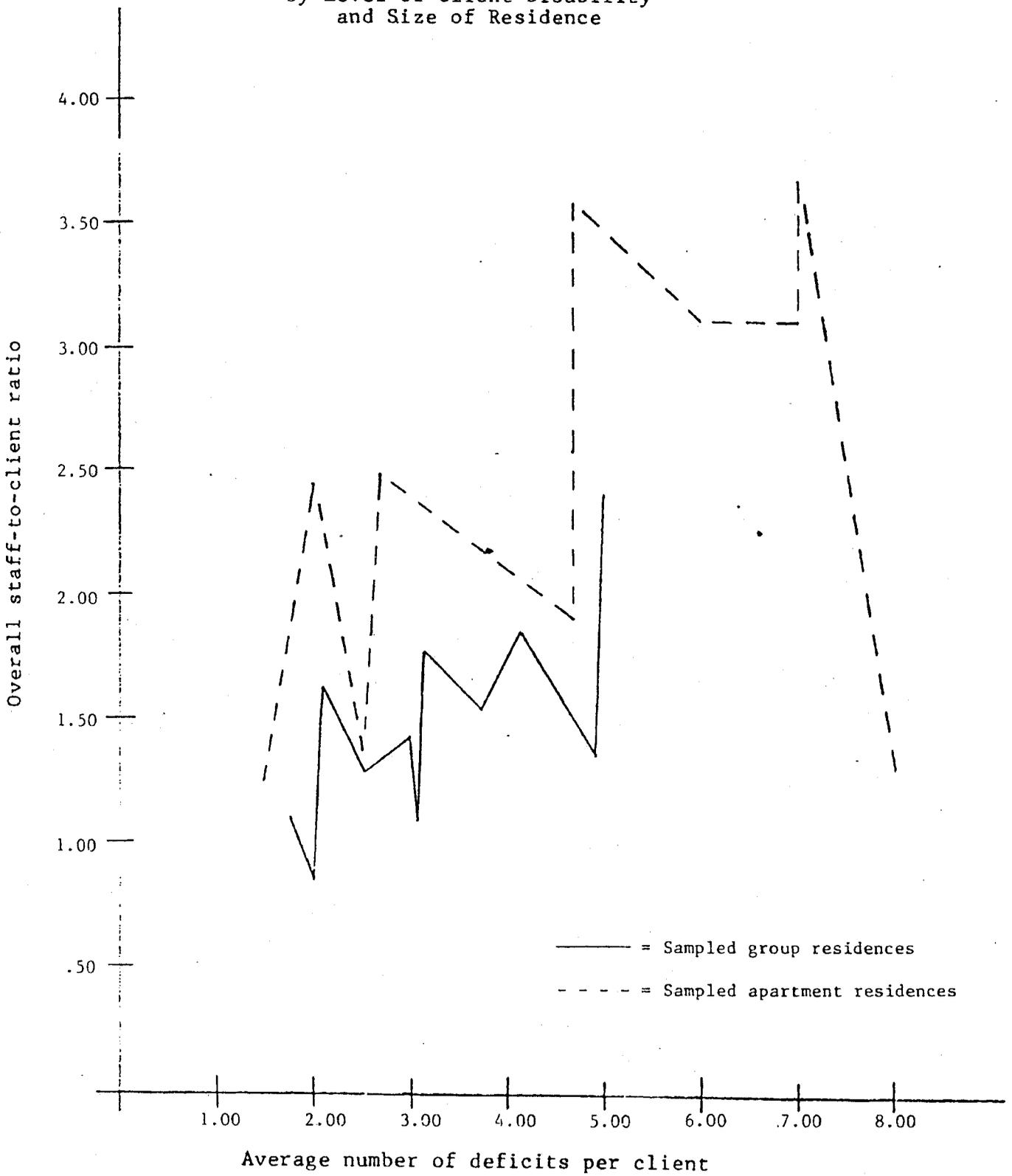
Table 10. RESIDENCES OVERALL STAFF TO CLIENT RATIOS BY RESIDENCE, TYPE/SIZE AND AVERAGE LEVEL OF DISABILITY OF CLIENTS LIVING IN THE RESIDENCE

Overall staff to client ratios	Average level of disability of clients living in the residence			
	1.50-8.00 deficits per client (all residences)	1.50-2.50 deficits per client	2.51-4.99 deficits per client	5.00-8.00 deficits per client
ALL RESIDENCES	(N=24)	(N=9)	(N=9)	(N=6)
Median	1.72	1.25	1.79	3.13
High	3.74	2.44	3.58	3.74
Low	0.85	0.85	1.09	1.30
GROUP RESIDENCES	(N=12)	(N=5)	(N=6)	(N=1)
Median	1.40	1.14	1.49	2.41
High	2.41	1.64	1.87	2.41
Low	0.85	0.85	1.09	2.41
APARTMENT RESIDENCES	(N=12)	(N=4)	(N=3)	(N=5)
Median	2.44	1.85	2.44	3.13
High	3.74	2.44	3.58	3.74
Low	1.25	1.25	1.91	1.30
VOLUNTARY AGENCIES	(N=15)	(N=9)	(N=4)	(N=2)
Median	1.44	1.25	1.66	3.08
High	3.74	2.44	2.44	3.74
Low	0.85	0.85	1.09	2.41
STATE BDSOs	(N=9)	(N=0)	(N=5)	(N=4)
Median	1.91		1.79	3.13
High	3.58		3.58	3.13
Low	1.30		1.35	1.30

While disability level of the clients served appeared to account most significantly for the variance in staffing levels, the variables of residence size and, to a lesser extent, auspices also independently influenced this variance. Specifically, the data showed that median overall staff-to-client ratios for apartment residences were significantly higher than those of group residences even when the level of disability of the clients served was considered. (See Figure 1.) Median staff-to-client ratios for the sampled apartment residences ranged from 30 percent to over 60 percent higher than those of the sampled group residences serving clients with comparable levels of disability. Similarly, a comparison of State-operated and voluntary-agency-operated residences serving clients with comparable levels of disability revealed that State residences had modestly higher median staff-to-client ratios than voluntary agency facilities. The reader should note, however, that these differences in the median staffing levels by residence auspices were small (less than .20:1) and may be largely attributable to the greater proportion of apartments among the State residences than among the voluntary agency residences in the study's sample (67 percent versus 40 percent).

While level of client disability, size of residence, and, to a lesser degree, residence auspices related to the general trends in the facilities' reported staffing levels, considerable differences in the reported staff-to-client ratios between residences of similar size and consonant auspices, serving clients with comparable levels of disabilities, suggest that these variables do not fully account for the wide variations in reported staff allocations among the visited residences. This unaccounted for variance is indicated by the wide range between high and low overall

Figure 1. Residences' Staff-to-Client Ratios by Level of Client Disability and Size of Residence



staff-to-client ratios reported in Table 10. It is even more clearly shown by the disparity in overall and categorical staffing levels between individual residences of like size and auspices, serving clients with very similar average deficit levels. (See Table 11.) Consider for example, the two voluntary group residences visited, which served clients with an average of 2.00 and 2.11 deficits, but had overall staff-to-client ratios of 0.85:1 and 1.64:1, respectively. Or consider the two State-operated apartments, both operated by the same BDSO and both serving clients with an average of 4.67 deficits, but having staff-to-client ratios of 1.91:1 and 3.58:1, respectively.

In general, the substantial variance in staff-to-client ratios for residences serving clients with comparable levels of disability of similar size and of consonant auspices, suggests that even with consideration of these variables, much of the noted variance in the staffing levels of the facilities remains unexplained. This unexplained variance transgresses all categorical staffing ratios. Clinical staff-to-client ratios in voluntary-agency-operated group residences serving clients with an average of 1.50 to 2.50 deficits ranged from 0.01:1 in one facility to 0.25:1 in another. Similarly, direct care staff-to-client ratios in State-operated apartments serving clients with an average of 6.00 to 8.00 deficits ranged from 1.11:1 to 2.80:1.

This noted variance in staffing levels requires further examination. Such examination is required both to identify the reasons for the unexplained variance in staffing levels, cited above, and to determine the appropriateness of the variance seemingly due to disability levels, size, and auspices. This latter focus to the examination is particularly important in view of the findings related to quality

Table 11. RESIDENCES IN STUDY'S SAMPLE BY LEVEL  
OF CLIENT DISABILITY AND OVERALL/CATEGORICAL  
STAFF TO CLIENT RATIOS

Residence description	Average number of deficits per client	Overall staff to client ratio	Adm. staff to client ratio	Clinical staff to client ratio	Direct care staff to client ratio
Vol. apartment residence	1.50	1.25	0.14	0.12	0.99
Vol. group residence	1.79	1.10	0.23	0.09	0.78
Vol. group residence	2.00	0.85	0.23	0.01	0.62
Vol. apartment residence	2.00	2.44	0.04	0.54	1.85
Vol. apartment residence	2.00	2.44	0.04	0.54	1.85
Vol. group residence	2.07	1.14	0.12	0.14	0.87
Vol. group residence	2.11	1.64	0.25	0.25	1.14
Vol. apartment residence	2.50	1.25	0.14	0.12	0.99
Vol. group residence	2.50	1.28	0.18	0.16	0.99
Vol. apartment residence	2.67	2.44	0.04	0.54	1.85
Vol. group residence	3.00	1.44	0.24	0.05	1.15
Vol. group residence	3.07	1.09	0.16	0.11	0.80
State group residence	3.14	1.79	0.05	0.14	1.60
State group residence	3.71	1.54	0.02	0.36	1.16
Vol. group residence	4.13	1.87	0.15	0.38	1.35
State apartment residence	4.67	1.91	0.05	0.15	1.71
State apartment residence	4.67	3.58	0.11	0.20	3.27
State group residence	4.90	1.35	0.03	0.10	1.22
Vol. group residence	5.00	2.41	0.23	0.23	1.96
State apartment residence	6.00	3.13	0.11	0.22	2.80
State apartment residence	6.00	3.13	0.11	0.22	2.80
State apartment residence	7.00	3.13	0.11	0.22	2.80
Vol. apartment residence	7.00	3.74	0.04	0.54	3.15
State apartment residence	8.00	1.30	0.05	0.13	1.11

of living conditions and range of provided services reported in Chapter II. As the reader will recall, State-operated residences, and particularly State-operated apartments, tended to offer less satisfactory living conditions and a significantly narrower range of program and treatment services than voluntary agency residences. Client assessments and treatment plans also were substantially less up-to-date in State residences. Thus, although State-operated residences, especially State-operated apartments, have employed substantially more staff to serve their more disabled clients, their programs continue to appear less comprehensive than those of voluntary agency residences.

#### Utilization of Staff

In conducting its review of the "care givers" of the sampled residences, Commission staff also sought to determine how various staff personnel were utilized in the 24 facilities. This review, based on Commission on-site interviews with facility staff and telephone interviews with BDSO and voluntary agency management personnel responsible for community residential programs, revealed differences in the utilization of direct care and clinical staff members among the visited programs. While the noted variation in the utilization of direct care staff appeared to be related to the size of the residential modality, e.g., group residence versus apartment, the differences in the use of clinical staff seemed to be largely dependent on the individual clinical management priorities of the sponsoring voluntary agency or BDSO. The review also indicated that while both voluntary agencies and the State BDSOs relied most heavily on shift staff, voluntary agencies tended to make partial use of "live-in" staff more often than the State.

In regard to the direct care staff, the variation was most apparent in the range of job assignments in group residences versus apartments. Most group residences (8 of the 12 in the sample) had at least one full-time equivalent staff person assigned to housekeeping and/or food preparation responsibilities. This staff assignment for housekeeping/food preparation reduced the level of these responsibilities on other direct care staff, allowing them to focus attention on personal services and programming with residents. Apartments, on the other hand, tended to rely less on discrete housekeeping and/or food preparation staff. In one-third of the 12 sampled apartments, there were no staff specifically assigned to these duties and in 5 of the remaining 8 apartments only 0.15 to 0.35 of a full-time equivalent staff person was assigned these duties. In most of these latter five apartments, this staff position was filled by an itinerant dietician who consulted with regular apartment direct care staff regarding diets; rarely did this person assist in actual meal preparation.

This difference in the job responsibilities of direct care staff in group residences and apartments, though reasonably determined based on the size differential of the residences, placed very different performance expectations on direct care staff personnel in the two modalities. Generally staffed with only two, and sometimes only one, direct care person during a given shift, the apartment modality required direct care staff members to prioritize tasks, balance responsibilities, and schedule time in a more sophisticated manner.

Another noted difference in the utilization of direct care staff between group residences and apartments related to the role of the facility manager. Each of the group

residences in the study's sample had a staff member serving as a full-time facility manager, and many also had a full-time assistant manager title. In the visited apartments this management/supervisory role was usually filled part-time by a staff member, who often served in this capacity for two, three, and in one case, four apartments. Thus, direct care staff in apartments were generally afforded less regular, continuous supervision than those in group residences. In addition, apartment direct care staff, due to the irregular presence of the manager, also had to assume more responsibility for addressing management problems, ranging from requesting facility repair service to solving disagreements.

These differences in the responsibilities of direct care staff in apartment versus group residences suggest that the performance expectations for direct care staff in apartments are higher than for those in group residences. This finding may partially explain the program operation difficulties of State-operated apartments cited in Chapter II. Although performance expectations appear to be different for the apartment and group residences' direct care worker, training and recruitment efforts are virtually the same.

Another area of staff utilization in the New York City community residential facilities which was of special interest to the Commission was the use of clinical staff. The introduction of federal ICF-MR facility status and Medicaid financing for 18 of the 24 sampled residences in 1979, allowed and encouraged these residences to hire more clinical staff and the Commission was interested in the

roles these new staff members had assumed.<sup>10</sup> Readers should note that the scope of the Commission's review of clinical staff utilization was limited to identifying the services these staff members provided and did not include an evaluation of how their services have benefited the clients of the visited residences. Since few clinical staff persons were on-site during Commission site visits, follow-up telephone calls were made to each voluntary agency and BDSO to clarify the responsibilities of clinical staff assigned to their community residential facilities. This review included all five of the voluntary agencies represented in the sample, but only one of the three BDSOs. The other two BDSOs were not included, as they did not have complete clinical teams in place at the time of the Commission's review.

In reviewing the responses to this follow-up survey on the clinical staff utilization in the visited residences, readers should note that, in general, both the voluntary agencies and the BDSO representatives were unclear as to the actual utilization of clinicians in their residences. In several cases, representatives indicated that they could provide only general estimates. Especially noteworthy is the absence of any allocation of time for clinical staff to travel to residences. Since clinical teams usually served as many as two or three residences, and in at least one case, six residences, it is clear that traveling to residences may account for a substantial proportion of their work time.

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<sup>10</sup>The October 1980 Commission policy analysis review of the conversion of traditional community residences for the developmentally disabled to ICF-MR status (Converting Community Residences into Intermediate Care Facilities for the Mentally Retarded: Some Cautionary Notes) reported that a major concern of voluntary agency sponsors of these converting facilities was that inappropriate utilization of clinical staff could alter the homelike atmosphere of the residence.

However, even recognizing these limitations, it was apparent from the agency and BDSO responses that clinicians were largely utilized to conduct routine client assessments, to prepare quarterly treatment plans, and to offer training and consultations to residence staff. There was very limited utilization of clinician time to provide direct care, therapy, and/or treatment services to clients. Specifically, responses to the survey indicated that psychologists, speech therapists, and occupational therapists spent the majority of their time (51 percent on the average) on client evaluations and assessments. They spent most of their remaining time, or 39 percent of their total time, on staff consultations and in-service training. Notably, only 10 percent of these clinical staff persons' time was reportedly spent on direct care, therapy, and treatment services to residents.

Nurses also tended to spend most of their time on client evaluations and assessments and staff consultations and in-service training. However, nurses reportedly spent a greater percentage of their time on direct care and treatment services to residents. Among all of the voluntary agencies and the one BDSO, nurses were reported to spend an average of 21 percent of their time on direct care and treatment, 39 percent of their time on client evaluations and assessments and 41 percent of their time on consultations and in-service training.

These average reported figures on clinical staff utilization among the residences clearly show the trend among agencies not to assign significant direct care service responsibilities to clinical staff persons. These figures do not show, however, the wide variation in use of clinical staff among voluntary agencies and the one responding BDSO.

Reported utilization of psychologists, speech therapists, and occupational therapists for direct services to residents varied from no utilization in two responding voluntary agencies and the one responding BDSO to one-third of their time by another voluntary agency. Similarly, nursing staff time reportedly spent on client evaluations and assessments varied from a low of 15 percent of their time to a high of 65 percent of their time. And, the reported use of psychologists, speech therapists and occupational therapists for in-service training and staff consultations ranged from one-third of their time in one voluntary agency to 75 percent of their time in another. (See Table 12.)

These variations in the reported utilization of clinical staff members by the sampled residences indicate that while there is a definite tendency of sponsoring agencies to employ clinical staff for client assessments and staff training rather than to render direct care, therapy, and treatment services to residents, there remains considerable variance in the actual use of these personnel among the sampled agencies/BDSO. Interestingly, this variance did not appear to be related to the disability level of clients, size of residence, or State versus voluntary agency operation. Instead, it appears to relate to the clinical management priorities of individual sponsoring agencies.

An analysis of the sampled facilities' staff scheduling among residences, conducted in the course of the review of staff utilization, indicated that almost two-thirds (63 percent) of the visited residences relied only on shift staff. Of the remaining residences, all but two used a combination of shift staff and "live-in" staff, relying most heavily on shift staff. Only two residences, both voluntary-agency-operated apartments, used only "live-in" staff. This analysis also revealed that, while both State and voluntary-agency-operated residences primarily used shift staff,

Table 12. REPORTED UTILIZATION OF CLINICAL STAFF IN SAMPLED RESIDENCES 53.  
 BY VOLUNTARY AGENCY OR BDSO SPONSOR AND BY PERCENTAGE OF TIME  
 SPENT ON DIRECT SERVICES TO RESIDENTS, EVALUATION AND  
 ASSESSMENT, AND CONSULTATION AND IN-SERVICE TRAINING

Clinical staff	Reported percentage of time spent		
	Direct services	Client evaluations and assessments	Staff consultations and in-service training
VOLUNTARY AGENCY NO. 1			
Psychologists, speech and occupational therapists	0.	50.	50.
Nurses	10.	15.	75.
VOLUNTARY AGENCY NO. 2			
Psychologists, speech and occupational therapists	5.	75.	20.
Nurses	10.	65.	25.
VOLUNTARY AGENCY NO. 3			
Psychologists, speech and occupational therapists	33.	33.	33.
Nurses	33.	33.	33.
VOLUNTARY AGENCY NO. 4			
Psychologists, speech and occupational therapists	0.	50.	50.
Nurses	50.	50.	0.
VOLUNTARY AGENCY NO. 5			
Psychologists, speech and occupational therapists	20.	40.	40.
Nurses	20.	40.	40.
STATE BDSO NO. 3			
Psychologists, speech and occupational therapists	0.	60.	40.
Nurses	0.	30.	70.
AVERAGE			
Psychologists, speech and occupational therapists	10.	51.	39.
Nurses	21.	39.	41.
All clinical staff	15.	45.	40.

voluntary agency residences made more use of "live-in" staff. Only one State residence (an apartment) made use of "live-in" staff, and then only partially, while six of the voluntary agency residences made partial use of "live-in" staff and two voluntary agency apartments used "live-in" staff exclusively.

Finally, it was noted in comparing the costs of residences using only shift staff, a combination of shift staff and "live-in" staff, or only "live-in" staff that residences using some or all "live-in" staff tended to have lower costs than residences relying exclusively on shift staff, even when consideration was made for the level of disability of the clients served and the size of the residence (group versus apartment residence). Readers should note, however, that the cost differences tended to be small and that they are difficult to definitively attribute to the use of "live-in" staff due to the overall idiosyncratic variations in per client costs discovered in the Commission's review. (See Chapter IV, The Costs of Care.)

#### Staff Salaries

Another aspect of the Commission's review of staffing issues was a comparison of salaries paid to direct care staff. Although attempts were also made to compare salaries paid to administrative and clinical staff members, these comparisons could not be conducted due to incomplete and incomparable data. In conducting this review, Commission staff asked senior management personnel of the sponsoring voluntary agencies and BDSOs to report entry level direct care staff salaries. The reader should note that the entry level salaries reported in this section reflected salaries in September 1981.

The review of entry level direct care salaries revealed that the average entry level salary for the five voluntary agencies was \$9,920 with a reported range of \$9,000-11,000 among agencies. (See Table 13.) All three of the BDSOs in the study's sample reported entry level salaries of \$10,410. These reported salaries indicate that the State offers higher entry level salaries than four of the five voluntary agencies, with only one voluntary agency offering a higher starting salary of \$11,000. It should be noted, however, that actual entry level direct care staff salaries for State-operated residences usually exceeded the reported \$10,410 since most of these employees have work experience at a developmental center raising their salaries to at least the second step of the Grade 9 pay scale or approximately \$11,000.

State workers also received better benefits than their counterparts in voluntary-agency-operated residences. While fringe benefit costs of State-operated residences in the sample amounted to 33 percent of the personal services costs of the programs, fringe benefit costs in the sampled voluntary-agency-operated residences only averaged 18 percent of the personal services program costs. Although a thorough analysis of the fringe benefit packages offered by the voluntary agencies and the State was beyond the scope of the Commission's study, a preliminary review of these benefit packages indicated that the discrepancy between State and voluntary agency benefits was not so much in the types of benefits offered as in the extent or value of the coverage.

For example, both voluntary agencies and the State provide health and dental insurance coverage, but the State plans appear more comprehensive, with lower deductibles and lower employee paid premiums. Similarly, while both the

Table 13. ENTRY LEVEL SALARIES OF DIRECT CARE STAFF  
MEMBERS BY SPONSORING VOLUNTARY  
AGENCY/BDSO AND AUSPICES

<u>Sponsoring agency</u>	<u>Entry level salary</u> <sup>1</sup>
Voluntary Agency No. 1	\$ 9,000
Voluntary Agency No. 2	9,500
Voluntary Agency No. 3	9,800
Voluntary Agency No. 4	10,300
Voluntary Agency No. 5	11,000
State BDSO No. 1	10,410
State BDSO No. 2	10,410
State BDSO No. 3	10,410

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<sup>1</sup>All cited salaries reflect voluntary agency and State BDSO entry level direct care salaries for September 1981.

State and voluntary agencies offered retirement plans, the State plan appears to offer more at less cost to the employee. In addition, it should be noted that in most, though not all cases, the State worker was allowed more vacation, sick, and personal leave days and more paid holidays than his or her voluntary agency peer.

An interesting adjunct to this finding is that voluntary agencies, despite their lower starting salaries and less comprehensive fringe benefits, tended to seek and obtain job candidates with more advanced educational backgrounds than the State BDSOs. While management staff in the voluntary agencies indicated that many criteria were used to select appropriate direct care staff persons, most stated that they sought, and usually were able to recruit, candidates with Bachelor degrees. This was not the case in the sampled BDSOs. In addition, voluntary agencies also actively encouraged their direct care staff to pursue further education.

At the same time, it should be pointed out that the staff in State-operated residences may have more experience working with persons with developmental disabilities. As noted above, most direct care staff in State residences had at least one year of work experience in a State developmental center.

#### Summary

In summary, the 24 visited facilities differed significantly in their staff-to-client ratios, utilization of direct care and clinical staff and staff salaries. As indicated in the chapter, these differences were sometimes related to the level of disability of the clients served and/or the size of the residence or the auspices of the provider. In other instances, significant differences were

noted that were seemingly unrelated to any apparent treatment service needs of the residents or programmatic feature of the residences. In all cases, these variations raise important questions relevant to the allocation and utilization of staff in New York City community residential facilities serving the developmentally disabled. While the findings in this study do not sustain allegations that staffing levels or staff utilization are inappropriate or cost-ineffective, they do indicate a need for serious evaluation of the allocation and utilization of staff in New York City community residence programs by the Office of Mental Retardation and Developmental Disabilities.

This need is paramount with regard to the utilization and allocation of clinical staff persons whose services are relatively costly. Though the review's finding that clinical staff spend little time on direct treatment services does not necessarily indicate that their time should be redirected to direct services, the overall idiosyncratic utilization patterns of clinicians by the State and voluntary agencies in these programs suggest that there are no uniform performance objectives for clinical services among the programs.

## CHAPTER IV

### The Costs of Care: An Examination of the Fiscal Expenditures of the Facilities

An essential aspect of the Commission's review was an examination of the costs of care in the sampled community residences. This review, based on reported expenditure data for the residences for fiscal year 1979-80, revealed that the average per client cost in State developmental centers in the New York City area was approximately 29 percent greater than the average per client cost among the sampled community residence programs for the same fiscal period. The findings also indicated, however, that per client costs among individual community residences in the study's sample varied widely, with a low annual per client cost in one voluntary agency group residence of \$16,892 and a high annual per client cost of \$57,600 in one State-operated apartment residence. They also showed that the average annual per client cost of the visited apartment residences, and particularly of State-operated apartments (which tended to serve the sample's most disabled population) were higher than the average annual per client cost of the New York City developmental centers (\$47,760 versus \$37,024).

Largely reflective of the variation in staff-to-client ratios reported in Chapter III, these noted variations in the cost of care also appeared to be related to the level of disability of the clients served and the size of the residence modality. Specifically, the most costly residences tended to be apartment residences and those residences serving the most disabled persons. However, like the variation in staffing levels, the Commission also noted differences in the operating costs among residences, unrelated to these variables or any apparent programmatic feature of the residence.

The findings related to the cost of care in the sampled community residences reported in this chapter are based on facility prepared expenditure reports for fiscal year 1979-80, the most current fiscal year for which complete expenditure data for the sampled facilities could be obtained at the time of the Commission review.<sup>11</sup> These expenditure reports included only the costs of the clients' care at the residence, and therefore, do not reflect the total care costs for the resident. More clearly, the per client costs reported in this chapter do not include the costs for the client's day program, estimated at approximately \$12,000 annually per client, or the costs of medical care services rendered to the client and charged to the Medicaid program.<sup>12</sup> Expenditure data were obtained from 23 of the 24 visited community residential facilities. Fiscal data from one of the sampled residences, a State-operated apartment, were not included in this analysis because it did not open until July of the 1980-81 fiscal year.

The findings related to the cost of care in the State developmental centers in the New York City metropolitan area are based on total costs of the center for fiscal year 1979-80 as reported to the Commission by the OMRDD. These reported costs, unlike the reported costs of the sampled

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<sup>11</sup>Readers should note that the fiscal year reporting periods differ for voluntary-agency-operated facilities and State-operated facilities. Most voluntary agencies report their fiscal expenditures on the New York City fiscal year, July 1-June 30, while the State BDSOs report their fiscal status on the State fiscal year, April 1-March 31.

<sup>12</sup>All but one of the 160 clients in the study's sample attended at least five hours of day program each weekday as required by OMRDD rules and regulations.

community residences, included day program and ancillary medical and dental care and other costs for residents of the centers. To allow for this variance between the cost reporting by developmental centers and community residences in the sample, Commission staff deducted \$13,425 from the average annual per client costs of developmental centers--\$12,000 to reflect the annual per client reimbursement paid by the State for day program services and \$1,425 to reflect the developmental centers' average per client ancillary medical and dental care and other costs. (See Appendix C for a description of the developmental center annual per client costs.)

#### Limitations of the Data

In reviewing the findings presented in this chapter, the reader should be aware of certain limitations of the cost data reported. First, as noted above, the data presented are based on voluntary agency or State OMRDD prepared expenditure reports. The Commission did not audit these reports. In addition, expenditure report data for six of the sampled facilities which opened or converted to ICF-MR status after the beginning of the 1979-80 fiscal year were annualized to reflect a full year's operation. Similarly, rent expenses, not reported by eight residences since the Facilities Development Corporation (FDC) handled their leasing arrangements, were obtained directly from FDC and added to these residences' prepared expenditure reports. It should also be noted that in several instances, voluntary agencies and BDSOs indicated that actual expenditures for certain cost categories, e.g., transportation, were not available for individual residences. In these cases, the reported costs for the expenditure category were estimated by the sponsoring voluntary agency or BDSO from aggregate costs for several of their residences for the particular cost component.

In addition, it should be noted that reported expenditures from State-operated residences appeared to be understated, as several cost categories for other than personal services (OTPS) costs were either unreported or under-reported by State-operated residences. For example, State residences reported no OTPS expenditures for office space, insurance, and rental of equipment and reported an average of only one-half of one percent of the total expenditures for miscellaneous OTPS costs, compared with the voluntary agencies' average of over 15 percent for miscellaneous OTPS expenses. Presumably, these unreported and under-reported OTPS costs of State residences were reflected in the BDSOs' institutional costs. The Commission estimates, based on expenditures by voluntary-agency-operated residences for these cost categories, that the expenditures reported by the State residences are understated by approximately 15 percent. However, no adjustments in the reported expenditures of State-run residences were made in the data presented in this report to reflect these understated costs.

Also, one voluntary agency was only able to provide average cost data on its sampled apartments based on aggregate costs for clusters of four apartments operated by the agency. This agency operated four apartments in the study's samples: two were a part of one, four-apartment cluster and two were a part of another four-apartment cluster. The reported costs of these apartments, therefore, are approximations, possibly reflecting actually higher or lower costs of the other apartments in the cluster.

Finally, as pointed out above, the reported costs of developmental centers in the New York City metropolitan area and the sampled community residences were not comparable and adjustments were made to the reported developmental centers' costs to deduct estimated day program and ancillary medical and dental care and other costs not included in the

community residences' reported costs. Although these adjustments were based on the best available estimates, it should be noted that, due to the incompatibility of the cost reporting systems of developmental centers and community residences, precise comparisons between institutional and community residences' costs in the New York City area cannot be made. Therefore, the cost comparisons between developmental centers and community residences reported in this chapter should be considered approximations.

Comparisons of Developmental Center and  
Community Residence Costs in the New York City Area

According to reported figures from the OMRDD, adjusted average annual per client costs for the five developmental centers in the New York City area in fiscal year 1979-80 ranged from a high of \$92,931 at a relatively new center still bearing high capital construction costs to a low of \$26,776 at another center. The adjusted average annual per client cost among all five centers in the metropolitan area for fiscal year 1979-80 was \$37,024. (See Table 14.) This overall average developmental center per client cost was \$8,385 higher, or 29 percent greater than the overall average per client care cost of the 23 sampled community residences. (See Table 15.)

However, it must be emphasized that the lower overall average per client cost of the sampled community residences was largely attributable to the significantly lower average per client cost among group residences in the sample (\$26,030). (See Table 15.) The average annual per client cost among apartment residences (\$39,156) was actually \$2,132 greater than the average per client cost among the developmental centers. And, more significantly, the average per client cost among State-operated apartment residences (\$47,660) in the sample was nearly 29 percent greater than the average per client developmental center cost.

Table 14. COSTS OF DEVELOPMENTAL CENTERS  
NEW YORK CITY, FY 1979-80

Developmental center	Total cost	Number of residents	Total average cost per resident	Adjusted average cost, per resident <sup>1</sup>
Total	\$117,244,149	2,324	\$50,449	\$37,024
Bronx	6,381,358	60	106,356	92,931
B.M. Fineson	13,829,277	344	40,201	26,776
Brooklyn	27,269,001	564	48,349	34,924
Manhattan	8,394,328	141	59,534	46,109
Staten Island	61,370,185	1,215	50,510	37,085

<sup>1</sup>Excludes \$13,425 approximate annual per client costs for day program and ancillary medical/dental costs.

Table 15. COMPARATIVE COSTS OF DEVELOPMENTAL  
CENTERS AND COMMUNITY RESIDENTIAL PROGRAMS  
NEW YORK CITY, FY 1979-80

Residential facility	Number of facilities	Total costs	Number of residents	Average cost, per resident <sup>1</sup>
Developmental centers	5	\$117,244,149	2,324	\$37,024 <sup>2</sup>
Community residential facilities	23	4,467,608	156	28,639
Group residences	12	3,253,771	125	26,030
Apartment residences	11	1,213,837	31	39,156
State-operated residences	8	1,445,138	39	37,055
Voluntary-agency-operated residences	15	3,022,470	117	25,833
State-operated group residences	3	730,231	24	30,426
State-operated apartment residences	5	714,907	15	47,660
Voluntary-agency-operated group residences	9	2,523,540	101	24,986
Voluntary-agency-operated apartment residences	6	498,930	16	31,183

<sup>1</sup> Average is used instead of the median reported elsewhere in this chapter because these costs are client- rather than facility-specific.

<sup>2</sup> Excludes \$12,000 to reflect State annual reimbursement rate for day program services and \$1,425 to reflect avaral annual per costs for ancillary services from reported developmental center costs.

It should also be noted that the overall lower costs of the sampled community residences was largely influenced by the substantially lower average annual per client cost among voluntary agency residences versus State-operated residences. The average annual per client cost among sampled voluntary-agency-operated residences (\$25,833) was over 30 percent lower than the developmental center cost, while the average annual per client cost among sampled State-operated residences (\$37,055) was nearly the same as the average annual per client cost among the centers.

As explained in the next section, the lower costs of voluntary-agency-operated programs are largely attributable to the more disabled residents served by State-operated residences. Similarly, the higher costs of apartments, especially State-operated apartments, are partially attributable to their serving clients with more severe disabilities than group residences. However, detailed analysis of the apartment costs indicated that, even with consideration for the level of client disability, apartments were more costly than group residences, and often more costly than developmental centers. Seven of the 12 sampled apartment residences, and notably all but one of the State-operated apartments, reported annual per client costs exceeding the adjusted average annual per client cost of developmental centers in the New York City area. This finding is perhaps the most noteworthy of the comparison cost data findings between developmental centers and the sampled community residences because the visited apartment residences, together with the sampled State-operated group residences, served a client population most comparable with that of the developmental centers in the New York City area.

In summary, comparison of the average annual per client costs of developmental centers and the sampled 23 community residences in the New York City area revealed that the average developmental center cost was approximately 29 percent higher than that of the visited residences. Simultaneously, however, this comparison revealed that, in general apartment residences and especially State-operated apartments were more costly compared to the developmental centers.

Further Analysis of Annual Per Client Costs  
of the Sampled Community Residential Programs

Commission staff further reviewed the annual per client costs of the sampled community residential programs to better understand the wide variations in reported annual costs among residences, ranging from less than \$17,000 to over \$57,000 per client. In conducting this further review, as with the review of staffing levels among residences, the Commission looked for relationships between the variables of level of client disability, residence auspices, and residence size and per client costs. The findings of this review, like the review of staffing levels, are also usually reported using median (rather than average or mean) per client costs, because calculation of the mean is skewed by the extreme highs or lows.

This review indicated that the reported variance in per client costs among the visited community residences was largely attributable to the wide variations in personal services costs among the residences, reflective of the wide range in the residences' staff-to-client ratios reported in the previous chapter. Reflecting this consistency with the staffing level variance, variations in per client costs were also generally related to the level of client disability and

size of facility. Though the data also revealed wide variations in the median per client costs of State versus voluntary agency facilities (\$43,093 versus \$27,876), this variance was largely accounted for by the more severely disabled clients served in State residences and the greater proportion of apartment residences in State-operated sampled facilities. Two-thirds of the State-operated sampled residences were high-cost apartments compared to only 40 percent of the voluntary agency sampled residences.

The disability level of the residents served appeared to be the dominant variable influencing the cost of the residence. Median annual per client costs for all residences and all subgroups of residences by size and auspices rose as the level of disability of the clients living in the residence increased. (See Table 16.) Specifically, the median annual per client costs among all residences increased from \$22,808 in residences serving clients with an average of 1.50 to 2.50 deficits to \$32,960 in those serving clients with an average of 2.51 to 4.99 deficits to \$46,473 in those serving clients with an average of 5.00 to 8.00 deficits. Similarly, median annual per client costs for group residences ranged from \$20,909 in residences serving clients with an average of 1.50 to 2.50 deficits to \$33,982 in residences serving clients with an average of 5.00 to 8.00 deficits. And, median annual per client costs for State-operated residences increased from \$32,960 to \$52,871 as the level of client disability increased from an average of 2.51 to 4.99 deficits per client to 5.00 to 8.00 deficits per client.

Though the level of client disability was consistently and significantly related to the variations in per client costs, residence size also appeared to independently influence these costs. The per client cost data showed that median costs in apartment residences were higher than those