The Looming Crisis in Care and Housing for Oklahomans Aging with Serious Mental Illness

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for the Serious Mental Illness and Aging Taskforce of Mental Health Association Oklahoma
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About the Contributors

Lobeck Taylor Community Advocacy Clinic
The Lobeck Taylor Community Advocacy Clinic (CAC) at The University of Tulsa College of Law offers student attorneys the opportunity to explore the ethical, strategic, and theoretical dimensions of legal practice by solving real-life legal problems in a structured learning environment. CAC students serve the community by providing representation that increases access to justice for low-income individuals and families, as well as advocacy, capacity-building, and systemic reform on behalf of non-profit organizations and community groups.

Mental Health Association Oklahoma: Serious Mental Illness and Aging Taskforce
Mental Health Association Oklahoma’s Serious Mental Illness and Aging Taskforce requested this report from the Lobeck Taylor Community Advocacy Clinic at The University of Tulsa College of Law. The Taskforce asked the CAC to examine Oklahoma law and policy related to the housing and care needs of people aging with serious mental illness and co-occurring physical conditions.
Introduction

Oklahoma is facing an increase in the number of people aging with serious mental illness. Currently, about 180,000 Oklahomans over the age of 50 have some form of mental illness and 40,000 of these Oklahomans live with serious mental illness.¹ By 2050, this population is expected to double due to aging baby boomers.² As these individuals age, they will need care for mental illness as well as the various physical health conditions that come with aging.

Around 180,000 Oklahomans over the age of 50 have some form of mental illness. 40,000 live with serious mental illness.

Unfortunately, people aging with serious mental illness, particularly those who also have physical health conditions, struggle to find stable housing and appropriate health care. To prevent a future crisis in access to care, we must take steps now to ensure Oklahoma can meet the needs of the growing population of older people with serious mental illness.

This report identifies barriers to housing and access to care for people aging with serious mental illness in Oklahoma, recommends possible solutions to address these barriers, and provides a framework for statewide long-term planning.

We begin by defining a few key terms as they are used in this report: Aging includes people age 50 or older. Typically, the term “aging” contemplates those nearing retirement age, generally 67 and older. However, serious mental illness reduces life expectancy by 10-25 years.³ People with serious mental illness have a greater need for physical care at a younger age because of the stress mental illness places on the body, coupled with a lack of routine access to physical health treatment.⁴

Serious mental illness (SMI) includes major mental disorders, such as schizophrenia or severe anxiety disorder, which often lead to chronic disability.⁵ SMI does not include dementias such as Alzheimer's.⁶

A co-occurring physical condition is a physical health problem that requires some form of medical treatment.

In Oklahoma, four different types of facilities are available to aging individuals with SMI and co-occurring physical conditions: Independent Living, Residential Care, Assisted Living, and Nursing Facilities. Independent Living Facilities serve individuals who can live on their own. Residential Care Facilities serve individuals who can participate in activities of daily living, such as dressing and grooming, but need some assistance, such as
reminders to do laundry or take medicine. Assisted Living Facilities assist with activities of daily living and some intermittent nursing care. Finally, Nursing Facilities provide the highest level of health care. Each facility is discussed in detail in the Facilities section of this report.

This report also discusses barriers to care and housing, which include facility discretion regarding resident admission and involuntarily discharge, as well as cost. These barriers have created a system where facilities tend to focus on serving either mental illness or physical health needs, but not both. Few facilities focus on meeting both physical and mental health needs—this is a major gap in access to care in Oklahoma.
Legal and Social Context

This section offers an overview of the legal and social context of health care and housing for people aging with SMI. First, it identifies a critical area of law—the Medicaid program—and notes how specific aspects of federal Medicaid law shape Oklahoma’s housing and health care options for this population. Next, it discusses how issues of cost and funding affect access to services. Finally, it identifies the role stigma plays in limiting access to care and housing.

Legal Context

Federal and state law—including statutes, regulations, and court decisions—shape the housing and health care systems for people aging with SMI and co-occurring physical conditions. This report focuses on the role of statutes and regulations. Statutes are put into effect by Congress at the federal level, and the legislature at the state level. Regulations are created by executive branch agencies to implement statutes.

In the Facilities section of this report, we discuss Oklahoma state law, and in particular, the state licensing rules (regulations) governing facilities that care for people aging with SMI in Oklahoma. In this section, we focus on Medicaid, a federal health insurance program that is one of the most important areas of law for people aging with SMI. As we discuss below, federal Medicaid law shapes the services provided to people with SMI in Oklahoma.

Medicaid

Medicaid is the public health insurance program for low-income people. Medicaid is authorized by federal statute and jointly administered by states and the federal government. The Centers for Medicare & Medicaid Services (CMS) administers Medicaid at the federal level and the Oklahoma Health Care Authority administers Medicaid at the state level.

Three areas of Medicaid law play a particularly important role in shaping access to care and housing for people aging with SMI:

Institutions for Mental Diseases (IMD) Exclusion: The IMD Exclusion was designed to reduce the role of large, state-run mental hospitals in caring for people with mental illness. It bars the Medicaid program from paying for health care services in large institutions with the primary purpose of treating mental illness. Specifically, Medicaid will not reimburse providers for health care services if the patient is between 21-65 years old and in a mental health institution with more than 16 beds.

Gradual Dose Reduction (GDR) Requirement: The GDR, a part of the regulations governing Medicaid, is aimed at reducing the reliance on...
antipsychotic medications and ensuring that those medications are used only where medically necessary.\textsuperscript{13} Under the GDR, facilities must attempt to wean most patients off of antipsychotics at least once.\textsuperscript{14}

**CMS Nursing Home Quality Initiative:** The Quality Initiative is a system that rates the quality of care in nursing homes, using a variety of measures.\textsuperscript{15} For example, a nursing home’s quality rating may be lowered based on the percentage of residents receiving antipsychotic medication.\textsuperscript{16} While well-intended, CMS quality measurements regarding antipsychotics can lead nursing homes to deny admission to people with SMI who are taking antipsychotics.

**Cost and Funding**

Cost and funding challenges add to the complexity of delivering mental and physical health care to people aging with SMI. Three key factors are: (1) the services and facilities Medicaid reimbursements cover; (2) Oklahoma’s recent cuts to Medicaid reimbursement rates and; (3) the correlation between lower lifetime earnings, greater reliance on public benefits, and SMI.

Medicaid reimbursement affects which facilities aging individuals with SMI and co-occurring physical conditions can afford. Medicaid will only pay for room and board in institutions, such as Nursing Facilities, unless a waiver program is available.\textsuperscript{17} Thus, it does not cover the cost of living in non-Nursing Facilities. Waiver programs make it possible to receive services not otherwise covered by Medicaid’s traditional health plans, in certain situations.\textsuperscript{18}

About 70 percent of all Nursing Facility residents in Oklahoma rely on Medicaid.\textsuperscript{19} Oklahoma has consistently cut Medicaid reimbursement rates at the state level to the point that many facilities are losing money every day on Medicaid patients.\textsuperscript{20} At a minimum, these cuts may push Nursing Facilities not to admit patients with high levels of need. Even worse, cuts may force Nursing Facilities to close.

On average, individuals with SMI have lower lifetime earnings than people without SMI.\textsuperscript{21} This often means that individuals with SMI rely heavily on public benefits.\textsuperscript{22} The increasing number of aging individuals who rely on those benefits has the potential to overextend benefit programs in unprecedented ways.\textsuperscript{23}

**Social Context**

Stigma plays a role in limiting access to housing and care for people with mental illness. Research has shown that the primary reasons why people with mental illness do not seek medical treatment are stigma and embarrassment.\textsuperscript{24}
Many people have negative attitudes and perceptions about people with mental illness.\textsuperscript{25} Often, this is connected to the idea that people with mental illness are dangerous, an idea fed by media stories focused on mental illness in the context of violent offenders.\textsuperscript{26} Perhaps surprisingly, some health care professionals, including mental health professionals, hold the same kind of negative beliefs about people with mental illness.\textsuperscript{27} 

Many people with mental illness are aware of these negative attitudes. Sometimes, these attitudes can become internalized, which is called "self-stigma."\textsuperscript{28} Self-stigma may cause some people to attempt to disassociate from their mental illness and others to live in shame, rather than seek support.\textsuperscript{29} 

Stigma can limit access to long-term care and other housing for people with mental illness.\textsuperscript{30} Public perceptions about how individuals with mental illness behave may affect whether a facility will admit them.\textsuperscript{31} Facilities may use the misperception that people with mental illness are violent as a pretext to screen out persons with mental illness. 

Stigma can also negatively affect the care people with mental illness receive from health care providers.\textsuperscript{32} A recent study found that doctors are less likely to offer the same quality of care to people with mental illness as they do to the general population.\textsuperscript{33} For example, doctors are less likely to do the following: prescribe medications for life-threatening diseases, such as heart disease; recommend surgery after a major health issue, such as a heart attack; and hospitalize a patient after an emergency room visit.\textsuperscript{34} 

Finally, in Oklahoma, facilities that serve people with mental illness are not required to train staff on how to interact with residents with mental illness.\textsuperscript{35}
Facilities

Residential Care Facilities, Assisted Living Facilities, and Nursing Facilities are the housing options available to aging individuals with SMI and co-occurring physical conditions. Oklahoma statutes and regulations define each facility and set the bounds of physical and mental health care services the facility may provide under its license.

Each facility offers a different level of physical and mental health care. Thus, each facility is appropriate for different types of people, depending on their health care needs. Below are the definitions of each facility type, the physical and mental health care services each provides, and payment options.

**Residential Care Facilities**

Residential Care Facilities are Private Pay Facilities that Accommodate the Mental Health Needs of Aging Individuals with SMI.

A Residential Care Facility (RCF) is an institution that provides housing, food, and supportive assistance. RCFs are the only type of facility we found that specifically cater to people with mental illness. The Residential Care Act lists factors a RCF must consider when deciding to admit residents to its facility. The Residential Care Act specifies that a resident must be able to walk, must not be bedridden, must be capable of managing their own affairs, and must not routinely require skilled nursing or intermediate care.  

**Residential Care Facilities cater to the needs of people with mental illness.**

Although Oklahoma law requires RCF residents to be able to live independently, the facility may assist with activities of daily living (ADLs). ADLs include assistance with meals, dressing, or bathing. In addition, RCFs assist in preparation of meals and medication storage, distribution, and administrations.

These facilities also assist in personal care as necessary for the health and comfort of the resident. Mental health services available in a RCF include transportation to outpatient mental health treatment, and the distribution and administration of antipsychotics and other oral medications. Current regulations do not allow RCFs to administer anything beyond oral medications.

Living in a RCF costs around $800 per month, a housing cost that must be covered by out-of-pocket funds such as savings and income from Social Security benefits.  

For many residents, the RCF acts as a representative payee to collect housing payments. A representative payee is an organization that receives Social Security or SSI benefits on behalf of residents who cannot manage or direct the management of
their benefits. A similar program exists for people who receive benefits from the Veteran’s Administration. A payee’s main duties are to use the benefits to pay for the current and future needs of the beneficiary and save any benefits not needed to meet current needs. A payee must also keep records of expenses.

**Assisted Living Facilities**

Assisted Living Facilities Offer a Wide Range of Services, But Are Too Costly for Many Individuals with SMI and Co-occurring Physical Conditions.

An ALF is a facility with two or more people unrelated to the operator, who need assistance with their activities of daily living, and have varying nursing care needs that do not reach the level of need that NFs provide. While ALFs have discretion to determine the particular services they will provide, under an ALF license, facilities may offer the following services:

- Assistance with personal care, meals, housekeeping and laundry;
- Nursing supervision during nursing intervention;
- Intermittent or unscheduled nursing care;
- Medication administration;
- Assistance with cognitive orientation;
- Any specialized service or unit for residents with Alzheimer’s disease and related dementias, physical disabilities, or other special needs that the facility intends to market;
- Assistance with transfer or ambulation; and
- Programs for socialization, activities and exercise.

**Assisted Living Facilities serve people who need assistance with activities of daily living.**

ALFs can expand and contract their services based on patient need. A facility may extend the range of services provided toward the outer bounds of the permissible scope of an ALF license. Facility administrators have described the outer bounds of the scope of physical care they can provide as a “one-person lift.” A one-person lift means that a single staff member is able to lift the patient without help. When a patient needs more than one staff member to lift them, the facility may consider transferring or discharging.

ALFs may also provide physical health services on site, such as home care, hospice, nursing care, and physician visits. ALFs are not required to provide mental health services beyond medication administration. However, the facility must disclose available services on its license application and resident services agreement.

These facilities primarily market themselves to aging people. The admission criteria for an ALF is based on the services it chooses to provide. One ALF administrator described residents as needing more personal care services than are feasible at home or in an independent living retirement community; needing help with some activities of daily living such as dressing,
bathing, or minor help with taking medications; and needing supportive health care but not the around-the-clock medical care and supervision of a nursing home.\textsuperscript{54}

ALFs cost on average $3,033 per month for basic services.\textsuperscript{55} These facilities accept out-of-pocket resources from residents or family members or private long-term care insurance. Out-of-pocket resources may also include any government benefits paid directly to the individuals. If an individual is fortunate enough to have private long-term care insurance, policies will often cover the cost of staying in an ALF.

**Nursing Facilities**

*Nursing Facilities Primarily Meet the Housing and Acute Physical Care Needs of Aging Individuals with SMI.*

Nursing Facilities (NF) primarily serve aging individuals with serious physical conditions. These individuals are unable to live independently because they have physical health needs that require a high level of care. NFs offer routine skilled nursing care, personal care, and rehabilitation services. NFs accept payment for mental and physical health services through private long-term care insurance, Medicaid, and out-of-pocket payments.

NFs are licensed to provide health-related care and services to individuals on a regular basis.\textsuperscript{56} NF residents must require a level of intensive care and services that can only be provided by a NF.\textsuperscript{57} For example, facility administrators have described this level of physical care as a “two-person lift.”\textsuperscript{58} A two-person lift means that two aides are required to move the patient. In addition, some NFs offer skilled nursing care and rehabilitative services.\textsuperscript{59}

NFs are licensed to provide the highest level of health care services of all Oklahoma facilities.\textsuperscript{60} The Nursing Home Care Act confers the power to the Oklahoma Health Department to establish the licensing and certification system.\textsuperscript{61} Health Department regulations list many examples of nursing, personal, and other care services that NFs may provide. For example, NFs must turn residents who are confined to bed every two hours or as needed, keep residents clean and free of odor, and assist the resident in securing other services recommended by a physician.\textsuperscript{62} However, individual facilities may expand upon the list.\textsuperscript{63}

State licensing laws require NFs to provide psychological or psychiatric counseling as needed.\textsuperscript{64} However, discretion is built in because the determination of need is based on an evaluation by the facility’s physician. Thus, mental health services are arguably discretionary beyond medication administration.
Barriers

People with SMI and co-occurring physical conditions face barriers to housing and care. A barrier can include anything that inhibits their ability to enter or remain in a facility or anything that inhibits them from receiving mental or physical health care services in a facility. In Oklahoma, at least two barriers are shared across facility types: (1) discretion and (2) cost and funding.

Discretion

Under Oklahoma and federal law, RCFs, ALFs, and NFs generally have the discretion to determine who to admit, involuntarily discharge, or involuntarily transfer, with greater discretion for admission decisions than discharge or transfer decisions. Even where discretion is limited by regulations, it is generally up to residents and their family members to enforce their rights under the law. Discretion is a barrier because it can prevent aging individuals with SMI and co-occurring physical conditions from entering or remaining in a facility.

Residential Care Facilities

Compared to ALFs and NFs, Oklahoma’s RCFs have the most discretion to make admission, involuntary discharge, and involuntary transfer decisions. In RCFs, physical health problems can be a barrier to admission or a reason for discharge. For example, Oklahoma regulations provide that an RCF can admit a resident who is capable of self-administering medication, such as insulin. However, RCFs still have the discretion to decide whether to admit an insulin dependent resident, as well as whether to involuntarily discharge a resident who becomes insulin dependent.

Discretion is a barrier because RCFs, ALFs, and NFs can determine which residents they admit, discharge, or transfer.

Individuals with SMI are 2-3 times more susceptible to diabetes than the general population, due to the side effects antipsychotics have on the body. Further, RCFs may choose not to admit an insulin dependent resident because they are at risk of receiving a notice of deficiency during health care inspections if the resident fails to correctly administer the insulin. Thus, facility discretion on admission is a barrier to a large part of this population.

In addition, some providers report that RCFs are increasingly choosing not to admit potential residents who have a SMI and spectrum disorder, a mental disorder marked by impairments in the ability to communicate and interact socially and by the presence of repetitive behaviors. This choice is based on past physical conflicts between residents with spectrum and residents without spectrum.
In making involuntary discharge decisions or transfer decisions, RCFs may discharge a resident for medical or safety reasons, or for non-payment. Residents must be given proper notice, except in emergencies or where resident safety is at risk. Thus, RCFs effectively have broad discretion to involuntarily discharge or transfer.

**Assisted Living Facilities**

Under Oklahoma law, ALFs are required to describe the population they will admit based on the services they provide. An individual ALF’s admission criteria must also appear in the resident service agreement and license application. Facilities have the discretion to deny admission to any applicant if the facility determines they are unable to meet their needs.

Anecdotal evidence provides insight into how both stigma and staffing can play an important role in an ALF’s discretion to deny admission to people aging with SMI and physical conditions.

Stigma about mental illness may contribute to an ALF’s discretion regarding who to admit. If the facility is concerned that staff, other residents, or their families will have objections to new residents with SMI, the facility may not risk admitting them.

In addition, there is no requirement that staff in ALFs be trained to handle patients with SMI. If a facility’s staff has no training on how to interact with and care for residents with a SMI, the facility may determine it cannot meet the needs of a potential resident with SMI, and may decline to admit them.

Finally, ALFs must routinely screen their residents for appropriateness of placement. A resident may be inappropriately placed if:

- The resident needs care or services that exceed the care or services available in the ALF;
- The resident’s physician determines that the resident requires physical or chemical restraints in situations other than emergencies;
- The resident poses a threat to self or others; or
- The assisted living center is unable to meet the resident’s needs for privacy or dignity.

If the facility determines that a resident is inappropriately placed, it may involuntarily discharge that person from the facility, which is called “termination of residency.” Oklahoma regulations governing ALFs require notice and other steps that an ALF must take before discharging a resident involuntarily, but the regulations contain exceptions for “emergency” immediate health needs and physical safety of the resident and others. Despite some limitations on ALF discretion to discharge or transfer, it is certainly possible for a facility to discharge a resident, even without giving notice or following other procedures.
Nursing Facilities

The dynamics of admission, involuntary discharge, and transfer decisions in NF’s are similar to those in ALFs. NFs have broad discretion on admission decisions and may only admit people they have the staff and resources to care for, but all residents must require the high level of care nursing homes are designed to provide).

For involuntary discharge and transfer, NF’s are similar to ALFs. Despite some limitations on NF’s discretion to discharge or transfer, exceptions in the law make it possible for a facility to discharge a resident without giving notice or following other procedures.

In the context of admission decisions, stigma and staffing can play a role in NFs, just as in ALFs. In the admissions process, NFs may screen out potential residents with serious mental illness. These decisions may be driven by stigma, cost concerns, or a lack of training on how to care for this population.

Once admitted, a NF has discretion to determine whether they or their staff are meeting the patient’s needs. If someone with SMI requires care that NF staff are not trained to provide, the facility may determine that it no longer meets the patient’s needs and involuntarily discharge them.

For example, someone with schizoaffective disorder may “shadow” a staff member when he or she needs additional care. Shadowing is when someone with serious mental illness follows someone closely. If staff are not familiar with shadowing, or how the patients’ needs manifest, the facility may determine it is unable to handle the resident. In addition, anecdotal evidence suggests NFs may “dump” challenging residents on hospitals by transferring them to a hospital and then refusing to re-admit them.

In NF’s, discretion surrounding discharge and transfer is not complete, as discharge or transfer must be justified and documented, and residents must be given notice. But the notice requirements do not apply for “emergency” situations and where the physical safety of the resident or others is at risk. This effectively gives NFs broad power to discharge residents they deem too challenging, including people with serious mental illness.

Cost and Funding

Cost and funding create barriers to access for RCFs, ALFs, and NFs. Cost and funding are barriers to RCFs and ALFs because they are private pay facilities that do not accept Medicaid. While NFs accept Medicaid, cost and funding are still barriers because mental health care, such as counseling, therapy, and certain medications are cost prohibitive.

Cost and Funding are Barriers in RCFs and ALFs Because They are Private Pay Facilities.

A RCF is a private pay facility whose residents must rely on out-of-pocket funds,
such as retirement, savings, and social security benefits, to pay for housing costs.\textsuperscript{92} Due to these payment limitations, RCFs create barriers for potential residents who do not have sufficient funds to live in a RCF and do not have or qualify for Social Security or SSI benefits. Despite these payment limitations, RCFs are the least expensive SMI facility, and thus more accessible than ALFs and NFs.

Similarly, ALFs are private pay facilities, but they are too expensive for many aging individuals with SMI and co-occurring physical conditions. In 2017, the median cost of care in an ALF in Oklahoma was $3,033 per month.\textsuperscript{93} ALF costs can start at $4,000 per month in larger metropolitan areas, just for basic services.\textsuperscript{94} When residents’ physical or mental health needs increase, so does the cost per month for add-on services (such as speech therapy, skilled nursing, or hospice).\textsuperscript{95}

Medicaid generally does not cover the cost of living in an ALF, which is more than three times the cost of a semi-private room in a RCF.\textsuperscript{96} Thus, aging individuals with SMI and physical conditions are unlikely to have the out-of-pocket resources or a private insurance plan to cover the cost of living in ALFs.

\textit{Cost and Funding are Barriers in NFs Due to Medicaid Cuts and Costs of Care}

Although NFs accept Medicaid, cost and funding is still a barrier to entering a facility. During the application process, the NF can recognize a serious mental illness that might make a resident expensive to care for and simply deny admission to that resident.\textsuperscript{97}

Medicaid reimbursement rates also play a role in limiting access to care. As noted earlier, Oklahoma has cut Medicaid reimbursement rates at the state level to the point that many facilities are losing money every day on Medicaid patients.\textsuperscript{98} One nursing home administrator reports that Medicaid rates cause their facilities to lose around $20 per resident per day.\textsuperscript{99} That loss increases as patients’ needs increase, making people with mental illness and physical health problems less desirable for NFs.\textsuperscript{100}
Conclusion

People aging with serious mental illness and co-occurring physical conditions are some of the most vulnerable people in our state. They and their families face instability and uncertainty in accessing housing, supportive services, and health care. Oklahoma must take action to research, plan, and advocate for an increase in access to housing and care for this population.
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Appendix I: Continuum of Care

This table represents the range of facilities available to aging individuals with SMI and co-occurring physical conditions. It compares:

- Mental and physical health services
- Barriers to entry
- Payment options for both housing and services
### Continuum of Care

<table>
<thead>
<tr>
<th>More Independent</th>
<th>Less Care</th>
<th>Less Regulatory Complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INDEPENDENT LIVING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Estimated Monthly Cost:</strong> 10% of monthly income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Barriers:</strong> Must be able to live independently with limited supportive services. No screening for sobriety or mental health status. Residents need not have income.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Housing Payment:</strong> Out-of-pocket, public housing vouchers, and some are mixed housing models where free market renters help subsidize prorated renters</td>
<td></td>
<td></td>
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<tr>
<td>• <strong>Mental Health Services:</strong> Case manager to check in and recommend community resources</td>
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<td></td>
</tr>
<tr>
<td>• <strong>Physical Health Services:</strong> None</td>
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<td></td>
</tr>
<tr>
<td>• <strong>Health Services Payment:</strong> Out-of-pocket, Medicaid, private Insurance</td>
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</table>

**Enhanced Residential Care**
- Same as regular RCFs but must have 2 staff members awake and at the RCF at all times and must employ a Registered Nurse.

<table>
<thead>
<tr>
<th>More Care</th>
<th>More Regulatory Complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RESIDENTIAL CARE FACILITIES</strong></td>
<td></td>
</tr>
<tr>
<td>• <strong>Estimated Monthly Cost:</strong> around $800 for a semi-private room (often capped based on SSI income)</td>
<td></td>
</tr>
<tr>
<td>• <strong>Barriers:</strong> Must be able to walk without assistance and participate in activities of daily living (ADLs), such as grooming and dressing.</td>
<td></td>
</tr>
<tr>
<td>• <strong>Housing Payment:</strong> Out-of-Pocket</td>
<td></td>
</tr>
<tr>
<td>• <strong>Mental Health Services:</strong> Medication administration, assistance in accessing psychiatric care, facility must have agreements with mental health providers for emergency mental health needs and behavioral rehabilitative services</td>
<td></td>
</tr>
<tr>
<td>• <strong>Physical Health Services:</strong> Assistance in accessing dental and physical health services. Education on early warning signs to recognize health problems.</td>
<td></td>
</tr>
<tr>
<td>• <strong>Health Services Payment:</strong> Out-of-pocket, Medicaid and private Insurance</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Less Independent</th>
<th>More Care</th>
<th>More Regulatory Complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSISTED LIVING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Estimated Monthly Cost:</strong> starts around $3000 - $4000 for basic services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Barriers:</strong> Expensive. Facilities have discretion to make admission, discharge and service determinations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Housing Payment:</strong> Out-of-Pocket and Private Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Mental Health Services:</strong> Discretionary. Facilities may choose to open a mental health unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Physical Health Services:</strong> Medication administration. Intermittent or recurrent nursing care services, help with ADLs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Health Services Payment:</strong> Out-of-pocket, Private Insurance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>More Care</th>
<th>More Regulatory Complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NURSING HOMES</strong></td>
<td></td>
</tr>
<tr>
<td>• <strong>Estimated Monthly Cost:</strong> starts around $4000</td>
<td></td>
</tr>
<tr>
<td>• <strong>Barriers:</strong> Expensive without Medicaid or long-term care insurance. Facilities have discretion to make admission, discharge and service determinations.</td>
<td></td>
</tr>
<tr>
<td>• <strong>Housing Payment:</strong> Out-of-pocket, private insurance, and Medicaid</td>
<td></td>
</tr>
<tr>
<td>• <strong>Mental Health Services:</strong> All facilities must do medication administration, beyond this, the scope of behavioral health services is discretionary.</td>
<td></td>
</tr>
<tr>
<td>• <strong>Physical Health Services:</strong> Services must meet the highest levels of patient need</td>
<td></td>
</tr>
<tr>
<td>• <strong>Health Services Payment:</strong> Out-of-pocket, Medicaid and private Insurance</td>
<td></td>
</tr>
</tbody>
</table>
Appendix II: Payment Matrix

This table is a matrix detailing the forms of payment that may be used to fund mental health housing and care. It shows:

- The variety of payment options available
- Who receives the money
- What the money can be used for
# Housing and Health Care Payment Matrix

<table>
<thead>
<tr>
<th>Source</th>
<th>Payment Exchange</th>
<th>Used For</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out-of-Pocket</strong>: Funds from an individual or a family member. Out-of-pocket funds may include income from public benefit programs, described below.</td>
<td>Individuals or family members pay service providers or facilities directly.</td>
<td>Housing, food, and other costs of living. Housing and health care services in assisted living facilities.</td>
</tr>
<tr>
<td><strong>Veteran’s Benefits</strong>: Two types of Veteran’s Administration (VA) benefits may be used by aging individuals with SMI: VA Health Care and VA Pension.</td>
<td>VA Health Care provides health care for eligible veterans. Typically, this care is provided only in VA facilities. VA Pension benefits are paid directly to the individual, who can then pay a service provider or facility. For individuals who need assistance managing their money, facilities can sign up to be “fiduciary” and receive funds directly from the VA.</td>
<td>VA Health Care covers mental and physical health care services. VA Pension may be used for housing, food, or other costs of living.</td>
</tr>
<tr>
<td><strong>Social Security Retirement or Disability Income</strong>: Retirement Benefits are for older adults at retirement age. Disability Income is for individuals with a medical condition that is expected to last at least one year or result in death. Because these benefits are based in part on work history, they may not be available to many aging individuals with SMI because of the correlation between lower lifetime earnings and serious mental illness.</td>
<td>Payment from the Social Security Administration (SSA) is delivered to the individual, who can then pay a service provider or facility. For individuals who need assistance managing their money, facilities can sign up to be “representative payees” and receive funds directly from SSA.</td>
<td>Housing, food, and other costs of living.</td>
</tr>
<tr>
<td><strong>Supplemental Security Income (SSI)</strong>: For aged, blind, and disabled people with no or limited work history.</td>
<td>For an individual living alone and paying for their own housing, the 2017 SSI rate is $735 per month, paid to the individual. For individuals who need assistance managing their money, facilities can sign up to be “fiduciary” and receive SSI funds directly from SSA.</td>
<td>Housing, food, and other costs of living.</td>
</tr>
<tr>
<td><strong>Medicaid</strong>: Government funded and administered health insurance for low-income and disabled individuals.</td>
<td>Mental and physical health care providers bill Medicaid for services.</td>
<td>Mental and physical health services within the bounds of a Medicaid plan. Medicaid typically does not cover housing costs outside of nursing facilities.</td>
</tr>
<tr>
<td><strong>Private Insurance</strong>: Offered through an employer or purchased by an individual. Because of the correlations between lower lifetime earnings and SMI, aging individuals with SMI are unlikely to have private insurance.</td>
<td>Mental and physical health care providers bill the insurance company.</td>
<td>Varied physical, mental health, and long-term care services, depending on the type of plan.</td>
</tr>
</tbody>
</table>
Sources

Appendix III: Mental Health Facility Guide

This is a guide for aging people with SMI and co-occurring physical conditions (and their families and friends) who are seeking housing and care. The guide compares the following criteria across the four main facility types in Oklahoma:

- Facility staffing
- Estimated starting monthly costs
- Forms of accepted payment for housing and medical services
- Admittance criteria
- Mental and physical services offered
# Mental Health Facility Guide*

<table>
<thead>
<tr>
<th>Housing Type</th>
<th>Independent Living</th>
<th>Residential Care</th>
<th>Assisted Living Facility</th>
<th>Nursing Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Housing Type</strong></td>
<td>Apartments</td>
<td>Suites</td>
<td>Apartments</td>
<td>Bedroom &amp; shared bathroom</td>
</tr>
<tr>
<td><strong>Staffing</strong></td>
<td>During Business</td>
<td>24/7</td>
<td>24/7</td>
<td>24/7</td>
</tr>
<tr>
<td><strong>Estimated Starting</strong></td>
<td>~10% of Monthly</td>
<td>~$800</td>
<td>~$3500</td>
<td>~$4000</td>
</tr>
<tr>
<td>Monthly Cost</td>
<td>Income</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Forms of Accepted     | Out-of-Pocket      | Out-of-Pocket    | Out-of-Pocket            | Out-of-Pocket    |
| Payments for Housing  | Public Housing     |                  | Private Insurance        | Private Insurance|
|                       | Vouchers           |                  |                          | Medicaid         |

| Forms of Accepted     | Out-of-Pocket      | Out-of-Pocket    | Out-of-Pocket            | Out-of-Pocket    |
| Payments for Medical  | Medicaid           |                  | Private Insurance        | Private Insurance|
| Services              | Private Insurance  |                  |                          | Medicaid         |
|                       |                    |                  |                          | Private Insurance|

| Mandatory Admission   | Have a mental      | Able to walk     | Must need assistance     | Must need routine health-related care and services, due to a mental or physical condition, that can only be provided by a Nursing Facility. |
| Criteria              | illness            | without assistance| with at least one of the following: | |
|                       | Capable of living  | Capable of managing own affairs | Personal Care | |
|                       | independently      | No routine skilled nursing needs | Nursing Supervision | |
|                       |                    |                  | Unscheduled Nursing      | |
|                       |                    |                  | Medication Administration| |
|                       |                    |                  | Movement or Walking      | |

| Basic Services Offered| Case Management    | Distribution & Administration of Medication | Medication Administration** | Medication Administration** |
| for Mental Illness    |                    | Coordinating Outpatient Mental Health Services | **Facilities may offer additional mental health services.** | **Facilities may offer additional mental health services such as counseling or therapy.** |

| Basic Services Offered| None               | Activities of Daily Living (laundry, meal preparation, room cleaning) | Personal Care | Nursing Services |
| for Physical Conditions|                    |                                                              | Nursing Supervision | Rehabilitative Services |
|                      |                    |                                                              | Intermittent or Unscheduled Nursing | Medication Administration |
|                      |                    |                                                              | Medication Administration | Dietary Services |
|                      |                    |                                                              | Transfer/Walking | Room Maintenance Services |
|                      |                    |                                                              |                  | Personal Hygiene Services |

* Students from The University of Tulsa College of Law’s Lobeck Taylor Community Advocacy Clinic developed this guide for Mental Health Association Oklahoma. This document offers a basic overview of the landscape of services available to people aging with serious mental illness in Oklahoma. This is not intended to be a comprehensive or authoritative guide and should not be used to plan actual costs and services for individuals. Please check with facilities for specific costs and services.