

STATE POLICIES PLAN
FOR THE PROVISION OF
RESIDENTIAL CARE
STATE OF MINNESOTA

STATE PLANNING AGENCY

November 14, 1968

FOR THE GOVERNOR'S COUNCIL
ON HEALTH, WELFARE AND REHABILITATION

November 21, 1968

INTRODUCTION

A. Charge and Response

On October 4, 1967 Governor LeVander made the following charge to the Governor's Council on Health, Welfare and Rehabilitation:

"Finally, but perhaps most importantly, a thorough review of the utilization of our state institutions -- particularly for the mentally ill and the mentally retarded. In this review we must consider the new trends and our emphasis in decentralized care, we must recognize the new efforts of private enterprise in caring for the mentally retarded and mentally ill; we must contemplate the impact of new medical approaches to treatment. Then we must determine how to use vacancies in present institutions, whether to build additional facilities and if so, where and what kind."


In response to this charge the staff of the State Planning Agency contracted with the Stanford Research Institute for information and analysis of alternatives relating to the provision of residential care in Minnesota. Subsequently, the staff with the assistance and advice of the Governor's Council on Health, Welfare and Rehabilitation, the Health Planning Task Force, and several subcommittees on Residential Care with representation from the Social Welfare Planning Task Force, the Vocational Rehabilitation Planning Task Force, staff members from State Departments and Agencies, and from voluntary agencies developed the policies and recommendations included in this plan.

B. Responsibility

The State has a responsibility to ensure that residential care is provided for any citizen, who, for reasons of physical or mental disability is not able to reside in his own home. The State discharges this responsibility through one or more devices: the direct provision of services; purchase of services; establishing standards and licensing of facilities, services, and practitioners; control of public funds utilized in providing services and facilities; statutory and administrative regulation of third-party payers for service. The State Departments of Welfare, Health and Education are responsible for ensuring that specific services are delivered. County Welfare Departments and local school districts have statutory responsibilities as well.

C. Assumptions

Residential care provides care on a 24 hour per day basis to an individual in any facility outside of his own home (except acute hospitals) and provides access to a variety of appropriate therapies. Therefore, it is an expensive form of care, which removes the individual from his own home, separating him from his family and in some instances separating him from his own community.

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- 1) It is accepted that residential care is necessary for some individuals but is only a part of a continuum of services including prevention, early detection, out-patient care, home health care, special education, day care and many other such services.
 - 2) It is assumed, on the basis of current trends, that the need for Residential Care programs for some of the groups presently served will decrease in the future with the development of a wide variety of community based non-residential programs serving a variety of needs. However, disability groups are being found to need residential care for which the State in the past has not provided care, for example, the drug dependent, the increasing numbers and the increasing percentage of the total population over 65 for whom residential care of various types is required must also be recognized.

D. The Plan consists of the following sections:

- I. Summary of Legislative and Budgetary Recommendations
- II. Policy recommendations relating to State residential care programs
- III. Recommendations relating to new and existing facilities and programs by disability group
- IV. Recommendations relating to Standards and Licensing
- V. Recommendations relating to Planning

I. Summary of Legislative and Budgetary Recommendations

A. New Legislation

1. "Cost of Care" - Bill to be introduced by Department of Public Welfare. State will reimburse counties at rate of 50% or more of net cost to county of care for retarded individuals under 18 years of age in any licensed facility.

1.9 million -

Estimated cost to state, biennium - 1.5 million

2. Amendment of Minn. chapter 145.125 to promote development of home health care programs by counties, or multi-county arrangements. State Department of Health.

Minimum subsidy per county = 3000/yr.

Estimated cost to state, biennium - \$522,000

3. Amendment of _____ to require local school districts to provide special education programs to all children who are able to benefit from special education. Federal funds available.

Estimated cost to state, biennium -

4. Legislation requiring reporting by local school districts of all children who are not being served by school programs and the reasons they cannot be served. To be presented by Department of Education.

Estimated cost to state, biennium - none

5. Amend legislation supporting daytime activity centers for mentally retarded to include rent, amortization, remove per capita limitation. Cost for last biennium -
To be presented by Department of Public Welfare.

1.8 million

Estimated cost to state, biennium - \$3.6 million

B. Appropriation requests

1. The State will continue to share (20%) financing of residential care for the elderly with federal (58%) and county (20%). Estimated by Department of Public Welfare to be 20 million for last biennium.

Estimated cost to state, biennium - 27 million

Estimated increased cost to state - 7 million

2. Provision of funds to Hastings State Hospital to develop small residential care units for mentally retarded.

Estimated cost to state, biennium - \$1.5 million

3. Increase support for long-term sheltered workshops for ~~mentally retarded~~ through Division of Vocational Rehabilitation. Cost for last biennium - \$600,000. To be presented by Department of Education.

Estimated cost to state, biennium - \$1.6 million

4. Appropriate State funds for matching federal funds for detection and treatment program of Crippled Children's Service.

Estimated cost to State, biennium - \$700,000

Total program, biennium- \$ ~~1,642,200~~ 15 mill
~~21,422,000~~

II. Policy Recommendations relating to State Residential Care Programs

A. Residential or Non-Residential Care: More Non-Residential Services Required

The State should increase the number and variety of non-residential care programs by direct service and by financial incentive, in some cases requiring legislative enactments, with the long-range goal of minimizing the number of persons in any kind of residential care, while maintaining a system of residential care for those who require it.

Advantages: Overall lowering of costs by not having to provide 24-hour a day care, increased number of persons able to remain in home, increased number of individuals able to achieve productive independent status through non-residential care programs, decreasing numbers in state residential care programs allowing more adequate care.

B. Role of Private Sector and State: Private and State Programs Should Continue

In addition to financing of care and other methods of stimulating program development in the private sector, and standard setting and supervision, the State will continue to develop residential care programs for mentally or physically disabled people, including those who are mentally ill, mentally retarded, alcohol or drug dependent, elderly, physically handicapped.

add sentence: State should develop for culturally dependent & economically dependent individuals, substantially poor black people & from Chicago
The same standards will be applied to State programs of residential care as are applied to the programs in the private sector.

Advantages: Stimulation of innovation through competition builds on existing program and staff strengths, State provides "back-up" for those unable to obtain care in private sector, increases options for placement, cost-benefit studies can be made.

* C. Single Purpose or Multi-Program Residential Care Centers: Multi-program centers recommended

The State should develop multi-program regional centers with varying degrees of residential and program specialization on the same campus for dysfunctioning persons not able to be served in community facilities. This does not preclude integration within programs to the degree necessary or desirable, but required separate program planning. Program standards for the different programs must be developed and adhered to. The development of multi-program facilities must follow the development of staff and program capabilities for each of the disabilities. Such centers should not be limited to present State residential care institutions.

Advantages: Flexibility in planning as groups increase or decrease in numbers, allows special programs for special groups, ability to serve multiple problem residents, maximizes use and interest of professional personnel.

* D. Centralized or Decentralized Provision of Care: Regional Centers Proposed

The State should develop presently existing institutional campuses into regional centers, utilizing the seven institutions for the mentally ill, plus three institutions for the mentally retarded as regional centers; further the State should judiciously phase out institutions judged to be inappropriately located or obsolete, and make the gradual addition of new regional program centers located more appropriately, for example, in the metropolitan area where the population of need is greatest.

- No. - Advantages: Maximizes and builds on present strengths, some concentration of skilled manpower, provides care nearer to home community, less costly than alternatives, new centers to be placed where resources are available.

E. Full Range of Services or Differential Services: Selected Services to be provided

The State will provide residential care of varying levels, and selected differential services dependent on the following variables:

1. The size of the disability group in question
2. The particular treatment requirements of the disabled group
3. The ability of the private sector to adequately provide the services

The extent to which these services will be rendered will also depend upon related federal policies, and the available federal, state and local resources for those services.

Advantages: Allows flexible programs to provide for variations in needs of disability groups, allows responsiveness to changes in financing and technology, permits specialized programs within certain centers.

F. Community-based (local) and Regional Services: Private community-based serviced to be encouraged

The State will provide appropriate services at the regional level according to the policies established previously and will encourage and, where appropriate, financially support to the greatest extent possible the establishment of community-based (local) programs by non-profit groups and/or proprietary owners when it appears that community involvement and the development of community services can better serve the needs of the disability group of concern.

Advantages: Private sector will provide capital funding, smaller facilities will be encouraged, utilization of community services will be maximized.

G. Manpower Development: Training programs and affiliations with schools and colleges to be developed

The State multi-program centers will, as a matter of policy, develop affiliated training programs for appropriate college, junior college, vocational school, and graduate students from schools within their region, or located conveniently. Further, affiliation with the University of Minnesota and appropriate specialists including but not limited to medicine, psychology, education, and related therapies will be formalized with the State hospital system, and include student training programs.

Advantages: Increasing trained manpower pool, increasing community awareness and involvement, provides staff satisfaction and interest, provides further attention and care for residents.

H. Research Programs: Evaluation of program essential

Research in the State system should be encouraged as appropriate. However, evaluation of effectiveness of programs and/or services, both new and ongoing, is a specific type of research that is essential.

Advantages: In disability groups under consideration differing modes of treatment are unknown as to benefit. Studies will assist in developing programs of maximum effectiveness.

III. Recommendations relating to new and existing facilities and programs by disability group

A. Recommendations relating to the elderly

1. The residential care of the elderly will continue to be financed by the federal, state and local levels of government as well as by individuals who have the ability to pay, and will continue to be provided principally by the private sector in community-based facilities.

Implementation:

- a. The estimated cost to the State for the 1967-69 biennium for nursing home care is \$20 million
- b. During the 1969-71 biennium increased support of the Department of Public Welfare will be necessary. Estimated by the Department of Public Welfare at \$13 million for F.Y. 1970 and \$14 million for F.Y. 1971 - Total equals \$27 million for the biennium 1969-71, which is 22% of the total cost; Federal contribution, 56%; County, 22%.

2. The State residential care centers must provide limited programs of nursing care for residents who are in state residential care for other than nursing reasons and require temporary care, or for those who cannot be placed in private care.

Implementation: The state presently provides this type of care; no change is required.

3. Residential care at clearly defined levels appropriate to the needs of the individual must be provided as the need dictates so that skilled nursing home care or extended care is not provided to those who do not require it.

Implementation: Federal regulations have required establishment of levels of nursing care: extended care, skilled nursing care, intermediate care; in addition, boarding care and foster home care is available. Some cost savings should result because of more appropriate utilization of care programs.

4. Essential services to the elderly in their homes must be provided throughout the State including:

Home health care, as provided by nurses and home health aids through certified home health care agencies.

Implementation: Financial support from Medicare provides 80% reimbursement. Subsidy required to stimulate program development equals \$3000 per county times 87 counties = \$261,000 per year.

5. The provision of day care in Nursing Homes for certain of the elderly who do not require 24-hour-day care, but would benefit from some supervision, and nutritionally adequate meals, should be considered as an additional service to be provided by licensed Nursing Homes.

Implementation: Eligible for Title 19 payment if classified as Rehabilitation care. Eligible for Title 3 (Older Americans Act) funding on a project grant basis. Through Minnesota Nursing Home Association and Conference on Geriatric Care.

B. Recommendations relating to the mentally ill

1. The State will continue to provide care and treatment for the mentally ill in the State hospital centers currently providing care. Care programs may also be developed at those centers not presently providing such care. Care provided may be short-term or long-term depending on individual need. Partial hospitalization programs and out-patient services should also be provided.

Implementation: Department of Public Welfare, Division of Medical Services.

2. More residential care programs for emotionally disturbed children and adolescents should be developed.

Implementation: Federal funds available through various Education Acts should be fully utilized. State funds necessary to encourage programs needed should be appropriated.

C. Recommendations relating to the mentally retarded

1. The State will increase the support of Daytime Activity Centers for retarded children: pre-school, school age who are unable to benefit from school programs, and post-school.

Implementation: Legislation required: including 1) rent and amortization inclusion, 2) removal of per capita ceiling. Estimated cost for biennium - 3.6 million. The Department of Public Welfare will introduce legislation.

2. The State will increase support of long-term sheltered workshops for employment of severely handicapped individuals.

Implementation: Requires an appropriation to DVR of 1.6 million dollars for next biennium (1967-69 - \$600,000).

3. The State shall reimburse the counties for costs of care of the mentally retarded so that consideration of whether care should be provided in a public or private institution will be made on the basis of the needs or the individual rather than relative cost to the county.

Implementation: Initial legislation to establish the principle of state sharing of costs for care in private institutions has been proposed with a minimum estimated cost of \$1.5 million. Rates and fees paid must be approved by the Commissioner of Welfare. Family responsibility for sharing shall be set at the same rate prevailing for state institutions. Legislation to be presented by Department of Public Welfare.



4. The State will provide residential care and appropriate services to mentally retarded persons from within the region

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served by the multi-program regional center. Some specialized services may be provided outside the regional center, and services may vary depending on available local community services, other state special services, availability of specialized personnel, etc.

Implementation: A step in developing a program for mentally retarded at Hastings State Hospital has been proposed, calling for facilities for 60 retarded at a cost of \$1.5 million.

5. The State will require special education programs for all mentally retarded children able to benefit from such programs.

Implementation: Requires amending State law. Federal funds available. To be presented by Department of Education.

6. The State will require reporting to the State Department of Education the names of all children who are not being served by the school programs and the reasons they cannot be served. This information is needed to enable those responsible to plan for services for such children.

Implementation: Requires legislation. To be presented by Department of Education. No budgetary request.

D. Recommendations relating to the Alcoholic and Drug dependent

1. Community Mental Health Centers should develop programs for information and referral as well as for out-patient treatment of the alcoholic and drug dependent person.

Implementation: Recommendation to Community Mental Health - Mental Retardation Boards.

2. It is essential that industry increase its efforts to provide for early identification and referral of the alcoholic and drug dependent.

Implementation: Commission on Alcohol Problems, Department of Employment Security.

3. The statutory responsibility for inebriacy rests with the County Welfare Departments. Expertise in alcoholism and drug dependency counseling should be acquired.

Implementation: Through Department of Public Welfare, Division of Field Services.

4. Acute detoxification of alcoholics should be provided and short-term treatment programs considered at community hospitals, with effective referral to the treatment program such as those provided at the State regional center and the community mental health center. This will require:

- a. Education of physicians, graduate and undergraduate and

of hospital personnel.

Implementation: Through the Minnesota Hospital Association, State Medical Association and the University of Minnesota.

- b. Financial support for the acute care and short-term treatment within hospitals.

Implementation: Through changes in hospitalization insurance and whatever federal, state and local sources can be found.

5. The State regional multi-program centers should provide both short-term treatment and long-term care for alcoholic and drug dependent persons. Special expertise in alcohol and drug dependency should be acquired by such centers.

Implementation: Administratively through Division of Medical Services, Department of Public Welfare.

6. The development of half-way house facilities in the community is to be encouraged.

Implementation: Recent amendments to the Community Mental Health Center Act provide for federal funding of programs for care of alcoholics and drug dependent persons. Local matching should be sought from industry, United Fund and other agencies. Encouragement can be provided through the Council on Alcohol Problems, the Minnesota Commission on Alcohol Problems and associated educational programs.

7. Research programs on the problems of abuse of alcohol and drugs should be carried out to make further information available on which to base treatment programs.

Implementation: Through Commission on Alcohol Problems, with Department of Public Welfare, Department of Health, University of Minnesota, other public and private agencies.

E. Recommendations relating to the physically handicapped child

1. Pediatric nursing care: convalescent care shall be provided in Convalescent and Nursing Care units or Extended Care Facilities attached to hospitals.

Implementation: Permission must be obtained from State Health Department.

2. Long-term care for those severely handicapped children requiring primarily nursing care shall be made available for children in a wing at a centralized facility in the metropolitan area.

Implementation: Glen Lake - Oak Terrace Nursing Home has competence for this type of care.

3. Expand detection and treatment program of Crippled Children's Services.

Implementation: State appropriation must be made each biennium to augment the federal funds available but inadequate. Cost estimate for biennium - \$700,000.

4. Detection and diagnostic programs should be developed within regions as much as possible and coordinated with health department staff, school districts and County Welfare Departments.

Implementation: Administratively through Crippled Children's Service.

5. The State shall continue to operate detection and treatment services to the physically handicapped children through Crippled Children's Services. The State shall encourage the development of a new program for residential care, and treatment of handicapped children (associated with a medical center in the Twin Cities Metropolitan area) and should subsidize the program through Crippled Children's Services appropriations for those children not covered by hospital insurance and not eligible for medical assistance. This new program should offer a full range of services including medical, psychological, rehabilitative and educational programs to those unable to receive care from other sources due to the complex nature of their disability.

IV. Recommendations Relating to Standards and Licensing

- A. Program Standards are to be developed for residential care facilities for the mentally retarded. Program standards are to be applied to State programs as well as to programs provided in the private sector.

Implementation: Through Department of Welfare, Medical Services Division.

- B. Program Standards should be developed and applied relating to activities which should be provided within nursing homes, such as recreational and group activities, occupational and therapy, etc. Program standards must be applied to public as well as private facilities.

Implementation: Through State Health Department, Hospital Services Division.

- C. Standards and methods for a complete evaluation of the physical, mental and social disability for each individual for whom residential care is sought must be developed and required for placement in a licensed private or state facility.

Implementation: Department of Public Welfare with the assistance of State Department of Health, State Department of Education and other appropriate private and public agencies.

V. Recommendations Relating to Planning

- A. Regional planning for residential care, as well as for other services should be initiated. The area-wide Comprehensive Health Planning Councils as they are formed should assume responsibility with the staff of the State Multi-program Centers, Community Mental Health - Mental Retardation Boards, County Welfare Boards, Special Education regional representatives, State Health Department regional personnel, and other public and private groups and agencies. Common regions as outlined in Executive Order No. 9 should be utilized where possible.
- B. Area-wide Comprehensive Health Planning Agencies, where they exist, must develop review criteria and should review and approve the addition of residential care beds within their regions.

Implementation: The State Comprehensive Health Planning Agency must work with area-wide agencies in fulfilling these responsibilities.

- C. Local school districts are required to develop special education programs. These may be developed on a multi-district basis if necessary, throughout the state. Planning for these programs may include residential facilities. In addition, the educational responsibilities of the school systems and the treatment role of the Community Mental Health Centers and other treatment resources must be integrated for maximum impact of the emotionally disturbed child.

Implementation: Planning for Special Education and residential care for children within regions to include Boards of Education and Community Mental Health - Mental Retardation Boards.