78

McKNIGHT/DPW WORK GROUP

RESIDENTIAL SERVICES RECOMMENDATIONS

(RESPONSE TO FIRST DRAFT)

by

BRIAN R. LENSINK

CONSULTANT

OCTOBER 5, 1983

A. THE FOLLOWING ARE ASSUMPTIONS ABNOUT MINNESOTA WHICH HAVE BEEN EITHER EXPRESSED BY MEMBERS OF REACTOR PANEL OR ARE ASSUMPTIONS YOU EXPRESSED IN THE REPORT. PLEASE RESPOND TO EACH STATEMENT.

1. MINNESOTA HAS THE MOST AGGRESSIVE AND PROGRESSIVE RESIDENTIAL SYSTEM IN THE UNITED STATES.

Response:

Minnesota may have the most aggressive residential system but I don't believe they have the most progressive. With very little "in-home" residential support, foster care (particularly for adult), minimum supervision residences, special residence for the difficult to service (i.e. sensory impaired, MI/MR, aggressive, and retarded offenders), and with 2400 people still in state hospitals, I would hardly say progressive. On the other hand, with 5000 ICF beds in the community and 2400 ICF beds in state hospitals, I do believe aggressive would be a good description. Several other states have what I believe would be considered a more progressive system with a full continuum of services using a wide variety of residential options. These states have also focused more on keeping people well supported at home and have more aggressively reducing their state hospital populations.

These comments are not meant to be chastising, for Minnesota has certainly not been standing still in the area of residential development. It is only hoped that the weaknesses of the current system are recognized and corrected.

2. WRITTEN STATEMENTS/POLICY REFLECT A COUNTY RUN RESIDENTIAL SERVICES, NOT IN REALITY.

Response:

I fully understand the ambivalence which currently exists in regard to accepting the fact that Minnesota has a county run system. Everyone I talked to, however, knows that that is the system in Minnesota. It is strongly recommended that this <u>reality</u> be accepted and that each of the major "players" in the system take their appropriate "positions" or roles, help each other "play" or implement their roles so the "team" or system can function properly.

The state must provide leadership, direction, support and trust in the counties. The counties must work hard to successfully plan and obtain quality services for their mentally retarded citizens, and the service providers must work to provide the services that the counties want in order to meet the specified needs of the clients. If each part of the system accepts it's role even though it may be threatening and also helps the others take their's, the system can work better and the retarded person will benefit.

3. LACK FAMILY IN-HOME SERVICES: FUNDING FOLLOWS "BUILDINGS." WHICH ARE OUTSIDE IN-HOME.

Response:

In this consultant's opinion, the Minnesota system has encouraged residential placement outside the home. With one of the highest placement rates per capita it would be difficult to say otherwise. It is recommended that a concerted and planned effort be developed to turn this process around and help future families maintain their mentally retarded children at home. Continued dependence on out-of-home placement will slowly but surely bankrupt Minnesota and not serve the best interests of its retarded citizens.

4. MINNESOTA SERVICE SYSTEM IN NOT "BAD", BUT MINNESOTA NEEDS AN ARRAY OF SERVICES, NOT DESTROY PRESENT SYSTEM.

Response:

Minnesota is not "bad" - it is doing its best by recognizing areas of weakness and planning to make needed corrections. To destroy the past is fool hardy, however, to stay in the past would be equally as fool hardy. Minnesota has a large base of service and now needs to expand its array of services, commit itself to a service delivery approach and then continue its positive direction with the same enthusiasm and energy it has had over the past 10 to 15 years.

5. LACK OF FLEXIBILITY IN FUNDING.

Response:

This is definitely a severe problem which needs correction as quickly as possible. The elimination of funding source, disincentives, application for appropriate waivers, and commitment to help the county develop necessary options are major steps forward to improve this nagging problem.

6. FLEXIBILITY IS NEEDED IN TYPES OF BUILDING THAT PROVIDE SERVICE TO DIFFERENT TARGET POPULATIONS.

Response:

I agree totally with this observation. Minnesota must be more creative in the use of existing buildings and put a halt to new construction. With the current number of ICF beds, no new construction should be needed for many years.

7. HOUSING HAS IMPROVED FOR PEOPLE.

Response:

I'm sure this is a true statement and that fact should not be forgotten as a major achievement for Minnesota.

8. SERVICE NEEDS BASED ON BUILDING TYPES (ICF_MR A/B, SILS) RATHER THAN INDIVIDUAL NEEDS.

Response:

This is a common problem with the ICF program nationwide. The recommendations made in the first draft report (i.e. residential recommendations 2, 3, and 4) speak to this concern.

9. PLEASE CLARIFY - WHEN PEOPLE ENTER ARIZONA SYSTEM DO THEY HAVE CHOICES? WHAT ARE THEY?

Response:

Yes, there are many options in the Arizona system. A client needing a residential service can receive "in-home" support, respite or sitter service, foster care, a variety of residential alternatives including apartments, boarding homes, residences in typical neighborhoods (all with differing amounts of staff support and program structure) or they can be placed in the training center (institution) under some very rigid criteria. All of these options vary in size and location depending on client needs.

Sometimes the residential options needed by the client are not available for we do not have enough to meet all the needs. When we get more funding to open more residences or when we have an opening due to movement the person will be serviced While the person is waiting, other support is offered to the parents and usually taken.

10. MINNESOTA SYSTEM: TEAM LEADER/CASE MANAGER IS IN PROVIDER ORGANIZATION THAT ASSIST PROGRAM DEVELOPMENT FOR PERSON.

Response:

Many times it is very appropriate for a large agency to have case managers or social workers to help coordinate the services provided to clients - particularly if they are in multiple programs.

This does not mean that they can replace the functions of the county case manager unless specifically contracted to do so. The functions of eligibility determination, service plan development and follow along, and service authorization and payment still must be maintained by the county for they are ultimately responsible for the client and the services provided. It is this consultant's belief that the roles of various case managers must be distinct and clear and must differ as do the roles as described in response A.2..

11. ASSUMPTION IS THAT PLANNING AND MONITORING WILL IMPROVE SERIVCES.

Response:

I am totally confident that planning and monitoring will improve services. It will also improve trust and credibility with the state legislature and other groups critical to the success of the service system for mentally retarded citizens.

12. WHICH GROUP IN STATE WILL LEAD DEVELOPMENT OF ASPECTS OF "VISION?" QUESTION DPW POSITION TO DO THIS. SUGGESTION IS FOR "OPEN" PROCESS THIS IS NOT HAPPENING.

Response:

The vision is everyone’s responsibility. DPW has articulated some vision in its rules and I believe they can assist in going further. The county, service providers and advocates all have a responsibility however and if they all work toward this end, those who drag their feet will be pulled along.

13. CASE MANAGERS MUST BE IN PROGRAM DEVELOPMENT. QUESTION THIS.

Response:

I disagree that case managers must be in program development. I even believe that they should not be in program development. If a case manager is highly invested in the development of a certain program they could easily loose there perspective or objectivity as to the best service to meet a client's needs. I strongly believe it is best if program development can be done by a professional outside of case management- someone who can become a real expert in the specific program area as suggested in service delivery system recommendations 5 and 9 of my first draft report. This allows the case manager the opportunity to interact with all programs objectively.

In some small counties it may be financially impossible to separate these roles but even then it should be done with caution and understanding of possible conflict.

14. "EVIL ASSUMPTION" - PROVIDERS ARE THE EXPERTS IN PROGRAM DEVELOPMENT. WHY "EVIL?"

Response:

I believe providers should be experts in developing programs but the territory should not be "reserved" for only providers. The counties must develop expertise in program development so they can put together the continuum of services they want and need for the clients they serve. Many times providers develop programs which they are most comfortable with or which interest them, their boards or their professional staff. These may not be the programs which the county wants to purchase.

There is plenty of room to have many experts in program development. If the state, county, or service provider has weakness in the area of program development expertise, it will hurt the whole system by throwing it out of balance and into an area of mistrust and disrespect.

15. IMPLEMENT RULES/REGULATIONS IN EXISTENCE.

Response:

I support this response totally. Only after implementation will you know if changes are really needed. If needed - change.

16. EVERYONE NEEDS TO BE MONITORED. SYSTEM NEEDS TO BE MONITORED. NOT JUST LICENSE PROGRAMS.

Response:

I fully support this response and have already made it a recommendation.

17. BROADER APPROACH TO QUALITY PROGRAM BESIDES LICENSE.

Response:

I fully support this response and have already made it a recommendation.

18. DO YOU UNDERSTAND ALL THE ACCREDITATION PROCEDURES, UTILIZATION REVIEW, QUALITY ASSURANCE, ETC. IN MINNESOTA?

Response:

I probably do not know about everything in this area as it pertains to Minnesota. I do understand typical ICF utilization reviews and quality assurance and generally find them weak. If the recommendations made in regard to evaluation and monitoring are really already in place then certainly you are ahead of the game. If not, then I prefer evaluation on monitoring as recommended to more traditional Medicade processes.

19. LACK IN CLIENT OUTCOME MEASUREMENT TOOLS/PROCESS/PROCEDURE.

Response:

Most states, including Nebraska and Arizona, are deficient in client outcome measurement processes. These processes tend to be expensive, intricate, and difficult to initiate on a systems wide basis. Any substantial progress you can make in this direction would be progressive.

20. IN MINNESOTA IF ANYONE NEEDS SERIVCE, THEN ASSISTED IN GETTING SERVICES.

Response:

I believe the case management system should be available to everyone at least for eligibility determination and needs assessment activities. Armed with this information the case manager can then advocate for the clients needs. Lack of funds, waiting lists and large demand levels make it difficult for most states to meet all of the needs.

21. ASSUMPTION: FAMILY IS FIRST CHOICE OF PLACE SERVICE DELIVERY. IS THIS ALSO FOR ADULTS?

Response:

This is always a difficult question. Generally, it is normal for an adult son or daughter to leave the family home and live on their own. The question is - when? It also depends on the family. Will the family allow the retarded son or daughter to grow and develop or will they over-shelter and over-protect. Is the retarded person making it impossible for the family to lead a normal life or are appropriate supports available for family relief?

Like most questions in regard to retarded persons, this one must be made based on the individual situation. There is a time, however, when alternate plans outside the family home must be made - this is when the parents are getting older. I believe plans should be made for alternative placement several years prior to the parents death. It is very difficult for a mentally retarded person to deal with a death and a new home all at once. It is much better if the parents can help with the residential transition well before they are unable to lend such support.

When economic times are difficult, such as they are now, I believe it becomes even more important to support the family and save all residential openings for those who need them most.

22. ASSUMPTION: SYSTEM IS CLOSED AT COUNTY LEVEL AND PROVIDER LEVEL. NEEDS TO OPEN UP TO GENERATE NEW PROGRAM.

Response:

I fully agree with this response. A good county case management system would help keep the system open and the county involved in generating new programs.

B. THE FOLLOWING ITEMS THE MEMBERS OF THE REACTOR PANEL FELT WERE MISSING FROM THE REPORT. PLEASE RESPOND TO EACH STATEMENT.

1. Not everyone who needs services will receive them. (p.28)

2. Target population - define.

3. Priority setting - who gets services and which services are used. (p.15)

4. Clarify: everyone deserves service, but not everyone is eligible for services.

Response:

All four of these items seem to relate and deal with availability of service. In most states there are not sufficient services to meet the needs of the mentally retarded population. It is also highly realistic to suggest that there never will be sufficient service. Therefore, we have to deal with priorities and the reality that everyone who needs service will not receive them and if received or when received, they may very likely not get everything which is needed. In my opinion, anyone who believes otherwise is naive and unrealistic.

Every service delivery system which accepts and deals with this reality have to develop some type of priority criteria to assist in making these difficult decisions.

I would recommend that Minnesota also develop such a criteria so as to assist the counties in their job of case management and to let the public know the state's priorities. A sample of this type of criteria is included in Addendum I.

5. WHAT SERVICES SHOULD BE OPTIONAL? MANDATORY?

Response:

I don't believe you can make services optional or mandatory if your system is client based. Each client should be reviewed and a determination should be made as to that client's priority regardless of the services needed.

6. SERVICES NEED TO BE AVAILABLE TO FAMILY (INCLUDING FAMILY NETWORK) FOR ADULT MEMBERS.

D. THOUGHT PROVOKING REPORT. CONCLUDING REMARKS.

1. Concern: Dual System

   a. M.A. DAC vs. DAC

   b. M.A. SILS vs. SILS

   PROBLEMS WILL RESULT FROM THIS. PLEASE COMMENT AS TO WHAT PROBLEMS YOU VISION.

Problems only need arise if Minnesota neglects to eliminate the disincentives pointed out in "Fiscal Disincentives in the Service System for People with Developmental Disabilities" by Thomas J. Chapel and in the Welsch vs Noot consent Decree. The elimination of these inequities are crucial to avoiding a "dual" or "two class" system.

If equity is not established, people who have been ICF residents will end up with priority services even if the need is not as great as a non-ICF individual. Our various levels of government have real financial problems. We must realize and accept that our retarded citizens are supported with limited public funds and not unlimited entitlements. Financial disincentive on the state or the county will cause many problems for retarded citizens.

It is <u>strongly</u> recommended that legislative action be taken to eliminate these barriers to equal service access. The county should pay the same for service regardless of the funding source.

2. PERSONS FUNDED BY WAIVERED SERVICES WILL BE MORE PERSONALLY ACCOUNTABLE FOR SELF/MONEY. MIDDLE CLASS LIVING (ICF-MR) WILL END. INDIVIDUAL RESOURCES WILL HAVE TO BE USED FOR BOARD/ROOM/CLOTHES/FOOD/TRANSPORTATION/ETC. LIVING STANDARDS CHANGE SUBSTANTIALLY.

Response:

It is true that living standards may change if Minnesota develops a system of services which is closer to the living style of the mainstream of society. Utilization of existing residences rather than building new facilities tends to keep life style and living environment more in line with the typical family. It also builds a system more in line "cost wise" with the "tax paying" public.

These changes don't mean that retarded people have to live in poverty conditions. Housing can be in good repair, clean, neat and comfortable without being expensive and fancy.

3. REPORT HAS THE FOLLOWING STATEMENT MISSING. PEOPLE NEED TO MOVE TO EQUAL OR BETTER LIVING ARRANGEMENTS.

Response:

I don't know if I can include that statement in the report or not. I feel that people need to move to a residence which meets their current program needs. If they move from a new, modem, and well equipped and staffed ICF to a moderately furnished thirty year old home in a typical community but have the program and supervision they need in that residence, then that would seem appropriate to me. In fact, if that environment allowed more independence and freedom, I would consider it a better living arrangement.

ADDENDUM I

PLACEMENT PRIORITY PROCEDURES

DIVISION OF DEVELOPMENTAL DISABILITIES

DISTRICT II

OPERATING PROCEDURES

SUBJECT: - PLACEMENT

FILE NO: AD-03 EFFECTIVE 7/1/81

PREPARED BY: Linda Tchida
Pat Healy Suellen
Hixon Linda
Gonzalez Sue
Brandt Charlotte
Thummel Nancy
Porterfield

APPROVED: Ronald S. Barber

Ronald S. Barber
District Program Manag

PURPOSE: In order to establish a procedure for the placement of clients into vendor operated and/or state operated programs in District II.

PLACEMENT PRIORITY CONSIDERATION

1.0 Emergency-Clients who, without provision of an immediate service, will experience serious mental or physical harm. It is recognized that children requiring foster care, children referred by Child Protective Services, and persons referred by District Program Managers are automatically assigned the highest priority for placement.

2.0 The following clients placement needs are equal in priority. Decisions regarding placement are made based on client movement goals, client appropriateness, client need.

2.1 Clients who are not currently receiving services through DDD operated or supported programs.

2.2 Clients currently in a ODD operated or supported program who require a placement as recommended by the IPP team.

3.0 Clients whose needs are not being met in their current program.

4.0 Out of state persons cannot be considered for services until they are residents of Arizona.

OPERATING PROCEDURE

1.0 Vendor agencies are to notify program areas of expected vacancies no less than two weeks before the vacancy is to occur. When a vacancy exists in a vendor program, the vendor will contact the service area contract coordinator who will notify the intake coordinator. The intake coordinator will be notified by the appropriate service area representative of a vacancy in state operated programs.

2.0 Upon notification of a vacancy in a vendor or state operated program, it will be the responsibility of the intake coordinator to immediately notify the case managers to present referrals at the next scheduled case conference or if necessary to convene an emergency case conference.

3.0 From the candidates presented, case conference committee members will prioritize: candidates to fill the vacancy; however, the final decision/selection rests with the vendor/program area. In cases where the vendor/program area chooses not to follow the prioritized listing, it will be the responsibility of the vendor/ program representative to respond to the case conference committee in writing of the rationale for the decision.

4.0 All clients moves will be coordinated through the assigned case manager and must reflect the consensus of the client's team.

5.0 Except in extraordinary circumstances, any residential placement is assured a miximum of sixty days and any day program placement, a minimum of thirty days, for adjustment. If after that period, it is demonstrated any documented that all resources have been exhausted and adjustment has clearly not been achieved, the IPP team will re-convene to recommend an alternative placement. The case manager will present the need and recommendations at the next scheduled case conference.

REQUEST FOR CHANGE IN PLACEMENT AND/OR SERVICES

1.0 When the IPP team identifies the need for change in placement or services, the case manager will present the team's recommendation to case conference.

2.0 Appropriate evaluations and/or supporting data on the client must be completed prior to presentation before the case conference committee.

CLIENT TRANSFERS

1.0 An emergency may occur which necessitates a client transfer from one program area to another. When prior notification of case manager is not possible or feasible, the area representative or their designate will notify the case manager within two working days.

ARTICLE 5

PROGRAM PLACEMENT

R6-6-501 PURPOSE

The purpose of the Program Placement process is to ensure that developmentally disabled persons in need of residential and day services from the Division of Developmental Disabilities (DDD) are objectively considered for available funded services.

R6-6-502 FUNCTION

The Program Placement Committee (PPC) performs the following functions to ensure that this takes place:

1. In conjunction with the DDD contracting agent for that district, identifies current vacancies;
2. Determines priorities for placement and movement of individual clients into and through services;
3. Identifies generic and/or non-DDD funded alternatives to placements;
4. Identifies appropriate individuals for vacancies and/or newly contracted openings.

R6-5-503 COMPOSITION

A. The Program Placement Committee is appointed by the Program Manager and shall consist of, but not be limited to, the Assistant Program Managers, or their designees, who are responsible for the delivery of client services. In addition, one member of the committee may be a client advocate who is consumer representative, but not an employee of DDD or a district service provider. Clients, responsible parties, and service providers with openings under consideration may attend PPC meetings as observers or to provide additional perspective, but may not vote.

B. A simple majority of PPC members shall constitute a quorum. The client advocate must be included in all decisions of the PPC. Appeals of PPC decisions shall follow Article 18, Programmatic Administrative Review.

C. DDD Case Managers shall be responsible for assuring the presentation of the developmentally disabled person's need for day or residential services to the PPC. Clients and/or responsible parties and service providers may assist in the presentation.

D. The Division of Developmental Disabilities shall establish statewide criteria for assigning priorities for services.

REM:de
6/20/83

ARTICLE OF INSTRUCTION
PROGRAM PLACEMENT

A. The Program Placement Process

1. All requests for program placement must be made by a member(s) of the developmentally disabled person's Individual Program Plan (IPP) team for case planning through the person's Division of Developmental Disabilities' (DDD) Case Manager. Recommendations will represent the team's concensus. The team will complete a placement evaluation consistent with the Arizona Revised Statute (36-551.01) and the DDD Instruction.

2. DDD Case Managers are responsible for securing evaluations to substantiate the need for a program should the PPC determine that the current or existing evaluations and assessments are insufficient to support the need for the proposed service.

3. Individual program needs as documented by the Case Manager or other team members are surfaced by the Case Manager through presentation to the Program Placement Committee (PPC). The Program Placement Committee may identify possible alternatives to placement, assign a priority for openings and indicate necessary action steps through the minutes.

4. After the initial recommendation, the DDD Case Managers must notify the Program Placement Committee of all significant changes affecting the client's placement or need for placement. Individual priority for placement must be reviewed at least semi-annually by the PPC.

5. The Program Placement Committee shall select appropriate individuals based upon the established priorities for referral to program openings. A record of all PPC decisions shall be made in the meeting minutes.

6. Factors such as urgency, geographic area, and date of request will be considered to determine which client will be referred to an opening when two or more clients with the same priorities can benefit from the service,

7. Each district must attempt to secure the services of a client advocate to serve as a standing" member of the PPC for a period of no less than six months.

B. Priorities for Placement

Placement priorities are identified to assist in internal planning and do not reflect the level of the Division's involvement with a client or family. Selections for openings are based on the following priorities:

1. Priority 1
    a. Court-ordered placements.
    b. An individual currently receiving Foster Care services who require continuing residential service when no longer eligible for Foster Care in order to prevent endangering his/her safety and welfare.

c. Individuals who are residing in a DDD-funded residential program- and need a day program because they are no longer eligible for other day program funding excluding those clients funded under ARS 15-765.

d. Individuals in need of a day program because the family unit has and continues to show signs of deterioration due" to the provision of 24-hour care to the individual. Without the provision of a day program a residential crisis is expected to occur within 90 days.

e. An individual 18 years and older who resides in a community setting which is not funded by DDD and in which there has been a pattern of abusive/neglectful treatment as documented by the Case Manager or other professionals.

2. Priority 2

   Individuals currently in a program operated or supported by DDD who require a progressive or regressive move as specified and documented by the IPP team.

3. Priority 3

   Individuals with a current or projected programmatic need for a DDD-operated or supported service as identified in the case plan or IPP.

4. Priority 4

   Persons desiring a DDD service to replace the individual's current service excluding those programs provided by an agency which is mandated by law to provide them.

C. Eligibility

Requests will be considered by the PPC only for those persons who have been determined eligible to receive Developmental Disabilities' services as defined in ARS 36-551 and DES Article 3, Eligibility for Developmental Disabilities Services. Persons residing out of state will not be considered for services except in the case of a child covered by the Interstate Compact on the Placement of Children.

D. ARS 15-765.C: Educational Residential Placement

The school district shall notify the District Program Manager in writing that the Individual Educational Planning (IEP) team believes the placement of a child into a private residential program is necessary to provide special education. The residential placement shall be made by mutual agreement between the school district and the Division of Developmental Disabilities following a recommendation from the IPP team.

The District Program Manager will forward the school district's request for residential placement to the Program Placement Committee via the Case Manager. The Program Placement Committee shall consider the following in determining eligibility for an ARS 15 placement:

1. The referral for placement is to be based only on the child's identified educational needs relative to the student's handicap.
2. If an appropriate educational placement is available/obtainable, environmental or home conditions or lack of transportation shall not be the determining factor for residential placement.
3. All placements through ARS 15-765 are contingent upon the avail ability of funds.

REM:de
6/30/83

C. THE FOLLOWING STATEMENTS ARE OUR RESPONSES TO YOUR RECOMMENDATIONS. PLEASE RESPOND IF APPROPRIATE.

GENERAL RECOMMENDATIONS:

1. DPW HAS LEADERSHIP RESPONSIBILITY AND THEY HAVE THE MONEY. DPW NEEDS TO COORDINATE EFFORT SO THERE IS AN "OPEN" PROCESS. LEADERSHIP IS THE ABILITY TO FACILITATE. DPW AS A LEADER HAS RESPONSIBILITY AND ACCOUNTABILITY.

Response:

I fully agree with these comments. DPW is not seen as providing leadership nor as being "open" in its planning. Great improvements are needed in this area in order to obtain credibility.

DPW also has the money but I would suggest that the funding be channeled through the counties as indicated in the first draft service delivery system recommendations 8 and 9. The counties control dollars by contracting for services with the providers. This way the providers know they have to work with counties and that they must provide the services which are planned and RFP'd.

2. CLARIFICATION OF ROLES OF PROVIDERS, STATE AND COUNTIES. ONE ASPECT OF THE VISION IS IMPLEMENTATION OF THE VISION. EXAMPLE: ESTABLISHING PRINCIPLES WHICH GOVERN SERVICES.

Response:

The state must incorporate the "vision" or principles into the rules, the monitoring system and the state plan. The counties must respond to the state by incorporating that same "vision" into their case management activities, the county plan, and their RFP's and contracts with service providers. The service providers must implement the "vision" in their everyday activities. The state must reinforce the county, the county must hold the service provider accountable, and the service provider has to hold staff accountable. Together they can and will realize the energy that can be generated by a common "vision" and the striving to attain those ideals.

DPW MUST HAVE INPUT FROM OTHERS INVOLVED.

Response:

DPW must develop every opportunity possible to obtain input in their policy development and planning activities. This can only build credibility and support.

4. NEED TO LINK COUNTY PLANS (CSSA PLANS) WITH DPW PLANS. ESTABLISH GOALS AND OBJECTIVES FOR FIVE YEARS, NOT A FIVE YEAR PLAN. NEED TO TIE BUDGET TO PLANS. IMPLEMENTATION OF A TWO YEAR PLAN MORE REALISTIC BECAUSE OF BUDGET CONSTRAINTS. PROVIDERS NEED TO DEVELOP GOALS AND OBJECTIVES ALSO. COUNTY COMMISSIONERS MUST HAVE OWNERSHIP IN PLAN. WHAT DOES "COUNTY" MEAN? (COUNTY COMMISSIONERS? SOCIAL SERVICE DEPARTMENT?) COUNTY PLAN MUST BE DEVELOPED BY "OPEN PROCESS."

Response:

I strongly disagree that a two year plan is more realistic because of budget constraints. You missed the point of first draft recommendation 3. You want to show the legislature and everyone what the long-term need is and how it relates to the various biennial requests. If you show legislators the long run each year - over and over - they will never be hit by surprise. They will also have sore sense that you know what you're doing and where you want to go. If you don't get what you need, go back the next time with the same plan. Again, no surprises, only consistency and stability from people confident in what is needed. Spend your time selling a long range plan rather than reacting to biennial requests.

Also, think bigger than a county CSSA plan. The county should plan for total service delivery within their jurisdiction. Even if the state actually makes the payment under medical assistance, the county could still authorize placement and therefore include ICF's in their plan. The county should also plan long range so the state will know where they are going and be able to support their effort.

County would mean County Commissioner and Social Services Director in that order. All other comments I agree with totally.

5. CLARIFY FIRST POINT ABOUT ROLE OF CASE MANAGER. WHO WILL DEVELOP NEW PROGRAMS? MORE THAN JUST IDENTIFYING NEED. WHAT IF NO ONE RESPONDES TO RFP. CAN A COUNTY PROVIDE SERVICES? IS THIS A CONFLICT OF INTEREST? {CASE MANAGER VS PROVIDER).

Response:

Unless absolutely necessary, the case manager should concentrate on case coordination activities and not new programs. I don't believe their expertise and experience are in those areas. Instead, I suggested that the county hire a Residential Services Supervisor or Program Services Supervisor to concentrate on program planning, development and contracting responsibilities.

If after developing an RFP for a needed program, private providers would not respond or were unreasonable in their response, the county could run the program on a "pilot" or "demonstration" basis. This occurred during the early stages of development in Arizona and the state started 13 residential programs. The private providers quickly decided they better respond and now we are in the process of giving these programs back to the private sector to operate.

I don't believe that it is a conflict of interest for the county to operate the services. At the same time I don't recommend they do it unless it is absolutely necessary.

6. CAN STATE PROVIDE SERVICE? AGAIN, CONFLICT OF INTEREST? WHAT IS THE ROLE OF STATE OPERATED SYSTEM? WHAT IS THE ROLE OF LEGAL SYSTEM? THAT IS, COURTS COMMITS TO STATE OPERATED FACILITY, NOT COMMNUNITY RESIDENTIAL FACILITY IN THAT COMMUNITY FACILITY CAN REJECT APPLICANTS FOR ADMISSION, WHILE STATE OPERATED FACILITIES CANNOT. WHAT IS YOUR CONCEPT OF "LEAST RESTRICTIVE ENVIRONMENT?" IMPLIED PROTECTION OF STATE OPERATED FACILITY AND NOT PRIVATE COMMUNITY FACILITY. STATE HOSPITAL WILL SURVIVE.

Response:

The state could provide service without it being a conflict of interest but I would strongly discourage this - particularly in a state which generally has the county administer services. Further, the state has not been noted for quality {i.e. Welsch vs Noot) and the expense tends to be astronomical (i.e. $128.00/day). Finally, the state has no experience or expertise in managing small, dispersed local services.

The states challenge, and it is a large one, is to decrease the population of the state hospitals and to increase the quality.

I would strongly recommend that you work for legislation eliminating court commitment of mentally retarded persons and work on a volunteer system like many others states (i.e. Nebraska and Arizona among others). This would take the pressure off of ill-equipped state hospitals and put the challenge on the whole system where it belongs.

My concept of "least restrictive alternative" is placement in those programs which provide maximum freedom and prudent risk which allows the retarded person to experience, grow, and develop but with competent guidance, supervision, and support. It is really a simple concept and should not be made complex.

State hospitals will survive in the short run but will not be affordable in the long run. If high quality community service systems are allowed to flourish they will be the service of choice and institutions will slowly fade as the primary resource for the severely retarded.

8. WHAT IS CASE MANAGEMENT? REDEFINE/REWRITE 3rd STATEMENT CONCERNING PRIVATE PROVIDERS HAVING TOTAL CONTROL. (BOTH LYLE AND WALT AGREE) CASE MANAGEMENT SHOULD BE CONCERNED WITH CLIENT GOALS. CLIENT FIRST. CLIENT BECOMES CASE MANAGER.

Response:

If you have agreement that service providers do not in reality drive the Minnesota system then you are welcome to disregard this recommendation. From what I have learned, they have too much power and throw the system severely out of balance.

I agree that the client should be first but as I have explained in previous responses, clients being case managers is unrealistic. We need to look at client needs but competent, informed people must manage the situation.

8. CLARIFY AND EXPAND. CLAIRFY YOUR OPINION ABOUT ROLE OF REGIONAL COORDINATOR AND HOW THIS AFFECTS CONTROL BY COUNTY. WHAT IS RANGE OF COUNTY CONTROL?

Response:

These questions were answered in my response to B 10 through 16.

9. CONTRACTUAL ARRANGEMENTS EXIST FOR SERVICES EXCEPT OF RESIDENTIAL. EXPAND AND CLARIFY. DO YOU MEAN ALL MONIES IN SAME POT? EXPAND ON DISINCENTIVES - REMOVE, HOW?

Response:

I am recommending that the county enter into contracts with service providers for all services they provide for mentally retarded persons. The state may still make the payment through its medical assistance program but only if the service was provided through a contract with the county. This process would put the state and county in a partnership as to their relationship with service providers. If a provider had a bed available which was licensed by the state and the county had a contract with the provider to provide the service then payment would be made. This partnership would give the county control with state supervision and ultimate fiscal responsibility.

If the county wanted to purchase non-ICF licensed services, they would not have to enter into partnership but would still utilize the contracting procedure.

If current contribution inequities or disincentives were eliminated and the counties financial share of all services (i.e. ICF, CASSA or SILS) were the same, then there would be total objectivity in the procurement of services and they would be based solely on client need.

16. EXPAND ON CLIENT OUTCOME. OPINION IS THAT THE CONTINUM CONCEPT IS OVERRATED. ARE YOU RECOMMENDING THAT THESE STANDARDS BE INCORPORATED INTO LICENSING? OR ARE YOU ADVOCATING BRINING IN CONSULTANTS FOR ACCREDITATION?

Response:

My recommendation did not focus on client outcome evaluations. Though this approach is ideal for measuring quality, it is very expensive and difficult to implement in a dispersed system.

Licensing tends to be a fairly mechanical process which focuses on facilities and staff. This is needed in order to ensure facility soundness and space adequacy but is generally not sufficient to ensure quality of programs. Evaluation and monitoring standards such as ACMR/DD tend to focus more on processes and procedures which should be in place. This generally is more directed toward program quality.
I am not suggesting that Minnesota require outside accreditation or outside consultants but instead to use resources (like is utilized in the Arizona system described in the first draft report) from within the state to monitor services. DPW could be the entity doing the evaluation using standards which could be developed by a statewide task force. Employees from provider agencies, parents, and interested citizens could be used to do the monitoring under state supervision. Evaluation reports could be sent to the provider being evaluated and to the county where the agency is located and corrective action plans could be jointly developed. <u>RESIDENTIAL RECOMMENDATIONS</u>:

1. AGREE. IDENTIFY SOME ABSOLUTES.

Response:

These are really dependent on the philosophy of the individual state but I feel strongly about items A, B, C, D, E, F, G, H, I AND L from my first draft recommendations.

2. "ARRAY" OF SERVICES. NOT JUST SINGLE-FAMILY HOUSING, NEEDS TO INCLUDE MULTI-UNIT HOUSING WHICH MAY BE MORE APPROPRIATE. ARRAY OF SERVICES SHOULD CONTAIN THE CONCEPT OF THE NATURAL PROPORTION OF PEOPLE. SOCIAL INTEGRATION AS WELL AS PHYSICAL INTEGRATION.

Response:

I fully agree with these observations and further comments are included in responses to other items in this report.

3. CRITICAL ISSUE IS MINNESOTA HAS RIGID FUNDING, BUT WANT FLEXIBILITY OF SERVICE BASED ON NEED. DIFFICULT ISSUE - HOT TO WE IDENTIFY WHAT SERVICES ARE NEEDED AND THEN THE COST? LINKS WITH OUTCOMES/PERFORMANCE.

Response:

From my first visit to Minnesota, it was obvious that people knew what was needed. I don't believe I can articulate it as well as they can. The problem was fitting the service into the existing funding structure - particularly ICF criteria so as to get maximum Federal financial participation. This can be done through the waiver and the cost will follow the program description.

4. RESPONSE TO ISSUE: SPLIT REAL ESTATE ORGANIZATION AND SERVICE PROVIDER ORGANIZATION - SPEAK TO ISSUE OF TRADE-OFF OF STABILITY VS CHANGE IN ENVIRONMENT.

Response:

I do not believe that real estate development and service development make good "bed fellows." I believe that the objectives of each pursuit can often get at cross purposes with each other and make for a difficult situation for the provider who has both interests to juggle. I believe that stability for human beings is important and for one who is a little less capable, it becomes an even more important issue-not to speak of that persons parents or relatives. Programs should change and not the environment if at all possible. As already indicated, this is a basic philosophical principle which I personally value, as do most parents and retarded persons.

The system, if it is client based, must be structured to preserve stability while providing only those services which are absolutely needed.

I am not suggesting that retarded citizens are incapable of accepting change or should never move, I only believe that moves should be planned for the client's benefit not the program's benefit.

5. AGREE - MECHANISM/PROCEDURE IS IN PLACE TO DISSEMINATE THIS SET OF GUIDELINES, BUT NOT CONTENT OF GUIDELINES.

Response:

Obviously, the content of the guidelines needs to be developed so appropriate education can begin.

10. SIGNIFICANT STATEMENTS. STANDARDS NEED TO BE MONITORED AT STATE LEVEL, BUT, THIS IS HOW OUR PRESENT STATE OPERATED SYSTEM EVOLVED. STANDARDS NEED TO REFLECT CLIENT OUTCOMES. COUNTIES NEED TO BE APART AND TO HAVE INPUT INTO THIS PROCESS OF STANDARDS OF RATE-SETTING. NEED FOR COUNTY FLEXIBILITY.

Response:

I agree with your comments.

11. NEEDS THE <u>MOST</u> CLARIFICATION. WHAT DO YOU SEE AS ROLE OF REGIONAL SPECIALIST?

Response:

Please refer to my response to item B. 10 through 16.

Response:

I totally agree that family services are needed, perhaps more than ever when the client is an adult. I have already expressed my opinion on "in-home" or "family" services and feel it is an important adult service.

7. ONLY 3% OF FUNDS GOES TO FAMILY SUPPORT AND SILS.

Response:

This emphasizes the imbalance in the Minnesota residential system. Out of home placement is easier to obtain than in-home support. This should be changed as quickly as possible.

8. FAMILY ROLE THRU-OUT LIFE CYCLE OF PERSON. "MAY" VS "SHALL" SITUATIONS.

Response:

I believe the family should always have a major role through-out the client's life cycle. I don't believe, however, that "shall" is something which can be mandated. Many personal problems of family members may preclude an ongoing relationship and which may be detrimental to the retarded person if it were required.

Good case management will have family involvement and support as a priority and of course the system should strongly encourage family participation and involvement by including them in all decisions.

9. WHO MAKES DECISION FOR RESIDENTIAL PLACEMENT? COUNTY HAS LITTLE TO SAY ABOUT PLACEMENT.

Response:

I believe that the county, if it is to be the focal point for service delivery, should make the final decision on residential placement- Of course this should not be an arbitrary decision but one based on a team approach. If the county has little to say about placement today - then I would recommend that they be given more say. in the future. Other of my recommendations support this premise.

10. DEFINE REGIONAL SPECIALIST.

11. WHERE IS DPW TODAY?

12. COUNTY CONSORTUM APPROACH OR CASE MANAGEMENT DELEGATION WOULD BE BETTER THAN REGIONAL SPECIALIST.
13. NOT KNOWING WHAT DPW MEANS.
14. CLEAR DEFINITION/CLARIFICATION OF ROLES OF COUNTY, DPW, PROVIDERS, CLIENTS.
15. REGIONAL SPECIALIST CONTRIBUTES TO MORE ROLE CONFUSION, ALSO RESULTS IN TIME DELAYS, WHICH ARE NOT ACCEPTABLE.
16. JUSTIFY REASON FOR REGIONAL SPECIALIST - SUNSET THE POSITIONS EACH YEAR.

Response:

All of the above items deal with the role of the Regional Specialist which DPW discussed with the consultants during our visit. I cannot provide a lot of definition for it was not provided to us in any other form than a brief discussion. This is the reason why I made the recommendation in regard to clarification.

I tend to agree that DPW could enter into a tight contract with the counties through which Medical Assistance ICF payment or funding authorization could be delegated within well defined dollar limits.

I believe that DPW also wanted these specialists to be program consultants to the counties - assisting them in program development activities. I believe my original recommendation is still the most effective way to deal with this issue.

17. CLARIFICATION OF HEALTH DEPARTMENT ROLE IN DEVELOPMENT OF PROGRAMS.

I did not have the opportunity to study any information or talk: to any officials in regard to the Health Department or its role in program development. In most states, its only role is to perform health and sanitation inspections within various programs - particularly residences. Seeing that this was not very well presented in my orientation, I am assuming that their role is small.

18. ROLE OF ADVOCATE FOR CHOICE OF RESIDENTS OPTIONS BY FAMILY/CLIENT NOT JUST TEAM.
19. TEAM FUNCTIONS IN TERMS OF DECISIONS - CLIENT/FAMILY INVOLVEMENT.
20. WHAT IS THE TEAM? RULE 185 vs Rule 34.
21. DOES ANYONE HAVE A RIGHT TO VETO TEAM DECISIONS?
22. WHEN DOES TEAM INVOLVEMENT BEGIN?

Response:

I don't believe we have nor should we have a free market place when it comes to mental retardation services. Further, I don't believe that clients have been sufficiently informed on the options nor do I think they have an appropriate experience base to be the primary determiner of an appropriate residential option.

The family, of course, is a major participant in decisions regarding placement. Many times parents are over eager to make a placement due to tremendous stress and financial pressures. Parents many times wait until the breaking point before making the difficult decision to make an out of home placement and are not willing to accept alternatives as easily as when not in this high stress situation.

The team must be aware of all these dynamics as well as the actual needs of the client. The skill of a good case manager is what brings everyone together behind the best, most beneficial decision on behalf of the client. Many times an outside client advocate can provide important assistance and support during this process.

Just so there is no misunderstanding, it is my recommendation that parents and clients always be members of the team. It is the responsibility of the professionals on the team to fully explain their positions and ideas in ways that parents can understand.

The team should include the case manager, parent, client, and other professionals who have information in regard to the needs of the client (i.e. service provider staff, school teacher, therapists, physician, etc.). This will be further described in the case management section of this report. The team gets involved after eligibility has been determined and service plans are being developed.

The team develops the overall service plan and obtains authorization for the appropriate services to be delivered. The county has the ultimate say as to which services can be provided based on availability of resources.

All of the discussion and recommendations given thus far pertains to case management as described in Rule 185. Of course, similar team approaches may be utilized in specific programs or by provider agencies in order to develop the individual program plan for a client as described in Rule 34.

23. WHO IS GOING TO GENERATE NEW PROGRAMS? EXISTING PROVIDERS? NEW PROVIDERS?

24. RFPS AND LACK OF RESPONSES TO RFPS. THE PROCESS - WHO WILL RESPOND - HOW TO GET A MORE VARIED RESPONSE - WILL COUNTIES PROVIDE SERVICES?

25. MINNESOTA LACKS ZERO - REJECT PHILOSOPHY.

28. ENCOURAGEMENT FOR POTENTIAL VENDORS/PROVIDERS TO DEVELOPMENT NEW PROGRAMS.

30. RPFS NEED TO REFLECT LEVEL OF SERVICES AND TARGET POPULATION.

Response:

If the laws and rules governing services in Minnesota were enforced it would appear that either a state hospital or the counties would have ultimate responsibility for serving mentally retarded citizens. In other words, the buck stops at the state hospital or the county court house. These entities have to deal with the problem regardless of the difficulties involved.

The service providers don't have the same pressure and can choose who they wish to serve. We all know that the state hospital has always been the last stop but this is slowly changing over to the county. If the county has ultimate responsibility {as delegated by the state) then it needs to have total flexibility in meeting its responsibility. I believe that counties should be able to provide service (as described in another response)if necessary and should have total control over the array of services it needs to meet its responsibility.

Service providers will not be hurt under this approach but they may have to be more responsive to the needs of the county. If they want the dollars they may have to be willing to serve some people that wouldn't have been there first choice in the past. If service providers won't respond because of the complexity of the clients then the county may have to provide the service. Of course, the county has to be willing to pay a fair price for the services they want developed.

It has been the experience in Arizona that private providers will respond to RFP's and will creatively address needed programs when it is the only way they can continue to grow and expand. The county must develop or obtain the necessary expertise to properly describe the services they need in RFP form and to help service providers develop their responses.

26. ALL SERVICES CAN OCCUR IN COMMUNITY BUT ALL SERVICES DO NOT OCCUR IN COMMUNITY.

Response:

I fully agree with this response. Every effort should be made to make all services available as close to home as possible and within typical community setting. Clients learn by observing and will learn appropriate skills if they are constantly participating with and learning from their "normal" peers.

27. RIGIDITY IN MINNESOTA IS BAD - NO FLEXIBILITY IN FUNDING TO MEET NEEDS.

Response:

This appears to be a half-truth. I don't believe Minnesota is bad but I would agree that current funding patterns greatly limit the ability to meet individual client needs appropriately.

29. REGULATORY PROCESS FOR WAIVERED SERVICES:

a. WHO WILL WRITE

b. WHO WILL MONITOR

C. WHO WILL ENFORCE

31. IMPORTANT: HOW ARE WAIVERED SERVICES GOING TO SAVE MONEY?

32. IMPORTANT: ADDRESS DOUBLE STANDARD OF WAIVERED SERVICES VS NON-WAIVERED SERVICES.

Response:

All of these questions pertain to waivered service and will be dealt with jointly, DPW will have to write the waiver (hopefully using input from this process) and will have to monitor and enforce compliance. Some of this may be able to be delegated to the counties through contract but that will be up to the state.

Waivered services will only save money if existing clients are moved from more expensive ICF residential programs into the new less expensive waivered services. The inflow of new clients must be tightly controlled. Also, decertification of expensive ICF beds must be implemented so that those beds emptied, due to the move to waivered services are not immediately back-filled thereby making the existing system even larger.

A double standard will be set if DPW does not address the county contribution disincentives which currently exist. Ideally, some combination of CSSA, SILS, and other funding can be used interchangeably by the counties (without it affecting their contribution) so that all clients can be treated equally.

It must be remembered that the implementation of waivered services is not the only answer to solving many of the problems identified within the Minnesota system. All of the recommendations must be implemented together or the problems will not change and may even get worse.