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STATE OF MINNESOTA

DEPARTMENT Human Services

Office Memorandum

TO : Members, Institutional Care and Economic Impact Policy Board

DATE: January 16, 1985

FROM : Leonard W. Levine, Commissioner
Department of Human Services

PHONE: 296-2701

SUBJECT: State-Operated Community Services Pilot Project Proposal

PURPOSE:

This document is in response to the Board members' request to provide them with the Department of Human Services' preliminary plans to develop state-operated community-based services for persons with mental retardation. This is intended only as a preliminary sketch; nothing more should be inferred. The information contained herein is intended only to establish some parameters of such a pilot project. More detailed material will be developed, in accordance with the attached timeline, as program variables are determined.

STATE HOSPITAL ADMISSIONS/READMISSIONS - THE "NEED":

State hospital admissions are sought either because appropriate community services have not yet been developed or because they are not available in sufficient numbers. (Attachment A - Summary of MR screening Results.)

The reasons most frequently cited for admissions or readmissions to state hospitals are the need for respite services by families, the need for medical and health care supervision and/or the need for intensive behavior intervention.

Reliance on state hospitals for care of individuals with medical and/or behavioral problems is the single biggest factor hindering initial or continued placement in community settings.

In addition, however, state hospitals offer a number of specialized programs which are not available in the community.

PLANNING PRINCIPLES:

With the above factors in mind, the Department has developed the following state-operated community services pilot project. These are the planning principles which shaped the plan:

1. The services developed in this pilot program should be responsive to identified needs of Minnesotans with mental retardation.
2. The services developed in this pilot program should give a high priority to the state's compliance efforts with Welsch, to furtherance of the MR Title XIX Waiver. (See Attachment E - DHS Proj. MR Reduction by F.Y.)
3. The services developed should primarily address "gaps" in the existing community-based system, rather than duplicate existing services, and should seek to develop private-provider potential in the pilot project region.
4. The costs of the state-operated community services pilot project should be borne by a reduction in hospital expenditures. (Attachment B - Department of Human Services Projected Cost Reduction by Fiscal Year.)
5. The plan should minimize state hospital employee reductions and maximize the transfer of state hospital employees to the state-operated community services. (Attachment C - DHS Projected Employee Reduction by Fiscal Year.)
6. The plan should be operational during the 1986-87 biennium, and should contain strong outcomes-measurement and reporting mechanisms.

DEFINING THE SCOPE OF THE PILOT PROJECT:

The proposal for a state-operated community services system poses a number of difficult, and even controversial, policy questions which are discussed briefly at the conclusion of this report.

It will be necessary, in light of the difficulty of those longer-range policy considerations, to require very specific definitions of the purpose of the state-operated community services pilot.

A carefully crafted project will provide opportunity to see if the state can:

1) test alternative case management models for relocating state hospital residents to appropriate community placement,
2) play a central role in developing facilities and programs, including private sector, to fill gaps in the MR service array in a given region of the state,
3) coordinate institution "downsizing" and development of community alternatives,
4) minimize disruptions to the lives of state hospital residents, employees and their families in a time of state hospital downsizing, while at

the same time maximizing use of the pool of the expertise represented by those same employees, and

5) perform the above responsibilities with fiscal efficiency and programmatic effectiveness.

In addition, it would be helpful to see whether this model can be useful in dealing with other state hospital groupings, i.e. the mentally ill.

PROPOSED SERVICE MODELS:

The Department proposes that pilot project development have these focuses:

Residential (Long Term): Small homes housing up to six adults or up to three children will be developed. They will be staffed twenty-four hours as appropriate to client needs. Development of these homes should emphasize primarily - if not exclusively - care for medically fragile or behaviorally impaired residents. Houses would be located in residential neighborhoods and individuals would maximize use of already-available community services. Direct care staff would be on-site with professional support services providing consultation, direct service, and training, as appropriate.

Residential-Respite (Short Term): The same settings as noted above would provide short-term relief to primary care-givers. Emphasis would be on immediate temporary care rather than training of clients.

Day Habilitation - Non-Facility Based; This service would provide staffing support to adults on job sites with non-handicapped persons. Successful pilot programs for severely disabled persons have been done elsewhere in the nation.

Support Services: Supportive services for clients and direct care staff would provide:

- Diagnosis and Evaluation: Professionally-staffed assessments and "work-ups".
- In-Home Respite Care: Trained direct-care staff providing relief for primary care-givers in the individual's home.
- Family Support: Trained professional and direct-care staff providing training directly to the individual and/or the family as well as emotional support to the family to help maintain the retarded individual at home.

- Provider Training and Technical Assistance: Consultative, back-up given to privately-operated community-based service providers to enable admission and/or maintenance of the individual in other community programs.
- Crisis Intervention: On-call, immediate professional and para-professional intervention to address acute behavioral episodes to prevent demission from community programs or removal from their family.

The services listed above would be available to current state hospital residents targeted for placement as well as to persons who are at risk of being admitted to state hospitals. These represent service configurations which will, finally, be determined by local need.

MANAGEMENT:

The Department recommends that these services be developed and operated by a regional management entity in the catchment area of the state hospital. The project director would be responsible for providing:

- administration
- quality assurance
- service staff.

The following management outline represents an overview of the major issues to be addressed and resolved before the pilot project can become operational. The intent of the plan is to make the best use of existing employees, administration and training capabilities and to minimize disruptions and duplication in those areas.

For the pilot project the project director will:

A. Report to the Commissioner of the Department of Human Services through an assistant commissioner

B. Be responsible for the overall management of the project:

1. Develop and adhere to internal organization policies, including staffing patterns, and strategies to integrate the project into county social service delivery networks
2. Negotiate purchase-of-service contracts, as appropriate, e.g.:
    a. Personnel administration
    b. Purchasing
    c. Financial management of operations and project funding
    d. Professional program services

3. Coordinate planning and services with the counties, private providers, state hospitals and regional service specialist(s)
4. Develop quality assurance plans and outcomes measurement tools
5. Maintain control of physical plants
6. Supervise staff assigned directly to the project
   a. Develop position descriptions
   b. Select employees within applicable constraints
   c. Evaluate employees
   d. Schedule employees

For the pilot project the central office will:

A. Select and supervise the on-site director and specify reports, data and content of communication with the central office
B. Review existing policies, procedures and legislation to determine the necessity of any legislative or administrative relief and negotiate to accomplish it
C. Authorize physical plant and equipment acquisitions
D. Cooperate in evaluating the project and assist with preparation of periodic, and final, reports to the Legislature.

PILOT SITE SELECTION CRITERIA:

The selection of pilot project site(s) should be made in light of the following considerations:

- Willingness of county agencies in the catchment area to cooperate
- A state hospital management structure capable of supporting the project
- Need for services to fill in the "gaps" in the regional array of services
- Compatibility with Department of Human Services priorities

Assuming the above criteria can be met, and in consideration of limitations on time and resources, it is recommended that the pilot project be established in only one state hospital catchment area.

PHASED IMPLEMENTATION:

The management entity should be established by January 1986 with initial implementation of supportive services as described above. (Attachment D - Time Frame.)

Operation of long and short-term residential programming (each of which requires location and preparation of physical plant) with corresponding day

services, would follow. Quality assurance strategies would begin at the same time as administration activities and be carried out as services became operational.

PERFORMANCE INDICATORS:

In order to adequately measure the success of these projects, two sets of performance indicators should be applied: one for project implementation (service delivery), and one for the management entity.

Indicators for project implementation include funding viability pursuant to reductions in state hospital expenditures; responsiveness to unmet needs; number and utilization of state hospital employees; functional skill growth; and social and physical integration into the community.

Performance indicators for the management entity include cost-effectiveness of the operation; level of interaction with corresponding counties and community groups, meeting established timelines, favorable licensing and other monitoring reports, and the level of community and user acceptance achieved.

REPORT TO THE LEGISLATURE:

At the close of the project, December 1987, an evaluative report to the Legislature will be prepared and presented. In addition to evaluating the project itself, the report will make recommendations for changes in the administration, funding and governance of services to Minnesotans with mental retardation.

POLICY CONSIDERATIONS:

This section merely lists those issues, the resolution of which the Department identifies as essential to the long-term success of state-operated community services or to any other restructuring of mental retardation services systems. These issues cross a variety of areas and are not presented in any priority order:

- Case management: county vs. state relations in the pilot project area
- Relationship to the Welsch consent decree
- Relationships with the state hospital, DHS and counties
- Funding methodology and flow of dollars, i.e.: rate setting, source of funds, accrual to the project of dollars saved in state hospital "downsizing" (this can be accomplished only by an additional appropriation or a revision of the Department's biennial budget request)
- Relationship with the Title XIX MR Waiver
- Real property issues: purchase vs. lease

NEXT STEPS:

See Attachment D - Time Frame.

The Department is prepared to immediately begin development and implementation of this plan.

ATTACHMENT B

DEPARTMENT OF HUMAN SERVICES
PROJECTED COST REDUCTION BY FISCAL YEAR
(In Thousands)

	Proj. Cost Reduction 6-30-85	Proj. Cost Reduction 6-30-86	Proj. Cost Reduction 6-30-87	Total Reduction 84-87
Brainerd		873.0	1,058.0	2,318.0
Cambridge		67.0	1,573.0	1,640.0
Faribault		301.0	1,551.0	1,852.0
Fergus Falls		379.0	898.0	1,277.0
Moose Lake		379.0	780.0	1,159.0
St. Peter		180.0	603.0	783.0
Willmar		88.0	479.0	567.0
		2,267.0	7,392.0	9,659.0

(DHS BUDGET REQUEST)

ATTACHMENT A

Summary of State Hospital Clients
Fall, 1984

Note: The total number of clients "screened" was 2,014; however, some fields- do not total this number due to recording errors- All percentages are rounded to the nearest whole number.

Age	Number	%	Sex	Number	1	MA Elig.	Number	%
0-18	108	5	M	1,179	59	Y	1,990	99
19-30	628	31	F	834	41	N	24	1
31-55	1,098	55						
56-65	123	6						
65 +	57	3						
TOTALS	2,014			2,013			2,014	

Level of Function	Number %
Unknown	42
Not MR	5
MR, Not Specified	3
Borderline	0
Mild MR	126
Moderate MR	150
Severe MR	437
Profound MR	1,251
TOTALS	2,014

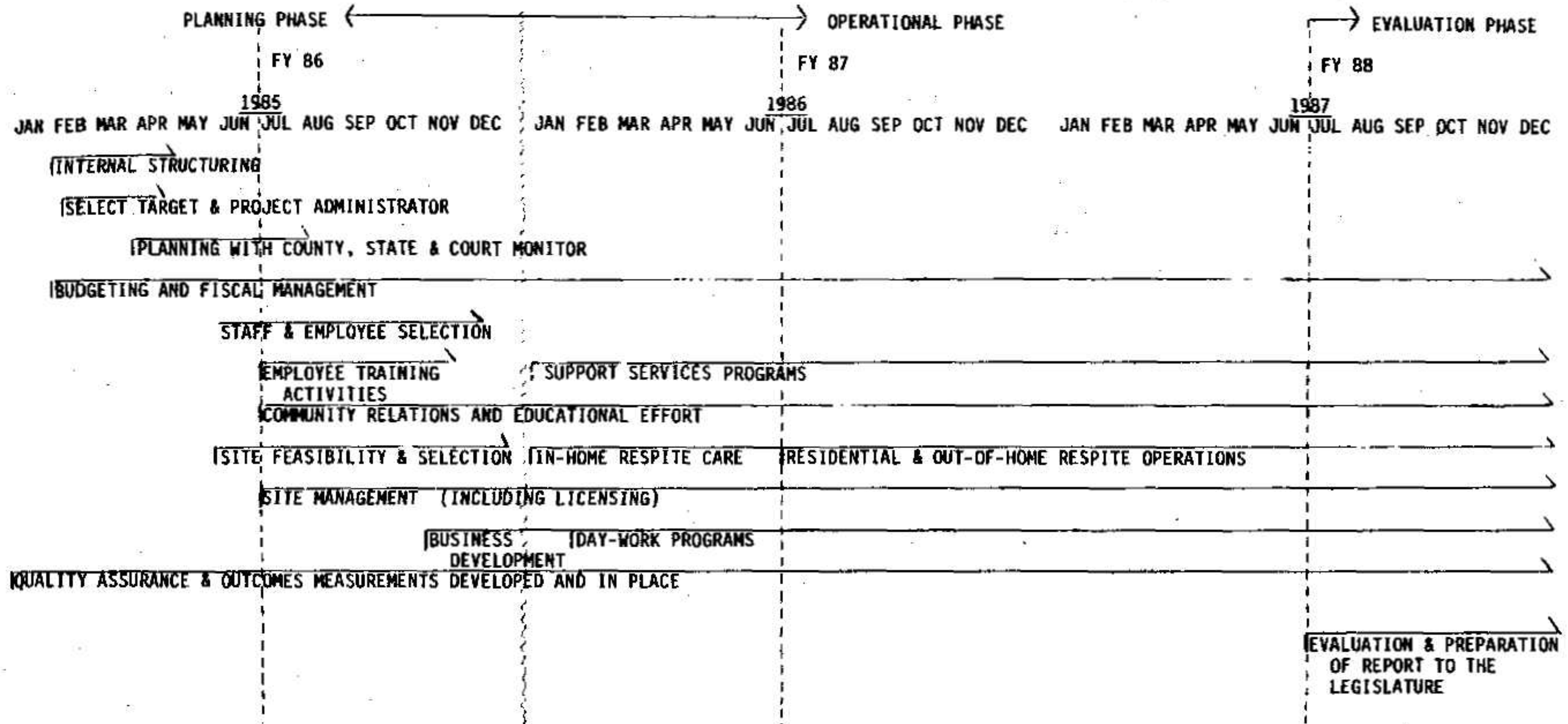
Level of Supervision	Number	%
Independent	0	--
Semi-Independent Moderate	6	21
Supervision	26	1
Substantial Supervision	295	15
Intensive Supervision	1,668	84
TOTAL	1,995	

DEPARTMENT OF HUMAN SERVICES PROJECTED EMPLOYEE REDUCTION BY FISCAL YEAR

	Proj. Emp. Reduction 6-30-85	Proj. Emp. Reduction 6-30-86	Proj. Emp. Reduction 6-30-87	Total Reduction 84-87
Brainerd		75	35	110
Cambridge		79	78	157
Faribault		78	68	146
Fergus Falls		45	27	72
Moose Lake		39	22	61
St. Peter		30	22	52
Willmar		24	22	46
		370	274	644

ATTACHMENT D

TIME FRAME



ATTACHMENT E

DEPARTMENT OF HUMAN SERVICES
PROJECTED MR REDUCTION BY FISCAL YEAR

	Proj. MR Reduction 6-30-85	Proj. MR Reduction 6-30-86	Proj. MR Reduction 6-30-87	Total Reduction 84-87
Brainerd	19	26	28	73
Cambridge	43	62	64	169
Faribault	37	51	56	144
Fergus Falls	15	21	22	58
Moose Lake	11	17	18	46
St. Peter	12	17	18	47
Willmar	11	16	18	45
	148	210	224	582

Medical Needs	Number	%
Unknown	2	21
No Serious Medical Heeds	459	23
Needs Regular Visits	718	36
Needs Nurse On Site Daily, but not constantly	603	30
Needs Medical Personnel on site all times	232	11
TOTAL	2,014	

Vision (with glasses)	Number	%
Unknown	65	3
No Impairment	1,312	65
Difficulty - Level of Print	310	16
Difficulty - Obstacles in Environment	159	8
No Useful Vision	168	8
TOTAL	2,014	

Hearing (with hearing aid)	Number	%
Unknown	50	3
No Impairment	1,718	85
Full Hearing With Aid	8	21
Difficulty at Level of Conversation	132	7
Difficulty of Alarm Sounds	6	21
Hears Only Very Loud Sounds	32	2
No Useful Hearing	68	3
TOTAL	2,014	

Personal Mobility	Number	%
Unknown	13	1
No Impairment	1,239	62
Assistance of Another Person	190	9
With Device (walker, self-propelled wheelchair)	153	8
Up in Chair Only, Propelled by Others, Motorized	410	20
Completely Bedridden	9	21
TOTAL	2,014	

Cerebral Palsy Status	Number	%
Unknown	127	6
No Manifestations	1,609	80
CP - Minor Functions Impairment	57	3
CP - Feeds Self, Speech Intelligent	26	1
CP - is Feed, Speech Unintelligent	195	10
TOTAL	2,014	

Seizure Status	Number	%
Unknown	25	1
So History of Seizures	1,015	50
Has History - Currently Has None	431	22
Minor Seizures - 1 to 10/month	84	4
Major - 1 to 10/year	278	14
More Than 10 Major Sei2ures/year	181	9
TOTAL	2,014	

Toileting	Number	%
Unknown	3	21
Full Control	772	41
Occasional Loss of Control - Bladder or Bowel	521	27
Frequent Loss of Control	236	12
Incontinent; no Control	378	20
TOTAL	1,910	

Communication	Number	%
Unknown	5	21
No Expressive Communication Impairment	324	16
Has Connected Speech - Difficult to Understand	346	17
Uses a Standard Sign Language	19	1
Expresses Self With Gestures and/or some sign	451	23
No Function Expressive Communication	869	43
	2,014	

Injurious to Self Number	%	Frequency	Injurious to others Number	%
1,129	56	Not a Problem	1,033	51
54	3	Less Than I/Year	55	3
151	8	More Than 1/Year; Less Than	283	14
166	8	More Than I/Month; Less Than	235	12
185	9	More Than I/Week; Less Than I/Day	258	13
223	11	More Than I/Day; Less Than I/Hour	129	6
79	4	More Than 1 Episode/Hour	15	1
21	1	Constantly	2	21
2,008			2,010	

Self Preservation	Number	%
Yes	223	11
No	1,770	88
Unknown	15	1
	2,008	

Supportive Service Receiving	Number	%
Rout. Med.	1,861	93
Spec. Med.	1,258	63
Spec. Dent.	1,347	67
PT	502	25
OT	823	41
Spch. Ther.	761	38
MH Serv.	974	48
Trg. for Fam.	164	8
Spec. Transp.	1,302	65
Spec. Rec.	1,788	89
Legal Guardian	1,690	84
Conservator	78	4
Legal Aid	335	17
Vol. Inst. Adv.	358	18
Vol. Exp. Adv.	253	13
Behav. Mgmt.	1,622	81
Day Respite	21	1
Overnight Respite	2	21

Team Choice	Number	%
At Home with Waivered Services (W.S.)	5	21
At Home or in Comm. without W.S.	6	21
In Comm. with W.S.	71	4
Boarding Care Home (ICF-II)	1	21
Nursing Home (ICF-I)	1	21
Nursing Home (SNF)	3	21
ICF/MR (includes S.H.)	1,716	88
Neither ICF/MR or W.S.	0	0
Undecided	0	0
Other	157	8
TOTAL	1,960	

Recomm. Residential	Number	%
Nat./Adopt Family	10	1
Foster Care	15	1
Relatives - not immed. Family	7	21
Own Home - Independent	0	0
Own Home - Supervision less than 24 hours	1	21
Own Home - 24 hours	5	21
Out-of-Home-Supervision less than 24 hours	1	21
Out-of-Home-24 hour Supervision	48	2
SNF	6	21
S.H.	1,313	66
ICF	21	1
ICF/MR	560	28
Other	14	1
TOTAL	2,001	

Recomm. Day	Number	%
Preschool-home based	66	3
Preschool-center based	11	1
Elementary School	44	2
Second School	66	3
Post-School Transition	28	1
Adult Day Care	1,629	82
Long-Term work Act.	65	3
Shelt. Employ.	40	2
Protect. work Stat.	19	1
Compet. Employ.	3	21
Retirement	15	1
Other	9	1
TOTAL	1,995	

FW-06