

**OPTIONS TOO:  
ACTING TOGETHER TO PROMOTE  
COMMUNITY ALTERNATIVES FOR  
PEOPLEWITH DISABILITIES**

**FEBRUARY 15, 2007**

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February 15, 2007

To the 2007 Legislature:

On behalf of the Minnesota State Council on Disability (MSCOD), the Minnesota Department of Human Services (DHS), and the Minnesota Housing Finance Agency (MHFA), I am pleased to submit the report of the Options Too Steering Committee.

In 2005, the Minnesota Legislature passed a law establishing a work group to prepare recommendations on how to help Minnesotans with disabilities relocate from nursing homes to homes in the community, and prevent inappropriate nursing home admissions in the future. The legislature charged three state agencies with convening the work group: the Minnesota State Council on Disability (MSCOD), the Minnesota Department of Human Services (DHS), and the Minnesota Housing Finance Agency (MHFA). The project was named “Options Too” to build upon the prior work of the “Options Initiative” started in 2001 by the DHS.

After extensive study, analysis and discussion, the Steering Committee reached four major conclusions:

1. **Minnesota has made progress.** Ongoing efforts are paying off, evidenced by incremental progress in reducing the number of disabled persons who are inappropriately placed in nursing facilities.
2. **Current programs and funding must be maintained.** The job is not done. People with disabilities continue to be placed in nursing homes despite their potential to live successfully in the community. Existing programs and funding must be maintained so that we do not lose ground in our efforts to reverse the trend of institutionalization.
3. **Gaps in the current system must be filled.** Although current activities are paying off and should be continued, major gaps in the system remain. The Options Too report identifies these gaps and provides recommendations on how to fill them. The most significant gaps include:
  - a. **Data and Information.** Lack of data and information on which to base policies and programs and to link people with available housing and services.
  - b. **Housing.** Lack of affordable, accessible and supporting housing options.
  - c. **Transportation.** Inadequate availability of accessible transportation options for people living in the community.
  - d. **Quality Assurance.** Inadequate methods of evaluating quality and safety of services.
  - e. **Ongoing Monitoring and Gaps Analysis.** No systematic, statewide method of ensuring that a continuum of services is available and that gaps in services are identified and filled.

4. **We need to continuously assess whether the system is working.** The Options Too recommendations are based on a snapshot in time of the current programs and funding. The interagency work group should continue to serve as a guiding force in ongoing systems analysis and improvement.

Overall, Minnesota made great strides in transitioning individuals with disabilities under age 65 out of nursing homes, but the job is not done. Stronger efforts are necessary to achieve the goal of preventing nursing home placement for all people with disabilities who, with adequate services and support, could live meaningful and productive lives in the community. The Options Too report and recommendations represents an important step in the right direction for all Minnesotans.

Sincerely,

## INTRODUCTION

The 2005 Minnesota Legislature directed the Minnesota State Council on Disability (MSCOD), the Minnesota Department of Human Services (DHS), and the Minnesota Housing Finance Agency (MHFA) to convene a work group to assist Minnesotans under the age of 65 in relocating from and avoiding placement in institutional settings. Specifically, the work group was asked to make recommendations concerning:

- Coordinating the availability of housing, transportation, and support services needed to discharge persons from institutions to community-based services;
- Improving information and assistance needed to make an informed choice about relocating from institutional placement to community-based services;
- Identifying gaps in human services, transportation, or housing access which are barriers to moving to community-based services;
- Identifying strategies which would result in earlier identification of persons most at risk of institutional placement in order to promote diversion to community-based services or reduce the length of stay in an institutional facility;
- Identifying funding mechanisms and financial strategies to assure a financially sustainable community support system that diverts and relocates individuals from institutional placement; and
- Identifying changes to state law that are needed to address any federal changes affecting policies, benefits, or funding used to support persons with community-based services and avoid institutional placement.

This report highlights the organization and operations of, and recommendations made by the work group, “Options Too Steering Committee,” formed in response to the legislation. The group’s name reflects and builds upon accomplishments of the earlier “Options Initiative” organized by DHS which operated from 2001 through approximately 2004.

## POLICY BACKGROUND

### **Medicare/Medicaid Overview**

**Medicare** is a federally funded program that pays for certain health care expenses for people who are aged 65 or older or who qualify because of a disability. Enrolled individuals make co-payments, but most of their medical care is covered. Medicare is divided into four parts. Part A covers hospital bills, Part B covers doctor bills, Part C provides the option to choose from a package of health care plans and Part D covers prescription medications.

- ▶ **Part A** provides coverage for the cost of hospital stays for defined benefit periods with the amount of coverage decreasing over time. Part A also covers limited stays in nursing

homes known as skilled nursing facilities (SNF) up to a maximum of 100 days during a benefit period; the current average nursing home stay is 2½ years. Medicare A does not pay for assisted-living facility stays, but may cover the cost of some services—home health care and doctors' visits—provided in such facilities.

- ▶ **Part B** provides coverage for those who pay monthly premiums to Medicare. Part B pays 100% of the cost of most part-time skilled home health care; 80% of certain services such as outpatient hospital services, physical, occupational and speech therapy, doctors' services related to preventative screenings, lab fees, and medical equipment such as wheelchairs; and 50% of most outpatient mental-health services.
- ▶ **Part C** involves government-subsidized, privately sold insurance managed care plans known as Medicare Advantage plans. Beneficiaries pay their monthly Medicare Part B premiums in addition to their Medicare Advantage plan costs, generally overall pocket expenses are lower and coverage is slightly better than the traditional Medicare program.
- ▶ **Part D** covers outpatient prescription medications and is administered by private health plans and Prescription Drug Plans. Similarly to Part C, coverage is generally better than traditional Medicare. Premiums vary according to coverage and if a beneficiary has a limited income, Medicare will pay most of the drug costs under a special program.

**Medicaid (also known as Medical Assistance)** is a jointly funded state and federal program offering health insurance to those who are low-income and 65 or older, disabled or eligible for other government aid. Beneficiaries must meet various income and asset restrictions which vary by state. In Minnesota, be under the age of 21 or 65 and older, or be a parent or caretaker of a dependent child or a pregnant woman or certified blind or disabled and must also meet income restrictions (\$798 per month for a single and \$1,070 for a couple) and asset restrictions (\$3,000 for a single and \$6,000 for a couple). Medical Assistance provides (in some instances with small co-payments):

- ▶ Clinic and physician' services for preventive care, including routine physicals, other office visits, immunizations, ambulance, emergency room services when used for emergency care, inpatient and outpatient hospital care, laboratory, x-ray, family planning, pregnancy related services, nurse midwife, medical equipment and supplies, hearing aids, physical, occupational, speech, respiratory and rehabilitative therapy, transportation services, mental health services, alcohol and drug treatment, prosthetics, nursing facilities, home health services, private-duty nursing, personal care services, group homes for people with the diagnosis of mentally retardation, prescription drugs, eye exams, eye glasses, chiropractic care, podiatry, dentures and dental services.
- ▶ Specific to home care services, Medicaid will cover equipment and supplies such as wheelchairs and diabetic supplies, home health aides, personal care assistants, private duty nursing, skilled nursing visits either face to face or via telehome care technology, and occupational, physical, respiratory and speech therapy. All of these services require prior authorization except for home care therapy services and the first nine skilled nursing visits per calendar year.

- ▶ Specific to nursing home care, Medicaid will cover the cost of the nursing home care plus the services delivered in that setting as described in the general coverage section.

Individuals who are eligible for both Medicare and Medicaid coverage are considered “dually eligible.” In this situation, the Medicare program is considered the primary coverage with Medicaid ‘wrapping around’ what Medicare pays. Medicaid will cover the costs of co-pays, co-insurance and deductibles from the Medicare program. Fourteen percent of Medicaid beneficiaries and 17% of Medicare beneficiaries are individuals who are dual eligible. Forty percent of the program spending in Medicaid and 24% of the program spending in Medicare is dedicated to serving those who are dual eligible. The majority of individuals who are long term residents of nursing homes and whose care results in significant program spending are individuals who are dual eligible.

Congress authorized CMS, in the Medicare Prescription Drug Improvement and Modernization Act of 2003, to expand the number of insurance plans offered to beneficiaries under Medicare Part C for three specific targeted populations; these plans are known as special needs plans (SNP). The three targeted populations are (1) those individuals who have been or who are at risk of being a resident for more than 90 days of a long term care facility, (2) individuals who are dual-eligible or (3) individuals who have a chronic illness as defined by CMS. Eighty percent of SNP plans approved by CMS since 2003 have been for individuals who are dual eligible. CMS is required to present a report to Congress on the effectiveness of SNP plans in reducing program expenditures by December 31, 2007.

### **Medicaid Waiver Program**

Medicaid, enacted in 1965, was designed to provide primary medical care to low-income Americans and meet the long-term service needs of people with disabilities and chronic conditions when the person was placed in an institutional setting. The concept of Medicaid being used exclusively to support placement in institutional settings however began to change with further advances in medicine and the greater acceptance of people with disabilities living in the community. Beginning in the 1980s, there has been a steady increase in options available to states to underwrite long-term services and supports in home and community-based settings through Medicaid Waiver programs. Today, approximately 28% of Medicaid’s long-term care spending dollars is directed to home and community-based services through waiver programs.

While states have flexibility in designing waiver programs, states must meet certain requirements and obtain approval from the Federal Centers for Medicare and Medicaid Services (CMS). States must evaluate whether the applicant is at risk for institutional placement, that the average annual spending per waiver recipient is no greater than the average annual spending per person in an institution and that the plan will help ensure the recipients’ health and welfare. Additionally, funding provided through a waiver program must not replace funding available through other sources, and states must exhaust other sources, such as a state’s traditional Medicaid program or special education services provided by school districts, before using waiver funding.

Waiver program requirements also differ from those of the traditional Medicaid plan. Medicaid is an entitlement program, meaning anyone eligible may receive services; whereas for waiver programs, states must set a cap on the number of individuals who can participate. Medicaid provides uniform services to eligible individuals throughout the state, while the waiver program allows a state to vary the types of services and individuals it serves. Further, the waiver program allows for different eligibility requirements for certain populations in different areas of the state, as opposed to traditional Medicaid, which requires the use of the same standards throughout the state.

Federal contributions for each state's waiver programs are determined yearly. Historically, the federal share has accounted for slightly more than half of the total funding of the waiver programs in Minnesota. In fiscal year 2003, the federal government paid 50.7 percent of total expenditures for Minnesota's Medicaid programs.

### **Minnesota's Medicaid Waiver Program**

Minnesota's Medicaid Waiver Program includes, but is not limited to: Elderly Waiver (EW) Traumatic Brain Injury (TBI), Community Alternatives for Disabled Individuals (CADI), Community Alternative Care (CAC), and Mental Retardation and Related Conditions (MR/RC). Eligibility for each waiver requires a determination that the individual is in need of hospital or nursing level of care and a certification by a physician, social security administration, state medical review team, or local county officials of a diagnosis of a medical condition consistent with the waiver sought to be provided.

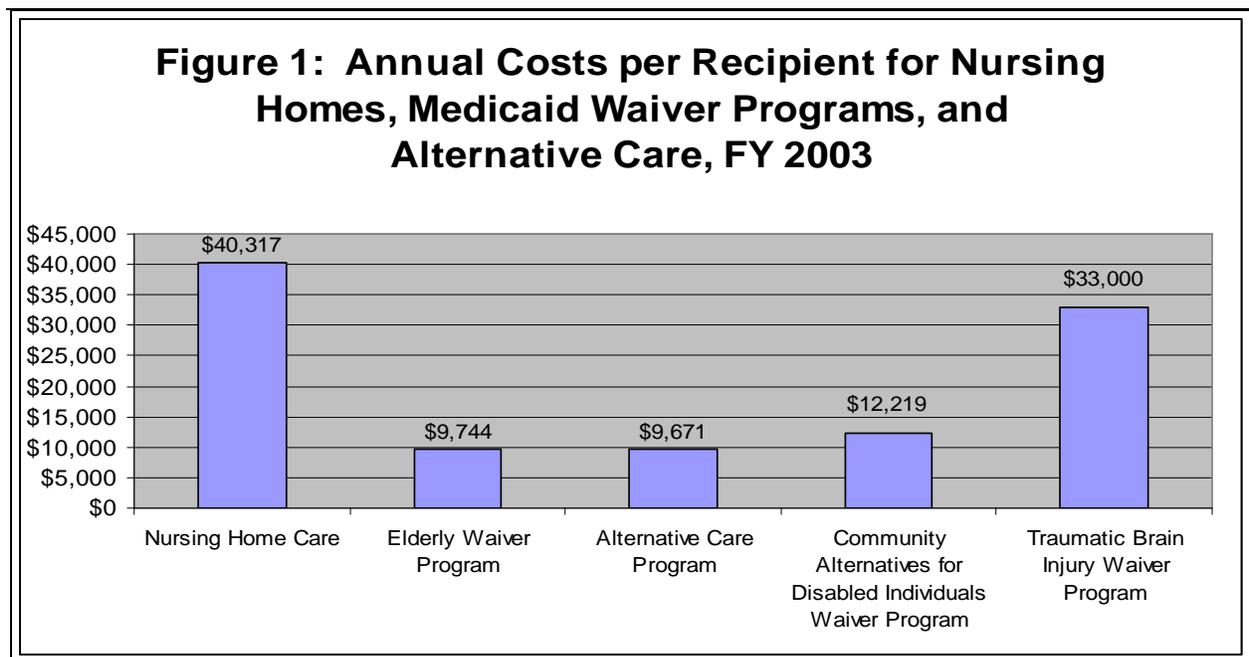
The following six services are included within each of the above waiver programs:

- case management (locating, coordinating, and monitoring social and daily living activities, medical services and other services needed by a person and his or her family);
- homemaker services (providing general household activities by a trained homemaker when the usual homemaker is unable to do so);
- equipment, home, or vehicle modifications (modifying equipment, homes, or vehicles, consistent with the person's disability, to help the person achieve greater independence);
- extended personal care assistant services (assisting with eating, bathing, dressing, personal hygiene, and other activities of daily living beyond the scope or variety of services available under the state's traditional Medicaid plan);
- respite care (providing short-term care in the home or out of it, when the usual caregiver is unavailable or needs a rest); and
- transportation (giving the person access to community services, resources and activities tied to the person's needs and preferences as demonstrated in the plan of care).

Other services are available but only for certain waiver programs. For example, extended prescription medication is covered only by the CAC waiver; supported employment services are covered only by the CADI, MR/RC, and TBI waiver. Some services are unique to one waiver; the MR/RC Waiver covers 14 services that other waiver programs do not include. Further, some services available under a waiver program are only available in certain areas of the state. For

example, under the MR/RC Waiver, the Consumer-Directed Community Supports program is not available throughout all of Minnesota.

In a report to the Legislative, the Office of Legislative Auditor found that in fiscal year 2003 that expenditures for Minnesota's Medicaid Waiver programs totaled \$1 billion, representing 21% of all Medicaid spending in the state. Specifically, the MR/RC accounted for \$800 million, the CADI waiver accounted for \$73 million, the TBI waiver accounted for \$38 million, and the CAC waiver accounted for \$8 million. The Office of the Legislative Auditor also found that in fiscal year 2003, the average annual cost per recipient for nursing homes was about \$40,300, about four times as high as the cost per recipient for the EW and CAC programs, about three times as high as the cost for the CADI Waiver program, and about 20 percent higher than the cost of the TBI Waiver program, as shown in Figure 1.



Results of the model used by DHS to forecast Medicaid expenditures indicate that the state roughly breaks even for the EW program. This model takes into account some of the other factors that affect nursing home usage, including changes in Minnesota's elderly population and general economic conditions. Specifically, the model's results suggest that the population of nursing home residents declines by one for every four recipients added to the EW program. The model indicates that the CAC program affects nursing home usage by about the same amount as the EW program, but the CAC program has a less beneficial impact on state spending because the state pays the full cost of CAC while the cost savings from people leaving nursing homes are divided between the federal and state governments. In the past, DHS tried estimating the impact of the CADI and TBI Waiver programs on nursing home usage but the results were not statistically significant.

### **The U.S. Supreme Court Decision - *Olmstead* v. L.C.**

The United States Supreme Court in *Olmstead* held that a state's failure to transfer individuals from institutions into community-based programs once treating professionals have determined that such placement is appropriate may constitute a violation of Title II of the Americans with Disabilities Act (ADA). *Olmstead* involved two women with mental retardation, "L.C." and "E.W."; additionally, L.C. has a diagnosis of schizophrenia and E.W. has a diagnosis of a personality disorder. L.C. and E.W. received treatment in a psychiatric unit of a hospital in Atlanta, Georgia. Both, despite having their treatment teams determine that their needs could be met in community-based programs, remained institutionalized in the psychiatric unit for several years. L.C. and E.W. subsequently sued the State of Georgia for failing to place them in a community-based program once treating professionals determined that such placement was appropriate.

The *Olmstead* Court found that unjustified institutional isolation by Georgia of L.C. and E.W. could constitute a form of discrimination. Specifically, *Olmstead* requires states to provide options such as community-based services for persons with disabilities beyond institutional services when:

- Licensed professionals reasonably determine that community placement is appropriate;
- The person does not oppose such placement; and
- Placement can reasonably be accommodated, taking into account resources available to the state and the needs of others receiving state-supported disability services.

The *Olmstead* decision specifically established that requiring individuals to receive services in segregated institutions can constitute illegal discrimination under the ADA. The *Olmstead* decision however did not provide a specific timetable by which all individuals have to be appropriately served nor did it require termination of institutional settings for persons unable to handle or benefit from community settings. Further, the *Olmstead* decision, without setting forth specific elements, stated that a state would not likely be in violation of the ADA if it has a comprehensive, effectively working plan for placing qualified individuals in less restrictive settings and its waiting list moves at a reasonable pace not controlled by a state's efforts to keep its institutions fully populated.

On January 14, 2000, CMS issued a letter to all state Medicaid directors strongly recommending that states factor in certain principles and practices in developing comprehensive, effective relocation/diversion working plans. The principles identified in the letter were:

- Provide an opportunity for all interested stakeholders to be integral participants in plan development and follow up;
- Take steps to prevent or correct current and future unjustified institutionalization of individuals with disabilities;
- Ensure the availability of community integrated services;
- Ensure that informed choice occurs regarding community or institutional service options; and

- Ensure quality assurance, quality improvement and sound management support to implementation the plan.

### **Minnesota's Options Initiative**

DHS implemented the Options Initiative in 2001 to increase access to community supports by persons under 65 who are living in nursing homes. According to DHS, 3,000 people under 65 were living in nursing facilities and approximately 65% of those individuals had been in a nursing facility for over one year at the inception of the Options Initiative. The primary focus of the Options Initiative was to provide nursing home residents with information to assist them in relocating to the community.

Finally, the Options Initiative required nursing home residents to receive face-to-face “long-term care consultation” assessments. If the person chose community-based services after the initial consultation, a written relocation plan was completed within 20 working days of the assessment. The plan also set forth the services needed and a timeline to ensure a smooth transition. If the person chose to remain in the nursing facility, additional face-to-face assessments were scheduled on continuing 12-month intervals.

Individuals who decided to transition to the community became eligible to receive “relocation service coordination” services. These services assisted individuals in planning and arranging for services and supports needed in the community. Providers under the Options Initiative were informed that they would receive payment for their services in assisting persons in relocating from institutions for up to 180 consecutive days prior to discharge. Also, the Options Initiative allowed some very low income individuals to receive a monthly financial supplement (up to \$130) through Minnesota’s “shelter-needy” option through Minnesota Supplemental Aid assistance.

The Options Initiative also required that county officials conduct face-to-face assessments before admitting a person under 65 to a nursing facility. The assessment requires an in-depth interview of the person, a presentation of home and community-based service options to ensure informed choice, and assistance in determining supports the person needed. The assessment should result in the creation of a goal-oriented, person-centered plan. Emergency placement is permitted with limited exceptions and in the event a person is placed in a nursing facility through an emergency screening, a face-to-face meeting must be conducted within 20 days of admission.

As of January 1, 2004, DHS reported that the Options Initiative had experienced some success. Seventy percent of the individuals under 65 in nursing homes had received a long-term care consultation since January 1, 2001. In the subset of those individuals who had received a consultation (1,785), approximately 500 individuals had opted to receive relocation case management services. DHS also reported that the nursing home population of residents under 65 had dropped to 2,716.

In reviewing Options Initiatives data, DHS found that individuals under 65 who had the following factors were most likely to successfully transition from a nursing facility:

- No disruptive or abusive behavior,
- No need for assistance in getting out of bed,
- Possessed self preservation skills,
- Possessed meal preparation skills,
- Possessed money management skills,
- Possessed medication management skills, and
- Age of the individual.

### **Nursing Home Population**

When the Options Too work group reviewed statistical data provided by DHS between calendar years 2000-2005 concerning nursing home demographics and admission rates, several trends became evident:

- The concentration of individuals with a diagnosis of mental illness in nursing facilities is rapidly increasing. Fifty-two percent of the entire nursing home population had a diagnosis of mental illness in 2005 whereas only 32% of the entire nursing home population had a diagnosis of mental illness in 2000.
- The age demographic of individuals between 45-64 in nursing homes as a percentage of the nursing home population is increasing. Thirty-four percent of all nursing home admissions in 2005 were for individuals between the ages of 45-55 – an increase of 4% from 2000. Forty-nine percent of all nursing home admissions in 2005 were for individuals older than 55 – an increase of 2% from 2000. In comparison, the percentage of all nursing home admissions for individuals younger than 44 in nursing homes dropped from 22% to 13%.
- A significant number of individuals within nursing facilities will be readmitted within 12 months after discharge. At any given time, approximately 30% of the entire nursing home population is comprised of individuals who do not change from year to year. Fifty percent of the individuals within the nursing home population will be discharged within 180 days but will be readmitted during the calendar year. Individuals under 65 who had two admissions per calendar year accounted for 31% of all admissions.
- The average length of stay in nursing facilities is decreasing. In calendar year 2000, 68% of all of the individuals admitted to a nursing facility had an average stay of at least 90 days and 58% of the individuals admitted had a stay of at least 180 days. In calendar year 2005, 43% of all the individuals admitted to a nursing facility had an average stay of at least 90 days, and only 27% of the individuals admitted had a stay of 180 days or longer.

Individuals under 65 in nursing homes in Minnesota are therefore likely to have a mental illness diagnosis, be at least 45 years old, and if discharged, be a good candidate for readmission within 12 months.

### **STEERING COMMITTEE ORGANIZATION AND OPERATIONS**

Staff from DHS, the MSCOD, and MHFA (Interagency group) met from the summer through the fall of 2005 to assemble a Steering Committee and put initial administrative arrangements in place. The Interagency group agreed that MSCOD would serve as the lead agency for the effort. The Bremer Foundation graciously awarded grant funds to MSCOD to support the efforts of the project. The Interagency partners secured the assistance of Hallelund Health Care Consulting to provide oversight for Steering Committee operations.

The Interagency group put in place various arrangements to provide and obtain public input as the Steering Committee was organized and began operations. These included creation of a special website containing all Steering Committee meeting agendas and minutes, work group reports, preliminary and final recommendations. The website also provided the public and interested consumers an opportunity to provide timely input to the Steering Committee. Additionally, information was placed on the State Council on Disability's website listserv, as well as those of other disability advocacy and service provider group websites to facilitate input to the Steering Committee.

The Interagency group sought to obtain key stakeholders for Steering Committee membership that represented a wide variety of perspectives. Stakeholders were selected from disability advocacy groups, service provider organizations, county social service departments, nursing home trade associations, general and specialty hospitals, Centers for Independent Living, managed care providers, public housing, representatives for the three designated agencies. Steering Committee Members (and in some cases, alternates who actively participated) are listed at the report's conclusion.

The Steering Committee meeting schedule began with a half-day retreat held in January, 2006, at Courage Center in Golden Valley. Key agenda items included:

- A review of the history of the enabling legislation and the Options Initiative administered by DHS;
- A review of target population demographics;
- Discussion of how to identify priority issues to be addressed and the need to concentrate efforts on priority issues; and
- Discussion and group decision to use an operating strategy where efforts would build on already-existing studies, reports, and accomplishments.

Using group process techniques and after obtaining input from the public, the Steering Committee decided that housing, transportation, gaps analysis (including target population data availability/collection concerns) and quality assurance were the priority issues that the Steering Committee should focus its attention. After its initial meeting, the Steering Committee met monthly from February through October of 2006, and completed its meetings in December,

2006. The Interagency group met monthly to assist the work of the Steering Committee and work groups. The work groups met between February and October of 2006 to research and prepare recommendations from the Steering Committee.

Three work groups were subsequently set up to explore specific housing, transportation, and gaps analysis issues and strategies. Quality assurance was a fourth area identified by Steering Committee members as a priority concern, however, because DHS was in the process of preparing two reports to the Legislature on quality assurance at the time this report would be submitted the Steering Committee decided not to form a work group on the issue. The Steering Committee did however commit one entire meeting to discuss the issue of Quality assurance and to review the ongoing work of DHS.

### **STEERING COMMITTEE RECOMMENDATIONS**

The Steering Committee in crafting its final recommendations to the Legislature was mindful of letter of the law of the enabling legislation and the spirit of the law which sought understanding of the complexity of the issues surrounding location and diversion with specific practical solutions that could be implemented. In balancing the letter and the spirit of the law, the Steering Committee has set forth below information and recommendations to the Legislature. First, the Steering Committee discusses below its responses to the six specific areas contained within the Legislation. The report then sets forth the five most pressing issues found by the Steering Committee with strategic solutions and recommendation to be adopted by the Legislature. The solutions and recommendations indicated below with an asterisk are ideas that the Steering Committee believes the Legislature should act upon during the current legislative session.

#### **Steering Committee Response to Enabling Legislation**

Based on its deliberations and input from its work groups, the Options Too Steering Committee strongly believes that a significant part of the solution of reducing the number of individuals under 65 in nursing homes can occur through the following action steps:

- *Maintain current programs and funding started under the previous Options Initiative. However, simply maintaining current programs and funding will not be enough as new strategies and programs are needed due to the changing demographics of the population in nursing homes to be diverted and relocated.*
- *Provide funding for accessible housing and for services that are lacking in the continuing care system. Individuals are currently living in nursing homes because there are inadequate housing and continuing care services in the community.*
- *Improve information among all stakeholders about funding and services. Lack of information on funding and services is having an adverse impact on nursing home admission and relocation. Improving information among all stakeholders will require MSCOD and DHS to routinely assess the continuing care system to identify gaps in services.*

- *The Minnesota Legislature should direct that MSCOD and DHS, in partnership with the other key state agencies and advisory input from key stakeholders, routinely convene to monitor accomplishments and progress in addressing existing gaps, and identify and propose responses to new gaps as they evolve.*

As discussed above, the Options Too enabling legislation directed that Steering Committee to address six specific issue areas. The text in italics below identifies the language from the enabling legislation.

***Coordinating the availability of housing, transportation and support services needed to discharge persons from institutions to community-based services.***

While Minnesota provides substantial resources to discharge persons from institutions to community-based services, the Steering Committee found significant gaps existing in housing, transportation and support services. Several counties in Minnesota have no public transportation options available for individuals with disabilities. An individual may spend more than two years on a Section 8 housing voucher waiting list. Finally, the lack of personal care attendants to serve individuals with disabilities is so sparse in certain areas in Minnesota that living in the community is not a viable option.

MSCOD, MHFA and DHS must work with counties and local agencies to develop a statewide housing tracking system that will monitor the number of accessible and affordable rental housing units, their features and whether the accessible units are currently being used by households with disabled members. A statewide clearinghouse of information must be established to match consumers with available housing units and community services in each community of the state. Ideally, consumers must be able to easily see the full array of options that are available to them for accessible housing, services and providers. The Housing Link program should be considered as a viable model for a statewide system for providing information to consumers.

Additionally, DHS in conjunction with the MSCOD must periodically collect information on consumer needs and preferences through surveys, focus groups and other activities throughout various communities in the state. Information collected should guide state and local decisions so that housing, continuing care, and quality assurance programs and services are consumer centered and not program centered. Hennepin County is currently testing a pilot which may serve as a model for a statewide system.

***Improving information and assistance needed to make an informed choice about relocating from institutional placement to community-based services.***

The Options Too group believes that improving information is critically important to achieve the goals of diversion and relocation. Improving the quality of information so that consumers can make an informed choice and interested stakeholders can assist consumers in making an informed choice will require a multi-faceted approach. DHS must: (1) create a centralized statewide clearinghouse of information; (2) provide additional training to providers and county

officials; and (3) continue to mandate use of relocation service coordination and long-term care consultations.

MSCOD, DHS and MHFA should be charged with the responsibility of developing and managing a statewide clearinghouse of information on housing, transportation, and social services. A centralized statewide information clearinghouse system is valuable because it ensures that stakeholders have easy access to information that they need. The model also facilitates feedback from consumers promoting a responsive system and one that furthers a consumer-centered approach.

DHS needs to enhance the knowledge of relocation and diversion funding and service options among providers and county officials through training. Unfortunately, too many providers and county officials lack information and are unable to help individuals stay or relocate to the community. DHS should conduct periodic training programs on existing funding and services, ways to use health care dollars for transitional expenses, housing programs and community support services.

The Options Initiative had success in facilitating relocation and diverting individuals from nursing facilities through the use of relocation service coordination and long-term care consultations. Unfortunately, approximately 30% of the nursing home population did not receive such services. DHS should continue to mandate use of relocation service coordination and long-term care consultations, given the prior success of such tools and because such services did not reach all consumers.

***Identify gaps in human services, transportation, or housing access which are barriers to moving to community-based services.***

The following gaps in the relocation and diversion delivery system were identified:

- Information – Consumers and providers have no ready source of current information on funding and service options nor are they aware where to find such information. Government officials lack sufficient information to appropriately identify and fill service delivery gaps. The process for early identification and diversion of persons at risk for institutional placement is inadequate. In certain instances, hospitals unaware of community services discharge individuals to nursing homes.
- Affordable and accessible housing – Many individuals live in nursing homes because they don't have access to affordable, appropriate housing or adequate tenancy support systems.
- Inadequate transportation options – Non-emergency transportation services does not exist in seven counties in Minnesota and in many counties there is very limited hours of service. No coordinated statewide transportation system exists.
- Quality assurance – There is no systematic method for ensuring that clients are safe and receiving high quality effective services. We need more information about the quality

and success of nursing home diversion and relocation services, including post-relocation services after someone moves to the community.

- Lack of ongoing statewide method of filling gaps – No entity within state or local government is responsible for identifying and filling gaps. There is a lack of an ongoing, statewide method for identifying and filling gaps in services within communities.

DHS and MSCOD should work with the counties, the Centers for Independent Living and other organizations to create a statewide gaps analysis process for periodically assessing the availability of needed services in each community and determining what gaps in services exist in Minnesota. Also, data collected by the Minnesota Department of Health as part of licensure and certification reviews should be used to better understand the characteristics of non-elderly persons living in nursing homes so that diversion and relocation services can be improved, and so that people living in nursing homes unnecessarily can be identified and offered relocation services.

The Legislature should require DHS to establish a coordinated, statewide quality assurance system to measure and improve the quality of services and consumer satisfaction. DHS is currently developing recommendations for the Commissioner on such a quality assurance system. The quality assurance system should also ensure that nursing home diversion and relocation services are effective and promote long-term success.

***Identify strategies which would result in earlier identification of persons most at risk of institutional placement in order to promote diversion to community-based services or reduce the length of stay in an institutional facility.***

The individuals most at risk for long-term institutional placement are individuals living in areas where continuing care services are scarce, are individuals with mental illness and/ or individuals with two or more of the following characteristics:

- Disruptive or abusive behavior
- Need assistance getting out of bed
- Limited self-preservation skills
- Limited meal preparation skills
- Limited money management skills
- Limited medication management skills
- Are older than 45 years of age.

Individuals living in areas within Minnesota where continuing care services are scarce, who have been diagnosed with mental illness and those among us who are over 45 and have limited daily living skills will remain at the highest risk of institutional placement until, as discussed above, gaps in the continuing care delivery system are routinely identified and filled with additional services and funding.

Identifying specific strategies that respect individual autonomy, ensure safety, and reduce the length of the stay within long term institutional care entities for the above identified

subpopulation within nursing homes requires an in-depth analysis which should include medical professionals that unfortunately was beyond the financial resources of the work group. Additionally, there must be consensus among stakeholders in the continuing care delivery system as to correct “solution” in order to achieve long-term success among the broader community. The Legislature therefore must charge DHS, MSCOD, the Department of Health and community stakeholders with the responsibility to develop recommendations that will reduce the average length of stay within long-term care facilities. The agencies charged with this task should be required to include within their work group medical professionals who provides care to individuals with chronic and severe medical conditions, consumer advocacy organizations, members from the Social Workers Leadership Council, the Minnesota Hospital Association, and officials from associations comprised of nursing home organizations.

***Identify funding mechanisms and financial strategies to assure a financially sustainable community support system that diverts and relocates individuals from institutional placement.***

The majority of individuals currently being admitted to nursing facilities are individuals with mental illness. Current programs that assist individuals with mental illness such as the “Bridges” program that provides transitional rental assistance for persons with serious and persistent mental illness must be maintained and expanded. However, maintaining current programs such as Bridges is not enough.

As the Legislature received testimony and considered legislation on expanding services and the safety net for individuals for individuals with mental illness last Session, additional funding for individuals with mental illness is needed. The Legislature should provide funding for ongoing gaps analyses and to develop a statewide information clearinghouse system as discussed above. The fruits of the funding by the Legislature in the above two areas will not be limited exclusively to those with a mental illness diagnosis but to the entire population of individuals living in nursing homes who are able to and desire to live in the community.

***Identify changes to state law that are needed to address changes in federal law that affect policies, benefits, or funding used to support persons with community-based services and avoid institutional placement.***

The current federal administration has encouraged states to implement programs and policies that would facilitate individuals being able to move from long-term care institutions to consumer-controlled/owned housing through “Money Follows the Person” grants. Unfortunately, many of the “Money Follows the Person” grants are not applicable for Minnesota because of the state’s prior success in diversion and relocation. DHS should however continue to examine what opportunities exist through “Money Follows the Person” grants.

In an effort to expand potential options for individuals to utilize community-based services, DHS should seek to facilitate consumer-controlled/owned housing by combining housing and services through the 1915(j) option of the Deficit Reduction Act of 2005. The current language of 1915(j) prohibits the use of this option for people living in provider-owned housing. DHS should obtain a waiver from the federal government to amend the State’s Medicaid Plan, then seek to pair

funding received under 1915(j) with additional housing funds such as the Group Residential Housing (room and board) grant.

## **Steering Committee Recommendations to the Legislature**

The following issues and recommendations to the Legislature are significant high priority issues that the Steering Committee identified through the diligent work of the committees and input of community stakeholders. Under each heading, the Options Too group has set forth some of the key issues on the topic. Following the discussion of issues, the Options Too group has set forth specific recommendations that can be undertaken by the Legislature. As discussed above, items with an asterisk are ideas that the Steering Committee believes the Legislature should act upon during the current legislative session.

### **Data and Information**

Lack of information among stakeholders negatively impacts diversion and relocation. Consumers and service providers lack information about available funding, housing, and service options. Additionally, policymakers and public officials lack information to make sound policy decisions about programs and funding.

Individuals with disabilities, or those authorized to act on their behalf, too often lack information about complex rules and regulations governing publicly funded health programs and funding such as transitional allowances. DHS staff is working on training modules for counties and contracted providers focusing on comprehensive information on relocation service coordination and substitute decision making. The Disability Law Center is also working on a training module on resident rights and substitute decision making related to power of attorney.

Many stakeholders feel that relocation and diversion information is not reaching consumers because of a lack of knowledge and bias among providers. Nursing home social work positions are often high-turnover entry level positions filled by those who may have a limited knowledge of the available community infrastructure in place to serve a transitioning population. Additionally, there are still attitudes that prevail in some places among social workers that people with disabilities who are in nursing homes cannot live independently.

Some county workers need training that relocation service coordination is a statutory obligation that must be offered to people with disabilities under age 65. There is also confusion in many counties as to where the responsibility for nursing home relocation resides. Six of the state's eight directors of the Centers for Independent Living indicated at a meeting held in June of 2006 that there was confusion as to who within the county is the contact for relocation service coordination in most of the counties they serve. Further, many county officials don't know that transitional funding exists or how to access it despite information being available on the DHS web site.

There are also multiple issues surrounding what data is collected, how data is collected, when data is collected and to whom data should be sent among providers, counties and DHS. For example, counties and contracted providers define nursing home diversions differently resulting

in differences in how diversion is calculated. Counties have questions about exactly what data is being tracked by the long-term care consultation process and the Minimum Data Set (MDS). (DHS staff indicates that the agency does not use MDS due to concerns about data integrity and accuracy.) One of the most common requests from the counties has been to know the day a person enters a supervised nursing facility. The number of people in a nursing home at any given time varies, but long-term care consultation data are generated quarterly, so changes in the number of individuals reported to be in nursing homes may lag from one to three months behind. Counties also have concerns that there is no single point person assigned to receive and track data issues from the counties to ensure they are responded to, and followed through to, the end of the process.

### **Recommendations**

- Ongoing training should be available for county workers and nursing home social workers on community funding, housing and service options.\*
- Best practices on data collection and tracking should be developed and adopted by the state, counties, and their contracted providers. A standard definition for "diversions" should be developed, and tracking of diversions should be standardized across the board.
- Data collected by the Minnesota Department of Health as part of licensure and certification reviews should be used to better understand the characteristics of non-elderly persons living in nursing homes, and to identify those who will benefit most from relocation services. This information will also improve the level and consistency of diversion and relocation services offered to these individuals.
- DHS and the counties should develop improved methods of communicating about funding and service options.
- There should be a single point of contact within counties for answering questions regarding relocation services. All counties should inform organizations that do education about relocation service coordination, or vendors who provide relocation service coordination services, as to who the point of contact is within the county for questions. DHS has indicated a willingness to designate a single staff person for counties to ensure their questions are answered. Any discrepancies in data should also be reported to this contact and for follow up. Counties may also direct questions to Policy Quest.
- There should be a procedure for counties or relocation service coordination vendors to relay questions or issues about data to DHS and a mechanism to ensure the questions are addressed in a timely fashion.
- Transitional Services funds for relocation of people under age 65 are not being used to their greatest potential. DHS should improve training and information provided to counties, and improve procedures for applying for and obtaining the funds.

- County social workers/case workers should provide individuals with disabilities information regarding their rights and responsibilities. The information provided should also include educational training and resources on planning for risk management during transition from the nursing home to the community.
- Counties and/or DHS should require hospital social workers to first explore and document community options before exploring nursing home placement.

### Housing

Issues surrounding housing concern a lack of supply, lack of information as to the existing supply, lack of supportive tenant based programs and administrative rules.

There is a very acute lack of affordable housing options for persons with low to modest incomes throughout Minnesota. A sizable majority of persons seeking discharge or diversion from nursing homes are adversely affected by this serious shortfall. There are three basic types of development/assistance that make housing affordable to low-income households:

- Public housing constructed and operated completely with federal funds and managed by a local “public housing agency;”
- Project-based rental assistance constructed with private or private/public capital, owned and managed by private companies, but having income and/or operating expense subsidies provided by federal/public or nonprofit sources;
- Tenant-based rental assistance in the form of a voucher that eligible households may use to shop in the community for housing available from private landlords willing to accept the subsidy and comply with program requirements. The prime funding source is federal, with some very small, targeted programs receiving state/local funds (for example, the “Bridges” rental assistance program for persons with serious and persistent mental illness in Minnesota is funded with state appropriations provided to MHFA in partnership with DHS).

All of the housing stock and assistance provided through these various approaches has been under unrelenting budget pressures for years. The federal government has reduced to near-crisis level the funding provided to local agencies for operating expenses and repairs needed to keep public housing projects viable. Properties with project-based rental assistance have subsidy contracts are often at risk for reduction or cancellation by the federal government. Some of these properties are further at risk of “going market rate” when owners either complete 20- to 30-year commitments to make their rents affordable for low-income households, or when owners reach a point at which they may be permitted to “prepay” subsidized funding balances and cancel affordability obligations.

Tenant-based rental assistance is pressured by tremendous levels of unmet demand, resulting in some local programs around the state having waiting lists that are five, 10, or more years long. Additionally, rent levels on a very high percentage of properties – particularly in the Twin Cities

– exceed the maximums permitted for program eligibility, and an increasing number of landlords are declining to participate in this programming.

Persons diverting or relocating from nursing homes can't afford the cost of community rental housing, and the supplies of subsidized "project-based" units and voucher-type "tenant-based" rental assistance are extremely inadequate. Major increases are needed in federal and state funds allocated for affordable housing options, including supportive housing.

This drastic lack of affordable housing options affects all households with low incomes who need help with rental expenses. In the case of persons seeking to leave or avoid nursing home placement, discharge planners and others involved in relocation/diversion efforts cite the lack of housing as a very major -- sometimes *the* critical -- reason for long delays or inability to complete a relocation, or provide a person with an ongoing, stable community living arrangement.

A number of organizations have been promoting initiatives over time to create a range of housing options for persons with a disability, including those who are/have been homeless. Relocation/diversion housing needs must be better integrated into these ongoing efforts.

Currently there is no effective statewide mechanism in Minnesota to track available accessible and affordable units, rental or otherwise, and their current occupancy demographics. Housing Link currently performs this function effectively within the metropolitan areas of Minneapolis/St. Paul, but lacks appropriate funding to expand this service/function statewide. This information is needed:

- So persons diverting/relocating from nursing homes who need an accessible unit can readily locate what's available, and landlords can readily list their properties and locate potential renters;
- From a monitoring standpoint, to determine if a significant number of units are occupied by households without disabled members, and if follow-up action is required to relocate them so designated units are opened up for the households they are intended to serve;
- From a development standpoint, to determine if there are actual shortages in markets around the state that require support for construction and/or remodeling, or if shortages are due to unavailability of timely information on supply/demand.

The collection of this information will not only assist all policymakers throughout the state in addressing issues which are the subject of this report but will also assist policymakers in making decisions for an aging "boomer" population that anticipates an active retirement.

Many nursing home residents who are eligible for transition have a mental health diagnosis. These individuals occasionally need an array of community support options that include basic rental assistance, housing developments with on-site "front desk" and similar supportive services, adult foster care, and supportive units integrated into conventional rental projects.

Federal regulations require transition to the community to be completed within 180 days once the transition process has begun. All counties raised different questions about the 180-day clock. Questions included: when it starts, how it's triggered, is it calendar or business days, etc. There is also a concern that 180 days is not always enough time to accomplish lining up the required resources, (in particular housing, but sometimes also staffing,) within the allotted time.

### **Recommendations**

- Work with housing agencies and policymakers to expand the ability of disabled tenants receiving tenant-based rental assistance, Section 8 voucher, to use the funds toward home ownership, as permitted by the federal government.
- Increase the amount of state "shelter-needy" funds under Minnesota Supplemental Aid, or provide other income subsidies to cover housing costs for people moving from institutional settings to community housing.\*
- Increase state funding for the Bridges Program administered by MHFA, which provides rental assistance for persons with serious and persistent mental illness.\*
- Increase state funding for the consolidated, multi-agency "Super Request for Proposal" process administered by MHFA, which finances affordable, and supportive, housing.\*
- Increase funding to establish adult foster care homes and assisted living options for people with mental illness who are at-risk of institutional placement.\*
- Increase funding and authorization for a statewide rental housing vacancy referral system such as Housing Link to provide information to people about available affordable and accessible housing units.\*
- Work with housing agencies and policymakers to give rental assistance preference to people with disabilities who are in a nursing home or are at-risk of being placed in a nursing home.
- Explore a federal waiver or authorization to permit people with disabilities living in nursing homes to take their room and board rates with them to pay for housing costs in the community for a specified period of time.
- DHS should seek to facilitate consumer-controlled/owned housing by combining housing and services through the 1915(j) option of the Deficit Reduction Act of 2005, and seek a federal waiver to obtain additional housing funds such as the Group Residential Housing (room and board) grant.
- Seek a waiver for the federal 180-day maximum timeline for nursing home transition, which frequently cannot be met due to problems in securing housing. The waiver should allow one or more 30-day extensions under specific circumstances.

- Increase communication between the agencies and public officials working on relocation and diversion with those in the affordable housing field, particularly in homelessness assistance. This will help facilitate incorporating the needs of people with disabilities into housing policies and programs.

### **Transportation**

Persons of all ages who have disabilities or frailty may be dependent on specialized services to provide transportation required for work, health care, everyday shopping needs and socialization. An uneven patchwork of transportation resources exists throughout the state.

Seven counties lack any type of public transit system accessible for people with disabilities. In many locations service is only provided for persons connected with a certain program or facility. Many resources are age-targeted for seniors, meaning younger persons with identical needs go unserved. Where local/county funds are involved, service often stop at county borders, even when the major regional population center with important resources is nearby but outside these limits. Hours of service vary tremendously, with evening and weekend coverage often being greatly reduced or not scheduled. For example, service ends in many communities by 5:00pm, preventing people with disabilities from attending evening functions or jobs. Even where administrators in a locale attempt seek creative solutions to the above limitations by pooling equipment and resources for better delivery and utilization, insurance restrictions create barriers sufficient to negate all the good intentions.

### **Recommendations**

- Establish the goal that people with disabilities will be able to access public transit services in all 87 Minnesota counties for at least 14 hours every day by the year 2010.\*
- Utilize existing county and local transit providers and increase hours of service where needed to match proposed goals.\*
- Develop and build on existing broker systems to provide a one-stop regional call-in center that will match up rides based on the person's needs (stretcher, wheelchair or ambulatory) and reimbursement structure (Medical Assistance or public transit fares).\*
- Seek state and federal matching dollars and/or federal grants for transit, in order to build capital and sustain costs of operation.\*
- Seek partnerships with transportation providers including, but not limited to, Medical Assistance transportation providers, to offer services to supplement existing county and local transit providers.
- Identify a reimbursement structure to provide regional service agreements to offer service across county lines, with a general limitation to a 50-mile one-way trip maximum, unless the rider pays a supplemental fare.

- Riders should be able to schedule rides at least four days in advance, but providers must guarantee same-day service availability for rides that are 25 miles or less.

### **Quality Assurance**

The Options Too Steering Committee strongly believes that a joint proclamation by the Governor's Office and the Minnesota Legislature that administrative policymakers shall develop and execute policy decision based upon a philosophy of consumer choice would significantly enhance options for individuals. Leadership is needed to set forth a guiding principle that provides direction to administrative policymakers throughout Minnesota government. When people are given choices, the marketplace responds with higher quality goods and services.

There is no systematic method for ensuring that clients are safe and receiving high quality and effective services. We need more information about the quality and success of nursing home diversion and relocation services, including post-relocation services after individual moves to the community. Currently, there are 87 counties each providing relocation service coordination a little bit differently. Standards for person-centered planning, and maintaining a quality process and commitment to relocation service coordination with so many people involved in the relocation process, is important for people with disabilities for DHS to ensure integrity in the process.

DHS currently has two Quality Assurance initiatives that are being conducted across the Disability Services Division. These initiatives include multiple consumer and provider or advocacy representatives who accurately reflect the current population of non-elderly individuals with disabilities residing in nursing homes.

Some of the persons diverted/relocated from nursing homes have been homeless at various points in their lives, and may become homeless again if the relocation experience isn't successful or adequate support isn't provided long term. State policies on responding to long-term homelessness and nursing home diversion/relocation consequently are interrelated, and this connection needs to be more fully explored. The definition of homelessness should include those individuals currently residing in a nursing home who would not have a home readily available to them if they were discharged today.

Vocational or educational goals that could facilitate either employment or volunteer opportunities should be incorporated into the relocation process. While some skilled nursing facilities that serve a primarily non-elderly population of persons with disabilities currently employ this practice prior to discharge, it is not a common practice. Current strategic planning and systems redesign efforts within DHS and the Department of Employment and Economic Development to achieve improved employment outcomes for Minnesotans with disabilities will assist in this regard, but to date have not expressly included the transitioning target population that is the object of this report. Non-governmental organizations within the community should also be explored as key partners to develop the educational component of a successful transition plan.

In many cases, non-elderly individuals with physical disabilities who are being discharged from an acute-care setting are often placed in a nursing home. Successful planning and intervention

while the person is in the hospital, and timely access to home and community based services, could prevent many people with disabilities under age 65 from being institutionalized. A future partnership with provider systems or trade groups representing hospitals, or the social workers providing the discharge planning, is recommended. Similarly, timely and early involvement in the discharge planning process by the county can successfully divert individuals from skilled nursing facility settings.

### **Recommendations**

- Establish a philosophy of promoting consumer choice in all state programs and activities relating to housing and services for people with disabilities.
- DHS should establish a coordinated, statewide quality assurance system to measure and improve the quality of services and consumer satisfaction. The quality assurance system should also ensure that nursing home diversion and relocation services are effective and promote long-term success.
- Identify strategies that would result in earlier identification of persons most at risk of institutional placement, in order to promote diversion to community-based services or reduce the length of stay in an institutional facility.
- Require nursing homes, hospitals, and other institutions to adopt procedures and monitoring practices to ensure that discharge planning for people with disabilities begins at the time of admission.
- Require state agencies working on diversion and relocation efforts to monitor the status of persons who have relocated to the community to assure that diversion, discharge planning, and community placement programs are working to prevent homelessness or readmission to institutions. The community placement program should include the person's educational or vocational goals.

### **Ongoing Monitoring and Gaps Analysis**

No entity within state or local government is responsible for identifying and filling gaps. There is a lack of an ongoing, statewide method for identifying and filling gaps in services within communities. The failure to have an agency charged with the responsibility of identifying and filling gaps has a negative impact on diversion and relocation.

The Options Too Gaps Analysis Committee reviewed several gaps analysis, including the DHS "2030 Planning Initiative," the Southeast Metropolitan Seniors Agenda for Independent Living's "Building for the Senior Boom," and "Transformation 2010" initiative. Members of the committee also conducted interviews with officials of Hennepin, Olmsted, Dakota, Kittson and Polk counties as well as disability advocates. Additional information was also reviewed from the Centers for Independent Living (CILs) and the Association of Minnesota Counties.

While community capacity and service infrastructure questions were included in the interviews conducted, the greatest barriers and challenges brought forward by interviewees surrounded data collection, consistency, storage, and data reporting. This applied to information regarding the size and health status of the population, as well as data elements that would assist in identifying the key elements of a successful transition plan from a skilled nursing facility to community-based settings.

Similarly, reporting processes, frequency of reporting, and the limitations of the technological infrastructure were cited, as was communication patterns among stakeholders responsible for relocation services, and training to ensure that both relocation staff at the county level and contracted services providers are equipped with the information needed to execute a successful transition.

Multiple data sources are currently being used to track non-elderly Minnesotans with disabilities residing in skilled nursing facilities. These include long-term care consultation data, information gathered at the state level from DHS and the Department of Health, and locally collected data in each of the 87 Minnesota counties. The reliability of these data are often uncertain, since each county tracks data somewhat differently, and in some cases, there is a gap between what policy advocates and county staff believe should be tracked and the actual data elements being tracked. Additionally, the interval between data collection and reporting can result in population discrepancies.

While some infrastructure currently exists to address data issues – including metro-area county/DHS sessions and DHS-sponsored "Meet Me" calls with counties concerning program milestones – there isn't regular communication between all interested parties (both data collection and reporting staff and policy staff) in a way that is most useful to the state, counties and any current contracted providers of relocation service coordination. Barriers cited regarding this communication issue include: staff resources and time committed to making the process run smoothly for all at the state and county levels, information technology systems issues at the state and county levels, and the political will to make improvements. Additionally, policy and budget challenges facing counties, many are the result of federal actions contained in the Deficit Reduction Act, have seen relocation service coordination decline as a priority topic.

The counties seem to be asking for more regular communication between themselves and DHS. Ongoing communication and a formalized infrastructure to facilitate this is something that counties and advocates agree would help in both the development of sound policy and inter-stakeholder relationships. It has been many years since the last state/county meeting was held that included representatives from all counties.

DHS data indicates that a large percentage of the current skilled nursing facility population targeted by this report has significant mental health needs, with a diagnosis of a mental health condition, an ongoing need for antipsychotic medications, or both. For example, Dakota County reports that approximately 60% of the people with physical disabilities it relocates also have a mental health diagnosis. Successful relocation of these individuals will require an ongoing need for mental health and/or chemical health services.

## **Recommendations**

- Extend the Interagency Task Force and Steering Committee to continue planning, implementation and monitoring of relocation and diversion efforts. Add the Department of Transportation to the Interagency Task Force and Steering Committee.\*
- Develop and conduct two ‘snap’ surveys, one with the counties and one with hospitals and nursing homes. In addition, hold regional meetings with counties to gather information about what's working and what's not regarding relocation service coordination.
- DHS should work with the counties, MSCOD, the Centers for Independent Living and other organizations to create an ongoing statewide gaps analysis process for periodically assessing the availability of services in each community and determining what additional gaps in services remain.
- Incorporate a representative from the DHS Mental Health and Chemical Health Divisions into any future planning process for relocation service coordination.



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