

SUMMARY OF TESTIMONY
PRESENTED TO HOUSE COMMITTEE
ON DE-INSTITUTIONALIZATION

**Governor's Planning Council
on Developmental Disabilities**

Minnesota State Planning Agency
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INTRODUCTION

In response to the charge given by the Speaker of the Rouse In establishing a special committee on De-institutionalization, six hearings were held during the months of May and June 1976.

The purpose of the hearings was to gather information needed by the legislature to make judgments concerning care being provided the mentally ill, mentally retarded and chemically dependent citizens of Minnesota and to equip itself with data necessary for future legislative decision-making regarding that care.

After an initial hearing reviewing recent impetus in the care of the mentally ill, mentally retarded and chemically dependent and identifying general categories of information needed, hearings were held on three major subjects: (1) quality of care in the state (institutional and community-based), (2) costs of care and (3) roles and responsibilities of various levels of government in the provision of care.

The following pages are an attempt to summarize information and opinions expressed to the committee concerning quality of care.

As a summary of sometimes lengthy and detailed testimony, it suffers from significant weaknesses:

- (1) Statements are, of necessity, taken out of context.
- (2) Statements of some witnesses are omitted If they are considered restatements of ideas expressed by previous speakers.
- (3) Statements made in reply to a specific question, when presented in summary form, appear to have more general application than was intended by the speaker.

In spite of these weaknesses, it is hoped that this attempt to summarize

information received will assist both legislators and witnesses in clarifying essential policy issues.

Witnesses whose testimony is quoted or paraphrased in this summary are the following:

Vera Likins, Commissioner of Public Welfare

Wes Restad, Assistant Commissioner for Residential Services

Michael Weber, Assistant Commissioner for Community Programs

Daniel Connor, Assistant Executive Director of Minnesota Association
for Retarded Citizens

Walter Baldus, Association of Residences for the Retarded in Minnesota

Mary Work, Mental Health Association

Robert Van Hour, President, Health Central, Inc.

Janet Brodahl, Department of Health

David Lloyd, Region IX Human Services Board

Roger Lynn, Director, Hewitt House

Robert Nafie, President, Minnesota Day Activity Center Association

Ed Schnettler, President, Community Programs Association

John Stocking, Administrator, Anoka State Hospital

Harriet Mhoons, Director of Social Services, Anoka State Hospital

Representative John Corbid, Committee Member

Representative James Swanson, Committee Member

Calvin Herbert, Fiscal Analyst, House Appropriations Committee

Kevin Kenney, Legislative Analyst, House Research

Bill Quirin, Director, Office of Human Services

Kevin Kenney
House Research
September 20, 1976

HOW CAN THE LEGISLATURE ASSESS THE QUALITY OF CARE PROVIDED THE MENTALLY ILL, "MENTALLY RETARDED AND CHEMICALLY DEPENDENT IN THE STATE?"

1. The committee was presented the official HEW definition of de-institutionalization which includes a concept which may be a general measure of assessing the quality of care. This concept is "a responsive residential environment which is as nearly normal as possible".

2. "Standards of quality, whether they relate to community facilities or state institutions, would perhaps best be measured by the outcome with individuals, if in fact individuals become better prepared for functioning in our society." (Weber, 5/17)

3. "The state should set standards for what kind of services should be provided, what they should look like, what should happen because those services were provided." (Work, 6/28)

WHAT ARE SOME SUGGESTED MEASURES OF THE QUALITY OF CARE?

1. The comprehensiveness of the scope of services provided to clients. (Herbert, 5/3 - Restad, 5/17) Note: The broad range of services provided patients at the state hospitals was identified for the committee.

2. Qualifications of the staff. "The employees (of state hospitals) are just as capable and dedicated and a human cross-section of the population as they are in any other facility." (Likins, 5/17) "You have in the state hospitals regularly employed doctors who are not licensed to practice medicine in the state of Minnesota. The patients in private hospitals are receiving far more intensive treatment." (Van Hour, 6/28)

3. Specialists needed by severely and multiply handicapped patients are more available in the state institutions. (Restad, 5/17) "I think the professional expertise is available in the community," (Connor, 6/14)

4. In-service training. All employees of the state institutions must receive a minimum of 81 hours in-service training annually. (Restad, 5/17) "We provide a wide range of in-service training and experiences through ARRM and through the college systems. That will continue to improve and become more effective." (Baldus, 6/1)

5. Individualized treatment. "The concept of individualized treatment is put into practice in all of our hospitals." (Likins, 5/17) "Genuine alternatives to institutionalization require developmental services which embody a non-institutional philosophy in carrying out an individualized program plan." (Connor, 6/14)

6. Case records. "When it comes down to the actual provision of service to individuals, we rely largely on the case records to indicate what kind of service is actually being provided." (Weber, 5/17)

WHAT ARE CONSIDERED INVALID MEASURES OF QUALITY OF CARE?

"In the case of persons who are profoundly retarded with multiple handicaps, severe visual or hearing difficulties and extreme physical malfunctions, it is doubtful that the size, location or management of a facility is particularly pertinent." (Likins, 5/17) When asked whether the concept of de-institutionalization implies smaller community facilities, Mr. Baldus replied that size is not as important as the question whether the institution "totally controls an individual's life 24 hours a day. People must spend at least part of a normal working day outside of the facilities." (Baldus, 6/1) "The numbers of people you deal with is important. If you are going to interrelate, it is very difficult to relate in a unit of 44 people or 20 people." (Connor, 6/14)

WHAT ARE SOME OF THE OBSTACLES TO ASSESSING THE QUALITY OF CARE?

1. "We badly need more information, integrated information systems and the opportunity to experiment and evaluate results before anyone will be able to say with any great assurance what probabilities exist with success with different alternatives," (Likins, 5/17)

2. "Our technology has not advanced sufficiently to be able to identify what are the ideal outcomes. We are going to have to rely more on assumptions about what leads to quality care." (Weber, 5/17) "We do not have a good solid knowledge base in the provision of services to the mentally retarded in the community." (Baldus, 6/1)

THE PRINCIPAL MECHANISM FOR CONTROLLING QUALITY OF CARE IN INSTITUTIONS AND COMMUNITY IS THE LICENSE PROCESS.

1. "Our license standards are not ideal standards. We have to accept a minimum level of acceptable standards." (Weber, 5/17) "We also, during operations for technical assistance, provide some incentives for providing more than the minimum quality." (Weber, 5/17)

2. Department of Public Welfare Rules 34, 35 and 36 attempt to identify reasonable standards.

3. The licensing process.

(a) DPW staff: ten licensing consultants. "We tend to rely not as heavily on those people for having program expertise as we do on them for being able to enforce standards. We rely on our program offices to have expertise about how programs should be operated." (Weber, 5/17)

(b) Initial licensing involves licensing and program staff of the Department of Public Welfare, Health Department licensing staff, State Fire Marshall inspection, area mental health boards certifying

the need for the program and the local review team's recommendation to the licensing authority.

(c) License renewal: no additional fire inspection; notification of any change in program is required; if problems are identified, the Department may deny, revoke, not renew a license or issue a provisional license. "About 20% of second licenses issued are provisional licenses." (Weber, 5/17)

(d) Revocation of license:

1. It is "quite uncommon" to revoke a license because "we are unable to revoke a license unless there is evidence that the life or safety of the clients is in immediate danger."

(Weber, 5/17)

2. Has any license been revoked on the basis of misuse of funds? "To my knowledge, not." (Weber, 5/17)

3. Have you ever had a license revocation based on inadequate program management or inadequate treatment program?

"It would be unlikely that a license be revoked for reasons like that." (Weber, 5/17)

A. Health Department Licenses. In addition to licensing for health and sanitation in nursing homes and boarding care homes, the Health Department recently established a license for group homes called supervised living facility. "The Health Department is responsible for insuring health and safety components, the Department of Public Welfare regulates rehabilitative and social service programs." (Brodahl, 5/17)

IS LICENSURE AN EFFECTIVE MECHANISM TO ENFORCE QUALITY OF CARE?

1. The Office of Legislative Program Auditor is presently conducting a

project to evaluate the licensing mechanism as a means of assuring quality in community facilities. (Kenney, 5/3)

2. "We believe very strongly that good quality and benefit can and should be economical." (Connor, 6/14)

3. Lack of coordination between various regulating standards. "There are problems of coordination between the various agencies having jurisdiction. The process is confusing to providers and it involves long time delays." (Quirin, 5/17) "We have program licensing people for each of the three disabilities. We have joint commission on accreditation of hospital surveys for all three disabilities. Each of our state hospitals has a review board. We have Health Department surveys for intermediate care, skilled care, life safety code surveys, survey of laundry situations. Some MR facilities have 17 very different types of surveys, also, utilization review and quality assurance review from the Health Department annually. At each of our hospital campuses there is an advisory committee for each disability group. There are surveys and investigations within the formal mechanisms and there are a variety of informal surveys that are made for personal audits and surveys." (Restad, 5/17) Community residential facilities have most problems with the ICF/MR regulations. "Such requirements as detailed room size should be more flexible." "The supervision of Rule 34 has been quantitative in record keeping rather than checking as to whether an individual's program is being carried out. Standard enforcement should be tied to what the program is hoping to achieve for the individuals." (Connor, 6/14)

4. "Only four facilities have been licensed under Rule 36 to date. We think that there are about another 160 facilities that need to be licensed. With the number of licensing staff we have, we're not going to be able to enforce this." (Weber, 5/17)

Fluctuations in Costs. "It's going to fluctuate from one week to the next depending on the census. If the census goes down, the staff remains the same of course. We don't figure out a daily cost from one day to the next or one week to the next. I think we should." (Stocking 6/15)

WHAT COST DATA DO WE HAVE?

Note: The verbatim testimony quoted below was in addition to a considerable volume of cost data provided to the committee on handout sheets. The oral testimony was often an attempt to answer questions about the data handed out or an attempt to explain specific figures presented on the handouts.

"What does it cost per day to place an individual in the community? If someone is in a Rule 34 facility for the mentally retarded the average cost is \$17.85 per day. The day activity center is \$11.82 per day of service and transportation costs on an average of \$2.27 per day per person. Another cost within mental retardation are the costs of special education which are roughly \$2,200 per year per person." (Weber 6/1)

"If you add in the depreciation of buildings or overhead costs, it's costing slightly more than \$41.00 per day right now to keep a patient in one of the big ten hospitals in Minnesota." (Herbert 5/3)

"At Hewitt House (a psychiatric halfway house for young adults) the cost is \$9.70 per day for program costs, \$5.33 per day for room and board for a total of \$15.10 per day." (Lynn 6/1)

"Most of my costs in the facilities range in the \$24.00 per day range. My projections are that most community based facilities providing services to generally severely and mildly retarded people

ought to be somewhere in the \$26-30 range, that's providing services generally equivalent to the kinds of services in the state hospital system." (Balduis 6/1)

WHAT ARE THE FINANCIAL RESOURCES NOW AVAILABLE FOR CARE?

"We function with so-called cost of care programs in which the state according to statutory provisions reimburses the counties up to 70% of the cost of care for retarded or emotionally disturbed children in residential treatment centers, group homes, and foster homes. In actuality the counties are reimbursed at about 50%. In addition to the cost of care funding, other funds are available assuming the individual's eligibility in the SSI program, Minnesota Supplemental Assistance and through Medicaid. Medicaid has paid for nursing homes which care for some 11,800 primarily geriatric persons medically diagnosed as mentally ill. Other sources of funding include Medicare, private insurance companies, county expenditures, and those of other state and federal departments such as education, corrections, and veterans administration at the federal level the amounts of which in some cases we cannot estimate. The MR population is supported through essentially the same sources with the addition of state funds designated for special purposes such as day activity centers for the retarded, special education, and sheltered workshops.

Detoxification centers are funded primarily by state funds matched by local county dollars. The state share is now funded up to 85% for the first half of fiscal year 1977 which begins on July 1. After January 1, 1977 the state share will be 75%. Most halfway houses

have been funded primarily through use of private health insurance since the advent of mandatory coverage in group health insurance policies in 1973 and other private client fees. The room and board portion of the halfway house support is client fees, general assistance, state and local monies, and private donations. There has been use of Title XIX Medicaid money available for clients. Residential non-hospital treatment is funded primarily by Title XX (federal) and local public match, private health insurance, clients' fees, and two therapeutic communities have utilized national drug and alcohol special grant funds." (Likins 6/1)

Board and care facilities licensed under Rule 36 receive no direct federal payment for care of mentally ill people as occurs in the ICF/MR's." (Weber 5/17)

Community mental health funding. "Within the mental health centers there is not one single funding mechanism. Mental health centers may be receiving funds directly from the state, in some cases they may be receiving some demonstration funds, for example, from the federal government. There may be some foundation monies involved. There is a great deal of county funds involved. There may be some private donations or private fees from insurance companies or from the individual patients themselves." (Weber 6/1)

In fiscal 1975 we are projecting fee income of \$64,577. In fiscal 1976 we are projecting our income at \$99,630. In fiscal 1977 we're looking at about \$140,000. The basic increase here is directly related to insurance payments." (Schnettler 6/1)

Mercy Hospital (private hospital providing mental health care). "About 25% of our reimbursement is from Blue Cross, about 35% from all

other types of insurance, about 20% or so from Welfare and Medicare, the balance by the patients themselves which is rather a small part of it."

(Van Hour 6/28)

"In 1975 the legislature appropriated a total of \$450,000 for the biennium to be used for funding small homes for the mentally retarded and cerebral palsied persons." (Herbert 5/3)

Technical Assistance. "We do have an operation using federal funds to provide technical assistance to facilities trying to become operational for a license for mentally retarded individuals. That is, I believe a \$80,000 or \$95,000 a year operation. So it becomes rather expensive the more we invest in that kind of task." (Weber 3/17)

WHAT CAN BE DONE IN THE FUTURE TO ASSIST IN ASSESSING COSTS?

1. Uniform Accounting System, "One of the suggestions that should come out of this committee as a recommendation is to establish a program of some sort for short-term project to in fact try to rearrange the data or form an accounting system that is designed to allow comparability so that the people that are like us would be able to have something that would fit our data needs." (Voss 6/1)

2. Costs/Benefit Comparisons Can Be Made. "We have evidence that leads us to conclude the following about cost comparisons:

(1) Cost comparisons can be made if it is the sincere desire of the legislature, the department of public welfare, the providers of direct services, the parents groups, and consumers to determine true costs/benefits of various public and private facilities and services.

(2) It would be beneficial to do so as a point of reference for sound future planning and decision for fiscal responsibilities for federal, state and county authorities charged with planning

for and delivering these same services.

- (3) A genuine cost study and comparison will show that the highest benefit/cost ratios are achieved when the fewest number of clients end up in institutional settings.
- (4) We think that the real cost determinant will be directly proportionate to the numbers of people who can be advanced to more independent and productive situations.
- (5) The best way to assure that the data "base will yield useful benefit/cost figures for a variety of client/service/outcome combinations is to tie the cost determinations to the basic unit of analysis which is the individual client. (Connor 6/14)

3. "I recommend that the legislature grant to the regions the authority and the financial resources for the capital development of community residential services. (In Region X, five million dollars will be required to create facilities for 674 people.)" (Harley 6/28)

"There exists a payment mechanism where the defined principle need is health care. Medicaid was never intended for a funding source for a residential facility without a health related component. It might be unrealistic that Title XIX funds will be allowed by the federal government to be used for residential care that is for congregate living. Since the philosophy of community based residential living in Minnesota is normalization, we just may have traded a conflict situation between our intent and philosophies of care with those of the federal government which controls Title XIX funds. The issue of cost vs. social values of de-institutionalization must be continued to be studied and placed into perspective." (Brodahl 3/17)

"In 1953 the legislature designated county welfare departments as the responsible agent for after-care. They assigned the responsibility but they didn't provide any real mechanism for paying for that. You reaffirmed this assignment in 1967 with the hospitalization and commitment act which clearly states that the county welfare departments are required to follow-up to provide after-care for persons who had been committed. As far as I know, at that time, you didn't provide any financial mechanism for doing that either. The result that is in good and honest attempts to follow people, the resources simply are not there. I think we've got a lot of knowledge and a lot of the know how. What we don't have really is a really good arrangement for paying for it. I think that the state has a responsibility for other than state hospital care and community mental health centers. We think that the state of Minnesota has a financial responsibility to provide part of the cost for caring for people who do not need either one. Who need something different.

You don't know the number of preadmissions in the state hospitals, so that you don't know what that has to do with the cost per person. But some comparison of those numbers should give you some idea of the efficiency of dollars that you are spending in one place as opposed to another. Once this is done, some of the ancillary costs of not providing services should begin to appear. We often concentrate on how much it costs to deliver a certain service. There is another question that should be asked and that is how much does it cost not to do it? There are costs for not doing things, and they are high." (Work 6/28)

"The revolving door individual is a very expensive problem. In Ramsey County in the last four years, 23 people were committed 505 to

a detox receiving center costing \$85,290 and that does not include their hospital costs. Domiciliary care would be less costly and allow for possible treatment." (McKenzie 6/28)

SUMMARY OF TESTIMONY ON COST OF CARE

HOW CAN THE LEGISLATURE ASSESS THE COST OF COMPREHENSIVE (INSTITUTIONAL AND COMMUNITY) CARE FOR THE MENTALLY ILL, MENTALLY RETARDED AND CHEMICALLY DEPENDENT?

1. By Increases in costs over time.

"In the 1965 biennium we appropriated \$425,000 for daytime activity centers. In 1975, exactly 10 years later, we appropriated \$13.6 million. The amount of increase has gone very markedly running 100% or better by every biennium. If you take the total percent of increase in funding in this category, the period covered is 3200% Increase.

"In 1969 we had \$9.5 million going for special education. In 1975 in special education we had \$89.2 million.

"State hospital funding, especially at the state level, has gone from \$125.8 million to \$156.5 million in one biennium. I would suspect a large portion of that has gone for salary increases." (Herbert, 5/3)

2. By data on population in need of services.

"I have a memorandum here to Terry Sarazin from one of the employees who said it was estimated by the National Institute of Mental Health, 2% of the population has mental health problems, severe enough to require 24 hours residential mental health program intervention. In Minnesota this population would equal approximately 80,000 people." (Herbert, 5/3)

"According to the President's Committee on Retardation, an estimated 3% of the population is retarded and about 1% is severely

enough retarded to require services on a regular intermittent basis. 20% of the 1% require residential care. That translates for Minnesota to about 120,000 retarded people. 40,000 of them needing services and about 8,000 of them needing residential services. In a recent study of Mid-west institutions for the mentally retarded covering 9 states, Minnesota had the third highest rate of institutionalization per 100,000 population exceeded only by North and South Dakota.

"According to the nationally accepted formulas, Minnesota has about 225,000 problem drinkers. There are other estimates necessary for the abusers of other drugs." (Likins, 3/17)

3. By length of treatment required.

"How long does it take to treat somebody in a community facility as compared with the state hospitals? We don't have those figures and we will not have them for sometime because the technology that we have for evaluating clients is not sophisticated enough to be able to say with complete accuracy this person is exactly comparable to this person in terms of the seriousness of the disability, in terms of the difficulty of treatment and in terms of success of treating these individuals." (Weber 4/1)

"You (Van Hour) mentioned an \$80 to \$90 a day per diem for a shorter stay. And the hospital has a \$41 per diem for a longer stay. Before we can make any use of that information, we have to know how many of those folks whose shorter stay than spent a certain amount of time in the community without coming back for service. Or does the longer hospital stay give them a more permanent type of care." (Corbid 6/28)

"I don't think that kind of information you want exists. I can't tell you honestly whether a shorter stay at a higher rate is more economical than a longer stay at a lower rate. I don't think anybody else can." (Van Hour 6/28)

WHAT OBSTACLES PREVENT ACCURATE ASSESSMENT OF COSTS?

1. Inadequate reporting.

"There is no reason why United Fund figures have to be reported to **us**. We are trying to account for those various pieces of funds. But even there things like in some cases some of the communities' facilities get free rent. It's those kinds of figures that we will simply not be coming up with." (Weber 6/1)

"We have a formula that the state will pay a certain amount of the per diem for a day activity center. It is up to the day activity center or a sponsoring body to come up with the remainder. Often that is from Title XX at the county level, often it is from straight county funds, it may include some United Way funds, it may be a foundation grant, it may be a service club that is donating a certain share of the percentage. The majority of it would be county funds but we can't say with the information we have how much of it is actually county dollars." (Weber 6/1)

2. Use of averages is misleading.

"If you chose an individual patient and asked me how much it cost for that individual, I can't tell you that. I can tell you what the average costs per patient are." (Buelow 6/1)

"No hospital, as far as I know, is operating exactly at the average per diem and so that \$41.00 a day is averaging out not only different disabilities, different hospitals, but also different levels of care." (Weber 6/1)

"What is offered at the \$17.00 a day facility in comparison? In other words in the state hospital we're providing some type of work activity day activity center sheltered workshop or some such thing. We're providing a certain amount of medical care, physical therapy, speech, and so on. What I wanted to see was a direct comparison with the residential for the same services." (Samuelson 6/1)

"Again, that's really not possible because the \$17.85 for example **Is** the residential rate billed by a facility to the department. In some cases that includes the day activity center operation and in some cases it does not. There may be various levels of medical treatment, for example, if there is a nurse on duty within the Rule 36 facility, it would be reflected within the \$17.85 per diem. That is why you see the spread from \$8.00 to \$32.00 per day within the community." (Weber 6/1)

"Fergus Falls, Moose Lake, and other institutions where we have a mix of three programs, we can't always identify which personnel is working with chemical dependent, which ones are working with the mentally retarded and which with the mentally ill." (Buelow 6/1)

"In other words you are taking an average then. You don't really have a handle on the exact cost per patient." (Friedrich 6/1)

"I don't see how we are ever going to get the cost information because the information itself has never been categorized in a manner that we would like. It has been clearly categorized so that they know they are spending their money legally, but it has never been categorized in any way allow them to make a value judgment as to program vs. program. (Voss 6/1)

"We have a lot of data but it doesn't seem to really pull anything together. If it's difficult for you people to pull figures together in comparison for us, how in the world do you evaluate if the state hospital programs are top notch in comparison with residential or vice versa? How do you make those judgments if you can't give us the information so that we can try to make them?" (Samuelson 6/1)

State Accounting System. "I would like to say in defense of DPW and all other operating departments that part of our problem is the state accounting system that we are all part of." (Likins 6/1)

"I sincerely feel we should have some more sophisticated cost accounting system. I think \$41.00 a day which is given to us by the state department every year and charged back to the patient is really in a sense a phony figure. With the accounting system we work with, the statewide accounting system, the program budgeting, is difficult to determine costs." (Stocking 6/15)

Administrative Costs. "One of the problems we came up with at Lake Owasso was that it was almost impossible for DPW to break out its administrative costs, since Lake Owasso has always been run as an annex of Cambridge State Hospital. The administrative costs have always been combined and in terms of the county those administrative costs were from our point of view significant. Therefore, unless it is recognized there are many paper costs at the state level which become real costs when those are turned over to a local unit of government or to a private agency, unless that factor is realized, the state budgets may not have any relation to what it costs to run those agencies or those homes." (Orth 6/14)

5. In order to be eligible for federal reimbursement under Title XIX, "federal regulations require that many mentally retarded persons reside in a health related facility." The quality assurance unit of the Department of Health is required to conduct an annual assessment of patients. (Brodahl, 5/17)

6. The quality of services delivered, the severity of the disability of the persons being served and higher standards of care in the community or in a state hospital cause increase in the costs of care. (Weber, 5/17)

7. "The guideline rules and regulations for community facilities should be standardized throughout the state, thus not causing turmoil and chaos in establishing them." (Lloyd, 6/14)

8. "The state should set standards for what kind of services should be provided, what they should look like, what should happen because those services were provided." (Work, 6/28)

WHAT HAS BEEN THE EFFECT ON THE QUALITY OF CARE RESULTING FROM THE GROWTH OF COMMUNITY BASE PROGRAMS?

1. "De-institutionalization can and has resulted in some inappropriate • placements. The misplacement of such persons may not only be detrimental to them, but may impact adversely on the health and safety and well-being of the facilities, patients or residents." (Brodahl, 5/17) "We feel that an unplanned process has already placed approximately 2,500 retarded persons into the community since 1966. Some of our mentally retarded citizens who have left state hospitals are living in the community in environments as Institutionalized as the state hospital they left. It is estimated that 350 to 400 of the 2,500 retarded persons have been inappropriately placed in a general nursing home." (Connors, 6/14) "Discharge from the state hospital doesn't occur when a person

is well and when a person is really ready, in fact, to face living in a community. You've got more people out than in and nothing is happening."

(Work, 6/28)

2. "As far as residential based community facilities are concerned, our knowledge base is improving. We're beginning to generate the kind of expertise that is necessary to deliver services. Acceptance of the public of mentally retarded people is improving significantly." (Balduz, 6/1)

3. "The program relies heavily upon resident participation and volunteers. We don't have funding for follow-up of the patients." (Lynn, 6/1)

4. "It is necessary to expand support services in the community such as day activity centers and sheltered workshops." (Connor, 6/14)

5. "There is danger that the less clinical services, which are the services needed in the community will be neglected in order to achieve payment for more clinical services under third-party reimbursement." (Schnettler, 6/1) "The community mental health programs attempt to coordinate various other services in the community to assist disabled persons in establishing an independent, normalized life in the community." (Schnettler, 6/14)

6. "Day activity centers are really the basic building block of community based facilities for the mentally retarded." (Nafie, 6/1)

CONCERNS EXPRESSED ABOUT STANDARDS SETTING AND ENFORCEMENT.

1. There should be variations in the regulations and the fines for homes that are handling less handicapped people and are receiving lower per diem reimbursements from the Department of Public Welfare. (Corbid, 6/1)

2. The rate-setting mechanism establishes a lower reimbursement rate for rural areas although it may take a higher salary to attract professional persons to such areas. (Corbid, 6/1)

3. "It is the separateness right now between the state hospital system and community programs that is part of the difficulty. There isn't any coherence to the system that way it is now, and the result is that people get hurt." (Work, 6/28)

FINDINGS OF COMMITTEE ON VISIT TO ANOKA STATE HOSPITAL.

1. "90% of the cases have had previous treatment (in the community) which was unsuccessful." (Stocking, 6/15)

2. "We feel we are a community facility." (Mhoons, 6/15)

3. "Excluding 30 or 40 long-term mentally ill, the average length of stay comes to about 3-1/2 to 4 months for the mentally ill. Chemical dependency is much shorter." (Stocking, 6/15)

4. "We have five teams consisting of a psychiatrist, psychologist, psychiatric social worker and psychiatric nurse working with each individual who comes in." (Stocking, 6/15)

5. "Our hospital has no way of knowing what actually happens to a person after he went out of here," (Mhoons, 6/15)

6. "85% of the admissions on the chemical dependency side are voluntary. For the remaining who come in under a commitment, it's up to us to motivate them." If a committed patient leaves the hospital, "the hospital cannot follow them up." "A routine notice goes to the probate court regarding the change of status of any committed person in the hospital." (Stocking, 6/15)

7. During the tour of the hospital, there was very little provision of programs and services to the patients observed by members of the committee. (Swanson, 6/15)

OTHER TESTIMONY NOT YET SUMMARIZED

1. Systems of care; roles and responsibilities of agencies and levels of government to caring for mentally ill, mentally retarded and chemically dependent.

A. Outline of present division of responsibilities (presented by staff).

B. Suggested problems with present system and changes proposed by:

(1) Regional Development Commissions

(2) County Commissioners

(3) Human Service Boards (Region IX)

(4) Community Mental Health Centers

(5) Day Activity Centers

(6) Advocacy Groups for MI, MR, CD

2. Employees: concerns expressed concerning:

A. Protection of rights and benefits of state hospital employees in the event of closing or transfer (AFSCME)

B. Salaries of providers of care in community-based programs

3. Community Acceptance

A. Local zoning problems

4. Statistical data received:

A. Number of citizens in need of services

B. Number of facilities/programs now available in state—projected future needs.

C. Variety of "support services" needed to fill gaps in "continuum of care".