

Where People Live Recommendations

Introduction

Minnesota has undergone a massive transformation in the last several decades in moving persons from institutions to community-based settings. In the 1980s, Minnesota led the nation in the use of nursing homes and Intermediate Care Facilities for persons with Developmental Disabilities (ICF/DD). Policy changes at the state and federal level created opportunities to shift toward community-based care, most notably, the creation of the §1915(c) home and community-based waiver option under Medicaid. In addition, litigation in the late 1970s and early 1980s required the downsizing of state institutions and mandated the availability of home and community-based service options. Over time, moratoriums were placed on the development of nursing facilities and ICFs/DD and most recently adult foster care. In 2010, it is estimated that 87% of the public funds for long-term care services for people with disabilities is spent on home and community-based services.¹

Yet, the definition of community setting continues to evolve as persons with disabilities have been moved out of institutions. No longer is it enough to move someone from an institution to a smaller facility in a community setting and claim community integration has been achieved. What is an institution? What is the most integrated setting? The vision of *Olmstead* requires new analysis.

The Department of Justice provides some guidance:

The “most integrated setting” is defined as “a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.”...

Evidence-based practices that provide scattered-site housing with supportive services are examples of integrated settings. By contrast, segregated settings include, but are not limited to (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities.

Other federal agencies are working together to try and provide guidance to the states on the implementation of *Olmstead*. The U.S. Department of Housing & Urban Development (HUD) and the U.S. Department of Health and Human Services (HHS) have recently issued guidance to the States on the implementation of *Olmstead*. The recent guidance issued in Bulletins and Notices during the summer of 2012 are listed in the reference section. Besides bulletins and notices the Centers for Medicare & Medicaid Services (CMS) is expected to issue the final rule regulating where 1915(c) home and community based services waivers can pay for services. The proposed rule released on April 14, 2011 was more descriptive of the types of settings that will qualify for waiver funding. The final rule is expected to be issued this fall.

¹ Source: MN Department of Human Services Data Warehouse. http://www.dhs.state.mn.us/main/dhs16_166837#

Background

People with disabilities currently live in many different settings which are regulated by the Department of Human Services (DHS) and the Department of Health (MDH). See the Appendix for a brief background on each of the settings.

The legislative report “*Evaluation of Current and Potential Housing Options for Persons with Disabilities*” prepared by the Disability Services Division in April 2011, states: “Compared to other states, Minnesota traditionally has higher utilization rates of congregate settings to provide services and oversight to persons with disabilities and other groups, at higher costs per person” (page 13). In the table below, data provided to Senator Harkin in an August 28, 2012 letter indicates that state funding for people with disabilities totals approximately \$1.2 billion dollars. Out of the \$1.2 billion 35% or approximately \$413,000,000 million is spent on people with disabilities to live in their own homes. The remaining 65% is spent on a range of settings from small adult foster care homes to large institutes for mental disease and nursing facilities.

Table 1 - State Funding for People with Disabilities in SFY2011 (By Setting)

Setting	State Funding	Percent
Group Homes	\$ 542,418,377	45.88%
Own Homes	\$ 413,859,087	35.01%
Supervised Living Facility	\$ 68,645,635	5.81%
ICF/DD	\$ 64,203,703	5.43%
Nursing Facilities	\$ 50,056,644	4.23%
Psychiatric Hospitals	\$ 32,854,227	2.78%
IMD	\$ 7,443,974	0.63%
Board and Care Homes	\$ 2,792,675	0.24%
Total	\$ 1,182,274,322	100%

Currently, Medicaid pays the room and board and services provided in nursing facilities, ICFs/DD and Children Rule 5 facilities. Minnesota has five Home and Community-based Waivers (described in the Appendix) and important Medicaid state plan services such as Personal Care Assistance, Private Duty Nursing and Mental Health services that pay for services in the community (See “*What We Have*” report for a description of waivers and MA state plan services). The waivers do not pay for room and board but pay for the services that support the individual with a disability to live in the setting.

The Group Residential Housing (GRH) program is an income supplement to assist people with disabilities to pay for room and board in *licensed or registered* settings. The current maximum income supplement for the GRH Housing Rate is \$867 per month per resident. Services might be provided by Medicaid waivers, the GRH Supplemental Service Rate, the Difficulty of Care (DOC) payment, private foundation grants, or private pay. (See Appendix for matrix of service provided by each waiver)

The MSA Shelter Needy program is an income supplement to assist people with disabilities move into affordable housing. Services might be provided by the Medicaid self-directed supports option or Medicaid home and community based waiver services, private foundation grants, or private pay.

The three waivers that serve the most people are the DD, CADI and EW waivers. The 2011 Legislative Report on Housing ² provides the detail on persons using those three waivers by setting. For example, in fiscal year 2009, the number of people on the DD waiver was 8,000 or 55% of the 14,000 people lived and received services in corporate foster care. In contrast, 71 % of people on the CADI waiver lived in their own homes or with family and friends, 18% lived in corporate foster care and 11% were in assisted living facilities. The EW pays for a package of services call “customized living services “to individuals who live in a housing with services establishment that is licensed as an assisted living facility. The persons on the EW waiver receiving payment for services in housing with services establishments grew between 2001 and 2008, from 7% to 35%. The report concludes that “service costs could be reduced if more persons on the HCBS waivers were able to find suitable housing in the community, which is where they are increasingly seeking to reside”. (Page 38)

Recent housing reports³ have documented the barriers to living in the community for persons with disabilities. Below are some of the common barriers:

- The actual cost of market-rate housing is prohibitive to low-income individuals, including persons with disabilities.
- Consumers and service providers lack information about available funding, housing and service options.
- Lack of affordable and accessible housing options
- Lack of permanent supported housing
- Lack of housing in suitable locations near employment and accessible transportation
- Inadequate availability of accessible transportation options for people living in the community
- Individuals may not be able to access community settings based on: financial and credit history, eviction records, arrest records and unmet need for support services
- There are inadequate community based services and supports on a statewide basis to permit persons with disabilities including serious mental illness to live in market-rate housing.
- There is an inadequate focus of housing services and supports targeted to transition age youth.

DHS has several initiatives that currently support people moving from congregate settings to the community. In February, 2011, Minnesota was awarded a Money Follows the Person Rebalancing Demonstration Grant from the U.S. Department of Health and Human Services.⁴ Minnesota will

² MN DHS Disability Services Division *Evaluation of Current and Potential Housing Options for Persons with Disabilities*, April 2011

³ *Options Too: Acting Together to Promote Community Alternatives for People with Disabilities*, February 2007 and MN DHS Disabilities Division, *Evaluation of Current and Potential Housing Options for People with Disabilities*, April 2011

⁴ Money Follows the Person Rebalancing Demonstration webpage: www.dhs.state.mn.us/main/dhs16_162194#

leverage an award of up to \$187.4 million over five years to improve community services and support people in their homes rather than institutions.

Minnesota's goals for Money Follows the Person are to:

- Simplify and improve the effectiveness of transition services that help people return to their homes after hospital or nursing facility stays;
- Advance promising practices to better serve individuals with complex needs in the community;
- Increase stability of individuals in the community by strengthening connections among healthcare, community support, employment, and housing systems; and
- Increase use of home and community-based services by setting priorities to address specific institutional needs for reform.

Throughout the demonstration, DHS will continue to increase the proportion of State Medicaid expenditures for HCBS relative to those spent on institutional long-term care.

The OPC recognizes Money Follows the Person Grant, Return to Community Living, and Return to Community Living for People with Mental Illness are important initiatives that are primarily aimed at moving people with disabilities from nursing facilities, ICFs/DD and hospitals from the facility to the community.

In addition, if approved by the federal government and state legislature, two housing proposals in the *Reform 2020 Section 1115 Waiver* the Housing Stability Services Demonstration and Project for Assistance in Transition from Homelessness and Critical Time Intervention Pilot support the goals of Olmstead and should be included in the Olmstead Plan.

Persons needing accessible housing may also benefit from the access to market rate housing using waiver-provided funding for home accessibility modifications. For these reasons, the OPC believes that it should be possible to significantly reduce the number of persons in more expensive housing over a five year period. The OPC recognizes that there will be significant system planning to be undertaken to attain the identified numerical percentage reductions in settings such as corporate foster care and nursing homes including the likely need of closing beds and even facilities when people with disabilities are enabled to move into the community. The plan developed by the department must set numerical goal and periodic measure progress to assure the strategies are working as designed.

Recommendations for Housing in the Community

- The State must significantly increase the ability of persons with disabilities to afford and have access to market rate housing that the individual controls.
- Increase state funding for and access to rental assistance programs for persons with disabilities.
- Evaluate state funded housing and supports programs to determine if they are adequate, efficient, appropriately used or can be expanded based on the identified need. This includes Minnesota's

income supplement programs, in particular Group Residential Housing (GRH) and Minnesota Supplemental Assistance (MSA)- Shelter Needy Option

- Expand programs such as the Crisis Housing Fund that provide temporary rental, mortgage, and utility assistance for persons with disabilities to retain their housing while they are temporarily in less integrated settings or treatment facilities.
- Increase funding for a statewide rental housing vacancy referral system to provide information to people about available affordable and accessible housing units.
- The State shall use best efforts to form private public partnerships to fund additional affordable accessible housing for people with disabilities. Such partnerships may include seeking grants from foundations or corporations.
- Annually, during the assessment process and subsequent reviews, individuals with disabilities should be asked if they want to move to a more integrated community setting or make other changes to their living situation. This currently occurs in nursing facilities and should be expanded across all settings.
- Those who express an interest in moving to a different setting should be informed of the resources available to them for housing and services.
 - A person centered discharge plan and community support plan should be developed for people who choose to move to a new setting.
 - A peer integration specialist will be available to assist the individual with a disability during the planning process to ensure their personal needs and preferences are considered.
- Evaluate the impact of the adult foster care moratorium on the increased utilization of more restrictive settings including nursing homes, ICF/DDs, Board and Lodge Facilities with and without Services, and Housing with Services Establishments.
- Evaluate the populations residing in other settings including Board and Lodging establishments with and without services to determine if there is an Olmstead issue.
- The State Olmstead Plan should build upon the strategies identified in the Evaluation of Current and Potential Housing Option for Persons with Disabilities Report of April 2011
 - Improved access to rent subsidies
 - Creating and promoting accessible housing and accessible communities
 - Making better use of existing housing stock to expand choice and access
 - Assist persons with disabilities to become homeowners through the land trust program
- The State must develop a plan to assist providers in transitioning their service array to a different model.

- Use existing data systems to better inventory and monitor the continuum of housing options and the movement toward integrated community settings in Minnesota. This includes DHS, Dept. of Health, MN Housing, HUD, Dept. of Corrections, Dept. of Public Safety, and Housing Authorities statewide. Develop improvements as necessary.
- The State should convene a multi-agency collaborative Housing Task Force to work on the recommendations listed above, foster the development of new initiatives to address these identified issues, and help establish specific, measurable and achievable goals.

Goals:

- Increase the availability and access to integrated community settings in order to ensure that all people with disabilities have the ability to live in the most integrated setting possible.
- Reduce the number of persons with disabilities residing in nursing homes and ICFs/DD by 2,000 individuals over a five year time period through Money Follows the Person.
- A minimum reduction of 5% over the next 5 years in adult foster care beds and housing with services establishments. The money saved from reducing less integrated bed capacity should not be part of a budget reduction exercise but rather be reinvested into an array of existing or new and enhanced services.
 - Information about current use of family foster care and corporate foster care, and an analysis of capacity needed, will be available in the February 2013 foster care needs determination report to the legislature. The needs determination should inform the Plan.

STATE OPERATED SERVICES

State Operated Services (SOS) is a division of the Minnesota Department of Human Services (DHS) that provides direct care services to people with mental illnesses, chemical dependency, intellectual disabilities, and traumatic brain injuries. These services range from short-term acute care in hospital settings to long-term residential support services. SOS typically serves people who have difficulty being served by other providers, including people committed to the Commissioner of DHS. See Attachment A for a description of all state operated services.

The Olmstead concept of “most integrated setting” poses three important challenges for SOS services:

- Residential services: Some SOS services are provided in congregate residential settings that are populated primarily by individuals with disabilities. To comply with Olmstead, the State and counties need to work with residents to develop plans to consider and/or implement moves to more integrated settings.

- Acute care services: It is often extremely difficult to discharge patients to less restrictive settings when they no longer need a hospital level of care in SOS hospitals. A lack of local community providers who are able and willing to meet the needs of patients with complex, co-occurring conditions (including aggression) results in patients being “stuck” in SOS facilities until other arrangements can be made. This conflicts with the Olmstead standard of serving people with disabilities in the least restrictive setting possible.
- Forensics services: Forensic population faces numerous barriers to discharge back to the community. With length of stays in the 10-25 year range it is clear the Olmstead standard of serving individuals in the least restrictive setting is not always being met.

Minnesota State Operated Community Services (MSOCs)

Minnesota State Operated Community Services (MSOCs) provides community-based residential, vocational, and crisis respite services for about 450 people with disabilities annually. MSOCs have fifteen residential homes licensed as ICFs/DD that usually house six people for a total of about 90 residents at a time. MSOCs also operate 90 corporate foster care homes serving approximately 465 individuals annually. In addition, MSOCs provides a wide range of vocational training and supports for individuals. Nineteen Day Training and Habilitation (DT&H) sites serve about 850 individuals annually.

Recommendations

- The State and counties should engage in a person-centered planning process to offer individuals residing in MSOCs facilities a choice to move to a more integrated setting.
- Recommendations under the Where People Work section regarding Day Training and Habilitation Services (DTH) and the Where People Live section ICF/DD and foster care components apply to MSOCs.
- Review and study what role MSOCs can play to assist with transitioning an individual to another setting, providing crisis services, etc. This study would help determine what role MSOCs should play in the safety net system to assist with the transition to non-state operated programs some of the most difficult to serve individuals.

State Operated Forensic Services (SOS)

The term “forensic” is used by SOS to refer to specialized statewide evaluation and treatment to individuals with disabilities who are involved with the legal system due to a crime. During fiscal year 2012 Minnesota spent \$68 million to provide forensic services to individuals residing on a campus in St. Peter, Minnesota. This includes the Minnesota Security Hospital (MSH). See the Appendix for a description of SOS forensic services. The MSH is a supervised living facility for individuals who have been committed as Mentally Ill and Dangerous (MID) by a court. The supervised living facility funding includes all costs paid by the state to serve individuals in this setting, including behavioral health treatment and other medical care. In 2011, Minnesota opened a forensic nursing home to serve

individuals from the Minnesota Security Hospital, the Minnesota Sex Offender Program (MSOP), or who are on a medical release from the Department of Corrections (DOC).

As patients at MSH complete their treatment, they are moved to the Transition Readiness program and the Transition Services program, both of which prepare the individual to move back into their chosen local community. Upon completion of those programs, a Special Review Board and county representatives review each individual's record and decide whether the individual should be released to the community (see next section for more detail). In a presentation to the Olmstead Planning Committee, SOS staff estimated that MSH has 50 people in the Transition Readiness program and 82 people in Transition Services, all of whom could move to the community if the move were supported by the county, recommended by the Special Review Board, and approved by the Commissioner. However, very few people overcome these hurdles. Only 11 people were provisionally discharged from Transition Services in 2011, and only 12 people were provisionally discharged in 2010. The two Transition programs support 35% of the Minnesota State Hospital population.

In addition, SOS's St. Peter-based Competency Restoration Program has 26 beds. The purpose of this program is to provide treatment for people to restore their competence to stand trial. The average length of stay in this program is 6 months. SOS staff estimate that, at any one time, 40% of the beds in the program are occupied by people who have completed an evaluation and whose report has been submitted to the court. A major barrier to disposition and discharge is that criminal courts hold jurisdiction over these patients and have up to three years to take action.

The OPC requested information regarding the length of stay for individuals in forensic services. Data for patients served by forensic services on September 13, 2012 is included in the Appendix. The data provides a snapshot of the length of stay by current program, legal status and county of finance. The data shows that 108 of the Minnesota Security Hospital's forensic patients have been in forensic services for 10-25 plus years. Of the 108 patients the county of finance for half of the patients is Hennepin County. In addition, there were 147 patients in five transition programs 55 of who had been in forensic services for 10-25 plus years.

Civil Commitment and State Operated Forensic Services

Like most other states the inpatient forensic population of Minnesota consists of people who are being held according to Minnesota Rules of Criminal Procedure 20.01 (Incompetent to Stand Trial) and Minnesota Rules of Criminal Procedure 20.02 (Not Guilty by Reason of Mental Illness or Deficiency). However Minnesota is unique and has a third large category of commitment status—Mentally Ill and Dangerous—which is a civil commitment of indeterminate length (MN Statute 253B).⁵ Other states do not have a population labeled MI&D through a civil process.

Currently, there are approximately 420 people committed as MI and D in Minnesota; this number is comprised of approximately 270 inpatient at State Operated Forensics Services (SOFs) and 150 residing

⁵ The MI and D civil commitment is an "indeterminate" civil commitment which means that the petitioning party does not have to re-prove that the client meets the statutory definition at the expiration of a pre-determined time period as is the case with "determinate" civil commitments such as the Mental Illness or Chemically Dependent civil commitment, which must be "re-proved" annually. Instead, the burden shifts and the MI and D client must prove that s/he is no longer MI and D and qualifies for what is referred to as a "full discharge." These "full discharges" are granted to only a few people a year.

in the community⁶ in varying degrees of independence (such as Adult Foster Care, Institute for Mental Disease (IMD),⁷ community nursing home, Intensive Residential Treatment Service (IRTS), Board and Lodge, or apartment). The inpatient population at SOFS increases at the rate of approximately 10 to 15 per year. Indeterminate civil commitments means that individuals are committed through the civil court system and the provisional discharge is approved or denied⁸ by the Special Review Board (SRB). The SRB is a quasi-judicial panel of mental health and legal experts which was “established to address the treatment needs of the patient and protect public safety”⁹. Thus, SOFS staff does not have the authority to discharge patients. The rate of admission via civil court proceedings, versus the rate of provisional discharges via the SRB, has resulted in an ever-increasing inpatient population at SOFS.

Another barrier to discharge for individuals at SOFS is that the resources necessary for supporting the individual’s return to the community are under the direct control of the county social services agency. Counties do not have targeted funding for people that raise public safety concerns. This creates an incentive for counties to give preference to individuals without histories of public safety concerns. All of these factors contribute to the limited numbers of people leaving SOFS, even though SOFS staff believes that a large number of people in the program could live safely and successfully in the community.

Recommendations

- The State should establish a committee made up of multiple stakeholders to review, analyze and recommend changes to the Minnesota Statute 253B.18 regarding civil commitment of indeterminate length for persons who are mentally ill and dangerous to the public.
- The State should educate the Special Review Board and the Supreme Court Appeal Panel on the various community services and supports available to the individual to achieve a successful and safe return to community life.
- The State and counties should develop and implement a plan to move 132 individuals within a maximum of 2 years, based on client preference and within the parameters of the identified community and client safety risk. To assist individuals returning to the community, a person-centered discharge process should be developed that includes sufficient Peer Integration Specialists with the capacity to work knowledgeably within specific disability groups and as part of the multidisciplinary treatment team to aid the individuals.
- The State should develop an annual review process within one year, to assess all patients in forensic services to determine if the individual can move to a more integrated setting in the community given adequate supports and safeguards. When the review process determines that a return to the community is warranted, sufficient community resources must be made available to support the

⁶ Via the Provisional Discharge at a rate of approximately 10 to 15 per year.

⁷ Most notably Andrew Residence in Minneapolis.

⁸ Technically the SRB only makes a recommendation to the Commissioner of DHS, who has the final say, but the Commissioner rarely disagrees with the SRB’s recommendation.

⁹ Per the DHS website: The next level of appeal is the quasi-judicial SCAP (Supreme Court Appeal Panel, formerly known [and still in statute] as the Judicial Appeal Panel), then the Minnesota Court of Appeals, and finally the Minnesota Supreme Court before federal courts are accessed. The factors that the SRB considers are found in Minnesota Statute 253B and State Operated Services Policy 10020 and are essentially a combination of the client’s clinical progress and public safety. Other relevant Policies are SOS 10030 and SOS 6050.

individual's return to the community. The State must then initiate a petition supporting return to the community on behalf of the individual unless the individual objects. To assist individuals returning to the community, a person-centered discharge process must be developed that includes sufficient Peer Integration Specialists with the capacity to work knowledgeably within specific disability groups and as part of the multidisciplinary treatment team to aid the individuals.

- The State in collaboration with the counties must develop an appropriate array of community based services, including Forensic Assertive Community Treatment Teams, to assist individuals to remain in the community and assist those returning to the community.
- The State should seek technical assistance to address the treatment related aspects contributing to extremely long length of stays to assure that the treatment program at the Minnesota Security Hospital is evidence-based and meets current treatment standards.
- The State must rebalance forensic financial resources from the institution to community-based services.

Anoka Metro Regional Treatment Center (AMRTC) and Community Behavioral Health Hospitals (CBHHs)

Anoka Metro Regional Treatment Center (AMRTC) provides psychiatric services for patients who have acute mental illnesses requiring a hospital level of care and who are civilly committed. AMRTC has eight 25-bed units, and admitted 450 patients in 2011. SOS's Community Behavioral Health Hospitals also provide acute psychiatric care, but in small, 16-bed facilities that admitted a total of 1,488 patients in 2011. Average length of stay at AMRTC in 2011 was 88 days. At the CBHHs, the average length of stay is much lower, usually less than 20 days.

Like other hospitals, AMRTC and the CBHHs have utilization management systems that monitor utilization of their hospital beds and determine when a patient no longer requires a hospital level of care. However, discharging patients when they no longer require hospital services is very challenging due to several factors, including the complexity of discharge planning for patients with complex chronic disabilities; the challenges of coordinating effectively among hospital social workers, counties and community providers; the difficulty of finding appropriate and willing providers of services for people with aggressive histories; a lack of housing with services for patients with complex needs; and complicated funding streams that can make it difficult to fund appropriate placements.

As a result of these factors, AMRTC patients spent 10,670 days at AMRTC in 2011 when they did not meet criteria for a hospital level of care. Patients at the CBHHs spent an additional 3,300 days not meeting criteria, for a total of over 14,000 bed days during which the patients did not meet a hospital level of care. This represents about \$15.4 million dollars of inappropriate care expenses, borne primarily by the state.

The fact that so many patients are "stuck" in SOS hospitals and receiving services at an inappropriate level of care is of extreme concern, but concern is compounded by the fact that the CBHHs are usually full and AMRTC has a waiting list that recently exceeded 100 people. When beds are filled by patients whose conditions don't require them to be in a hospital, those beds are not available for others who do

require a hospital level of care. A significant amount of SOS staff time is spent managing the waiting list, which is typically reduced by diversions. Diversions include: contract bed referrals, hospitals writing their own provisional discharge, requesting a remote provisional discharge, IRTS referrals, nursing homes, assisted livings, and the use of ACT teams.

Each week AMRTC bed management staff and Hennepin, Ramsey, Dakota and Washington Counties case management staff review clients on the waiting list and hold meetings to plan for discharge of patients currently at AMRTC. AMRTC is starting to work with rural counties as well, so that discharge planning begins earlier in a patient's stay at AMRTC, thus reducing the number of days when patients don't meet a hospital level of care.

The AMRTC is licensed as a hospital but for Medicaid purposes is still considered an Institution for Mental Disease (IMD).¹⁰ Because most people served in IMDs are not eligible for Medical Assistance (MA) coverage, AMRTC services are primarily funded through a state general fund appropriation, with counties paying a small share. Under Reform 2020, Minnesota is requesting a waiver of the Institutions for Mental Diseases exclusion for AMRTC because it is operating as a tertiary hospital. This would allow Medicaid financing for the people aged 22-64 at AMRTC. If successful, Minnesota plans to use the state money that is saved to develop services for individuals with more intensive and specialized needs to move from AMRTC to the community.

Recommendations

- The State and counties should develop sufficiently robust community and housing services to improve the patient flow through the mental health treatment system, and within a maximum of 2 years eliminate the AMRTC wait list.
- Within a maximum of 2 years, AMRTC will ensure that patients who reach stability are discharged in 3-5 working days.
- SOS should evaluate how to make AMRTC wait list more transparent and accountable. The waiting list data should be included in the annual AMRTC Utilization Data report.
- SOS should continue to work with the Counties to implement person centered discharge planning that includes a multidisciplinary approach, including Peer Integration Specialists with knowledge of the needs of the individual.

Community Support Services (CSS)

Community Support Services (CSS) advances the State Operated Services (SOS) mission by strengthening the community living of people with clinically complex challenges. This is done through initiating and guiding innovative behavioral supports, building collaborative support networks and advocating for person-centered approaches. By facilitating activities that promote SOS as a leading partner in Minnesota's service systems, CSS involvement ensures that SOS has the capacity to meet targeted goals for providing state-of-the-art services.

¹⁰ IMDs are defined as facilities of 16 or more beds in which a majority of residents are age 22-64 and have diagnoses of mental illness. MA does not pay for services provided to residents in IMDs unless the resident is under age 21 or over age 65.

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Minnesota Specialty Health Center- Cambridge

In considering the values and expectations of the U.S. Supreme Court decision in *Olmstead v. L.C.*, 527 U.S. 582 (1999) it was the Committee's recommendation to develop a robust set of alternative services specifically designed to support individuals with developmental disabilities who exhibit severe behaviors which present a risk to public safety. These services, once implemented, will support people in the most integrated setting and eliminate the need for placement in the MSHS Cambridge program. The recommended services described in this section are more fully described in the section on Community-Based Supports and Services where the recommendation is to make them available for all persons with disabilities who are or may be at risk of crisis.

Recommendations

- Development of regional crisis services that consist of mobile teams of professionals and paraprofessional staff. This service will allow for the provision of assessment, triage, and care coordination to assure persons with developmental disabilities and who exhibit severe behaviors which present a risk to public safety receive the appropriate level of care at the right time, in the right place, and in the most integrated setting in accordance with the U.S. Supreme Court decision in *Olmstead v. L.C.*, 527 U.S. 582 (1999).
- This service will provide long term monitoring of individuals with clinical and situational complexities in order to help avert crisis reactions, provide strategies for changing needs, and prevent admissions to the MSHS Cambridge program.
- The long term monitoring will be implemented at the point when individuals experience contact with law enforcement, psychiatric hospitalization, or emergency room, visits related to actions that present a significant risk of harm to themselves or others or when school age youth experience truancy.
- These services will be provided where the consumer lives, strengthening the capacity of the services system to serve individuals with clinical complexities in their home.
- Services will include mobile wrap-around response teams located across the state for proactive response to maintain living arrangements. The maximum time for the crisis response will be one hour from the time the parent, family member, or legal guardian authorizes involvement.
- This service will provide families, caregivers, and staff at community based facilities and homes with state of the art training encompassing person centered thinking, multi-modal assessment, positive behavior supports, consultation and facilitator skills, and creative thinking. Training, mentoring and coaching as methodologies will result in increased community capacity to support individuals in their community.
- The service will include short term respite capacity for planned respite. It will also include crisis bed capacity with the ability to provide assessment, evaluation, treatment, and stabilization services that will avoid the inappropriate use of more restrictive settings, institutions, psychiatric hospitals, or jails. The Crisis bed capacity could also support individuals in transition to new living arrangements

- Funding for these services needs to be stable and provide for flexibility in service delivery.
- The consultative services will be available state-wide through the use of telepresence.
- Work force development will be supported for public and private providers. It should include a short term training component for existing professionals that achieves competency in the areas of positive behavioral supports and person centered planning and thinking. It should also include a long term strategy to develop a sufficient number of individuals with advanced training and competencies in treatment for individuals with developmental disabilities and other co-occurring clinical complexities.
- In order to secure this new work force and keep it stable, consideration should be given to the establishment of wage subsidies for specific professionals and paraprofessional with the highly technical skill sets.
- Most importantly this service should provide immediate access by families and other natural supports to the technical assistance and support described in these recommendations.
- The OPC is aware that there are a number of services that currently exist that provide portions of the services described targeted to specific disability population. It is recommended that the Department, in developing the Minnesota Olmstead Plan, consider incorporating these services into a comprehensive crisis service network.

Goal:

- End the use of the MSHS-Cambridge through the development of a robust array of community services.

Child and Adolescent Behavioral Health Services (CABHS)

- A priority of the Money Follows the Person grant is to move children from the Child and Adolescent Behavioral Health Services program in Willmar to their homes.
- The State must develop the capacity statewide to provide children with complex disabilities, hospital services in their communities.

Department of Corrections (DOC)

This needs input from DOC but the recommendation would be something general like this.

- DHS and DOC should convene a workgroup with Community corrections and other stakeholders to review transition services from correctional institutions to the community, jails to SOS facilities, mental health courts and other issues as identified by the agencies.

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Appendix

Nursing Facilities

Despite an aging population, the number of number of licensed nursing home beds decreased 30 percent between its peak in 1987 and 2009, from 48,307 to 33,878. (What We Have Report, page 40) The decreased demand is expected to continue as people exercise their preference for smaller home like settings or alternatives to traditional nursing homes. Nursing facilities have responded by increasingly moving toward short-term rehabilitative stays. For example, 82% of people admitted to a nursing facility in FY 2006 were discharged within 90 days. (“What We Have”, page 40)

In 2012, the average number of monthly Medicaid recipients living in nursing facilities was 17,038. The average cost per recipient was \$3,831.

Intermediate Care Facilities for People with Developmental Disabilities

In 2012, the average number of monthly Medicaid recipients living in ICFs/DD was 1,749. The average cost per recipient was \$6,423. ICFs/DD range in size, serving anywhere from 4 to 64 individuals. SOS has 90 ICFs/DD beds. In state fiscal year 2012, 47.4% of recipient days were spent serving people in ICFs/DD with 6 or fewer beds. In 2011, 2% of people in ICFs/DD moved into their own home. The majority of ICFs/DD previously closed due to state policy efforts to convert funding to home and community based services.

Another target population for Minnesota’s Money Follows the Person grant is Medicaid recipients living in ICFs/DD. Under the grant the state plans to move 467 people from ICFs/DD to homes in the community during the time period 2013-2016. Another goal of Money Follows the Person is to decrease ICFs/DD beds by 20%.

Certified Boarding Care Homes

Certified Boarding Care Homes provide nursing services and personal or custodial care, such as assistance with eating and grooming and supervision of self-administered medication. These facilities serve five or more elderly, physically disabled or mentally ill person. In 2009 there were 1,078 licensed beds in 21 facilities. These facilities are considered a nursing facility for MA certification and are licensed by the Minnesota Department of Health (MDH). MDH licensure standards for these facilities are less stringent than those for nursing homes and are not eligible to receive Medicare reimbursement.

Noncertified Boarding Care Homes

Noncertified Boarding Care Homes provide personal or custodial care, such as assistance with eating and grooming and supervision of self-administered medication. Nursing services are not required. These facilities serve five or more elderly, physically disabled or mentally ill person. In 2009 there were 847 licensed beds in 13 facilities. These facilities are not certified for participation in the MA program. MDH classifies these as institutional or health care facilities so residents are not eligible for home and community based waiver services and home care services. The group residential housing (GRH) program pays for room and board if the facility has GRH rate agreements with county agencies.

Board and Lodging Facilities

Board and Lodging facilities provide room and board with no services. Board and Lodging facilities are licensed by MDH but **not** as a health care facility. Thus, they are licensed by the number of rooms not beds. A Board and Lodge license covers board (provision of meals) and lodge (place to sleep). GRH pays for room and board for Board and Lodging facilities that are not Children's Residential Facilities.

Board and Lodging facilities licensure under DHS depends on the population served. A facility may be licensed under a Children's Residential Facility, Chemical Dependency rehabilitation program, residential program for adult mentally ill persons.

For children a Board and Lodging facility may be certified under MA as a Children's Residential Facility and room and board can be paid by federal payments for foster care and adoption assistance. In 2009, there were 94 children's residential facilities (formerly Rule 5 or Rule 8) with a bed capacity of 1,856.

Board and Lodging Facilities with Special Services

These facilities provide supportive or health supervision services such as assisting with preparation and administration of certain medications and assisting with dressing, grooming and bathing. They serve five or more regular boarders who need special services. Boarders may include frail elderly, mentally ill, developmentally disabled or chemically dependent. These facilities are licensed by either MDH or through a delegated agreement with local jurisdictions. In certain instances if the facility provides services to an elderly population it must also register as a housing with services establishment and obtain the appropriate home care provider license. No DHS program license is required. In 2009, there were 58 facilities licensed as Board and Lodging facilities with Special Services.

The room and board is paid for by GRH or private pay. Depending upon the population served, DHS program services may be funded under Rule 12, Residential services for mentally ill persons, Rule 25 chemical dependency care for public assistance recipients and if the person is MA eligible home health services. MA Home and Community Based waivers including EW, CADI, TBI and the state funded Alternative Care program may also pay for services.

Housing with Services Establishments

Most states license a facility that provides both housing and services. Minnesota and a few other states have separate regulatory structures for housing and for services.¹¹ Buildings in which a package of services is offered to residents must be registered with the Minnesota Department of Health (MDH) as housing with services establishments if 80% of the residents are age 55 or older. The separate housing registration and services licensure allows an establishment to contract with a service provider instead of furnishing services directly. Providers often have a separate licensure that authorizes their services. The most common licensure types are home care licensure and licensure as a board and lodging

¹¹ Mollica, Robert; Sims-Kastelein, Kristin; and O'Keeffe, Janet *Residential Care and Assisted Living Compendium: 2007* Nov 30, 2007

establishment.¹² The most common types of home care licensure are Class A, which authorizes provision of home care in any community residence and includes Medicare-certified home health agencies, and Class F, which is specific to housing with services establishments.

- **“Assisted Living” Services:** Since January 2007 housing with services establishments have been able to register with the Minnesota Department of Health as an “assisted living” provider if they meet additional criteria. Registration as an assisted living provider and services provided by a licensed Class A or Class F home care provider are required if an establishment or provider uses the term “assisted living” in marketing. The Elderly Waiver (EW), the Community Alternatives for Disabled Individuals (CADI) Waiver and the Brain Injury (BI) Waiver offer a service called Customized Living that is provided by assisted living providers in housing with services establishments. However, most people who receive assisted living do not receive publicly funded services.

Foster Care

Foster care provides services in small-group residential settings. DHS distinguishes between **family foster care**, in which a family lives with the persons with a disability that reside there—and **corporate foster care**, in which an organization has the licensure and provides staffing. Information about current use of family foster care and corporate foster care, and an analysis of capacity needed, will be available in the February 2013 foster care needs determination report to the legislature. Approximately 60% percent of DD Waiver participants live in foster care settings,¹³ and all other waivers have participants receiving foster care services. For waiver participants, the waiver pays for services. Room and board is often covered by Group Residential Housing and a portion of the resident’s income.

¹² Mollica, Robert; Sims-Kastelein, Kristin; and O’Keeffe, Janet *Residential Care and Assisted Living Compendium: 2007* Nov 30, 2007

¹³ Truven Health Analytics analysis of MMIS data, CY 2006 through CY 2010; data extracted January 2012.