MINNESOTA STATE PLAN FOR SERVICES TO PERSONS WITH MENTAL RETARDATION AND RELATED CONDITIONS

January 15, 1987 to January 14, 1989

Minnesota Department of Human Services
Mental Retardation Division
January 15, 1987

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

January 15, 1987

Dear Citizens of Minnesota:

On behalf of Governor Rudy Perpich and members of the staff of the Department for Human Services, I am pleased to present this state plan for mental retardation services. This plan covers the period from January 15, 1987 to January 14, 1989, and is submitted in keeping with Minnesota Statutes, section 252.291, subdivision 3 (d).

I hope that many citizens will take the time to read this plan and will support the initiatives outlined herein. We believe that the principles of service delivery described in the System Design section of the plan constitute an excellent blueprint for future initiatives on behalf of people who are developmentally disabled.

Sincerely,

SANDRA S. GARDEBRING
Commissioner

1987-1989 STATE PLAN FOR SERVICES TO PERSONS WITH MENTAL RETARDATION AND RELATED CONDITIONS

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DEPARTMENT OF HUMAN SERVICES

MISSION STATEMENT

The Department of Human Services, in partnership with the Federal Government, county, and other public, private, and community agencies throughout Minnesota, is a state agency directed by law to assist those citizens whose personal or family resources are not adequate to meet their basic human needs. It is committed to help them attain the maximum degree of self-sufficiency consistent with their individual capabilities. To these ends, the Department will promote the dignity, safety, and rights of the individual, and will assure public accountability and trust through responsible use of resources.

INTRODUCTION

Authority for Plan

Minnesota Statutes, section 252.291, subdivision 3(d), requires the Commissioner of Human Services to develop a state plan for the delivery and funding of residential, day, and support services to Minnesota's citizens with mental retardation and related conditions and to submit' that plan to the clerk of each house of the Minnesota Legislature on or before the 15th day of January of each biennium beginning January 15, 1985.

Definition and Scope of Developmental Disabilities

As a result of efforts by a coalition of organizations, the 1985 Legislature passed a bill which updated many obsolete references to persons with mental retardation and mental illness. This bill also makes persons with "related conditions" eligible for services previously provided only to persons who are mentally retarded. "Related conditions" is defined as follows:

> A person has a "related condition" if that person has a severe, chronic disability that is (a) attributable to cerebral palsy, epilepsy, autism, or any other condition, other than mental illness, found to be closely related to mental retardation because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation or requires treatment or services. similar to those required for persons with mental retardation; (b) is likely to continue indefinitely; and (c) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, or capacity for independent living. (M.S. Chapter 252.27, Subd. 1)

While the largest proportion of those labelled developmentally disabled are persons with mental retardation (75 percent), other individuals who have cerebral palsy, epilepsy, autism and other disabilities may be developmentally disabled if they also meet the criteria of severity, chronicity, age of onset, and substantially limited functional abilities.

The population of persons who are developmentally disabled in Minnesota is estimated at 101,470. This estimate is based on a prevalence rate of developmental disabilities of 2.42 percent of the state's 1985 population. However, less than 1 percent (or 41,900 people)of Minnesota's total population would probably be receiving services in the state's system.

For purposes of this planning document, "persons with mental retardation and related conditions" and "persons with developmental disabilities" will both be used within the context described above.

Terminology

In keeping with contemporary practice in the field of developmental disabilities, it is the policy of this administration to avoid all archaic, stigmatizing,dehumanizing, and syntactically incorrect_terminology and replace such_ language with appropriate socially valued references that emphasize the humanity and individuality of people with

HISTORICAL PERSPECTIVE

Chapter 312, Laws of 1983

Minnesota was an early leader in the development of community-based intermediate care facilities for persons with mental retardation (ICFs/MR). According to the February 11, 1983 report by the Legislative Auditor, Minnesota's population in community-based ICFs/MR was, on a per capita basis, higher than that of any other state (Legislative Auditor, 1983, p.12). The Legislative Auditor's report found that overreliance on ICFs/MR had been very costly because of the state's long-term investment in property and buildings. The report noted that "alternatives to__ICFs/MR care, such as semi-independent living services (SILS)and foster care, lack stable funding and are not well-developed." It was recommended that the availability and use of alternative forms of residential care be increased, existing facilities be encouraged to serve more dependent individuals, and development of new ICFs/MR be limited. (Office of the Legislative Auditor, 1983)

Legislative Moratorium of ICFs/MR

A legislative moratorium on development of ICFs/MR beds was embodied in Laws of 1983, Chapter 312, article 9. The moratorium was effective June 10, 1983, and required that under no circumstance could the number of beds, in the community and in regional centers combined, exceed 7,500 on July 1, 1983 or 7,000 on July 1, 1986.

On December 31, 1983, there were 2,417 ICF/MR beds in the regional centers__and. 5,036_ in_ the community, for a total of 7,453. In addition, there were 213 more beds that had been approved for development prior to the moratorium, but were not yet open.

County Case Management

In an effort to gain control of these widely dispersed programs, and to convert services from provider-driven to client (needs) - driven, the legislature mandated a decentralized, county-based program using county case managers to authorize individual services.

The 1985 Legislature passed Minnesota Statutes, section 256B.092, which established policies for the provision of case management to persons with mental retardation or a related condition and mandated that permanent rules be promulgated by July 1, 1986. This direction was consistent with the 1979 Community Social Services Act which gave planning and social service administrative responsibilities to the counties.

In 1986, Minnesota Department of Human Services Rule, parts 9525.0015 to 9525.0165 established standards for the provision of county case management with regard to persons with mental retardation and related conditions. The rule defines case management services as identifying the need for, planning, seeking out, acquiring, authorizing, and coordinating services. Case management services also include monitoring and evaluating the delivery of services to, and protecting the rights of, persons with mental retardation and related conditions.

Rule 53 and Determination of Need

The Legislature authorized the development of a new rate structure in 1983 which emphasized payments for services rather than buildings and administration. It also authorized counties to make recommendations to the Commissioner on the number, type, and location of new facilities and programs (determination of need) and required a county redetermination of need for existing services every two years.

Home and Community-Based Services Waiver

In 1983, the Minnesota Legislature directed the Department of Human Services to apply for a waiver from federal regulations to use Medicaid to support home and community-based services for persons with mental retardation and related conditions. Minnesota's reliance on regional centers and community ICFs/MR had resulted in a service system in which individuals were matched with services on the basis of what was available rather than on what was needed. A key objective of the home and community-based services waiver was to develop residential and habilitation programs that were tailored to the needs of individuals.

Another objective of the home and community-based services waiver was to provide assistance to families whose children or adult family members were "at risk" of placement in a regional center or community ICFs/MR. These in-home services include respite services, as well as visits from trainers, therapists, homemakers, and others. The Medicaid waiver may also pay for the costs of making minor physical adaptations to homes.

In addition to the residential and in-home services, the home and community-based services waiver supports the costs for day programs and county case management services.

Welsch Consent Decree

In the past 25 years, several forces have changed Minnesota's state regional center programs for persons with mental retardation. As in many other states, litigation has been one of the most important forces. In 1972, parents of Minnesota regional center residents successfully challenged the programs and care provided at the centers in a federal court suit. The case, now known as Welsch v. Gardebring, has continued to this day. In 1980, the parties ended one phase of the case by agreeing to a consent decree. The state agreed to make program and staffing changes at the regional centers and to reduce the number of residents with mental retardation from 2,710 to 1,850 by 1987. The decree will expire on July 1, 1987.

CURRENT STATUS

ICFs/MR Beds

As required in the Laws of 1983, Chapter 312, Minnesota has been reducing its use of and reliance on ICF/MR care by providing alternative community services. In 1983, Minnesota had 7,453 certified ICF/MR beds. Currently, Minnesota has 7,127 certified ICF/MR beds (only 6,800 beds are being used). The Department is submitting the additional certified beds to the Department of Health to remove them from the state statistical totals.

In addition, community ICFs/MR are serving more severely handicapped persons aided in some cases by use of special need rate funding and one time rate adjustments. With Minnesota's adoption of the 1985 Life Safety Code for ICF/MR facilities, many small (16 or fewer persons) ICFs/MR will likely modify their programs to serve more dependent persons as needed and recommended by county boards. Four facilities are currently undergoing such modifications and new proposals are expected at a rate of one facility per month.

Since 1980, 845 ICF/MR beds have been decertified in state regional centers. In F.Y. 1986, state regional centers experienced **a** significant net reduction of 209 in their population of persons with mental retardation. Twenty children having very severe disabilities were placed in community programs, primarily through the use of home and community based waiver services.

The Welsch v. Gardebring regional center population reduction target to 1,850 by July 1, 1987, was achieved in April, 1986, over one year ahead of time.

Case Management

Since the spring of 1985, county social service agencies have been working to achieve compliance with case management standards. Since each county's ability to achieve compliance is dependent upon the training and experience of their case managers in the field of mental retardation, the size of case managers' case loads, and the administrative and supervisory support available to them, most counties needed additional time to achieve full compliance with case management standards. All counties are required to be in compliance by July 1, 1987.

However, outstanding issues in regard to county case management remain, including: (1) lack of sufficient staff in some counties to provide adequate and effective case management for all eligible clients; (2) need for more intensified training of county case managers; and (3) need for evaluation and review of case management effectiveness and consumer satisfaction.

Rule 53

The new rules governing medical assistance reimbursement of ICFs/MR (Rule 53) were effective January 1, 1986. The 1985 Legislature mandated that the Commissioner of Human Services study mechanisms of reimbursement based on client needs, for ICFs/MR providers, training and habilitation agencies, and waivered services. The Department contracted with Lewin and Associates, a Washington, D.C., based consulting firm, to research reimbursement mechanisms and to make recommendations to the state on implementation of a new system. The state will modify the existing medicaid reimbursement rules to allow a targeting of dollars based on the differences in client need and resource use so there is no longer a disincentive to serve clients with greater needs. The results of this study are due by July 1, 1987.

Home and Community-Based Waiver

In April, 1984, the Department secured federal approval of a Medicaid waiver to provide home and community-based services to persons with mental retardation who otherwise would have remained in or been placed into a community ICF/MR or state regional center. The waiver was approved from July 1, 1984, through June 30, 1987.

The use of the waiver program by counties has increased dramatically over the last two years. Currently, there are over 700 persons receiving home and community-based services with an additional 300 persons who will be served by June 30, 1987.

	Persons Served
July 1, 1985	230
July 1, 1986	567
July 1, 1987	1,000

Welsch Status and County Use of Regional Centers

The Welsch Consent Decree is scheduled to terminate July 1, 1987, if the Department can demonstrate substantial compliance.

The Department believes it has made significant progress in demonstrating compliance in the following areas:

1. Reduction of the population of children in regional centers from over 250 in 1980 to 26 presently.
2. Reduction of regional center population from over 2,600 in 1980 to 1,770 presently. See Appendix A. for county utilization of state regional centers.
3. Development of alternative community services and funding options which have resulted in reduced regional center admissions.
4. Reduced reliance on psychotropic medications in regional centers.
5. Reduced reliance on separation and mechanical restraints and other aversive or deprivation procedures.

The Department is seeking to resolve compliance issues identified by the plaintiffs/Court Monitor which affect the Department's ability to demonstrate substantial compliance. The following is a partial listing of those issues:

1. Lack of sufficient community service options.
2. Lack of performance standards for service providers based on client outcome measures.
3. Lack of sufficient trained staff in both community residential and day services, as well as regional centers.
4. Continued reliance on the use of separation, seclusion, and mechanical restraint for a portion of class members residing in regional centers.
5. Lack of sufficient specialized equipment and qualified habilitation staff to provide and supervise services for physically disabled residents of regional centers.

Other Community Services

1. Semi-Independent Living Services (SILS)

Semi-Independent Living Services is a state and county grant program which includes training, counseling, instruction, supervision and other assistance required by a person's individual service plan. It may also include assistance in budgeting, meal preparation, shopping and personal appearance. SILS assures the placement of residents of ICFs/MR into independent living settings, the prevention of inappropriate placements into ICFs/MR, and increased independence for persons with mental retardation or related conditions who are no longer eligible for ICFs/MR or waivered services.

Over 800 persons are receiving SILS from 80 different licensed vendors. Seventy-nine counties are participating, and the average annual cost per person is approximately $4,600 (65 percent state, 35 percent county). Moreover, counties provide SILS to additional persons who do not have mental retardation or related conditions and, therefore, are not eligible for state grant funds.

There are 410 persons identified as eligible for SILS who are not being served due to limited state appropriations for this program. The major issues in this program are: (1) the lack of availability of SILS to enable persons no longer eligible for nor requiring ICF/MR or waivered services to live more independently in the community; (2) insufficient- state appropriation to fund SILS at the 80 percent reimbursement level required in state law; and (3) current allocation methods which do not provide sufficient incentives to increase program efficiency and effectiveness.

2. Family Subsidy Program

Consistent with state policy of preventing unnecessary separation of children from their families, this program provides funds to counties to reimburse families with severely disabled children up to $250 per month for specific items or services which are needed in order for the child to remain in or return to their natural or adoptive home. The grants pay for such items or services as medi-, cal insurance deductibles, medications, day care, respite care, special clothing, diet and equipment, and medical transportation.

Currently, there are 250 families receiving grants in 44 different counties. Over 70 percent of the children who are benefiting from grants have severe or profound mental retardation. There are 130 known eligible families waiting for a family subsidy grant which cannot be allocated due to limited appropriations.

3. State Operated Community Services

The Laws of 1985 authorized pilot projects to demonstrate the feasibility of state operated community services for state regional center residents with mental retardation. The Commissioner issued a request for proposal in December 1985 for such projects. Cambridge Regional Human Services Center and Faribault Regional Center were selected to develop pilot projects for up to 20 residents each. As of January 1, 1987, 12 persons with mental retardation from Cambridge Regional Human Services Center and Faribault Regional Center had been moved into state operated community services using a shift-staffed, four resident model. Follow-up evaluations are planned at six-month intervals to determine pilot projects' effectiveness.

4. Day Training and Habilitation Agencies

Training and habilitation agencies provide services to approximately 5,000 adults and 1,600 children. Most of the children receiving services are under age four years. Day services are provided by 110 agencies at 155 licensed community sites. More than 60 percent of adults receiving services live in ICFs/MR. The remaining 40 percent live in their own homes or in an adoptive home (23 percent), licensed adult foster care (7 percent), or another living arrangement.

Programmatically, the mission of service delivery is shifting from center-based health and social services, to community integrated services designed to achieve chronologically age appropriate outcomes for adults. This shift is resulting in the development of more diverse employment options for adults with mental retardation or related conditions.

As the adult service system more clearly defines its mission to include age appropriate services in the least restrictive environment a concomitant shift away from service delivery to children is occurring. As a result, more children are being served in public schools.

SYSTEM DESIGN

Values and Methodologies

Designing programs to serve individual human beings cannot be done in a value-free atmosphere. Consciously or unconsciously, attitudes and values toward children and adults with developmental disabilities are reflected in the behavior and attitudes of caregivers, in the location, size, and appearance of the environment in which services are provided, and in the selection of tools or materials to be used in delivering those services.

For example, we believe that our primary focus should be on the needs of the person with disabilities, that support of family and caregivers is necessary to help accomplish that task but should not obscure it, that the "system" should be based on the individual, and that human relationships are more important than bricks and mortar.

The following are concepts which have become generally accepted by parents and professionals as "best practices" to be followed in the field of developmental disabilities.

1. Normalization

   The most basic and effective concept in establishing a service system is the concept of normalization. It means making available to people with mental retardation the same patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society. Normalization is a deceptively simple concept. It has been mistakenly assumed to mean "making people normal" (a cure) or "making everyone behave the same" (regimentation).

   Outcomes or normalization goals have traditionally been stated in terms of persons who are developmentally disabled achieving independence. Considering the severity of some handicapping conditions, it is more accurate to state such goals in terms of individuals achieving measurable reductions in their dependencies and reaching levels of interdependence closer to the norm for non-handicapped individuals, all of whom are dependent on other people at different times in their lives. (Metropolitan Council, 1985)

2. Community Integration

   This is a corollary to the principle of normalization and simply means that all services should enable persons with developmental disabilities to be visible and active participants in their communities. Because people with the most severe learning disabilities have difficulty transferring or generalizing knowledge from one environment to another, and because research has demonstrated how powerful imitation or role-modeling can be for children and adults with developmental disabilities, training should occur in the setting where the behavior will be used. This means that residential programs would be provided in the person's home which is located in community neighborhoods where people without handicaps live. It also means that persons with developmental disabilties should be educated and integrated in their neighborhood schools, obtain health services in physicians' offices, work in community industries or businesses, receive religious nurture in churches or synagogues, and participate in recreational activities in community sports facilities. This plan recommends that service settings should never totally segregate persons who are handicapped from those who are not.

The concept of "partial participation" means that adaptations to activities and environments be made for individuals so they can participate in some way, using the same community resources available to those who are not handicapped. This principle affirms that persons with severe mental or physical handicaps have a right to participate, to whatever extent possible, in the life of their communities. Similarly, "natural proportion" provides an operating practice wherein programs, settings, and individual goal selection are designed so that persons with developmental disabilties can regularly interact with more non-handicapped people than handicapped people approximate to that ratio in the total population. (Metropolitan Council, 1985)

Support, Not Supplant, The Natural Home

The Mental Retardation Division supports and adheres to the policy of this state that all children, regardless of minority racial or ethnic heritage, are entitled to live in families that offer a safe, permanent relationship with nurturing parents or caretakers and have the opportunity to establish lifetime relationships. This policy is generally referred to as permanency planning and was adopted by the Minnesota Legislature as Chapter 9, Section 69, 1985 Special Session Laws of Minnesota amending Minnesota Statutes, section 256F.01 (PUBLIC POLICY).

Age Appropriateness

Nothing is more fragile than a. person's image. In. the past, adults with mental retardation or related conditions have been viewed as eternal children, incapable of growth and personal maturity. The inappropriate use of psychological test scores or "mental ages" as a simplistic means of assessing a person's capacity for learning resulted in a self-fulfilling prophecy that severely limited the potential of the person, more severely than did the disability itself. Therefore, it is the responsibility of the state to support positive imagery in environments designed to serve people with developmental disabilities.

Real Jobs, Real Homes, Real Schools

For many years services were provided according to a developmental model. This model derived from an early childhood education premise that all individuals grow and learn in sequential stages and that mastery of each stage of development is required before the next stage can be attempted. This resulted in teaching persons with developmental disabilities the skills and behaviors typically learned in each stage of growth from infancy to childhood to adolescence to adulthood. Too often, in adhering strictly to the developmental model, age-inappropriate goals and strategies were selected for those who were already adults. Inability of developmentally disabled persons to move quickly through the developmental stages led to the realization that it might take several decades, perhaps a lifetime, for them to acquire critical self-care, vocational, and socialization skills using a strictly developmental approach.

Current professional theory now requires use of the "Criterion of Ultimate Functioning." The most critical skills to be taught are those that are critical to develop the personal behaviors needed to function to one's maximum capability in domestic, educational, vocational, and social situations. Therefore, this plan supports the concept that the skills and behaviors which are necessary for integrated community life and that are valued by the individual and society should have priority when selecting goals and services. (Brown, Nietupski and Hamre-Nietupski, **1976)**

Service Coordination and Quality Assurance

In the past 15 years, there has been an unprecedented expansion in the number of community-based services throughout the nation and in Minnesota. Many new services and personnel have entered the developmental disabilities service system. While this period of rapid expansion- has alleviated some of the system capacity needs, it has also given rise to several problems centering on the quality of services. Although the services must meet certain minimum regulations, they vary considerably in the quality of operating practices and client outcomes.

1. Service Coordination

Case management is increasingly seen by parents and professionals as a vital link to the complex service system. Effective case management requires a variety of responsibilities. Case managers must be able to assess the client's strengths, limitations, and needs based on a variety of information sources. They should be able to work with clients and their families in developing individual service plans. They should have current knowledge about what and where services are available and keep abreast of advances in service technology. They should act as brokers to link their clients to the services they need. They should monitor a client's progress through direct observations, interviews, and data collection. They should act as class advocates for clients, representing their interests so that deficiencies in the service system can be corrected. (Metropolitan Council, 1985)

2. Quality Assurance

Licensing, client advocates, and quality assurance staff in regional centers, as well as other state and county monitoring groups can, and do, provide some safeguards to assure quality of services. In addition, as pointed out by the Legislative Auditor in describing "planning for the 'post-Welsch' era," there is a "need for continued outside monitoring and scrutiny of the regional centers and community facilities and programs. The experience of the past five years suggests that this outside scrutiny is needed to ensure that the hospitals do not retreat from the progress they have made and to point out areas where improvements are still needed."

The Developmental Disabilities Program, State Planning Agency, expresses the view that the most critical problem in Minnesota today is the issue of quality, outcomes, and appropriateness of services. Some opportunities exist to promote quality:

- Implement mandatory training for all staff who work with people with developmental disabilities.
- Provide clear guidelines to counties and providers that services should lead to outcomes such as increases independence, integration, and productivity. Collect data on outcomes and provide feedback to providers.
- Implement performance-based contracting rather than purchase of service arrangements.
- Provide a means of independent verification of good practice through monitoring set up outside DHS. Use volunteer committees as one example.
- Establish a mechanism to give positive recognition to providers and agencies rather than only focusing on negative actions.
- Work with counties and providers to determine how best to monitor dispersed settings. Traditional approaches of licensing are very limited in assuring quality supported employment and supported living services.

The Department recognizes that significant amounts of public resources are expended on services for persons with mental retardation. Part of quality assurance means maximizing the use of those resources for the appropriate levels of services. The Department is committed to efforts that will allow appropriate persons to become independent of the public service funding.

GOALS 1987-1989

Staff Training

Approximately 6,000 staff members provide residential, social, and employment support to persons with developmental disabilities. Staff training is provided to a greater or lesser degree, according to one or more of the following variables: (1) rules of the Department, including licensure, case management, day program or residential; (2) federal funding requirements (e.g., ICFs/MR regulations; and (3) commitment to training and/or resource availability of individual service providers.

What is needed is a "floor," a basic level of staff training required before staff are permitted to provide care to persons with developmental disabilities. The Department is proposing a legislative initiative which will supersede and standardize training requirements found in various rules governing services. It would amend Minnesota Statute, section 252.28, to authorize the Department to establish minimum training requirements for case managers and direct care staff.

In addition to entry level training, the Department is committed to assuring that employees in both the public and private sector are aware of advances in the field of developmental disabilities. Recent government supported research and demonstration projects in education, vocational training, and community residential services have produced improved teaching techniques, innovative theories of service delivery, and impressive data on achievements of severely handicapped learners. New technological devices and equipment have enabled persons with severe handicaps to improve their communication, mobility, and learning ability and open a wide range of educational, vocational, and social opportunities previously closed to them.

External Monitoring

Paid staff (licensing, Health Department, county case managers, etc.) do a good job of providing quality assurance for the people we serve. However, there is also a role for parents and interested citizens to help provide <u>external</u> monitoring of services. Therefore, the Department will request passage of legislation to fund and authorize such a program.

The following recommendations were taken from a December, 1986 report by Temple University professionals based on their extensive analysis of quality assurance in dispersed community programs and reflect the elements that would be in such a program for Minnesota.

> Given the limitations of our service system (or any service system), no "Quality Assurance System" can really assure that high quality services are always delivered to every person. By itself, no such system is sufficient; there are other factors that are necessary. For example, in a system in which the average case mana-

> ger's case load is over 100 individuals, or in which there is little or no value-based training, or in which required training is only on-the-job or extremely brief, or in which the salaries of the direct care personnel are abysmally low and turnover is very high, no "Quality Assurance System" can guarantee what the term implies. (None of these factors can assure quality by itself. In logical terms, all of the factors are necessary, but none are sufficient.) A different kind of monitoring can be conducted by parents and "significant others." According to the original article describing such a function, (Provencal, G. & Taylor, R. (1983). Security for parents: Monitoring of group homes by consumers. The Exceptional Parent, 13, p. 39-46. ... there is an important oversight role to be played by the "candid consumer. And when encouraged, this role can lead to improved programs which parents may come to trust more fully...Monitors do not visit homes where their relatives or wards reside...Visits are made approximately every 2 months...The monitor's primary responsibility is to evaluate the "feel" of each home; its appearance, atmosphere, warmth and overall sensitivity to...the resident's well-being. Quite deliberately, monitors do not assess individual client programs, procedure compliance, or performance toward standards that are to be reviewed by other agencies. (Conroy, Feinstein, and Lemonowicz, 1986)

C. **ICFs/MR Bed Decertification**

The statutory authority for a state plan for mental retardation services also requires that the plan include the number, type, and location of intermediate care beds targeted for decertification. Since ICF/MR bed use is now below 7,000 beds and the number of certified ICF/MR beds is rapidly decreasing, there is no need for involuntary bed decertification. However, continued voluntary decertification of beds is anticipated. In applying for renewal of the home and community-based services waiver, the Department is requesting 400 waiver "slots" (places) to enable several counties and residential services providers to accomplish service conversions which will make available to" their residents smaller, more normal living arrangements.

The following is a summary of the voluntary conversions from ICFs/MR to waivered services that are under negotiation between counties, providers and the Department of Human Services. While the following service conversions may not be achieved, other counties and facilities have contacted the Department to discuss service conversion of an additional 200 beds.

County	Provider	Number of People Served
Dodge	Woodvale Kassen	14
Hennepin	Hammer Residences (Main Building)	46
Ramsey	Wicklough, Inc.	73
Stearns	St. Elizabeth	14
Winona	377 Main (Winona)	11
Wright	Madden Haven South	45
		202

In addition, federal "look-behind" surveys and state licensing actions are anticipated to require the capacity for some involuntary conversions. At the time of the legislative moratorium on ICFs/MR development, concern was expressed that the moratorium would be a problem in meeting the terms of the consent decree* however, a February 1986 follow-up report by the Program Evaluation Division, Office of the Legislative Auditor, entitled "Deinstitutionalization of Mentally Retarded People," expressed the following opinion: 1) there was...no evidence that this moratorium has adversely affected compliance with the population reduction requirements of the (Welsch v. Gardebring) decree; indeed, the Department is likely to meet the consent decree's 1987 population reduction deadline with little difficulty. The 1988-89 biennium budget projects a reduction of 240 persons from regional treatment centers and corresponding reduction in certified beds.

Expanding Community Capacity for People with the Most Severe Disabilities

Historically, Minnesota and other states moved the most capable people back to their home communities first, leaving more severely handicapped people in inappropriate settings far from their homes.

While it has been well documented that virtually all children and adults with developmental disabilities, even those with high levels of physical or behavioral disabilities, can be served in ordinary homes if they are given adequate supports, it is equally true that we have developed an extensive network of ICFs/MR in Minnesota. Until the resources are available to do individualized residential placements for all children and adults, with size of residence not dependent on existing buildings, the Department will" work with counties and community ICFs/MR to assist with physical plant and/or staffing modifications so that small ICFs/MR can assist with meeting the needs of all persons, even those with more severe disabilities, in order for such persons to live in settings that are more normal than those in which they currently reside.

Home and Community-Based Waiver

This program has been very successful in reducing both Minnesota's high utilization of ICFs/MR and the need for new ICF/MR development. Continued efforts are necessary in this program, however, to assist counties in: (1) reducing reliance on group home models by encouraging alternatives such as family foster care and in-home support services;

(2) assuring effective local administration and payment to county agencies for services; (3) assuring appropriate and effective cost control procedures for service expenditures; (4) assuring that services are provided as authorized in the individual service plans and contracts and are effective in achieving desired client outcomes; and (5) assuring that supported employment initiatives are supported to enable client integration and development of greater independence in normalized work settings.

The Department will submit a request for renewal of the Title XIX Medicaid Home and Community-Based Services waiver to the federal government prior to April 1, 1987. The home and community-based waiver will be resubmitted and will expand services by 960 persons.

Community Services Technical Assistance

The Department will assist counties and service providers in areas such as case management, assessment, service planning, quality assurance, contracting, and cost effectiveness. The Department will provide intensive assistance through a network of regional services specialists, central office staff and information dissemination. Emphasis will be placed upon assisting counties with individual service planning, developing individualized cost estimates and assuring service quality.

Nursing Homes

In August, 1986, the Department received instruction from the federal Health Care Financing Administration regarding inappropriate placement of. persons with mental retardation or related conditions in skilled nursing facilities (SNFs) and intermediate care facilities (ICFs). These instructions stated, in part:

> "...If the primary need of a mentally retarded person is active treatment for his/her retardation, then the person should be placed in an ICF/MR. ...Only a small percentage of mentally retarded persons would appropriately be placed in SNFs ... A patient well enough to attend outside training would nearly always be well enough to be placed in an ICF/MR or other appropriate setting... Providers should be aware that failure to comply with the above mentioned regulation governing the appropriate placement of mentally retarded persons in SNFs and ICFs could affect Federal reimbursement... inappropriate placement may also jeopardize the 'approved' status of a state plan.'" (HCFA Transmittal No. 19, August, 1986)

In 1985, there were 1,221 persons with a diagnosis of mental retardation residing in nursing homes, 537 persons in ICF-1 and 685 in skilled nursing levels of care. Of these 1,221 persons, 379 persons were under 65 years of age, 181 persons receiving ICF-1 level of care and 298 persons receiving SNF level of care. ' Moreover, community DACs reported that 185 of their participants resided in a nursing home.

As a result of the instructions from HCFA, the Department has established special screening procedures for a person with mental retardation being recommended for placement into a nursing home or a resident in a nursing home, to prevent or identify inappropriate placements. The Department has requested additional funds to make available the appropriate alternative community services for persons identified as inappropriately placed in nursing homes.

Supported Employment

Madeleine C. Will, Assistant Secretary of the Office of Special Education and Rehabilitative Services recently wrote that:

> The development of viable supported employment programs is slowly replacing institutionalization and day activity programs as the method of choice in dealing with individuals with disabilities. As we envision it, supported employment combines the ongoing support typically provided in day activity programs with paid work opportunities. Such supported employment programs could occur in a variety of settings: in dispersed individual placements in a community, with publicly funded support staff rotating among sites; or in a mobile crew working in neighborhood settings: or in group placements, with many individuals hired as a team, supervised directly by a job coach. (Will, 1986)

The Department will continue to assist habilitation and training services such as developmental achievement centers in their move toward real work alternatives through supported employment. By the end of the F.Y. 1988-89 biennium, 120 persons should be receiving supported employment services, and the Department will be working with federal agencies to meet new standards which fund such services under Title XIX.

Division for Developmental Disabilities

With the addition of related conditions to the Division's responsibilities, and in keeping with similar actions taken in other states and at the federal level, the Department will request passage of legislation to change the name of the division to Division for Developmental Disabilities.

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COUNTY UTILIZATION OF STATE REGIONAL CENTERS
WELSCH V. LEVINE TARGET AS OF JUNE 30, 1986

COUNTY	Utilization on 6/30/86	Utilization on 6/30/80	Net Reduction since 6/30/80	1987 Target	Reduction Needed by 6/30/87
1 Aitkin	8	15	7	8	0
2 Anoka	35	53	18	45	0
3 Becker	9	20	11	13	0
4 Beltrami	16	28	12	17	0
5 Benton	11		6	12	0
6 Big Stone	2	5	3	3	0
7 Blue Earth	35	54	19	30	5
8 Brown	?.?.	35	13	19	3
9 Carlton	19	25	6 .	16	3
10 Carver	17	21	4	16	1
11 Cass	17	29	12	15	2
12 Chippewa	8	13	D	8	0
13 Chisago	4	7	3	6	0
14 Clay	22	32	10	99	0
15 Clearwater	9.	2	0	2	0
16 Cook	3	2	-1	9	1 '
17 Cottonwood	7	13	6	8	0
18 Crow Wing	29	50	21	97	2
19 Dakota	45	62	17	52	0
20 Podge	9	10	1	7	2
21 Douglas	17	26	9	16	1
22 Faribault (See Mar' in)	20				
23 Fillmore	9	23	14	13	0
24 Freeborn	13	30	17	18	0
25 Goodhue	12	24	12	17	0
26 Grant	3	9	6	5	0
27 HENNEPIN	425	564	139	394	31 -
28 Houston	5	16	11	10	0
29 Hubbard	5	13	8	8	0
30 Isanti	1	9	8	8	0
31 Itasca	27	30	3	20	7
32 Jackson	5	6	1	5	0
33 Kanabec	5	6	1	5	0
34 Kandiyohi	12	14	2	12	0
35 Kittson	9	12	3	6	3 .
36 Koochiching	12	20	8	11	1
37 Lac qui Parle	4	7	3	5	0
38 Lake	9	15	6	9	0
39 Lake of the Woods	2	5	3	3	0
40 LeSueur	16	25	9	14	2
41 Lincoln *(See Lyon)*	4				
42 Lyon (Region VIII)	5	27	22	19	- " 0
43 McLeod	11	20	9	14	0
-44 Mahnomen .	10	7	-3	4	6
45 Marshall	12	14	2	8	4
46 Martin (FMW)	8	62	54	33	0
47 Meeker	11	15	4	10	1
48 Mills Lacs	8	12	4	9	0
49 Morrison	15	36	21	19	0
50 Mower	29	41	12	23	6
51 Murray (See Lyon)	5 "				
52 Nicollet	12	13	1	11	1
53 Nobles	7	8	1	7	0
	9	14	5	7	2
55 Olmsted	34	57	23	42	a v
56 Otter Tail	39	53	14	30	9
67 Pennington	5	10	5	7	0
58 Pine	15	20	5	12	3
• 59 Pipestone	6	7	1	.5...	1
60 Polk	15	37	22	20 -	0
61 Pope	10	12	2	7	3
62 RAMSEY	224	306	82	203	91 !
63 Red Lake	12	13	1		6
64 Redwood	8	18	10	10	0
65 Renville	5	11	6	9	0
66 Rice	30	41	11	95	5
67 Rock	4	6	2	5	0
68 Roseau	11	19	8	10	o
09 ST. LOUIS	106	146	40	99	7
70 Scott	18	73	5	. 1 9	0
71 Sherburne	11	13	2	11	0
72 Sibley	15	15	0	.. 9	6
.73 Stearns	32	62	30	47	0
74 Steele	5	l7	17	13	0
75 Stevens	4	a	4	6	0
76 Swift	5	7	7	6	0
.77 Todd	15	36	91	18	0
	3	6	3	3	0
79 Wabasha	13	71	8	12	1
80 Wadena		18	10	, »	0
81 Waseca	5	15	10	9	0
82 Washington	20	27	7	23	3
83 Watonwan (See Martn) in)	7				
84 Wilkin	11	14	3	7	4
	19	30	11	20	0
86 Wright	11	14	3	12	0
87 Yellow Medicine	7	12	5	7	0
TOTALS	1.810	2.710	936	1.792	161

County utilization c
6/30/86 and persons who were on short term and long term visits and provisional discharge from the regional center.

Ewald Consulting Group, Inc.
Consultants in Governmental Relations and Association Management

DATE: January 22, 1987

TO: A.R.R.M. BOARD

RE: SYNOPSIS OF 1-20-87 GARDEBRING PRESENTATION

Sandra Gardebring, the newly appointed Commissioner of the Department of Human Services Monday presented an overview of the department's activities for the coming year and biennium.

Gardebring has been charged with the responsibility for administering a large and complicated department with a 1987 budget of $2.1 billion and numerous and complicated funding mechanisms.

Mental Health will receive a large amount of attention and funding increase for the biennium. In the funding area Gardebring plans on combining the numerous funding sources currently in use for mental health into one fund and then redisbursing those funds back to the counties. In this way the department can realize greater accountability and efficiency which translates into more effective treatment according to the commissioner. She also plans on better-defining the array of state services . available for the mentally ill that will be funded by the department.

The eight regional treatment centers will receive much attention over the biennium as well. Gardebring stated that one year from now the department will present its comprehensive plan of action for dealing with the treatment centers. Gardebring believes that handling this difficult situation in this matter will free the decision of what to do with the centers from being mere political or dollar issues late in the legislative session.. The effect of this proposal to plan for the future of the center has two other effects:
1) To take what some viewed as a "hot" subject this session out of the hands of those who would make it so; 2) To provide major departmental activity over the months intervening the 1987 and 1988 legislative sessions.

Mental Retardation was discussed in two important contexts. First, Gardebring envisions the mentally retarded population of the regional treatment facilities to decline by 400 persons during the biennium with a concommitant decrease in jobs of 600 and budget decrease of $11 million. She hopes to slowly decrease the number of jobs to reduce the trauma caused to those losing their positions. Second, waivered services to the mentally retarded, of which 700 are currently served, will increase to 1900 by the end of the biennium.

Other Key Points
Gardebring expressed her desire for system-wide licensing reform, including a major . overhaul of authority. She expressed her committment to reducing the fragmentation of services overseen by the department. The final and perhaps most critical statement she made was in stating her belief that the counties, advocacy group and the department had fallen down with respect to planning.

While this presentation was only a broad overview of the department's future activities and the specifics remain to be disclosed, based on her attitude Tuesday, Gardebring will decisively and confidently direct DHS in a manner to which most are unaccustomed.