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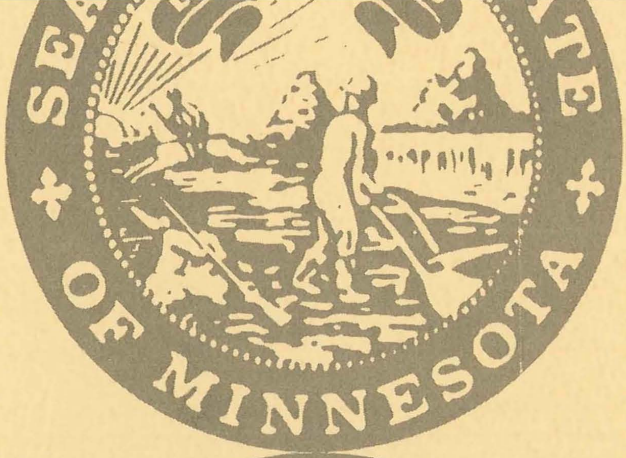
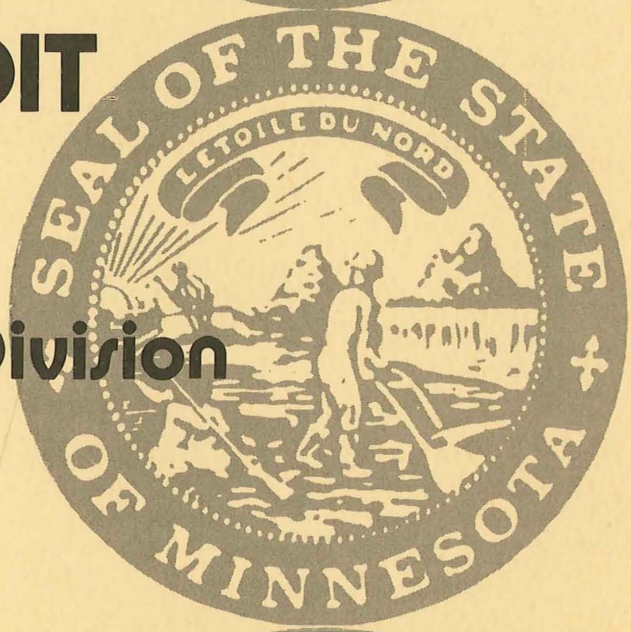
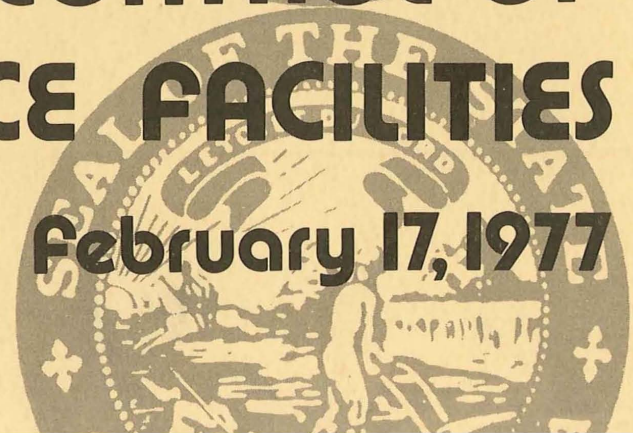




REGULATION AND CONTROL OF HUMAN SERVICE FACILITIES



February 17, 1977

STATE OF MINNESOTA
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State Legislature

LEGISLATIVE AUDIT COMMISSION

Program Evaluation Division

REGULATION AND CONTROL OF HUMAN SERVICE FACILITIES

February 17, 1977

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FOREWORD

The Program Evaluation Division of the Legislative Audit Commission was established by Chapter 204, Section 91 of the Laws of Minnesota for 1975. The Division is authorized to "determine the degree to which activities and programs entered into or funded by the state are accomplishing their goals and objectives, including an evaluation of goals and objectives, measurement of program results and effectiveness, alternative means of achieving the same results, and efficiency in the allocation of resources." This evaluation, *Regulation and Control of Human Service Facilities*, is the first Division report.

For each of the reports, a uniform review procedure is followed. After a preliminary draft is completed, it is submitted to all agencies directly involved in the evaluation. In addition, the report is reviewed by a Sub-committee of the Legislative Audit Commission prior to its release. The agency replies are included in the appendix.

Staff wishes to thank all of the 61 facility operators and their staff for the time and effort they contributed to the study. Regulatory activity managers were especially helpful, including Barbara W. Kaufman of the Department of Public Welfare, Janet Brodahl of the Minnesota Department of Health, Wes Werner of the Fire Marshal Division of the Department of Public Safety and Donald Cooper of the Department of Corrections. Also, the staff of the Audit Division of the Department of Public Welfare provided valuable assistance.

Martha R. Burt was the project director and chief author of this evaluation. She was assisted by Charles E. Rogers, Jr., Sharon Studer, Jo A. Vos, Marshall R. Whitlock, and Scheffel Wright.

Tradition dictates that the Chairmanship of the Legislative Audit Commission alternate between the House of Representatives and the Senate. Representative Fred C. Norton was Chairman for 1976 and was succeeded in 1977 by Senator William W. McCutcheon.

January 14, 1977

Bruce Spitz
Deputy Legislative Auditor
for Program Evaluation

SUMMARY OF FINDINGS AND RECOMMENDATIONS

The recommendations in the first four sections of this summary are meant to be acted upon immediately. Each can be undertaken by the appropriate authorities with no change in their existing jurisdiction or structure. The last section of this summary contains a discussion of more long-term and more comprehensive problems, solutions which may require significant changes in law, organizational structure, and philosophy. Presentation of data to support all findings and recommendations can be found in the body of the Final Report and in the nine staff papers prepared to accompany that Report.

IMPACT OF REGULATION

The Research Question: What effects has regulation had on the quality of care in human service facilities?

FINDINGS: QUALITY OF CARE

- In general, programs meet the licensing or regulatory requirements which pertain to them, although a significant number of programs in any licensing category remain only marginally in compliance. The level of care provided in programs thus depends in large measure on the stringency of the rule; what is marginal in one category may be average or good when compared to another category.

- Fire, life safety, sanitation, and medical emergency planning have changed for the better, although facility operators do not necessarily perceive these changes as impacting on quality of care.

- Record-keeping, which increases accountability, has improved dramatically in licensed facilities for the retarded and the mentally ill. In addition, many providers indicate that they are beginning to use their improved records for improved program planning.

- As stated in our Evaluability Assessment, regulation attempts to affect treatment effectiveness and client improvement by guaranteeing that conditions exist which might promote those ends (e.g., more, and more highly qualified staff, insistence on individual program planning). Enforcement of regulations in the MR and MI program areas has resulted in facility changes to attain compliance with regulatory requirements in the staffing and programming areas.

- Approximately 25% of the providers interviewed perceive that regulation has had positive impact on the quality of programming delivered in their facilities. However, 23% felt that programming had worsened as a consequence of regulation.

- Regulation has caused significant improvement in secure facilities run by local units of government.

FINDING: RESTRICTION ON ENTRY

- The drop-out rate among potential applicants for DPW licenses indicates a significant regulatory effect of simply having rules on the books.

FINDING: MEDICAID VERSUS FOSTER CARE

- The decision to fund care for the mentally retarded through Medicaid carries with it a heavy load of regulation. This mitigates against small facilities which provide only non-professional, foster care.

RECOMMENDATION:

- The legislature should either: (a) recognize that foster care will eventually disappear under the current funding mechanism, or (b) pass legislation committing the state to provide some alternative source of funding for small, non-professional group homes for the retarded. Such funding would require an estimated $750,000 to $1,250,000 per year, of which $375,000 to $625,000 would be funding in addition to that which the state already pays as its share of Medicaid costs.

FINDING: RULE WRITING

- DPW's current system of writing individual rules to cover each new type of residential care as it emerges has potential to inhibit the development of a continuum of care in the state's delivery system.

RECOMMENDATION:

- DPW and DOC should begin immediately to write comprehensive rules to cover a wide range of facility types. This can be undertaken as new rules are required or as old rules are revised. This would mean, for example, one rule for foster care for children, one for programming care for adults, etc.

FINDING: RULE ENFORCEMENT

- Some rules have been written and promulgated but are not being fully enforced due to staffing problems or a judgment that enforcement would have a negative impact on the delivery system.

RECOMMENDATION:

- Agencies should not promulgate rules which they cannot or will not enforce, nor should the legislature mandate such rules. Either enforce the present rules or remove them from the statutes. Adequate enforcement may mean increasing and/or upgrading regulatory staff (approximate cost: $45-60,000). It may also mean providing sufficient reimbursement to facilities to permit their meeting rule requirements.

COVERAGE

The Research Question: What gaps and overlaps exist in the present regulatory system?

FINDINGS: OVERLAPS AND GAPS

- Only one serious overlap or gap was found in the coverage afforded to human service facilities by state agencies, indicating that state agencies' efforts to coordinate their coverage and eliminate duplication have been quite successful to date.

- The one state agency overlap/gap discovered involves the confusion as to whether DOC or DPW should regulate group homes for juveniles. DPW regulates many non-correctional group homes; DOC is preparing to regulate a few correctional group homes; no state agency regulates a number of correctional group homes. This is an overlap, in that both agencies have some jurisdiction. It is also a gap, since neither agency does the whole job.

RECOMMENDATIONS:

- DPW and DOC should write compatible, comprehensive rules to govern juvenile group homes, to insure that similar standards prevail regardless of which agency regulates a facility. This should be done as soon as possible.

- DPW and DOC should coordinate inspection and enforcement of group homes to assure adequate, nonduplicative coverage, beginning immediately.

- New legislation should mandate jurisdiction over ALL community correctional facilities, regardless of source of funding, to either DPW or DOC. Currently, no agency has such authority.

FINDINGS: FEDERAL REGULATION

- Whenever facilities or individuals receive federal funds, they also become subject to extensive federally-required regulations.

- These federally-required regulations are frequently duplicative of state regulatory provisions.

- Frequently federal money is the only way to pay for residential care. Without the money, the care would not exist.

- Large residential facilities such as hospitals and nursing homes are subject to many federal regulations whether or not they receive money (e.g., U.S. Department of Labor, Occupational Safety and Health Act).

RECOMMENDATIONS:

- The legislature should appropriate money for MR foster care, if it decides that such care is desirable.

- DPW, with the backing of the Governor, legislature and state Congressional delegation, should either:

  a. request an increase in Title 20 funding to enable payment for family subsidy care, foster care, and other supportive care for the MR, MI and CD outside a health facility, justified as prevention of inappropriate institutionalization, one of Title 20's avowed goals; or

  b. request a waiver of HEW, to allow Minnesota to apply Medicaid funds to foster care, family subsidy care, and other care for MR outside a health facility, on an experimental basis. In effect, this would mean that HEW would accept state licensure in those categories of care in lieu of federal certification of ICF-MR facilities. This was attempted once before, but it seems to be time to try again.

FINDINGS: LOCAL REGULATION

- Much local regulation is not duplicative of state efforts.

- In some areas, notably, DOC, confusion exists as to the regulatory role of the department versus that of regional planning boards.

- In areas where local government possesses units which could assume regulatory roles, such as health and fire safety, delegation of state responsibility to local authorities is one way to reduce duplication. However, in at least one area where this has been tried and evaluated (MDH's Environmental Health Division), local authorities did not do very well.

RECOMMENDATIONS:

- Agencies and regional boards should clarify their respective roles in the areas of regulation, planning and recruitment of services. The legislature should direct those agencies not currently assuming state-wide regulatory functions to do so.

- State regulatory agencies should delegate regulatory responsibility to local authorities where these authorities possess the skill and staff to perform regulation, but monitor local performance to assure regulation up to state standards.

COSTS

The Research Questions: How much does regulation cost? What does the per diem rate buy in community facilities and state hospitals?

FINDINGS: COSTS OF REGULATION TO AGENCIES

- Programs for the mentally retarded which have ICF-MR certification cost, on the average, about $4,000/year to regulate. 75% of this figure derives from the cost of federal certification and MDH licensing. About 10% is attributable to DPW licensing. The rest stems from technical assistance given by DPW's MR Program Office.

- Programs for the mentally retarded which are paid for without federal funds cost approximately $1,800/year to regulate, on the average. DPW's costs are the same as for ICF-MR facilities. The difference is attributable to the absence of federal certification inspections and processing.

- The average cost to regulate facilities for the mentally ill is presently about $1,100/year. Approximately two-thirds of this cost is borne by the Department of Health. DPW carries the rest.

- DPW spent $569,914 in FY 1976 on all licensing activities.

- MDH spent $2,049,108 in FY 1976 on licensing and/or certification of human service facilities. The federal government pays slightly more than half of this amount.

FINDINGS: COST OF REGULATION TO FACILITIES

- All MR and MI facilities have incurred some cost increases as a result of meeting regulatory requirements. Small community-based MR facilities have incurred the greatest percentage increases (52%) to date, while state hospital programs for the mentally ill have incurred the least (2.93%).

- Cost increases stem from improvements and increases in staff in both MR and MI facilities. Direct care program staff increases account for the majority of the increase, followed by administrative staff and clerical duties performed either by program or clerical staff. Costs for building renovations and changes are usually under 10% of the cost increases.

FINDINGS: PER DIEM COSTS

- Average cost of care for the community-based MR facilities in our sample is $31.64; this figure includes the per diem rate plus the cost of externally-provided services. It compares to $40.92 as the sum of the actual average per diem cost of the state hospital MR programs we visited ($39.29) plus the average daily cost of special education service ($1.63), and to $41.00 as the overall state hospital per diem rate which all state hospital residents pay, regardless of actual cost, plus $1.63 per day for special education services.

- Average cost of care for the community-based MI facilities in our sample, adding the per diem rate and the cost of externally-provided services, is $29.20 ($21.11 omitting three programs with very high per diems), compared to $44.74 as the actual average per diem cost of the state hospital MI

programs we visited, and to $41.00 as the overall state hospital per diem rate which all state hospital residents pay.

- Moving all state hospital MR residents to community facilities and paying for externally-provided medical and other services at current private market rates would result in a per diem cost maximum of approximately $37.00. This represents a savings of $3.92 per day or approximately $4,829,000 per year under the actual state hospital costs for these residents, and a savings of $4.00 per day or approximately $4,927,500 per year under the current per diem rate (of which the state would save 43%). Special education costs are borne entirely by the state. Since they are included in the $37.00 figure, the saving versus the current per diem rate would be greater by the amount of special education costs for state hospital residents.

- Even greater savings might be realized by moving MI residents to community facilities, but in this case the network of community services is much less fully developed to handle the load than for the mentally retarded. For the MI, the state, private and third-party payers bear almost the whole burden of cost.

RECOMMENDATION:

- In conjunction with its present thrust toward reducing the populations in state hospitals, the legislature should simultaneously fund Regional Development Commissions, Area Mental Health/ Mental Retardation Boards, or other regional planning and recruitment bodies and direct them to actively plan and recruit providers for comprehensive systems of community care.

STATE DEPARTMENT REGULATORY OPERATIONS (DPW AND DOC)

The Research Question: How efficiently and comprehensibly do state regulatory departments perform their tasks?

FINDINGS: DEPARTMENT OF PUBLIC WELFARE

- Processing applications under new rules is frequently quite slow, due to:

  a. interagency coordination problems
  b. provider-Division communication difficulties
  c. lack of internal tracking.

- Old rules are less problematic, both because they are simpler and because all involved have more experience with them.

- Consistency across inspectors (and therefore across facilities and regions of the state) is poor.

- Technical assistance is available mostly for MR facilities. (MDH also does a considerable amount of technical assistance for ICF-MR providers.) Not much technical assistance is available through DPW for other population areas, although program offices within DPW do read all applications for licensure.

RECOMMENDATIONS:

- DPW, MDH, DOC and the State Fire Marshal should continue and expand their work on interagency coordination, clarifying points of confusion between agencies where these exist.

- DPW should clarify rule provisions in writing, providing facility operators with definitions of terms and examples of satisfactory compliance. DPW should develop workshops and make them available on a regional basis for new and old providers. The agency should use workshops to interpret new rules or rule changes, interpret old rules and adapt them to new conditions, etc.

- DPW's Licensing Division should immediately develop a system of internal tracking for license applications.

- DPW's Licensing Division should improve its consistency of enforcement through development of guidelines and examples, and through continuing inservice training and monitoring of enforcement in the field.

- Pass legislation to support and expand the technical assistance functions of DPW's Program Offices, as the best available resource for continued facility upgrading. This would entail approximately 10-12 new positions, at an estimated cost of $150,000-$200,000 annually.

FINDINGS: DEPARTMENT OF CORRECTIONS

- The Inspection and Enforcement Unit, which has responsibility for secure facilities run by local units of government, has written standards and has had considerable success in applying them, with resultant improvements in care.

- No other standards are developed to the point where they can be used, and no other unit of the Department assumes primary responsibility for regulating other correctional facilities.

RECOMMENDATIONS:

- Pass legislation to expand the Inspection and Enforcement Unit and give it responsibility for regulating all correctional facilities, including promulgating rules and regulations, inspecting facilities, and enforcing the rules. This would involve 2-3 additional positions, at an approximate cost of $30,000-$45,000 per year.

- DOC should actively assume the regulatory responsibility the legislature has given it, to promulgate and enforce rules and standards in community correctional facilities. The legislature should either reassert this mandate, or retract it by removing the responsibility from DOC by statute.

IMPROVING SYSTEM EFFECTIVENESS

So far, we have presented research questions, findings and recommendations for individual components of the current regulatory and service delivery systems. Each of the recommendations discussed thus far could be implemented within existing departments or through cooperative arrangements between existing departments. Recommendations which advise legislative action could each be undertaken separately, and some improvement in the regulatory or delivery system would result.

However, some aspects of the regulatory system require a broader view and a longer time frame. Below we discuss two complex issues related to broad aspects of the current system. For each, we pose and discuss a number of alternative approaches to broad system changes to meet particular goals.

The Research Questions: Can regulation improve treatment effectiveness?
What organizational structure best meets the state's needs for a regulatory system?

GOAL: EFFECTIVE TREATMENT AND CLIENT IMPROVEMENT

Treatment effectiveness is a delivery system goal, but is not a primary goal of the regulatory system. No rule or standard yet written in this state requires as a condition of licensure that a facility demonstrate client improvement as a result of its treatment. It is extremely doubtful that any rule or standard ever will contain such a requirement. One rarely knows how to cause such improvement with any degree of certainty for most of the conditions treated in human service facilities.

Regulation tries to improve treatment effectiveness by requiring that certain conditions believed to foster effective treatment exist in a facility. To this end, many regulations require particular staff qualifications, staff-client ratios, and a given number of hours per week spent in programmed activity.

Regulation enforces minimum standards. Some facilities governed by regulation will always verge on noncompliance, just as some facilities will always far exceed minimum standards.

If clear definitions of improvement exist, regulation can be used to promote improvement through development of more and more stringent rules – a strategy of "upping the ante." This would mean that a facility which today is barely in compliance will tomorrow find itself below minimum standards because a new and more stringent rule has raised the standard to a new level. Such a facility would either have to improve to the level of the new rule or close its doors.

Within many areas covered by regulation, such as fire and life safety or sanitation, improvement can be clearly defined, and new rules have used these definitions to raise the level of care in these areas.

Unfortunately, treatment effectiveness or client improvement is one area which does not yield readily to this strategy of improvement through more stringent rules.

Solutions to the problem of improving treatment effectiveness are not readily apparent. We outline several alternatives below, in the hopes of stimulating discussion of this issue, but without expecting that any alternative or set of alternatives is clearly better than any other.

ALTERNATIVES

ALTERNATIVE 1: Do nothing.

Recognize that licensing cannot effectively influence client improvement given our present state of knowledge about effective treatment, and abandon the goal of trying to assure that human service facilities produce improved clients.

ALTERNATIVE 2: Devise some technical change(s) in rule-writing procedures to permit flexibility in enforcing rules.

Presumably, flexibility would contribute to judging facilities on performance rather than on specific input criteria. Several changes would be possible in the Administrative Procedures Act (e.g., exclusion, waiver clauses in rules), but all seem to beg the question of what criteria to judge a facility on. The problem is not avoidance of specificity where specificity is possible. Rather, the problem is that we do not know how to be specific about client improvement, nor do we have data available on which to judge which facilities are or are not causing clients to improve.

ALTERNATIVE 3: Use licensing to promote client improvement through a series of graduated rules, each rule more stringent than the last, each rule after the first including some criterion of amount of client improvement to be demonstrated by the provider.

This would be possible if we could specify what criteria constitute a "better" facility and better performance on client improvement. It would shift the burden of proof to the provider, and make the provider justify a claim to annual license renewal through proof that his or her facility does in fact produce improved clients.

ALTERNATIVE 4: Develop a data base using annual performance data from all licensed facilities. Use these data to judge the performance of individual facilities. Couple excellent performance with monetary, status, or other rewards.

All attempts at performance evaluation require an adequate data base. We would be trying to develop an equivalent to the "in accord with accepted practice at the time" criterion in medical and legal malpractice litigation. Only then could we evaluate a given facility's performance and declare that it was less than it should have been.

ALTERNATIVE 5: Develop a system of technical assistance and/or monetary support for programs which desire to improve their treatment abilities.

This system would be independent of licensing, separating the "permit to operate" which licensing grants from stimuli to promote treatment effectiveness. This alternative is the most costly of the five, and would involve establishing a broadreaching technical assistance program to parallel licensing. If coupled with appropriate incentives to facilities, this alternative might have some chance of promoting better programs through systematic data collection and input to facilities.

GOAL: AN EFFICIENT AND ACCESSIBLE REGULATORY SYSTEM

FINDINGS: SYSTEM EFFICIENCY

- Only one overlap exists among state-level agencies.

- Gaps and lack of coverage can be attributed to:

  a. unclear or nonexistent legislative authority
  b. insufficient agency staff
  c. no funding to pay for improvements if they were required.

- Failures of agency coordination and cooperation constitute only a small proportion of state-level inefficiency.

- While inter-agency communication is sometimes slow, all state regulatory agencies in the human services area have worked to improve this situation in the past, and are continuing to work on it. Lag time between one agency's request and another agency's response in writing is between one and two months on the average, according to DPW files for MR and MI facilities in our sample.

- Major delays occur mostly when:

  a. the activity of a local or regional level of government rather than another state agency must feed into the licensing process
  b. providers do not send the agency additional requested materials, or the inspector cannot reach the provider to clarify relevant points.

- Providers are the main source of complaint about the complexity of the regulatory system and the number of inspectors they must answer to. However, the number and types of inspections necessary would not materially change under a centralized system, since different inspections entail different areas of expertise and would thus require multiple inspectors.

- Some increased level of coordination in the timing of inspections might be expected under a centralized system, and providers would find this desirable. However, current law makes coordination almost impossible in some areas (e.g., new nursing home legislation requires at least one unannounced visit annually, which virtually precludes inter-agency coordination).

- While coordination with other agencies and inspectors may now present problems, coordination with technical assistance programs is relatively easy and workable. Technical assistance now resides within the same agency, and sometimes within the same individual inspector, as do regulatory functions. Extracting the regulatory function and placing it in a separate agency might solve inter-regulator problems, but might create an equal number of regulator-technical assistance coordination problems.

- To a lesser extent, coordination with funding sources bears the same relationship to regulation as does technical assistance. Currently, most funding is controlled by the same agency (or its local counterpart) that regulates. Separating regulation from funding sources may promote objectivity, but may also result in less coordination.

CONCLUSION

Given good-will efforts by state agencies, plus proper legislative mandate where regulatory authority is now lacking, most complaints about the regulatory system's inefficiency seem to be amenable to solutions short of a major bureaucratic reorganization. In addition, reorganization which did not take account of the areas in which coordination is now good (technical assistance and some money areas) might create as many problems as it would solve. The principal reason for a completely independent regulatory authority would be if one or more agencies refused to cooperate in efforts to increase efficiency. Under such circumstances, a single agency head who had the authority to demand compliance would be advantageous. At present, however, little evidence indicates that this level of non-cooperation exists.

CHAPTER I

INTRODUCTION

The Legislative Audit Commission requested the Program Evaluation Division of the Legislative Auditor's Office to conduct an evaluation of state activities which regulate and control human service facilities. In our *Evaluability Assessment* issued on August 18, 1976, we focused attention on four fundamental questions of concern to the legislature. These questions are:

1. Coverage

   Are there gaps and/or duplications in the state's system of regulation?

2. Impact

   Does regulation achieve compliance of human service facilities with rules and standards? What types of care do human service facilities deliver? What effect does regulation have on the shape and development of the human services delivery system?

3. Efficiency

   How efficiently do state regulatory agencies accomplish the job of regulation?

4. Cost

   What does regulation cost state regulatory agencies and providers of human services? Are some facilities or facility types providing more care per public support dollar than others? What is a true or reasonable interpretation of a facility's per diem rate?

This final report addresses each of these four questions in turn.

A fifth question has proven impossible to assess within the scope of the present study. This question inquired into the effectiveness of licensed programs to help, cure, rehabilitate or reform their residents – in short, it asked about the success of human service facilities. If the legislature retains a continuing interest in this question, future studies focused on specific populations or programs can be conducted by this office.

DATA SOURCES

Even the four questions described above are very broad. We further defined our interests as containing an agency focus and a facility program focus. Within the agency focus we would address the efficiency, coverage, and some of the impact questions. To investigate agency impact, we needed data from regulated facilities, and we included some facilities to visit from every type of residential facility currently regulated.[1] For the most part, we visited two facilities of each type, selected at random from state agency listings, for a total sample of 21.

To investigate the facility program focus, we narrowed our attention to residential programs for the mentally retarded and the mentally ill (covered by the Department of Public Welfare's (DPW) Rules 34 and 36. We visited 17 randomly-selected community-based facilities of each type, plus three state hospital programs of each type, for a total sample of 40 residential programs. Combining these two samples yields a total number of 61 facilities visited. With two exceptions (hospitals and nursing homes), these facilities all have either the Department of Public Welfare (DPW) or the Department of Corrections (DOC) as primary regulator.

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[1] *Nursing homes, hospitals, DPW group homes, child-caring institutions, chemical dependency residential facilities, jails, adult correctional centers, juvenile detention centers, juvenile treatment centers, correctional group homes, facilities funded through CCA, special projects many funded initially through LEAA.*

The Basic Facility Interview

Providers at all 61 facilities visited by the study staff responded to a lengthy (1½ to 2 hours) interview which probed their perceptions of regulatory agency efficiency, helpfulness, consistency, ability to communicate clearly with providers, and impact on quality of care in the areas of maintenance, administration, record-keeping, program/staff and care innovations. These data form the basis for our conclusions and recommendations related to our regulatory agency focus.

Data for the Facility Program Focus

We wanted data on types of programming available and actually delivered to facility residents, plus evidence of facility compliance to regulatory requirements. We also wanted information on programming costs, compliance to regulations costs, and costs for services delivered to facility residents by community resources and hence not included in facility per diem rates (e.g., public school, day activity center, sheltered workshop, medical, dental, or pharmaceutical services). All of these data would help answer the impact and cost questions delineated above. Obtaining these data took approximately 6 hours for each community facility, and 14-15 hours for each state hospital program. Providers very generously made themselves and their records available to us for this intensive task.

Programs for the Mentally Retarded and the Mentally Ill

We decided to focus our program data collection on two types of facilities, those for the retarded and for the mentally ill, for several reasons. First, concentrated attention to particular program types was deemed necessary if we were to adequately describe the range of care, quality and cost in the state's delivery system. Thus, we wanted between fifteen and twenty facilities of a given type, including large state-run facilities, medium-sized community-based facilities, and small community facilities, to provide a representative description of care available in Minnesota. If we were to attempt a sample of such size, we clearly could investigage only one, or maximally two, program types, given time and personnel constraints. We reasoned that two types would be better than one, since we would then be able to compare program types on important dimensions. We picked facilities for the retarded and the mentally ill because both populations are involved in the current controversy over deinstitutionalization, and because we felt the two would provide some illustrative contrasts between what regulation can accomplish and what other mechanisms such as planning, recruitment and reimbursement are needed to assure a superior care delivery system.

Agency Records

In addition to data obtained from facility visits, we looked at agency records detailing the licensing or regulatory history of residential facilities. We looked at records for each facility we visited, and we also investigated records from an additional 13 facilities whose primary regulator is DPW, 13 facilities whose primary regulator is DOC and 6 facilities whose primary regulator is the Minnesota Department of Health (MDH). These 32 facilities represent two or more additional facilities apiece from each of the facility types listed in the footnote on page I-1. We attempted to have an additional three facilities of each type, but in some instances no agency records existed for us to look at. The facilities involved in these record searches were also selected at random from agency listings.

Agency records were searched for information about agency efficiency (speed of processing and causes of delay) and facility compliance (number and type of deficiencies issued, and by what regulatory agency). These data are analyzed for sources of delay in regulatory procedures, and as indices of successful or unsuccessful effects of regulation on facilities surveyed.

Inspector/Consultant Interviews

Finally, we interviewed 22 regulatory personnel (4 DPW consultants; 7 MDH surveyors in the areas of life safety, sanitation, nursing, and administration; 5 Assistant State Fire Marshals; and 6 DOC field supervisors, Inspection and Enforcement Unit personnel, and Community Corrections/LEAA officials). These interviews covered aspects of inspector workload; inspector perceptions of the amount of control

they have exercised, including any denials, revocations or condemnations they had been involved in; and their feelings about their impact on the facilities they regulate. Data obtained from these interviews are used to assess agency efficiency and workload, and to provide another perspective on the information received from facility operators.

Final Integrating Questions

Finally, this report addresses two complex and interrelated issues which permeate every aspect of the regulatory system:

1. Can regulation improve treatment effectiveness?
2. What organizational structure would most efficiently and effectively accomplish the state's goals for its regulatory system?

Chapter 6 focuses on these two questions, and makes recommendations for both the immediate and the long-term improvement of Minnesota's regulatory system.

CHAPTER II

COVERAGE

The Program Evaluation Division presented a systematic overview of the coverage responsibilities of state agencies in our *Evaluability Assessment* for this project (see *Evaluability Assessment*, Table 1, page 36).

To discuss the problem of coverage, we present a similar overview in Table II-1, and address the issues of agency responsibility, agency performance, and overlaps with federal, regional and local regulation.

OVERLAPS

For present purposes, "overlaps" shall be used to mean that two or more state agencies have responsibility for regulating the same aspects of the same facilities. "Layers," which we will discuss below, shall be used to mean that one state agency and one or more local, regional or federal agencies regulates the same aspect of the same facility. "Gaps" shall be used to mean that no state agency regulates the facility.

We feel it is important to make the overlap/layer distinction because, when we do so, we find that only one real overlap exists – both DPW and DOC have jurisdiction over correctional group homes for juveniles.

Even this overlap is more a confusion than a true overlap. DPW is responsible for licensing all treatment programs housing ten or fewer juveniles under its Rule 8 for juvenile group homes. DOC has responsibility for the same programs because they are correctional in nature, and because the department either provides financial support for such programs or runs them directly.

At present, the following conditions prevail:

- DOC has promulgated no standards for such programs, and does not inspect them in any systematic manner. The department is in the process of drafting standards.
- DPW does not actively pursue licensing for juvenile correctional programs. However, many of DOC's group homes have themselves requested DPW Rule 8 licenses. This occurs in juvenile programs under LEAA and CCA funding, and in some county-operated group homes.
- DPW is reluctant to enforce its own program standards on DOC group homes, even when it issues a DPW license.
- Correctional group home operators we interviewed are confused. Several of them actually expressed a wish that someone would take clear-cut responsibility for the programs and simply tell the operators who to answer to.

Recommendation II-1:

The legislature should clarify departmental regulatory responsibility for juvenile correctional programs.

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[1] *For a more detailed presentation of topics discussed in this chapter, see staff papers entitled, "Regulation in the Department of Public Welfare: Residential Licensing" and "DOC Regulatory Functions."*

TABLE II-1
STATE REGULATORY COVERAGE OF SELECTED HUMAN SERVICE FACILITIES

Facility Type / Agency	Jails, lock-ups, holding facilities	Correctional centers	Adult state institutions	Juvenile state institutions	Juvenile detention and treatment ctrs.	State group homes	County group homes	Adult community corrections	Juvenile community corrections	Hospitals	Nursing homes	Boarding care homes	Outpatient surgical centers	Special service facilities	Foster boarding homes	Family day care homes	Group day care centers	Child-caring institutions	Group foster homes	Detoxification centers	Residential prog. – mentally retarded	Residential prog. – chemically dependent	Residential prog. – mentally ill	Residential prog. – phys. handicapped	State hospitals
DPW			fc						sl	sl*	sl*	sl*			sl	sl fc	sl fc	sl	sl	sl	sl	sl	sl	sl	a sl
DOC	i	f i	a i*	a i*	f sl	sc*	sc*	f	f																
HFD (MDH)			sl*	sl*						sl fc	sl fc	sl fc	sl	fc							sl fc	sl+	sl+ fc	sl+	sl fc
EHD (MDH)	i*	i*	i*	i*	i*	sl*	sl*	sl*	sl*						sl	sl	sl	sl	sl			sl+	sl+	sl+	
SFM	i*	i*	i*	i*	i*	i*	i*	i*	i*	i	i	i	i		i	i	i	i	i	i	i	i	i	i	i
REGIONAL BDS.								CCA bds.	CCA bds.	HPC	HPC										HPC AB		AB		
LOCAL	a&i	a&i	a&i	a&i	a&i	a&i	a&i	a&i	a&i	a&i	a&i	a&i	a&i	a&i	a&i	a&i	a&i	a&i	a&i	a&i	a&i	a&i	a&i	a&i	

* = activity happens by invitation, rarely, or not at all.
\+ = program receives one or the other, not both.

Abbreviations:
- sl = state license
- sc = state certification
- fc = federal certification
- i = inspection
- CCA bds. = Community Corrections Act Boards
- HPC = Health Planning Councils
- AB = Mental Health/Mental Retardation Area Boards
- f = funding control
- a = administrative control
- a&i = approval and/or inspection by local zoning, building, fire and health authorities

Recommendation II-2:

DPW and DOC should make their standards for group homes compatible. Since the same juvenile frequently finds him or herself sometimes under Welfare's jurisdiction and sometimes under the court's, sometimes in a corrections group home and sometimes in a welfare one, the standards for the two types of homes should be similar. If standards are identical, an operator might be allowed to choose which department to be responsible to, thus eliminating any overlap.

LAYERS

Layers are probably more difficult to resolve than true overlaps, because different levels of government are involved and therefore the problems of coordination and agreement are greater.

Federal-State Duplication

Every time the symbols "FC" and "SL" (Federal Certification and State Licensure) appear together in Table II-1, federal-state duplication exists. This duplication occurs with hospitals, nursing homes, community programs for the retarded and the mentally ill, and state hospital MR programs. (It also occurs for day care homes and centers which want Title 20 reimbursement, but we did not include non-residential programs in our study and so have no information about the extent or type of duplication that occurs in them.)

Federal certification entails both an annual inspection and an annual quality assurance review. DPW program licenses involve annual inspection. Both federal certification and DPW inspections check the following things in common: disaster plans, written policies and procedures, employee orientation and continuing in-service training, resident records, facility records, employee health records, resident living areas, food services, physical, occupational, recreational and speech therapy, dental, medical, pharmaceutical, psychological, psychiatric and audiological services, and use and proportion of direct care staff needed. In addition, the federally mandated quality assurance review annually checks resident records.

If the facility is also a state hospital accredited by the Joint Commission for Accreditation of Hospitals (JCAH), every one of the items listed above receives yet another check by JCAH. (Proprietary and non-profit hospitals receiving JCAH accreditation are automatically deemed certified for Medicaid reimbursement.)

The problems generated by this duplication are many:

> "Everyone wants something in a slightly different form."
>
> "What one says, the other contradicts."
>
> "They don't vary so much in what they want. They just change emphasis. That's more problems."

In addition to the struggle with different reporting forms, providers subject to federal-state duplication must devote a great deal of time to doing the same things over again. Resident records reviews are a particularly onerous example. A facility must pull resident records, make them available to Inspector A for the week that A is in the facility, and then refile them. Two weeks later, Inspector B shows up and the whole process is repeated. Four months later, the same thing again with Inspector C. Needless to say, this represents a lot of wasted time for the provider, even though only one of these inspectors may be from a state agency. As one administrator of a community hospital expressed his frustration:

> "Just let them all come in for one week, at the same time. We could kick out all the patients, give most of the staff a vacation, and get it all over with once and for all."

Another solution would be for the state agencies to accept federal findings or vice versa. This suggestion is further discussed in Chapter VI of this report.

Local and Regional Layers

Regional. Regional layers usually involve planning bodies. Table II-1 shows Mental Retardation and Mental Health Area Boards, and Regional Health Planning Councils for welfare and health facilities, and Community Corrections Act Boards for some correctional programs.

Regional boards do not inspect facilities or serve as quality control agents. Rather, they certify that a facility fits into a regional plan of comprehensive care. They sign off on the need for the facility in the region. This is frequently a time-consuming process, and a source of frustration to facility operators trying to begin serving clients.

Regional control is not regulatory in the sense that we have been discussing in this report. It is not fair, therefore, to consider the problems it causes as regulatory problems. It does need coordination with both regulatory and funding agencies. We discuss this need for coordination further in Chapter III, pages III-9/10.

The only exception we have found to the statement that regional boards are not regulatory concerns Community Corrections Act Boards. The primary reason given by DOC for not developing standards and using them to inspect community corrections facilities is that decentralization of control is department policy. This means that DOC expects regional corrections units to set up and enforce regional standards. It seems inadvisable to us to advocate a system so prone to inconsistency of both standards and enforcement. In addition, it is unclear whether the regional boards in question understand this DOC expectation. They certainly have not issued any guidelines or standards, nor have they done any inspections, at least in the facilities visited by this study. We think it most reasonable that regional units retain responsibility for planning and for recruitment of care providers, while state-level agencies promulgate rules and enforce uniform standards in a consistent manner.

Recommendation II-3:

> The legislature should clarify the roles of DOC and Community Corrections Act Boards in regulating community corrections facilities. Specify the regional boards' responsibilities for planning and recruitment, and DOC's responsibility for regulation.

Local. All human service facilities are subject to numerous local regulatory agencies. These include zoning and land use boards, building code authorities, city and county health and fire authorities, and possibly also county welfare departments. For the most part these agencies perform functions which do not overlap with state regulation. In some instances, local authorities serve as the delegated representatives of state agencies. For instance, most fire inspections are performed by local fire inspection personnel, not by people from the State Fire Marshal's Office.

MDH also contracts with some counties for health and sanitation inspections. While this may seem a worthy tactic to reduce duplication and state agency workload, results appear to be mixed. Recently, MDH's Environmental Health Division inspected several facilities presumably inspected and passed by local health authorities, as a check on the quality control being exercised locally. MDH could give only marginal or inadequate scores to most of the facilities it inspected for this purpose. This result does not bespeak a great deal of confidence in the capacity of many localities to perform their own inspections.

Recommendation II-4:

> Regulatory agencies should delegate responsibility for enforcement of state standards to local authorities wherever duplication exists and local competence warrants, but retain thorough monitoring of local quality control by the state regulatory agencies.

CORRECTIONS-RELATED GAPS

We have already discussed the difficulties surrounding regulation of corrections group homes. Several other corrections facilities have little or no regulation:

- Insecure adult community-based correctional facilities are subject to no standards at all. Theoretically, they receive fire and sanitation inspections, but in reality these occur only by invitation, and invitations are rare.

- DOC-run secure facilities are subject to inspection only when the Commissioner invites some regulatory authority into the facility. The Inspection and Enforcement Unit of DOC, which inspects secure facilities operated by other government units, has no authority to force the state-run facilities to comply to the same standards the state sets for counties and municipalities.

- Insecure correctional facilities run by counties and private providers are subject only to the variable and unformalized standards set by local authorities. DOC does not assume regulatory responsibility for any such facility it neither funds nor administers.

- DOC has no single contact point where providers can find out about standards or facility requirements.

- DOC has promulgated no rules or standards, although they have been directed to develop standards for group homes, community correctional facilities, and secure facilities by the legislature. Standards for secure facilities are in the most advanced state of any, and are currently being used even though they are not official.

The Inspection and Enforcement Unit is the only section of the Department of Corrections which has shown itself willing and able to develop and enforce standards. It has operated under a handicap in its attempts to do this, since only in the last year has it acquired the authority to both set standards and inspect facilities to enforce them. Prior to that time, the legislature had given the Unit one authority without the other.

Since the Unit has demonstrated its capacity to run a regulatory program, we recommend that it be expanded and given the task of developing and enforcing comprehensive standards for all facilities within the state that have a correctional program, regardless of the program's funding source or administrative aegis.

Recommendation II-5:

> DOC (and if necessary, the legislature) should give its Inspection and Enforcement Unit the task of developing and enforcing comprehensive standards for all correctional programs.

Recommendation II-6:

> The legislature should provide the Unit with the additional personnel necessary to undertake the above task. This would mean 2-3 new positions at an annual cost of $30,000 to $45,000.

OTHER GAPS

Money Gaps

The problem of money arises several times in this report. The basic question about money relevant to this section of the study is: "Where is the money going to come from?" Without money, compliance to regulations which require significant upgrading of facilities becomes difficult to impossible. Since

these problems are addressed elsewhere in the report, we will simply note here that the lack of co-ordination between regulation enforcement and funding sources constitutes a significant gap in the system. Many providers mention it as the single most important change they would like to see in the state's regulatory system. Many others echo these sentiments with only slightly reduced fervor. See Chapters V and VI for further discussion of funding problems and recommendations.

Rule-Writing Gaps

Although DPW rules are developed by committees composed of care providers, advocates and consumers, many providers remain ignorant of the rule-writing process. Many providers we talked to were unaware that other providers and client advocates were involved in rule-writing. Indeed, many facility operators had no idea how rules were developed, and attributed their problems with the rules entirely to faceless and ignorant bureaucrats.

> "Who writes those things? I have no idea."
>
> "The regulations took a bureaucrat's mind to fathom."
>
> "Whoever wrote it (Rule 36) didn't look at the health rule first."
>
> "The committee who wrote Rule 36 should have been composed of providers, not office people."

In fact, each one of these comments is incorrect. But many providers remain unaware that rules reflect compromises among the conflicting desires of many different interests.

Recommendation II-7:

> Regulatory agencies should involve more providers in the rule-writing process, either initially or through numerous public hearings before rule promulgation. Develop better communications with providers to keep them informed of the rule-writing process.

Health Gaps

When DPW and MDH developed rules for adult residential programs (Rules 34, 35, 36 and 80) and for Supervised Living Facilities, they coordinated the rules. SLF covers all health-related aspects of care; the relevant DPW rule covers program-related aspects. The intention of both departments was that a facility would be covered by both rules, leaving no gaps in regulatory coverage.

Unfortunately, facilities currently licensed or about to be licensed under Rules 35 and 36 are not now required to obtain SLF licenses from MDH. The facilities may choose between an SLF license and a Boarding and Lodging license. The latter is much easier to achieve, and covers much less ground, so most facilities have chosen the Boarding and Lodging route.

In several years this choice will no longer be available, and SLF will be required. The present gap will have closed. However, this incident highlights a difficulty arising even when agencies try their best to eliminate coverage overlaps. If the timing of rules is mismatched, if one complementary rule starts or stops before the other one is ready, the result is a gap. It behooves all agencies attempting to develop complementary rules to attend to the problem of timing.

COORDINATION PROBLEMS

The general problem which this catalogue of overlaps, layers and gaps illustrates is the lack of coordination among rule-writers and rule-enforcers from different agencies. Chapter VI addresses this problem in some detail, and makes suggestions for solutions.

CHAPTER III

IMPACT OF REGULATION

This chapter focuses on two aspects of regulatory impact: 1) facility compliance with regulations; and 2) influence on development of the care delivery system.[1]

FACILITY COMPLIANCE WITH REGULATION

FROM THE PROVIDERS' VIEWPOINT

The most consistent, virtually universal, remarks we heard in interviews revealed providers' support for regulation:

> "Licensing is good. If someone weren't pushing, a lot of facilities would look a lot worse."
>
> "We need regulations. No doubt about that. There are some people out there just to make a buck."
>
> "There isn't a regulation that's bad – it's how it's applied. There has to be more flexibility."
>
> "Oh, it's necessary. It's just that we have to spend so much time writing everything down."

Even when endorsement of regulation is tempered by complaints about record-keeping or premised by the assumption that it's the other guy who needs regulating, facility operators believe that regulation has improved at least some aspects of care in their facilities. Table III-1 presents their perceptions of the impact of regulation.

Providers were asked how regulation in each of the nine areas listed in the left-hand column of Table III-1 had affected the quality of care for residents of their facility. Thus if a provider knew that administration in the facility had changed, but felt that this change had made no difference for the quality of resident care available, that provider's answer would appear in the "change, but no difference" column. If the provider thought that administration had improved, but that resident care had actually worsened as a result of decreased programming time available from the administrator, the answer would appear in the "care has worsened" column.

All providers felt that care had improved in one or more areas; no provider felt that regulation was entirely useless or detrimental. Table III-1 indicates that sanitation and resident records changes caused the greatest number of improvements in care quality, followed by supervision and health emergency changes. Providers saw no improvement resulting from changes in living or bedroom space available to residents. In all other areas, between one fifth and one fourth of all providers believed care had improved significantly as a result of regulation.

However, most providers do feel that in most areas regulation has made no change in the quality of care in their facility, either because no change was required, or because required changes affected very little of life in the facility.

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[1] *For a more thorough presentation of data reported in this chapter, see the staff paper, "The Impact of Regulation."*

TABLE III-1

PROVIDERS' REPORTS OF THE IMPACT OF REGULATION ON THEIR FACILITIES

In the area of:	Regulation has caused: Improvement	Change, but no difference	Care has worsened	No change
Fire/life safety	26%	51%	4%	19%
Sanitation	41%	0%	0%	59%
Health emergencies	34%	59%	7%	0%
Living space	0%	38%	0%	62%
Supervision	34%	0%	27%	39%
Administration	25%	37%	10%	28%
Facility records	20%	37%	10%	33%
Resident records	40%	27%	13%	20%
Programming	23%	11%	23%	43%

The criterion of care improvement used in Table III-1 is a very stringent one for regulation. It demands that the very people who are most discomforted by regulation nevertheless attribute good outcomes to it. Despite the hassle, they are saying, it has had good effects on the ultimate goal, quality resident care. Seen in this light, it is promising indeed that one fourth of the facility operators interviewed, on the average, perceived regulation as beneficial to quality care.

In addition to quality care, the state as licensing agent may be interested in other goals as well. Regulation should improve a facility's accountability to funders, consumers, and the general public. Regulation requires record-keeping for this purpose. The column in Table III-1 which indicates "change but no difference" reveals that many facilities did change their record-keeping practices. Such changes have meant significantly improved accountability, whether or not they impact on direct resident care. Thus, an accurate interpretation of Table III-1 from the point of view of meeting the state's goals would reveal that 57% of facility records, and 67% of resident records had significantly improved due to regulation.

If we also include the figures from the "care has worsened" column, which we might want to do because accountability has improved in these facilities, albeit at the cost of reducing direct programming time, improvement in accountability jumps to include 67-80% of the facilities visited.

Several dimensions of regulation produce results which are "good in themselves," although they do not impact directly on programming. For example, appropriate fire doors have virtually no effect on programming. Hopefully the facility will never have a fire, and the doors will never be needed. But all would agree that the doors are good in themselves, because they reduce the risk to human life and safety in the event of an emergency.

Fire, life safety, sanitation and health emergency plans all fall into the category of "good in themselves." A change in these areas, whether or not it affects programming, is desirable. From the state's point of view, therefore, we would consider that regulation had improved conditions affecting fire and life safety in 77% of the facilities visited, sanitation in 41%, and health emergency planning in 93%. We arrive at these figures by combining the percentages in the first and second columns of Table III-1.

FROM AN OUTSIDE VIEWPOINT

The Program Evaluation Division looked at several sources of data to determine from an objective viewpoint whether regulation has had an effect on the quality of care in human service facilities.

The Drop-Out Rate

When facilities need to apply for a license before they can begin operations, we can use the number of people who decide to drop out of the process before even filing an application as a measure of the control on quality exercised by rules. A person thinking of becoming a care provider first writes to the Department of Public Welfare (DPW) to obtain a copy of the rule governing the type of facility she or he is interested in running. DPW's Licensing Division keeps a record of all sets of rules and application blanks sent to potential new providers. By comparing the number of applications sent out with the number of new licenses issued and pending (those potential providers who actually went through with the application process), we can determine the drop-out rate. Table III-2 presents these data.

TABLE III-2

DROP-OUT RATE OF POTENTIAL PROVIDERS FOR DPW RULES 8, 34, 35 AND 36

Type of facility:	Applications sent out, 7-1-75 to 12-1-76	New licenses granted, 9-1-75 to 12-1-76	License applications pending as of 12-1-76	Drop-out rate #	Drop-out rate %
Rule 8 (group home)	76	16	19	41	54%
Rule 34 (MR)	117	19	32	66	56%
Rule 35 (CD)	53	41	4	8	15%
Rule 36 (MI)	41	9	10	22	54%

Table III-2 reveals a substantial drop-out rate for three of the four rules on which we have data. Simply having rules on the books apparently serves as a preliminary sorting device, weeding out people who have an idea they would like to enter the human services business, but who may have little idea of what that entails in the way of skill or organization.

It is probably true that some proportion of potential providers who drop out at this point would have made good facility operators, and became discouraged because the rules looked too forbidding at the outset. However, it is undoubtedly equally true that many would-be providers are appropriately eliminated at this preliminary phase of licensure.

The drop-out rate is a strong indicator of quality control exercised by regulation. It is an important one because it has very little cost attached to it. Drop-outs take up little or no department time, and never appear in department statistics of work accomplished. Yet the drop-out rate provides clear evidence that rules exert some influence over the delivery system. Drop-out rates for MDH rules display a similar pattern.

Records

Records of all types are significantly better in licensed than in unlicensed facilities. Also, recent (post-licensure) records in older facilities are much better than earlier (pre-licensing) records.

Facility records improved from none, in most cases, to statistics on admissions, discharges, applications and reasons for turn down, and some follow-up data. However, facility records were the worst of the records we saw, overall. Since they are mainly summary statistics reflective of the facility's annual occupancy characteristics, many facilities place little emphasis on them. This lack of emphasis stems from the fact that the facilities rarely use such information themselves. Those facilities which are forced by a larger system to collect such records (e.g., state hospitals) complain that they send the information off to St. Paul and never hear about it again.

Employee records were quite different in licensed and unlicensed facilities, and from pre-licensure to post-licensure in older facilities. Unlicensed facilities, if they had employee files at all, maintained their employees' applications for the job they were originally hired for, and little else. Licensed facilities maintained employee records containing writtene valuations of work performance, evidence of physical fitness, evidence of employee qualifications, and a record of inservice training. Those facilities licensed the longest were most likely to have complete files on employees. Employee files took higher priority in facility operators' minds than facility records, but were still secondary to resident records. Where choices had to be made about where to commit scarce clerical time, resident records came first.

Resident records showed the most consistent difference between licensed and unlicensed facilities, and the most improvement between pre- and post-licensure in older facilities. In many instances, documentation expanded from one line descriptions every three months to a weekly chronicling of activities complete with detailed goal statements, plans for helping residents achieve their goals, and contingency plans in case the basic plan did not work within a specified amount of time.

Programming

Regulation has affected both the amount and type of programming available to residents of Minnesota's human service facilities. Table III-3 presents data on the amount of programming we found in facilities licensed under Rule 34 (MR) and Rule 36 (MI), MI facilities as yet unlicensed, and state hospital programs for both MR and MI.

The most obvious comparison to make with the material in Table III-3 involves the amount of total services available in licensed versus unlicensed programs. Unlicensed programs, including state hospital programs for the mentally ill, provide approximately half the number of total programming hours that licensed facilities provide.

Licensed MI facilities in our sample deliver the most programming, and most of it is in the area of social services. This is not due to licensing itself, most probably, because most of the MI facilities already licensed serve acute patients, and represent fairly aggressive care providers – people who actively sought licensure rather than waiting until DPW came to them. They are thus a self-selected group, strong on programming. So it is somewhat unfair to compare licensed and unlicensed MI facilities at this point in time.

However, we must point out that community based facilities for the MR, which send their residents to 30+ hours of outside programming per week, augment that service by almost 20 hours of programming inside the facility every week. This figure is very close to the total number of programming hours offered by unlicensed MI facilities in the community. Since we selected a representative sample of MR facilities – some in the forefront of the field and some average and below-average facilities – it is a telling point that regulation plus program orientation generate such levels of care. Only the very bottom of the MR spectrum provides less care inside the facility than most of the unlicensed MI facilities in our sample.

Utilization of Community Resources. Rule 34 is responsible for the amount of community services used by licensed MR facilities. It is also primarily responsible for the extent to which MR programs in state hospitals use community resources, which would resemble the utilization level of state hospital MI programs without regulatory pressure to "get off the campus".

Medical Services and Type of Resident. Table III-3 reflects an area of substantive concern in its data on medical services used in MR programs. The 3-to-1 state hospital to CBF ratio indicates the substantially different populations served by the two types of facilities, with significant program and cost implications.

TABLE III-3

AVERAGE HOURS OF SERVICE DELIVERED PER RESIDENT PER WEEK IN FACILITIES OF DIFFERENT TYPES

	Type of Facility	Medical Services[a]	Social Services[b]	Community Services[c]	Total Services
MR	CBF[d] All Licensed N=16	1.4	19.8	31.5	52.7
	State Hospitals N=3	4.5	38.8	11.3	54.6
MI	CBF Licensed N=7	5.3	46.7	9.7	61.7
	CBF Unlicensed N=8	3.1	12.1	7.6	22.8
	State Hospitals N=3	7.4	20.4	.71	28.5

a. Medical services include nursing, medical, dental, dietary, pharmaceutical and physical therapy services available inside a facility.
b. Social services include recreational, occupational, speech, music and audiology therapy, educational and vocational training available inside a facility.
c. Community services include educational, vocational, social and medical services utilized outside the facility (in the community).
d. Community based facilities.

New Construction

Some facilities are so deficient in comparison to standards that the only reasonable thing to do is to start over. Enforcement of standards and rules has resulted in new construction in facilities under the primary jurisdiction of both DPW and DOC.

Four community facilities we visited (two MR and two MI) had committed over $100,000 each to new construction (three) or major renovation (one) as a direct consequence of fire and life safety requirements. Two more facilities (one MR and one MI) had spent between $10,000 and $50,000 on facility renovation to meet these standards.

In addition, state hospitals have received over $11 million from the Legislature so far for renovation and construction costs, of which $6.8 million is for fire and life safety expenditures.

DOC Inspection Impact. Within the Department of Corrections, the Inspection and Enforcement Unit has developed standards for secure facilities operated by local units of government. Since 1973 the Unit has been inspecting these facilities using their standards and has caused some significant changes.

There are a total of 152 secure facilities under the Unit's jurisdiction. Since 1973, the Unit has condemned two facilities for severe and continuing deficiencies, and is in the process of condemning one more. With tact and strong suggestions, the Unit has also caused:

- 14 new facilities constructed to replace outmoded ones
- 8 facilities extensively remodeled
- 3 new constructions underway
- 20 facilities with plans submitted to the Unit for new construction or renovation.

This means that 29% of the facilities under the Unit's jurisdiction have undertaken major changes resulting in greatly improved care. Many lesser changes have been effected as well in other facilities. The impact of regulation is most clear in this case.

Agency Records of Deficiencies

One would expect that good facilities would receive few deficiencies while poor facilities would receive many. One would also expect that facilities should experience a reduction in number of deficiencies as the years pass, since old faults would have been corrected and new ones not developed. We examined agency records with these assumptions in mind.

Unfortunately, the assumptions do not hold, and records of deficiencies are consequently a poor measure of quality of care. There are at least four reasons for this.

New Rules and Rule Changes. New rules are like new model cars – it takes several years for the manufacturer to get all the bugs out. Problems of interpretation and meaning, shifts in emphasis from year to year, the development of new types of care at the same time that new rules go into effect, all mean that the number of deficiencies or correction orders issued under a new rule fluctuate wildly in ways unconnected to the quality of care in the facility receiving the deficiency.

Frequently a new rule will be implemented in stages. The first year will see deficiencies issued in a few basic areas. The second and third years' deficiencies will reflect different and increasingly more sophisticated emphasis, until old care providers have caught up with the new ideas reflected in the new or changed rule. Because of this, a given facility may receive a large number of deficiencies for several years running. This is the case presently with many MR facilities, and will be so increasingly as Rule 36 goes into effect for MI facilities.

Inspector Inconsistency. Some inspectors give few deficiencies to facilities they believe are very poor, because they think the facility cannot cope with the number of deficiencies it really deserves. Some inspectors give many deficiencies on matters of small detail to very good facilities, because they believe the facility is so good it should be perfect, or that it can handle that number of deficiencies. Obviously such inconsistencies in inspection behavior mean that the number of deficiencies only tangentially reflects the quality of the program.

Philosophy – Medical vs. Program. Facilities with a program emphasis get good marks from DPW but frequently receive numerous deficiencies from MDH. The reverse occurs in facilities with a medical emphasis. The most extreme example of this different emphasis occurred during the first two years of ICF-MR certification. DPW handled certification during the first year, and issued an average of 10-20 deficiencies per facility it inspected. Using the same set of regulations, the number of deficiencies jumped to an average of 50-70 the next year, when MDH took over the inspection process. A few facilities received over 200 deficiencies. The difference reflects the different specific facility, physical plant and health procedure requirements contained in the federal regulations, which MDH fully surveyed. It did not reflect any changes in the facilities inspected.

Reimbursement and Quality Care. Finally, some providers ask for deficiencies. If their reimbursement mechanism will only let them charge for items which they had to do to meet regulations, there is no way to pay for improvements in care which exceed regulatory requirements. The way around this is to

get oneself cited for the improvement one wants to make. This means that some of the best facilities regularly have deficiencies on their record because they keep trying to improve the quality of care in their facilities.

For all four reasons described above, the number of deficiencies in a facility's record is a poor guide to the quality of the facility (at least for facilities where DPW is the primary licenser).

SUMMARY

We have examined the impact of regulation on the quality of care available in facilities from two perspectives — that of the provider and that of the Program Evaluation Division staff.

Providers indicate that regulation is a mixed blessing. It takes their time, and it frustrates them, but even they admit that regulation has had some salutary effects on their operation. All agree that regulation is necessary.

From the "outside" we have seen that regulation has caused providers to upgrade their safety, sanitation and health emergency conditions. It has significantly improved records, and hence accountability. It has affected programming, both in amount and in kind. It has forced replacement of unsafe structures. Finally, the simple presence of rules and standards makes potential providers think twice before starting a new facility.

IMPACT ON THE DELIVERY SYSTEM

REGULATION AND SMALL GROUP HOMES

Small facilities have undergone more change, proportional to their size, than large facilities. Regulation of group homes for the mentally retarded has been a focus of much distress in three primary areas: building and maintenance; record-keeping and administration; and professional expertise.

Many group homes are in ordinary houses owned by the facility operator and serving as the operator's residence as well as the residents' home. Indeed, many of the original group homes are the providers' homes, turned into residential facilities after the fact. Such homes frequently do not meet fire and life safety code provisions, and sometimes do not meet sanitation requirements either. Much money has been spent to comply with the regulations which accompany Medicaid funding, which require that these homes be brought up to an "unhomelike" standard. Providers complain that required changes have altered, or are attempting to alter, the very nature of their establishment, from a home to a nursing home.

This has not proved a problem for new providers, because they are aware of the requirements and look for houses to purchase or rent which will meet regulations in the first place, while still retaining a reasonably homelike atmosphere. However, this does not help the providers or potential providers who already have a home and want to become an MR facility. At the moment, regulations may be preventing some people from entering the MR care field because they mitigate against the small home operator.

While physical plant requirements frequently receive attention, they are only part of a combination of things that are making life hard for small unsophisticated operations. We also heard many complaints about record-keeping and administrative time, and about the need to hire professional help for both bookkeeping and programming purposes.

Here we arrive at the real crux of the group home dilemma. The group homes which have experienced the most difficulty are really foster homes. Providers are generous and humane people, but with no professional background in special education or mental retardation. Neither are they administrators, and the paperwork required by regulation drives them to distraction.

The new variety of small group homes, run by a corporation and employing trained professionals as houseparents, sharing the burden of administration and regulation through a central office staff, has had comparatively little difficulty with regulation.

The policy question for the state to resolve is: Do we want foster or custodial care in a small group home environment? Alternatively, do we want to insist that every retarded person placed outside his or her own home receive maximum programming effort at all times?

This is not an easy question to answer, and this report will not attempt to do so. We do want to point out that the question contains both programming and funding implications. Also, doing nothing officially to resolve the question at the present time is, in effect, a decision for programming and against foster care, because that is the direction current federal regulations take. A policy decision for foster care would actually mean a policy reversal, since the state now has a policy set by DPW to use Medicaid for financing the vast bulk of care for the retarded.

Recommendation III-1:

> The legislature should decide whether it wants foster care for adult MR residents of facilities housing five or more people. If that decision entails new or modified rules, regulatory agencies should make the appropriate rule changes. If it entails new or modified funding sources, the legislature should provide the funding necessary to implement the decision. Such funding would probably require an estimated $750,000 to $1,250,000 per year, of which half would be funding in addition to that which the state already pays as its share of Medicaid.

REGULATION AND THE CONTINUUM OF CARE

"Continuum of care" is a new term meaning that dependent or disabled populations should receive that level of care most appropriate to their level of disability. It also means that all levels of care — from temporary or outpatient assistance to persons residing in their own homes to lifelong 24-hour residential treatment — need to be available in a community's repertoire of services.

At present, many regulations potentially or actually hinder the development of a continuum of care. For example:

- Respite care, which involves temporary placement in a residential facility to relieve a parent of responsibility during times of family emergency or when parents need a brief vacation, is hindered by regulations which require full social and medical histories, medical examinations, and full programming attention for every admission, no matter how brief.

- Semi-independent living, which involves supervision of near-independent individuals in their own apartments, is not covered by any rule, and regulated facilities which desire to provide the necessary supervision using their own staff cannot get reimbursed for that service because it is not being delivered to official "residents" of the facility.

- Retirement, which involves foster care and maintenance of present level of functioning, but little ongoing effort to increase level of functioning, is currently disallowed under DPW program rules, although it is the order of the day in most nursing homes. Retirement is a real issue for the elderly in all disability categories, and for younger people who have experienced repeated failures in attempts to increase their level of functioning.

Recommendation III-2:

Write broader, comprehensive rules with a basic, universally applicable section and subsections applicable to particular facility types, which will cover all levels of care and permit development of new forms without undue regulatory complications.

INTERDEPENDENCY OF REGULATION WITH FUNDING, PLANNING, AND RECRUITING CARE PROVIDERS

Funding

Rules and standards are only part of the human services picture. If no money is available to pay for the improved care required by standards, quality care is impossible.

Rule 36, which covers residential facilities for the adult mentally ill, is a case in point. At present no funding source exists which will reliably and universally pay for the improvements the rule requires. Both care providers and rule enforcers know this. As a consequence, DPW has been reluctant to enforce the rule, and care providers have been waiting to see what they will really have to do. Many of them contemplate having to close down if the rule is thoroughly enforced. One facility in our sample has already done so, anticipating its inability to meet the requirements.

In brief, DPW has a rule on the books which it cannot fully enforce because many facilities cannot afford to meet its provisions. If DPW did enforce the rule, some facilities would improve, but some others would go out of business altogether. A net gain for the system of care is doubtful.

Recommendation III-3:

If the legislature wants Rule 36 fully enforced, it should provide funding for facilities to meet rule requirements.

Recommendation III-4:

In general, new rules or rule changes and enabling money appropriations should go together. Promulgating rules and standards which will not or cannot be enforced promotes general disrespect for rules and standards.

Planning and Recruitment

Minnesota has adopted a policy of regionalization with respect to human service planning and recruitment of care providers. Each region in the state has appropriate bodies with the responsibility for planning a system of care responsive to the needs of its own population. Regionalization is the order of the day in health, welfare and corrections planning — all the areas which this report addresses.

While determining what services are necessary is an appropriate regional activity, we believe that enforcement of standards should be statewide. Expectations and definitions for quality care should not vary on a regional basis, since we are talking about minimum acceptable levels of care for basic human needs.

Recommendation III-5:

To assure consistency of care in residential facilities, development and enforcement of standards should occur on a statewide basis. Where this is being done, as in DPW, it should be continued. Where it is not being done, as with correctional group homes and adult community corrections, it should be instituted.

While state-level agencies can and should enforce standards in human service facilities, thus assuring good care in the facilities that exist, they cannot guarantee that the right care is being delivered. This problem involves the continuum of care discussed earlier in this chapter. It is a planning and recruitment problem, not a regulatory problem, although regulations should be written in a way that does not hinder planning and system development.

Regional planning units must exercise their responsibility to develop the levels and forms of care their regions need. State-level agencies can then insure quality in those care facilities. The two functions are interrelated; neither should be blamed for doing only their own job. Both should work together to assure that their activities are complementary rather than obstructive.

Recommendation III-6:

> Regional planning bodies and state regulatory agencies should coordinate the tasks of planning, recruitment and rule or standard enforcement, including clarification of the areas of responsibility appropriate to each.

SUMMARY

The content of rules and standards affects the human service delivery system. So does their form. This section has examined how the content of regulations governing MR facilities impacts on small group home operations. It has also discussed how both content and form affect the possibility of developing a delivery system characterized by a continuum of care. In addition, it has explored the interrelationships among regulatory, planning and funding systems.

Each of these issues involves complex decisions and policy determinations. We strongly recommend that these policy matters be addressed directly by the legislature and by appropriate administrative bodies. Failure to deal with them does not mean that they will go away; they will simply be decided by default. A full understanding of how a regulatory system works means focusing and acting on these complex issues.

CHAPTER IV

COSTS

This chapter presents data on the costs incurred by state agencies (DPW and MDH) for regulation of facilities for the mentally retarded and mentally ill. It also reports costs incurred by licensed facilities in the process of meeting regulatory requirements. It then investigates the composition of a facility's per diem rate, and attempts to provide data that are comparable for state hospital and community based programs. Finally, it addresses some remaining knotty problems in the funding area.

REGULATORY COST TO AGENCIES[1]

Table IV-1 presents the cost to MDH and to DPW for licensing a single facility of a given type once. These are recurring costs, since each facility goes through an annual license and certification renewal process. The table shows mental retardation facilities with DPW Rule 34 licenses and various types of MDH and Federal licenses and certifications. It also shows facilities for the mentally ill with Rule 36 licenses and SLF licenses from MDH. The category "difficult program" is a DPW designation, and indicates that a particular facility had significantly more than the usual number of problems coming into compliance with licensing requirements. The cost varies accordingly, reflecting the extra time DPW consultants must spend with such programs.

TABLE IV-1

ESTIMATED TOTAL COSTS FOR LICENSING SERVICES AND REGULATORY ACTIVITIES, BY FACILITY LICENSURE CATEGORY, FISCAL YEAR 1976

Facility Type	DPW	MDH	Total	Technical Assistance Project	Adjusted Total
Mentally Retarded Facilities					
1. ICF-MR, SLF, and Rule 34	$ 370.80	$2,974.54	$3,345.34	$695.98	$4,041.32
2. ICF-MR, Boarding Care Home, and Rule 34	370.80	2,936.71	3,307.51	695.98	4,003.49
3. SLF and Rule 34 only	370.80	774.41	1,145.21	695.98	1,841.19
4. Difficult Program	1,236.01	2,974.54	4,210.55	695.98	4,906.53
Mentally Ill Facilities					
1. SLF and Rule 36	370.80	774.41	1,145.21	N.A.	1,145.21
2. Difficult Program	1,236.01	774.41	2,010.42	N.A.	2,010.42

The data in Table IV-1 indicate that DPW's cost for licensing either an MR or an MI facility is $370.80, which is slightly less than half of MDH's cost of $774.41 for processing a state Supervised Living Facility license. The Technical Assistance Project cost, $695.98, goes for helping new providers understand regulations and assisting their compliance efforts. This cost is presently borne by a grant from the federal government.

[1] *For a detailed presentation of this material, see staff papers entitled: "Costs of Regulatory and Control Activities of the Minnesota Department of Health/Department of Public Welfare."*

When a facility wants federal certification to obtain Medicaid (Title 19, Social Security Act) funding, the cost to MDH which performs the certification inspection jumps from $774 to $2,974. This represents a 384% increase; the comprehensiveness of ICF surveys for Medicaid accounts for this cost increase.

At present the entire cost of certifying programs for Title 19 reimbursement is paid by the federal government. However, legislation has been introduced in Washington to change this payment arrangement. There is strong pressure to make states pay certification costs according to the same formula used to determine state and federal shares of direct care costs. This would mean that Minnesota might have to assume 43% of certification, or $1,278 per certified program.

TOTAL DEPARTMENTAL EXPENDITURES FOR LICENSING AND CONTROL ACTIVITIES

In Fiscal Year 1976, the Department of Public Welfare spent:

- $243,244 on licensing residential facilities.
- $569,914 on all licensing, including residential.
- $871,804 on other quality control and compliance-related activities (e.g., technical assistance or program evaluation).
- for a grand total of $1,441,718 on quality control activities.

In Fiscal Year 1976, the Minnesota Department of Health spent:

- $2,049,108 on licensing and/or certification of human service facilities.
- $1,002,269 on activities indirectly affecting human service facilities under regulation (e.g., medical review or health facility planning and management).
- for a grand total of $3,051,377 (of which the federal government pays slightly more than half).

For a much more thorough discussion of this material, with detailed breakdowns of cost information, see the staff papers referred to in Footnote 1 of this chapter.

REGULATORY COSTS TO FACILITIES[2]

Table IV-2 presents the average per diem rates currently in force in the facilities in our sample. It also gives figures for cost of compliance. The cost of compliance figures represent a facility's estimated costs of compliance divided by its current per diem rate minus those costs (that is, its previous year's costs, before incurring compliance expenses).

$$\%\ \text{increase in per diem due to compliance} = \frac{\text{estimated compliance costs}}{(\text{1976 per diem} - \text{compliance costs})}$$

Table IV-2 indicates that small community-based MR facilities have incurred the greatest percentage increases (52%), while state hospital programs for the mentally ill have incurred the least (2.43%).

[2] *For a detailed presentation of this material, see staff paper entitled: "Cost of Compliance with Regulations Incurred by Facilities for the Mentally Retarded and Mentally Ill."*

TABLE IV-2

AVERAGE PER DIEM RATES FOR MR AND MI FACILITIES, AND PERCENT INCREASE IN PER DIEM RATES DUE TO COST OF COMPLIANCE

Facility Type*	Mean Per Diem Rate (Current Figures)	% Increases Due to Cost of Compliance (1975 to 1976)
All CBF-MR (N = 15; beds = 495)	$23.40	30.43%
Small CBF-MR (15 or fewer beds)	$19.69	51.93%
Large CBF-MR (16 or more beds)	$23.95	27.18%
State Hospitals – MR (beds = 1,704)	$39.29	7.66%
All CBF-MI (N = 13; beds = 650)	$22.50	12.53%
Small CBF-MI (25 or fewer beds)	$35.08	11.12%
Large CBF-MI (26 or more beds)	$20.13	12.79%
Licensed CBF-MI	$29.21	9.31%
Not Yet Licensed CBF-MI	$12.50	17.32%
State Hospitals-MI (beds = 286)	$44.74	2.93%

*CBF = Community Based Facility. N's reflect all facilities in our sample from which financial data on compliance costs were available.

State hospital MR programs have very low cost increases. This is somewhat misleading, since reconstruction programs at state hospitals are only about one-third to one-half completed. However, the figure of 7.66% includes all appropriations which the hospitals currently have in hand, or about half of the total amount required. Even anticipating all the money that will eventually be spent to bring state hospitals into compliance, the percentage increase due to regulation is unlikely to reach more than 12-15%.

Table IV-2 also clearly demonstrates that MR programs of the community type have experienced far greater cost increases than any MI facility. For further exploration of the sources of cost increases we will now turn to Tables IV-3 and IV-4.

SOURCES OF COST INCREASES

The largest single component of cost increases for all facility types except small community MI facilities is direct care program staff.

In small CBF-MI's, administrative staff additions marginally exceed direct care staff as a proportion of cost increases. In state hospital MR programs record-keeping time by program staff comes in a close second to direct care staff additions. In all other categories, direct care staff overwhelmingly represents the largest category.

Administrative and clerical staff constitute the second and third most prevalent and sizable categories of cost increase.

TABLE IV-3

PROPORTION OF COMPLIANCE COST ATTRIBUTABLE TO DIFFERENT NEED AREAS FOR MR RESIDENTIAL FACILITIES

Facility Type	% of Total Increase (1975-1976)
All CBF	
Direct Care Program Staff	17.1
Administrative Staff	17.6
Clerical Staff	6.4
	95.1*
Large CBF	
Direct Care Program Staff	74.9
Administrative Staff	15.5
Clerical Staff	7.0
	97.4*
Small CBF	
Direct Care Program Staff	52.9
Administrative Staff	27.8
Clerical Staff	5.1
	85.8*
State Hospitals	
Direct Care Program Staff	35.9
Record Keeping – Program Staff	31.3
Building Maintenance, Renovation, and Sanitation	17.8
Fire and Life Safety	5.7
	90.7*

*The balance, up to 100%, is composed of several miscellaneous categories.

Overall, staff additions – more, better and differently trained people – make up the vast bulk of regulatory impact. On the whole, building renovations, maintenance, sanitation and fire-related changes constitute about 10% of CBF-MI cost increases, less than 5% of CBF-MR increases, and slightly more than 20% of state hospital increases.

Small CBF-MR facilities, which complained most bitterly about both health/sanitation and record-keeping requirements, incurred only 5.1% and 1.7% of their cost increases in those categories, respectively. That which arouses the most ire is not always the most costly.

TABLE IV-4

PROPORTION OF COMPLIANCE COST ATTRIBUTABLE TO DIFFERENT NEED AREAS FOR MI RESIDENTIAL FACILITIES

Facility Types	% of Total Increase (1975-1976)
All CBF	
Direct Care Program Staff	53.8
Administrative Staff	19.9
Building Maintenance, Renovation and Sanitation	11.5
Clerical Staff	9.6
	94.8*
Large CBF	
Direct Care Program Staff	60.0
Administrative Staff	15.9
Building Maintenance, Renovation and Sanitation	11.7
Clerical Staff	6.2
	93.8*
Small CBF	
Direct Care Program Staff	31.5
Administrative Staff	34.7
Building Maintenance, Renovation and Sanitation	9.9
Clerical Staff	22.1
	98.2*
State Hospitals	
Direct Care Program Staff	79.6
Fire and Life Safety	12.2
Building Maintenance, Renovation and Sanitation	5.1
	96.9*

*The balance, up to 100%, is composed of several miscellaneous categories.

COST OF SERVICES AND THE PER DIEM RATE[3]

One of the recurring questions invariably asked about per diem rates involves the relative costs of state hospital and community facility operations.

In our visits to MR and MI facilities, we ascertained detailed information on the amounts of different types of services delivered, whether the service was delivered by facility staff or was purchased from outside community sources, and the cost of each service in wages, overhead and purchase price. Chapter III presented some data on types of programming available, and our staff paper on Impact of Regulation presents more. Table IV-5 gives average per diem costs for internally-delivered and externally-delivered community facility services, and state hospital per diem costs.

[3] *For a detailed presentation of this material, see the staff paper entitled: "Amount and Cost of Services Delivered in Facilities Serving the Mentally Retarded and Mentally Ill."*

TABLE IV-5

INTERNAL AND EXPERNAL PER DIEM COSTS

Cost Categories:	Population Served: MR	MI (total)	MI (without high per diems)
Internal – CBF	$23.40	$23.06	$14.97
External – CBF	$ 8.24	$ 6.14	$ 6.14
Total – CBF	$31.64	$29.20	$20.11
State Hospitals	$40.92**	$44.74	———
State Hospitals if all services purchased externally*	$37.17	$38.86	$30.77

*Obtained by adding estimated costs of services provided by state hospitals but which CBF's usually purchase externally to the average CBF per diem rate in our sample.

**Includes average cost of special education for MR children, distributed over all beds in the sample: $1.63 per day.

Table IV-5 shows costs for MR and MI programs separately. The third column of Table IV-5, labeled "MI without high per diems," gives average costs for community-based MI programs excluding three facilities in our sample which had per diems in the $90-100 range. Since these per diems are unusually high, the resulting sample estimates were biased upward. The figures in the third column of Table IV-5 therefore give a more accurate picture of the usual cost of community-based MI services.

Table IV-5 allows several interesting comparisons:

- Cost of services purchased externally by CBF's increase the real cost of services to CBF residents to about 1.25 – 1.3 of the per diem rate.
- The cost of all services provided by CBF's (Total-CBF) is still substantially less than state hospital costs.
- However, estimates of what it would cost to deliver the actual level of services currently provided to state hospital residents in a deinstitutionalized setting are substantially higher than the average per diems for the type of resident who presently occupies community facilities (i.e., state hospital residents require more services).
- The actual cost of providing services to MR residents in state hospitals ($39.29/day for our sample) is substantially less than the per diem rate charged in FY 1976 ($41.00). Since these residents are supported by Medicaid, this means that payments for MR residents are subsidizing other state hospital users at a rate of about $2/day (about $2.1 million/year, of which the federal share is 57 percent, or about $1,200,000).
- In addition, cost savings from deinsitituionalization would probably be reduced over time, since cost inflation in CBF's occurs at a faster rate than in state hospitals.
- The state hospital cost for MI patients is quite high ($44.74). Since the amounts and types of direct programming care going to state hospital MR residents is significantly greater than that going to similarly placed MI residents, one must ask why the cost is greater. One probable explanation involves the high turnover rate among MI patients in state hospitals. A great deal of MI care is devoted to admissions processing and discharge planning. Since regulations require admissions physicals, dental exams, programming work-ups and many other expensive services for residents who will only remain in the facility a short time, it is easy to see where regulation impacts on MI cost of care.

In summary, the case for institutionalization or deinstitutionalization is a very complex one to make. It must take into consideration not only money matters, but the level of community-based services already in existence, the needed growth in the community-based system, the probability of long-range cost increases, and the quality of life in state hospitals versus community-based facilities.

Our financial data indicate some areas where savings might be realized, but also argue caution in assuming that deinstitutionalization will necessarily result in long-run savings.

ASSORTED MONEY-RELATED PROBLEMS

INCENTIVES TO QUALITY CARE[4]

The present reimbursement mechanism for both MR and nursing home payments under Title 19 (Medicaid) contains many more "sticks" than "carrots." Restrictions on reimbursements for care improvement when such changes are not required to rectify deficiencies have caused some providers a good deal of frustration.

ALTERNATIVE FUNDING SOURCES

Many facilities find themselves unable to develop stable, simple, or unencumbered funding sources. Some money will pay for residential care but not for treatment, some will pay medical bills but not residential rates, and so on. Staffing grants, new construction or remodeling grants, work incentive or training money and private donations further complicate the picture. No one has a complete picture of all funding sources; a few knowledgeable providers come closest to a comprehensive understanding, but this is clearly in the realm of "folk wisdom."

Recommendation IV-1:

> Develop a comprehensive list of funding sources, including what types of care the money can be used for, and any restrictions on who can apply. Include information on who to call for assistance or to make application. Keep the list updated, at least semi-annually. Make the list available to all providers.

Part of the funding problem for small community facilities involves questions about what type of care is desirable. At present small facilities housing adult mentally retarded residents must use Medicaid reimbursement, and thus must comply with federal certification requirements. If intensive programming is the treatment of choice for these people, then the funding source and the requirements are justified. However, if foster care would be acceptable or preferable, no means currently exist to finance such a program (except private payment).

We have discussed this issue further in Chapter III, pages III-7 and III-8. The reader is referred to these pages, and to Recommendation III-1 for resolution of this discussion. That recommendation essentially suggests that the state provide stable funding for adult foster care if it decides that such care is a desirable element of a continuum of care.

NEW RULES AND REIMBURSEMENT FOR CARE IMPROVEMENT

In Chapter III, pages III-9 and III-10, we discuss the problems encountered by community MI facilities in locating money to finance the care improvements required by DPW Rule 36. Chemical dependency facilities have experienced some similar problems in meeting Rule 35 requirements, namely, "Where's the money coming from?" The reader is referred to this page, and to the recommendations accompanying the discussion in Chapter III, for more information on this matter.

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[4] *See staff paper entitled: "Incentives," for a more elaborate presentation of this material.*

One example will suffice to illustrate this problem. Counties pay $10/month to send one of their residents to a state hospital for treatment. The daily rate at most community facilities usually exceeds this amount. Given an individual in need of treatment, most counties opt for the state hospital, which costs the county virtually nothing, rather than asking where that individual will receive the best and most appropriate care.

While completely understandable from a monetary point of view, this behavior negates the treatment ideal — getting the right care for the individual.

It makes more sense to establish a system in which a state hospital becomes one of the community's treatment resources in a range of resources making up a continuum from the least to the most intensive care. This system should incorporate all the money available for care, eliminating the differentiation between county and state money which now produces placement decisions such as the one described above. The Northwest Citizens Advisory Task Force has recently submitted a report[5] detailing a plan that incorporates the ideas of regional control over both the care continuum and funding for services. We recommend that the Legislature study this report and consider implementing its recommendations.

[5] *"Fergus Falls State Hospital Study: Final Recommendation to the Minnesota Legislature." Submitted by the Northwest Citizens Advisory Task Force, Northwest Regional Development Commission, January, 1977.*

CHAPTER V

STATE DEPARTMENT REGULATORY OPERATIONS

DEPARTMENT OF PUBLIC WELFARE[1]

The Program Evaluation Division investigated the efficiency, consistency and understandability of the activities of the Licensing Division of DPW. We also explored the role of technical assistance in relation to the licensing process.

EFFICIENCY

How much time does licensing take? Table V-1 compares the amount of time required to process licensing applications as estimated by Licensing Division personnel, with the actual time from submission of application to issuance of license derived from records on individual facilities, for Rule 34, 35 and 36 licenses.

Table V-1 indicates that actual processing time exceeds department estimates by a factor of two or more. The most accurate estimates are those for MR facilities, because that rule has been in operation longest and the process is more routinized. Figures for MI and CD licenses are inflated because some applications were received before the Division began enforcing Rules 35 and 36. Nevertheless, even if one reduces the estimates from agency records for MI and CD licenses by half to compensate for the Division's lag time due to start-up difficulties, time delays greatly exceed Division estimates.

TABLE V-1

LAG TIME FROM RECIPT OF APPLICATION TO ISSUANCE OF LICENSE: DEPARTMENT OF PUBLIC WELFARE

	Division Estimate		PED Estimate	
Rule:	Average	Range	Average	Range
34 (MR)	8.6 weeks	4-16 weeks	31 weeks	2-101 weeks
35 (CD)	10.4 weeks	4-24 weeks	45 weeks	28-78 weeks
36 (MI)	12 weeks	4-20 weeks	39 weeks	7-79 weeks

Sources of Delay

What are the causes of extended lag time in processing licenses? We found three principal reasons, all of which are known to the Division, and some of which are out of its control.

Coordination with Other Agencies. DPW will not issue a license without written or verbal communication from MDH and the State Fire Marshal (SFM) that the facility has complied with health and fire regulations. DPW initiates contact with MDH and SFM in writing as soon as it receives an application. It requests that MDH and SFM inspect the facility's premises, and report back to DPW. Written confirmations of successful inspection are sometimes delayed, and even verbal confirmation may take a number of phone calls. DPW can do very little about this, except to repeat requests for the necessary information. SFM averages 12 weeks from request to official notification for MR facilities, and 9.5 weeks for MI. Parallel figures for MDH are 6 weeks for MR and 7.5 weeks for MI.

[1] *For a more detailed presentation of the material in this section, see the staff paper entitled: "Regulation in the Department of Public Welfare: Residential Licensing."*

Recommendation V-1:

Regulatory agencies should continue to work on improving communication and coordination difficulties.

Provider-Division Communication Difficulties. About another third of the processing delays stem from communication difficulties between providers and Division personnel. These take several forms:

- The provider does not understand the rule.
- The provider does not understand the licensing consultant's attempts to explain the rule.
- The Division has not decided on a consistent interpretation of the rule, so the consultant cannot communicate clearly about it.
- The provider cannot reach the consultant.
- The provider and the consultant speak a different language (e.g., one is program oriented and one is medically oriented; or, the consultant has had no experience with the type of program she or he is assigned to regulate).
- The consultant cannot reach the provider.
- The provider does not send requested application material.

To address the problem of rule clarity – the provider's inability to comprehend what the rule demands, we suggest that the following steps be taken.

Recommendation V-2:

The Division should:

a) develop clear-cut and comprehensible administrative guidelines (in writing) which interpret the rule's provisions for both provider and consultant;
b) publish these manuals or guidelines and make them available to the provider;
c) develop a manual detailing step-by-step expectations for new license applicants, with examples or models of performance which the Division believes complies with the intent of the rule;
d) conduct workshops for new applicants and potential providers on rule meaning;
e) conduct continuing workshops for all providers on rule and interpretation changes;
f) conduct all workshops on a regional basis to increase accessibility for all providers.

Recommendation V-3:

If the legislature wants to see all of the suggestions in Recommendation V-2 implemented, it should provide the Division with the resources to do so. This should involve one additional staff person (maximum), at a potential cost of $12,000-15,000 per year.

To address the problem of licensers and providers speaking different languages, licensers should be hired and assigned on the basis of their expertise and experience in the program field, as well as their ability to enforce rules. We have addressed the problem of professional qualifications for licensers at great length in Chapter VI, and the reader is referred to that chapter for further discussion and recommendations.

Internal Tracking. Most of the remaining source of delay consists of failures of internal tracking and licenser workload. Not much can be done about workload (except to expand the number of personnel or extend the terms of licenses), but the internal tracking problem is amenable to rectification by immediate Division action.

A simple tracking mechanism could be developed to flag applications which have been around too long. The Division would have to decide on a definition of "too long" for receipt of reports from other departments, for receipt of additional information from the provider, and for remaining on a consultant's desk. A check-sheet would do, on which consultants recorded the vital information, dates and deadlines. Then, if a facility's file falls behind a file cabinet, someone will notice its absence before six months have passed.

Recommendation V-4:

The Division should develop and implement a simple system of internal tracking.

CONSISTENCY

Most facility operators in our sample (about 90%) felt that DPW inspectors were consistent with their own prior performance, or that any inconsistencies derived from real changes in the rules.

Consistency between inspectors is quite a different story. More than half of the providers who had experience with more than one DPW consultant reported many inconsistencies in enforcement. A similar situation exists with respect to consistency across facilities. More than half of those providers who knew the situation in other facilities similar to their own described inconsistencies in the demands they and the other facilities had to meet. Most frequently, this cross-facility comparison also involved different inspectors. The problem is that different inspectors interpret rules differently.

Another source of inconsistency, at least from the providers' viewpoint, revolves around enforcement in different types of facilities. Small facilities feel that they bear the brunt of regulation while state hospitals get away with murder. State hospitals tend to feel the same thing in reverse. We found no evidence of consistent favoritism on the basis of facility type.

Yet a third source of inconsistency described by providers does seem unfair, and should be stopped by department policy. This involves the diverse philosophies found among consultants about how many and what kinds of deficiencies to issue. Some consultants tag only the grossest violations in very bad facilities, while giving relatively good facilities long lists of minor deficiencies. Those same minor deficiencies exist also in the bad facilities, but were not tagged. Other consultants really hit the bad facilities, and do little more than chat with the provider in facilities they perceive as good. While it may seem unreasonable for providers to complain about the "casual chat" approach, there are some reasons for it. Providers have spent a good deal of time preparing for inspections (at the very least, they must put in the time with the inspector), and they feel they should be getting some constructive feedback for their effort. They feel that if the consultants trust them so much, why put them through the process at all? Either do it right, or don't do it at all" seems to be what these providers are saying.

Recommendation V-5:

The Division should expand its inservice training for consistency of rule interpretation, utilizing the guidelines suggested in Recommendation V-2.

Recommendation V-6:

The Division should develop a policy regarding how many and what kind of deficiencies to give to facilities, regardless of type or level of competence.

Recommendation V-7:

The Division should develop and implement a procedure for monitoring consultant interpretations of rule provisions, to use as ongoing feedback to improve consistency.

TECHNICAL ASSISTANCE

No easy answers exist to the problem of technical assistance. Should inspectors just be enforcers, or should they also be capable of advising providers about ways to meet the rule? Should they do even more than that, extending themselves to provide information for program improvement even when the rule does not require such improvement? Will inspectors be happy just being enforcers? What are the consequences of having inspectors who are simply enforcers and have no expertise or ability to judge the adequacy of compliance? If inspectors only inspect, who will give advice, and what kind of co-ordination will exist between inspectors and experts?

Chapter VI discusses these questions in some detail. Its recommendations pertain to the experience and program expertise we feel are most desirable for regulatory personnel. The reader should turn to this section for further discussion.

In addition to the technical expertise of licensers, many providers want and need more extensive help than even an experienced licenser can give. Such help should be available, if the state is truly committed to developing excellent care facilities.

The Technical Assistance Project housed in the Mental Retardation Program Office of DPW offers such help. The Project has always been and still is supported by federal funds. We heard nothing but praise for the staff of the Technical Assistance Project from all providers who had contact with them. Several providers expressed the sentiment that they would be very sorry to see the Project end. We too think this would be unfortunate.

Recommendation V-8:

> When and if federal funding expires for the Technical Assistance Project, DPW should adopt it as a permanent state function, and the legislature should provide appropriations for the purpose.

Recommendation V-9:

> Similar technical assistance efforts by other program offices within DPW should be developed and/or continued.

For further information on Licensing Division processes and provider perceptions of inspection, see the staff paper cited in Footnote 1 of this chapter.

DEPARTMENT OF CORRECTIONS

A discussion of the rule enforcement process within the Department of Corrections cannot parallel that for DPW, because very little similarity exists between the two departments. Facilities subject to inspections do not file applications, and facilities or boards which file applications do not get inspected. Furthermore, no set of standards yet exists, officially, although several are in various stages of completion. With no formal standards available, questions of rule clarity, provider comprehension and inspector interpretation or consistency are moot.

Quality control activities in DOC center on the Inspection and Enforcement Unit, which has responsibility for secure facilities run by local and regional units of government, and for Juvenile Treatment and Detention Centers. As described in Chapter III (Impact), the Unit has been quite effective in producing changes even without official standards. Comments from facility operators do indicate, however, that they did not know until after the first inspection, when they received a summary report and list of deficiencies, what standards they had to meet. While this is understandable, providers will appreciate official promulgation and distribution of the standards which cover their facilities.

Little else can be said about DOC's enforcement efficiency, since no other unit actively enforces any standards. Clearly, the Department has not been efficient about producing those standards the Legislature has directed it to write and promulgate, since none exist as yet, and few are very far advanced in the process. The only exception is the set of standards for secure facilities run by local government units. These will have taken 13 months from legislative authorization to promulgation, if all goes according to schedule.

Chapter II detailed the problems of coverage which prevail with corrections-related facilities. Since the Inspection and Enforcement Unit has shown itself willing and able to undertake an aggressive quality control position, we recommend that it be given the task of developing and enforcing comprehensive standards for all correctional programs, whether run or financed by the Department or not. Recommendations II-5 and II-6 state this suggestion formally.

For a detailed presentation of the data we collected relevant to the Department of Corrections and its enforcement activities, see the staff paper entitled: "DOC Regulatory Functions."

CHAPTER VI

IMPROVING SYSTEM EFFECTIVENESS

This chapter will summarize the major findings of this study, in an attempt to place several overarching issues in the field of regulation into perspective. This chapter contains not so much recommendations as a discussion of alternatives and choices.

The issues are:

- What level of care can (and should) regulation promote?
- Can regulation influence treatment effectiveness?
- Is the current bureaucratic structure adequate to meet the regulatory needs of the human service delivery system?

LEVEL OF CARE

The level of care in licensed facilities of all kinds depends primarily on the skills and attitudes of service providers. However, licensing and regulation may also affect the level of care, contingent upon:

- The stringency of rules;
- The relevance of rules to particular facilities;
- The level of enforcement of rules (which is in turn contingent on the available pool of inspectors, their consistency of enforcement and their expertise);
- The availability of monetary support for quality improvement.

RULE STRINGENCY

One can readily observe the impact of rule stringency on level of care when a new rule goes into effect. Facilities which already complied with all the requirements of the old rule suddenly find themselves out of compliance and faced with substantial (and expensive) changes to meet the new rule. In Minnesota, this has happened several times (e.g., when homes previously licensed as group homes or boarding and lodging establishments had to meet federal MR regulations, DPW's Rule 34 or 36, and MDH's Supervised Living Facility license).

This is a procedure of "upping the ante" for entry and continuation in the care delivery field. It can result in substantially increased levels of care in those areas where rules can specify exactly what they want to see, and where standards exist to indicate what is a "higher" or "better" level of care. These areas tend to be in the facility structure and maintenance areas, and in certain areas of policy and procedures. These are also the areas which reach a plateau; beyond a certain point, there is not much marginal benefit from expending more time, energy or money on them.

The ability of rules to develop increasingly more stringent criteria in all areas of concern may be an issue. We must consider that rules cover a variety of different content areas. As detailed in the *Evaluability Assessment,* these include: maintenance needs (physical safety, sanitation, nutrition, space, supervision, medical emergencies procedures), treatment needs (staff qualifications, program components and procedures), and administrative and management concerns (records, administrative practices).

In some areas, usually those involving inputs or processes, rules can specify requirements in great detail. As more sophisticated technology or procedures are developed, rules can incorporate these advances. This has happened, for instance, with smoke and heat detectors, sprinkler systems, and magnetic door closers in the area of fire safety. There are three problems with relying on increased rule stringency to improve level of care: 1) No matter how precise and stringent a rule specification is, if it specifies only inputs or processes, it does not guarantee outcomes; at most, it reduces the risk of negative outcomes significantly 2) Many areas of concern have thresholds; that is, beyond certain levels, more is not necessarily better (or if better, not so much better that anyone cares). Space requirements operate like this: if 80 square feet of bedroom space is good, is 160 square feet twice as good? 3) The marginal utility of each subsequent increase in standards may be low. That is, the first jump in level of care, say from foster care to programming and treatment, may be very great. The second jump, say from minimal levels of direct care program staff to high levels of such staff, may be moderately great. Each subsequent jump produces less and less marginal improvement, until the point is reached where the time and energy needed to make the jump is more than the payoff.

Because of these three problems, the state can probably go just so far with increased demands through rules. For some facilities, in some areas of regulation, this limit may have been reached.

Another problem arises in areas where outcomes are specifiable but technologies are not, because no one yet knows enough to lay out exactly what should be done. This pertains to treatment effectiveness most particularly, and will be discussed below. Briefly, the problem posed by this area of care is that stringency of inputs may price care out of existence, but will not necessarily guarantee the desired outcomes.

The question remains as to how far the process of increasing regulatory requirements should go. This problem involves many professional judgments: What is "enough" fire protection, "enough" surveillance of residents' medical condition, "enough" opportunity for self-determined activity, and so on. Professional judgments frequently disagree: regulations for ICF-MR's are a case in point. The combined requirements for MDH's Supervised Living Facility license and DPW's Rule 34 license contain about half the scope and specificity of federal Medicaid requirements, and cost less than half the money to administer. Minnesota authorities feel that their regulations are sufficiently stringent and provide for adequate levels of care. Yet they enforce the twice-as-stringent federal regulations because compliance is necessary to obtain money. Is this "overregulation?" Washington thinks not; many Minnesotans think it is. As long as the money flows, facilities will comply. However, should Medicaid money dry up, Minnesota will in all likelihood enforce only the less stringent requirements embodied in its own rules.

This dilemma extends beyond the residential human service facilities studied in this research. Day care faces a choice between an educational versus a babysitting emphasis; other areas face choices between foster care and treatment emphasis. All are bargainable issues; none are areas where all people will agree on what is "right". In the long run, rule stringency is a compromise between the ideal and the practical, and among different audiences' ideals.

RELEVANCE

Relevance and the related problems of rule comprehensiveness, breadth, and flexibility impact on the level of care in facilities through the "fit" of rule requirements to populations served.

Rules should not obstruct change, development and innovation in the care delivery system. Nor should they apply inappropriately high or low standards to individual facilities. We have already discussed (Chapter III) the restrictions on system development which providers feel the current rules contain. Rule writers need to make a fundamental decision about whether to write many different rules to cover each new type of facility as it emerges, or whether to write rules delineating universal requirements for broad categories of care (e.g., children's community residential facilities, adult community residential facilities, secure facilities, etc.) with needs for specific program areas handled as subparts of the basic rule. The advantages of the latter approach (broad rules) are numerous: 1) flexibility and timeliness; 2) promotion

of (or at least noninterference in) development of a continuum of care; 3) consistency of many requirements across similar types of people (e.g., children, dependent adults); and 4) ability to tailor a set of requirements to the particular characteristics (e.g., size, population) of a given facility.

When a rule is finely tuned to the population served, the appropriate levels of care should result. However, a conflict sometimes emerges in the rule writing process involving how broadly or narrowly a rule should be written. Minnesota has examples of both broad and narrow rules.

On the broad side, DPW's rules covering day care for children are fairly broad, and contain a basic cluster of requirements plus subparts stating requirements for specialized services and populations. Similarly, MDH's Health Facilities Division has only four rules (Hospital, Nursing Home, Boarding Care, Supervised Living Facility) to cover the whole range of approximately 900 health facilities in Minnesota,[1] and the State Fire Marshal operates with a single Life Safety Code subdivided into different requirements for facilities of different sizes.

DPW's Rules 34 (MR), 35 (CD), and 36 (MI) are examples of rules with a narrow program focus. Although each covers adult residential programs with treatment components, each remains a separate rule. Different individuals were involved in writing each, and each includes varying amounts of specificity about many areas, dependent upon what compromises the rule writing committees needed to reach. DPW's current practice regarding facilities used by adults is toward writing separate rules for each new type of facility and for each specialized population. For example, there are separate rules for detoxification centers and chemical dependency treatment programs, although both attempt to house and treat chemically dependent individuals for varying periods of time. This practice certainly creates time delay and uncertainty in the licensing of new facility types, and may promote inconsistency in the basic coverage available to all service users.

On the other side, DPW is presently engaged in a rule revision process that would combine the several rules now covering residential treatment programs for juveniles into one rule. DPW's Director of Licensing, Barbara Kaufman, says she much prefers a single broadly comprehensive rule, but that other interested parties (advocacy groups, providers) do not.

Broad rules promote flexibility and timeliness because relatively speedy administrative decisions can determine how to handle new or hybrid types of facilities. For instance, one broad rule with appropriate subparts might handle all adult community residential facilities from custodial or foster care through aggressive and intensive program care to semi-independent or halfway house care. Alternatively, the individual-rules-for-specific-facility-types approach may require one or two years to develop each new rule, if we take as examples the schedule of DPW's several latest program rules. By the time such rules are actually promulgated, conditions may already have rendered them partially obsolete. Changing narrow-focus rules entails similar lengthy time periods. By avoiding this time lag problem, broad rules with subparts would remove obstacles in the way of newly developing forms of care. Hopefully these new forms will fill gaps which presently exist in the care delivery system, and the goal of a care continuum will be furthered.

Finally, broad rules would go some distance toward the objective of simplifying regulation of facilities for people with multiple problems, and assuring that all children, for instance, or all dependent adults, receive similar protection for their basic needs regardless of the specific program they find themselves in.

From the point of view of governmental efficiency and flexibility, broadly comprehensive rules would seem to answer quality control needs most adequately.

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[1] *As of March 15, 1976.*

LEVEL OF ENFORCEMENT

Regardless of a rule's precision or stringency, the level of care available in facilities will not consistently meet requirements unless an active enforcement program exists. While some facilities may provide care exceeding standards, most will not make changes without surveillance. This fact may imply a "get away with whatever we can" attitude, but is at least as likely to reflect a facility's economic realities. Without this level of active enforcement, facilities may not be able to negotiate per diem increases to pay for improved care. We have encountered this problem among correctional group home operators and among providers of community based residential care for the mentally ill.

Level of enforcement depends on at least three elements: 1) ratio of inspectors to regulated facilities (i.e., inspector workload); 2) consistency of enforcement; and 3) expertise of inspectors.

Inspector Workload

Table VI-1 indicates the great variations in workload among the state's various inspection units. Workloads do not necessarily vary with the scope or detail of areas to be inspected. DOC's Inspection and Enforcement Unit personnel inspect all aspects of secure facilities, from toilets to administrative records; Environmental Health inspectors cover only sanitation; the fire marshals inspect for fire and live safety; DPW's residential inspectors must cover multiple areas of care within six or seven different facility types, all with separate rules. There are even inspectors who have nothing specific (i.e., in rule form) to inspect for. DOC's district supervisors would fall into this class, and the variation in their inspection activity reflects this fact.

TABLE VI-1

Agency	Program	Number of Inspectors	Number of Programs	Workload/Inspectors
DPW	Residential	10	404 (638)[1]	40 (64)
DPW	Non Residential	12	802	67
MDH	HFD	46	887	19[2]
MDH	LSC	10	911[3]	91
MDH	EHD	28[4]	12,369[5]	442
SFM		22	4,000[6]	182
DOC	I&E	3	90[7]	30
DOC	Other	—[8]	—[8]	—[8]

[1]The number in parentheses indicates the workload when the Division begins licensing 35 detoxification centers under Rule 32, and if the Division actively pursued nursing homes with five or more MI residents, as they should under Rule 36.

[2]Actually, twelve teams of three to five people each handle an average of 74 facilities per team annually.

[3]This figure is taken from MDH records and represents the number of certified facilities as of March 15, 1976. To be certified, they must be inspected by LSC inspectors.

[4]EHD has 22 full-time inspectors and six supervisors with part-time inspection responsibilities. Workload may be somewhat, therefore, underestimated.

[5]EHD licenses a wide variety of facilities, ranging from restaurants to lodging houses. 231 boarding and lodging licenses were issued in 1976; most of these were for human service facilities.

[6]SFM inspects a wide variety of facilities ranging from theaters to group homes. Most of the 4,000 figure are not human service facility inspections.

[7]Sixty-two lock-ups are inspected by local sheriffs and health officers. I&E examines their inspection reports rather than inspecting these facilities themselves.

[8]Other DOC personnel with inspection responsibilities in insecure facilities (specified or unspecified) varies. There are 24 county operated correctional group homes scattered throughout the districts of five district supervisors. At least eight other insecure projects are funded primarily through CCA in the outstate area; four district supervisors monitor these projects. In addition, two DOC personnel from the central office inspect and monitor approximately 12 insecure projects in the metropolitan area.

For some departments, the figures in Table VI-1 do not reflect a stable workload. This is true of DPW, where new rules and developments in the care delivery system cause quantum jumps in the number of facilities needing licensure (e.g., Rules 32 and 36 alone — detoxification and MI — potentially add 23 new facilities to the workload of each inspector). Similarly, resolution of the definition of "correctional facility" (a question presently in the Attorney General's hands), may add an unspecifiable number of adult and juvenile community corrections facilities to DOC's workload.

Where this level of instability prevails, enforcement of new areas may lag far behind the official date on which a rule is promulgated. Rapid increases in workload may cause system-wide delays, as when processing of licenses in all categories slows down under the strain. Alternatively, the agency may decide to selectively enforce the new rule (e.g., DPW has decided not to pursue Rule 36 licensure for nursing homes housing MI residents at present, unless the home itself seeks a license, because the Licensing Division does not have sufficient staff to do the job).

An insufficient number of inspectors to do the job clearly may lead to underenforcement, and consequently to levels of care lower than those specified by rule.

Consistency of Enforcement

The success of any rules depends on clear and precise administrative interpretations of rule provisions, which foster consistency and which are available to licensers and providers alike. The rule and the interpretations should stress indicators of outcomes, that is, whether the provider is meeting the intent or the goal of the rule. Many facility operators have voiced a desire for this mode of rule enforcement:

> "The trend toward dictation on a state level of what is appropriate programming is bad. Regulations don't give you leeway to experiment with programming."
>
> "The rules should be enforced by intent. Are we providing care that meets the intent of the rule? If we are, then let us alone."
>
> "Rule 34 specifies that residents should be allowed to open their own mail. Now I can see where you want to give residents as much normal activity as possible. I agree with what the regulation is trying to do. But around here, if we let residents open their mail, they'd eat it."

Rules require intensive and on-going inspection training to assure consistent interpretation and enforcement throughout the state. Our findings with regard to all inspectors except those from SFM indicate that consistency of enforcement across inspectors is a problem in any case, and should be remedied through both training and self-monitoring.

Recommendation VI-1:

Provide clear and precise rules and interpretations and distribute these to all providers and potential providers.

Recommendation VI-2:

Provide intensive and on-going training on rule interpretation for inspectors.

Recommendation VI-3:

Develop monitoring procedures to assess, systematically and periodically, the consistency of inspector performance in the area of rule interpretation and in the area of level of effort or scrutiny which a given facility receives.

Inspector/Licenser Expertise

Rules require not only precise interpretations, but specific program expertise on the parts of inspectors and licensers. Rules allow their enforcers discretion, and it would be unwise to place discretion in the hands of people who lacked the basis on which to make judgments. In addition to relevant academic training, that basis should be several years' experience in the program area they regulate, including time spent actually working in such facilities with, preferably, some proportion of that time spent in an administrative capacity for welfare, health and corrections regulators.

Inspector qualifications were a frequent source of provider comment and concern during our interviews at facilities. The most respected regulators were the state fire marshals, who were perceived as having a great deal of experience and first-hand knowledge of their own area, plus an orientation that the best way to insure safe buildings was to convince the operator through a process of reason and explanation that required changes were indeed necessary, and then to offer concrete suggestions as to the best means to accomplish those changes. In the words of one provider: "They really know their stuff, they're helpful, and you can reason with them." Providers found it easier to swallow some bitter and expensive pills when they came seasoned with respect, expertise, and reason.

The most frequently mentioned complaints about regulators involved excessive rigidity and lack of knowledge or understanding about the type of program under review. Often, these two defects occur together and result in inspectors with a "letter of the law" attitude even when the spirit of the law is being met. For example, one facility we visited was cited for lack of closet dividers. The intent of the rule in this instance is to provide demarcated individual closet space for each resident. The closet in question was a walk-in closet, with one rod on each side. Two residents shared the room, and each had one side of the closet. The walk-in space between the two sides of the closet provided everyone with a clear indication of which side belonged to whom. However, the inspector issued a deficiency in this case, and suggested either a physical barrier down the middle of the closet (which would effectively have barred entry to the closet) or circular cardboard partitions placed over both rods to divide the closet into a front half and a back half. The presence of a physical partition was the only way to meet the rule; a functional partition (the walk-in space) would not suffice.

We encountered similar examples, usually involving inspectors and surveyors who had a specific type of rule to enforce, little knowledge or understanding of the facility they were inspecting, and little willingness to "be reasonable" in accepting an outcome (each resident did, in fact, have their own identifiable space) rather than an input (closet dividers), as satisfying the requirement. Comments such as:

> "I never ask any questions of the MDH inspectors, or bring up any new areas they haven't asked about specifically, because every time I used to do that they would add new deficiencies to the list. They have an attitude of trying to find things wrong."

reflect the general level of dissatisfaction with regulators who are rigid, unknowledgeable, inexperienced, or all three.

In all fairness to MDH, these negative perceptions stem almost entirely from MR facilities unused to medical rules and requirements and subject for the first time to federal certification. Facilities of all other types perceive both MDH and SFM inspectors to be moderately (and appropriately) strict.

DPW licensing consultants received ratings midway between the general satisfaction with the state fire marshals and the sometimes negative comments about health department surveyors. On the whole, DPW consultants are perceived as quite flexible, interested, and fair, but not terribly knowledgeable about program aspects of the facilities they license. (This conclusion really only generalizes to MR and MI facility inspections; we did not visit enough of any other single type of facility to make definitive comments about all facility types. It also varies by size of facility; small facility operators evinced more satisfaction with DPW consultants than did large facilities, both community and state hospital.)

In general, comments by facility operators support our contention that rules in the hands of knowledgeable people with a flexible, outcome orientation are most conducive to quality care and would be well received, while the same rules in the hands of inexperienced people with a rigid, input orientation produce frustration, exasperation and resentment without necessarily improving the quality of care delivered at all.

The reason for regulators to have specific program expertise or other relevant experience should be fairly obvious. If we entrust regulators with some discretion to judge whether the intent or goal of the rule is being met by whatever procedures they find in particular facilities, then those regulators must possess the competence to make such judgments, and such competence is best gained through first-hand experience. Licensers for Michigan's Child Welfare Licensiing Division, for instance, are required to have five years of field experience in children's residential treatment programs, of which one year must be in an administrative capacity. Salary and recruiting tactics both aim at getting the best of the care providers, people committed to maximizing quality care through assertive regulation, into the licensing business. Licensers thus have intimate knowledge of providers' problems, can offer constructive criticism, and have the confidence and competence to make difficult discretionary judgments. The cost of upgrading Minnesota's regulatory personnel following this model would run approximately $150,000/year, estimating approximately 30 positions to be upgraded at about $5,000 additional salary per position.

Program rules enforced by experienced regulators also imply assignment on the basis of program expertise, not on the basis of geography or other convenience criteria. If enough facilities exist within a particular program area to warrant supervision by more than one regulator, geographical assignment can occur within program areas. In the long run, the impact on care delivery of program rather than geographical assignment should more than offset the somewhat greater travel time potentially involved in program assignment.

Recommendation VI-4:

Job qualifications for DPW, MDH and DOC regulators should include 3 to 5 years working in a facility or facilities of the type they intend to regulate. This experience should preferably include some time spent in an administrative capacity. Departments which currently do not include such work experience as part of their job entry requirements should change their requirements to conform to the above recommendation.

Recommendation VI-5:

Department of Personnel should more aggressively recruit regulatory staff who meet the experience requirements just recommended.

Recommendation VI-6:

Department of Personnel should reclassify positions and develop a compensation plan commensurate with the above recommendation.

Recommendation VI-7:

Job qualifications for State Fire Marshal and Assistant State Fire Marshal already meet the above criteria, and should remain as they are.

Recommendation VI-8:

The Legislature should provide regulatory sections of relevant departments with staff funding sufficient to allow successful recruitment of competent professionals meeting the experience crtieria recommended above (estimated cost = $150,000/year).

Recommendation VI-9:

Personnel assignments to regulatory duties should correspond to the employee's area of program expertise.

Recommendation VI-10:

Ongoing in-service training should provide regulatory personnel with the opportunity to keep up-to-date in their respective areas of program expertise.

MONEY FOR IMPROVEMENT

Finally, the level of care available in the state is contingent on somebody's willingness to pay. MR facilities amply demonstrate the impact of a generous funding source. With Medicaid footing the bill, MR facilities have substantially upgraded practically every area of care, from fire safety through record keeping to programming (see Chapter IV and staff papers for details).

Community facilities for the MI, and to some extent those for CD and juveniles, represent the opposite end of the spectrum. These facilities receive most of their funding from county welfare, private parties, and third party payers, none of which are currently able or willing to foot massive bills for quality improvement. New rules specifying increased levels of care raise serious questions of whether existing facilities can afford to meet the new requirements. One of the reasons why DPW's Licensing Division delayed enforcing Rule 36 for so long involved the Division's assessment that complete enforcement would force many facilities to close down. None of the available options -- facility closings, substantial noncompliance, or lackluster enforcement -- seem very desirable.

The fact remains: high quality care costs more than low quality care. Rules, without money, cannot single-handedly upgrade levels of care beyond a certain point.

SUMMARY: LEVELS OF CARE

We have seen that the level of care available in Minnesota residential facilities depends at least as much on decisions made by state officials as it does on provider skill and desire. These decisions involve the stringency of rules, their breadth and consistency of enforcement (primarily regulatory agency decisions), the number and expertise of inspectors and the availability of monetary support (primarily legislative decisions, with some regulatory agency component). In general facility operators have proven willing to upgrade the levels of care in their facilities if: 1) they know someone will be overseeing the process, and 2) they can get reimbursed for doing so.

TREATMENT EFFECTIVENESS

Treatment effectiveness is a delivery system goal, but is not a primary goal of the regulatory system. No rule or standard yet written in this state requires as a condition of licensure that a facility demonstrate client improvement as a result of its treatment. It is extremely doubtful that any rule or standard ever will contain such a requirement. One rarely knows how to cause such improvement with any degree of certainty for most of the conditions treated in human service facilities. This creates problems for rule-writers, since they must specify some formal requirement, but the usual tack involves specifying inputs or processes rather than outcomes.

Inputs, Processes and Outcomes

All rules are written for the purpose of guaranteeing some desirable end. In the case of sanitation, for example, the end in view is a healthy, germ-free environment. In this form the goal is specified, but the means to that goal, the inputs and processes necessary to achieve it, are not mentioned. This type of rule rarely occurs in the health area, however, because stating the means to the goal has proved sufficient

to guarantee the outcome. Thus, writing a rule which specifies that the dishwater temperature shall be 180° virtually guarantees that the plates will be germ-free. There is no intrinsic interest in 180° water, so this can hardly be the goal the rule was written for. But, since inspecting the water temperature is much easier than inspecting the germy state of each plate, and since the two procedures yield fundamentally the same results, rules in the health area stipulate input and process (water temperature and use of dishwasher) rather than outcome. When stipulating the input essentially guarantees the outcome, and when no other input or process will produce equivalent results, specific rules covering only inputs will yield desired levels of care.

Unfortunately, in many areas with which regulation concerns itself the cause and effect relationship between inputs and outcomes is not so clear-cut. One can specify hours of programming, but how many hours are "enough" or "too much?" Similarly, how do we determine that a specific staff-client ratio is adequate to serve the needs of all the clients in all the facilities that a particular rule covers? Sometimes specific rules covering programming concerns prove detrimental to the goal. This would occur when the facility was meeting the letter of the law and refused to do more, but the licensing agent nevertheless felt that the intent of the law was being violated (e.g., the facility provided the required staff-client ratio, but clients did not receive any individualized attention). Where a great deal of indeterminancy exists about appropriate means to desired ends, rule writing is extremely difficult.

Some people feel that rules should emphasize outcomes, and avoid requirements which can generate mere paper compliance. As one provider eloquently expressed the problem:

> "The rule (34) had good effects so far. We've come a long way in many areas. But the rule should keep moving. Keep pushing us to do better, or we're going to lapse into mere paper-pushers. It's easy to comply on paper, but we need the rule to keep pushing us into more and better programming efforts. Judge us by what we accomplish, and that will keep us on our toes."

The request in the above quote has not proved an easy one to honor. Regulation tries to improve treatment effectiveness by requiring that certain conditions believed to foster effective treatment exist in a facility. To this end, many regulations require particular staff qualifications, staff-client ratios, and a given number of hours per week spent in programmed activity.

Regulation enforces minimum standards. Some facilities governed by regulation will always verge on noncompliance, just as some facilities will always far exceed minimum standards.

If clear definitions of improvement exist, regulation can be used to promote improvement through development of more and more stringent rules – a strategy of "upping the ante." This would mean that a facility which today is barely in compliance will tomorrow find itself below minimum standards because a new and more stringent rule has raised the standard to a new level. Such a facility would either have to improve to the level of the new rule or close its doors.

Within many areas covered by regulation, such as fire and life safety or sanitation, improvement can be clearly defined, and new rules have used these definitions to raise the level of care in these areas.

Unfortunately, treatment effectiveness or client improvement is one area which does not yield readily to this strategy of improvement through more stringent rules.

Solutions to the problem of improving treatment effectiveness are not readily apparent, nor is it obvious that licensing and regulation can or should be asked to tackle the job. We outline several alternatives below, in the hopes of stimulating discussion of this issue, but without expecting that any alternative or set of alternatives is clearly better than any other.

ALTERNATIVE 1: Do nothing.

Recognize that licensing cannot effectively influence client improvement given our present state of knowledge about effective treatment, and abandon the goal of trying to assure that human service facilities produce improved clients.

This alternative assumes that rules can only specify inputs and processes hopefully leading toward desired outcomes, but cannot specify the outcomes themselves (i.e., successful treatment) as a condition of licensure.

ALTERNATIVE 2: Devise some technical change(s) in rule-writing procedures to permit flexibility in enforcing rules.

Presumably, flexibility would contribute to judging facilities on performance rather than on specific input criteria. Several changes would be possible in the Administrative Procedures Act (e.g., exclusion, waiver clauses in rules), but all seem to beg the question of what criteria to judge a facility on. The problem is not avoidance of specificity where specificity is possible. Rather, the problem is that we do not know how to be specific about the process of producing client improvement, nor do we have data available to judge which facilities are or are not causing clients to improve.

ALTERNATIVE 3: Use licensing to promote client improvement through a series of graduated rules, each rule more stringent than the last, each rule after the first including some criterion of amount of client improvement to be demonstrated by the provider.

This would be possible if we could specify what criteria constitute a "better" facility and better performance on client improvement. It would shift the burden of proof to the provider, and make the provider justify a claim to annual license renewal through proof that his or her facility does in fact produce improved clients. We outline below some components of a series of graduated rules. Such an innovation in rule-writing, and in the payment-reimbursement mechanisms which parallel rule-compliance, might provide positive incentives for delivering high quality care and effective treatment. We have called this innovation graded or graduated rules; it involves:

- Grades or classes of licensure. Issue Class A licenses, Class B licenses, and so on. A Class C license, for instance, would be the minimum standard license, equivalent to those licenses now being issued. A Class A license would signify that a facility had achieved excellence in care delivery. There might or might not be a Class B license, depending on whether it is possible to differentiate three levels of care quality or not. One criterion for granting licenses above Class C would be demonstrated and documented treatment effectiveness.

- Burden of proof on the facility operator. The lowest level of licensure (Class C) would be issued in a similar manner to current licenses. Each facility would begin at Class C, and would remain there until the facility itself actively demonstrated and presented proof that it met the next highest set of requirements. The facility would then receive a Class B license, and so on. This is most important, since we want Class A licenses to be special, not automatic.

- Rewards for excellence — term of licensure. A Class C license would be for one year, similar to current licenses. A Class B license would be for two years; a Class A license for three years. This would reward excellent facilities by freeing them from the work involved in annual relicensure. It would also free regulatory personnel to spend their time on those facilities which need the most improvement and surveillance.

- Rewards for excellence — financial. Provide monetary rewards to staff of all facilities above Class C, in the form of year-end bonuses for excellence or whatever form is the most appropriate.

- Rewards for excellence — status. Possession of a Class A license would mean considerable status for a facility, and would provide care consumers with a means to assess care quality. Discrepancies between level of per diem and class of license would also be revealing, as when a very high-priced facility managed only to obtain a Class C license.

- Reimbursement mechanism. Establish a reimbursement mechanism which allows per diem increases for quality improvements rather than limiting increases to items which correct deficiencies. The present reimbursement mechanisms actually restrict facilities which try to provide better than

minimum care. The Legislature may have to provide money for this purpose itself, since federal sources most probably will not allow payment for quality improvements. This mechanism would also need a way for higher-class facilities to obtain increases for normal inflationary costs and additional quality improvement costs for each year of multiple-year licensure.

ALTERNATIVE 4: Develop a data base using annual performance data from all licensed facilities. Use these data to judge the performance of individual facilities. Couple excellent performance with monetary, status, or other rewards.

All attempts at performance evaluation require an adequate data base. We would be trying to develop an equivalent to the "in accord with accepted practice at the time" criterion in medical and legal malpractice litigation. Only then could we evaluate a given facility's performance and declare that it was less than it should have been.

This would be a fairly expensive undertaking, but in a very real sense no systematic understanding (let alone change efforts) of the whole human service delivery system can be accomplished without information. This alternative proposes that criteria for judging successful treatment outcomes be developed, and that facilities regularly report their performance on these criteria to a state agency. Success (for example, number of months without committing a crime, number of months without using chemicals, self-care skills learned, etc.) is both easier to specify and likely to elicit more agreement among various parties than would the methods used to achieve it. In addition, if performance data were available, they could be used as part of an incentive system in conjunction with graduated rules. Thus, the facilities which prove most successful in treating clients (e.g., in the top ten percent) would receive a higher class of license, or a license for a longer term, or monetary incentives. In this way, rewards would be tied directly to performance outcomes, rather than to inputs. As a management principle tying rewards to outcomes is highly recommended.

ALTERNATIVE 5: Develop a system of technical assistance and/or monetary support for programs which desire to improve their treatment abilities.

This system would be independent of licensing, separating the "permit to operate" which licensing grants from stimuli to promote treatment effectiveness. This alternative is the most costly of the five, and would involve establishing a broadreaching technical assistance program to parallel licensing. If coupled with appropriate incentives to facilities, this alternative might have some chance of promoting better programs through systematic data collection and feedback to facilities.

These five alternatives are not mutually exclusive. A good data base would improve any regulatory system and should also promote increasingly effective delivery system design and management. The Program Evaluation Division does not really perceive any viable way to pursue the goal of increased treatment effectiveness without a good data base. Whether or not such a goal has top priority, though, is up to the legislature to decide.

BUREAUCRATIC STRUCTURE

The remaining issue to be discussed in this chapter is what bureaucratic structure best meets the needs of Minnesota's regulatory system. Below, we present a summary of our findings relating to the present system's efficiency and coordination. Further details pertaining to these findings are available in earlier chapters of this report and in several staff papers which the reader may request from the Program Evaluation Division office.

After we present this summary of findings, we discuss their implications for whether or not a large-scale restructuring of regulatory activities seems warranted.

The findings are:

- Only one overlap exists among state-level agencies.

- Gaps and lack of coverage can be attributed to:

  a. unclear or nonexistent legislative authority
  b. insufficient agency staff
  c. no funding to pay for improvements if they are required.

- Failures of agency coordination and cooperation constitute only a small proportion of state-level inefficiency.

- While inter-agency communication is sometimes slow, all state regulatory agencies in the human services area have worked to improve this situation in the past, and are continuing to work on it. Lag time between one agency's request and another agency's response in writing is between one and two months on the average, according to DPW files for MR and MI facilities in our sample, while the total licensing time, on the average, is 7-11 months for new programs.

- Major delays occur mostly when:

  a. the activity of a local or regional level of government rather than another state agency must feed into the licensing process
  b. providers do not send the agency additional requested materials, or the inspector cannot reach the provider to clarify relevant points
  c. agency workload is high.

- Providers are the main source of complaint about the complexity of the regulatory system and the number of inspectors they must answer to. However, the number and types of inspections necessary would not materially change under a centralized system, since different inspections entail different areas of expertise and would thus require multiple inspectors.

- Some increased level of coordination in the timing of inspections might be expected under a centralized system, and providers would find this desirable. However, current law makes coordination almost impossible in some areas (e.g., new nursing home legislation requires at least one unannounced visit annually, which virtually precludes inter-agency coordination).

- While coordination with other agencies and inspectors may now present problems, coordination with technical assistance programs is relatively easy and workable. Technical assistance now resides within the same agency, and sometimes within the same individual inspector, as do regulatory functions. Extracting the regulatory function and placing it in a separate agency might solve inter-regulator problems, but might create an equal number of regulator-technical assistance coordination problems.

- To a lesser extent, coordination with funding sources bears the same relationship to regulation as does technical assistance. Currently, most funding is controlled by the same agency (or its local counterpart) that regulates. Separating regulation from funding sources may promote objectivity, but may also result in less coordination.

CONCLUSION

Given good-will efforts by state agencies, plus proper legislative mandate where regulatory authority is now lacking, most complaints about the regulatory system's inefficiency seem to be amenable to solutions short of a major bureaucratic reorganization. In addition, reorganization which did not take account of the areas in which coordination is now good (technical assistance and some money areas) might create as many problems as it would solve. The principal reason for a completely independent

regulatory authority would be if one or more agencies refused to cooperate in efforts to increase efficiency. Under such circumstances, a single agency head who had the authority to demand compliance would be advantageous. At present, however, little evidence indicates that this level of noncooperation exists.

Even so, we present below our assessment of what a centralized regulatory authority probably can and cannot accomplish. If the legislature decides that these payoffs seem worth pursuing, centralizing regulation may be desirable.

We will first outline those goals we think a centralized agency can achieve. Then we will discuss several problematic aspects of the current regulatory system which will still be around after centralization unless they are clearly recognized and steps are taken to deal with them.

WHAT A CENTRALIZED AUTHORITY CAN DO

We think a centralized regulatory agency can achieve the following goals:

- Make both regulatory and coordinating authority equal to regulatory and coordinating responsibility.
- Enable relatively easy development of comprehensive and consistent rules and standards for all human service facilities.
- Enable a consistent orientation and value system (established and enforced by the agency director, if necessary) among regulators of different need areas, so that providers do not find themselves caught in the middle as they are now in the medical versus program model controversy.
- Eliminate duplication of effort.
- Increase knowledge and communication among inspectors about each others' activities, and the structure of the regulatory system in general.
- Provide a centralized location for public andprovider contacts with the regulatory system, including a public information function which develops and distributes manuals, guidelines and itemized procedures which interpret the regulatory system to the public.

Equalizing Authority and Responsibility

At present, no agency involved in regulation has the authority to command coordinated activity from any other regulatory agency. DPW, for instance, was given responsibility for coordinating all secondary inspections (e.g., health and fire inspections) for facilities in which DPW is the primary licenser.[1] The Department did not receive any more authority to make secondary agencies cooperate than it had possessed previous to the legislation. Relevant agencies have begun to meet and discuss these coordination problems, starting with the development of a common language and set of terms. However, much yet remains to be done. As long as the several pieces of the regulatory system remain in separate departments, answerable to different authorities, coordination among them will remain purely voluntary; no one will possess the authority to require recalcitrant units to cooperate. A centralized regulatory agency which includes all state regulatory units currently responsible for standards in any part of the human service delivery system would significantly improve this situation on the state level. All the other goals detailed below depend on consolidation of authority for their achievement.

[1] *Laws, 1976, Chapter 243.*

Comprehensiveness and Consistency

We have documented (in Chapter II) that gaps, duplications and inconsistencies exist in the coverage currently provided by the regulatory system as it now stands. For example, group homes serving troubled youth operate under at least four authorities (DPW Rule 8; LEAA funding; Community Corrections funding; DOC county and state group homes). Each authority has different (or no) requirements; some group homes find themselves subject to more than one authority and are either caught between conflicting demands or left virtually unregulated because neither authority can decide who is really responsible. One group home operator stated his confusion:

> "Somebody should be coming through here! We think there should be standards, and they should be enforced. But we don't even know who it's supposed to be. They should just tell us who we're responsible to."

A centralized agency would have the authority, and therefore the capability, to develop broad rules establishing consistent standards for facilities of a given type, regardless of who funded them or what agency had jurisdiction over the facility's residents. Such broad rules should also eliminate gaps, because a centralized regulatory agency would have authority over all facilities falling under the rule; the quality control function would be separated from planning, funding and recruitment functions, and would be comprehensive.

Orientation and Value System

Presently, the value systems of different regulatory units are in conflict. This is clearly demonstrated by the finding that the number of deficiencies issued to facilities for the mentally retarded by DPW is inversely proportional to the number issued by MDH. As one goes up, the other goes down. Facilities which are medically oriented receive more deficiencies from DPW for failures in the program area and less from MDH for sanitation and medical procedures. Just the reverse happens in facilities which are heavily program or "normalization" oriented. There seems to be no way to resolve this problem given the current authority structure; only a centralized authority can address it.

Duplication of Effort

In the same way that a centralized authority could contribute to comprehensiveness and consistency, such authority could also oversee development and revision of rules and standards to eliminate overlaps. Each section of the regulatory agency would then have responsibility for assuring quality within need areas pertinent to its expertise (sanitation to health; programming to welfare; and so on), and all other sections would accept the report of the section responsible. For example, no longer would three differing sets of inspectors review the same resident records searching for compliance to virtually the same set of requirements, as now happens when DPW, ICF, Title 19 Quality Assurance (and possibly also the Joint Commission on Accreditation of Hospitals) all do essentially equivalent records reviews. Again, only a centralized authority can coordinate which sections shall do what, and successfully insist that other sections take each other's word for the results of an inspection.

Intra-system Knowledge and Communication

Proximity within the same agency, plus a streamlined process of responsibility and intra-system coordination, should increase inspectors' knowledge of each others' responsibilities and performance. In addition, no one would have to check on things in facilities they inspect "just in case the other guy didn't look at them," since the development of consistent rules and efficient divisions of labor would eliminate the doubt which inspires such behavior.

Public Information Function

Obviously, all of the above changes would make the job of helping the public negotiate the regulatory system easier, since the system itself would be easier to understand. In addition, such a centralized agency would be the logical place for the public to go for information, and the logical unit to supply it.

WHAT A CENTRALIZED AGENCY CANNOT DO BY ITSELF

Several problems encountered in our research do not yield immediately to solution by centralization. The most important of these remaining problems are:

- Complications and delays caused by local (not state) requirements and clearances.
- Complications and overlaps caused by federal requirements and clearances.
- Confusion about the extent to which inspectors should also offer technical assistance, and co-ordination with technical assistance units which currently exist in several of the agencies which also house regulatory units.
- Coordination with funding sources, especially where regulations may require things which funders will not pay for.

Local Complications

Local building codes, health, fire and zoning requirements, planning and funding clearances and sign-offs add layers of regulation and delay for providers, little of which is under state control. A centralized state agency could study the plethora of local requirements (which vary greatly depending on which locality one examines) and determine whether the state might want to accept clearance by local authorities as adequate for state licensure. This already happens in some areas (e.g., the Twin Cities plus Olmsted, St. Louis and several other counties for some health inspections; county welfare departments for foster boarding homes and family day care), but the possibilities for extending such arrangements to the regulatory system as a whole have not been systematically studied. Until they are both studied and dealt with, local complications will remain a problem for providers.

Federal Complications

One of the largest sources of grief we encountered involved federal regulations for Title 19 certification, particularly for certification of facilities for the retarded as Intermediate Care Facilities-Mentally Retarded. Federal regulations are duplicative of much Minnesota state regulation. They also entail several layers of review within their own structure, as when a facility is subjected to the initial certification survey, plus bi-monthly Utilization Review checks, plus annual Quality Assurance reviews. At least two things might be possible in dealing with federal complications: 1) a centralized agency could stipulate that some part of the inspections to meet federal requirements be accepted by state authorities as adequate to meet Minnesota requirements (e.g., both DPW and MDH regular surveyors would have to accept Quality Assurance's resident records reviews); 2) a new attempt could be made to convince HEW that it should agree that a facility meeting Minnesota's requirements for licensure would be considered to have met federal requirements. Minnesota did attempt this second suggestion when federal guidelines for Title 19 certification first came out, with no success. However, it may be that HEW now has enough experience both with certification in general and with Minnesota's care system in particular that another approach would be worthwhile.

Technical Assistance and Funding

Both technical assistance and funding/reimbursement impinge on the success of regulation in more or less direct ways. A regulatory agency which takes no notice of its connections to these two functions cannot effectively do its job, since knowledge and money represent the means of meeting regulatory requirements. No easy resolution of the administrative connections among these three functions is possible, and we are not so presumptuous as to propose one. We do feel that such resolution would be made easier were a centralized regulatory agency to be embedded in a reorganized Department of Human Services, although we are not in any position to speak to the advisability of such a Department on any other grounds. A free-standing "Department of Regulation" would need to devote considerable ongoing effort and attention to developing adequate liaison with both technical assistance and funding sections of other agencies.

Finally, we reiterate that the legislature must decide whether the projected benefits of centralizing the regulatory system for human service facilities are worth a major reorganizational effort.

To end with another perspective, we include for your consideration a tally of provider comments when asked how they would revise the regulatory system if given a chance. Table VI-2 presents their (often extremely emphatic) replies.

TABLE VI-2

PROVIDER ANSWERS TO QUESTION:
HOW WOULD YOU REVISE THE STATE'S REGULATORY SYSTEM?

Answers relevant to rules	MR Providers (N=16)	MI Providers (N=16)	State Hospital (N=6)	Other Providers (N=24)	Totals (N=62)
1. Write broad, non-restrictive, flexible rules	6	6	4	1	17
2. Improve inspector qualifications, expertise and professionalism	11	8	3	3	25
3. Provide incentives for developing quality care	5	3	1	3	12
4. Improve consistency of enforcement	4	2	1	2	9
	26	19	9	9	63
Answers relevant to centralization					
5. Provide clear, consistent authority, eliminate buck-passing	8	5	6	2	21
6. Eliminate duplication and waste, streamline regulation	7	6	4	4	21
7. Coordinate all inspections	5	6	4	4	19
	20	17	14	10	59
Other Answers:					
8. Provide stable program funding	4	6	0	2	12
9. Provide more technical assistance	4	1	2	1	8
10. Nothing – everything is fine	0	2	0	5	7
	8	9	2	8	27
TOTALS	54	45	25	27	149

GLOSSARY

ABBREVIATIONS

DEFINITIONS OF FACILITY TYPES

DEFINITIONS OF DEPENDENT POPULATIONS

ABBREVIATIONS

CD = Chemically dependent

DOC = Department of Corrections

DPW = Department of Public Welfare

DVR = Division of Vocational Rehabilitation (in Department of Education)

EHD = Environmental Health Division

HFD = Health Facilities Division

ICF/MR = Intermediate Care Facility/Mentally Retarded (a level of federal certification for Title 19 reimbursement)

MDH = Minnesota Department of Health

MI = Mentally ill

MR = Mentally retarded

SFM = State Fire Marshal's Office

Titles 4-C, 18, 19 and 20 are all titles of the Federal Social Security Act.

Title 4-C = Grants to States for Aid and Services to Needy Families with Children and for Child-Welfare Services — Work Incentive Program.

Title 18 = (Medicare) Health Insurance for the Aged and Disabled.

Title 19 = (Medicaid) Grants to States for Medical Assistance Programs. Community Programs for the retarded can qualify for Title 19 money.

Title 20 = Grants to States for Services — to reduce dependency, abuse and neglect of children and adults, and to prevent unnecessary institutionalization. Community programs for the chemically dependent can qualify for Title 20 money.

DEFINITIONS OF FACILITY TYPES

DEPARTMENT OF CORRECTIONS

HOLDING FACILITIES – Local detention facilities used for detention of persons for not more than 24-hours excluding holidays and weekends.

LOCK-UP FACILITIES – Local facilities used for the confinement of persons for not more than 21 days.

JAILS – Local facilities used for indefinite periods of pre-trial detention and for persons serving sentences for up to a maximum of one year.

ADULT CORRECTION CENTERS (WORKHOUSES) – Local facilities used only for confinement and treatment of adults who are serving sentences of up to one year.

ADULT STATE INSTITUTIONS – State security correctional facilities for adults operated by the Department of Corrections. Facilities include Stillwater State Prison, St. Cloud Reformatory, Shakopee, Willow River and Lino Lakes.

JUVENILE STATE INSTITUTIONS – State security correctional facilities for juveniles operated by the Department of Corrections. Facilities include Sauk Center, Red Wing and Thistledew Camp.

JUVENILE DETENTION CENTERS – Local facilities used only for the temporary detention of juveniles for periods of time specified in Minnesota Statute 260.185.

JUVENILE TREATMENT CENTERS – Local juvenile facilities used only for the extended care and confinement of juveniles committed by the juvenile court.

STATE GROUP HOMES – Group homes are specialized facilities that provide foster care on a 24-hour basis for not less than four nor more than eight delinquent children. A state-operated group home is developed at the request of a state juvenile institution group home coordinator and is supervised by the Department of Corrections district supervisor for that particular region.

COUNTY GROUP HOMES – A county-operated group home (same as above) which operates under the direction of the juvenile court judge and is generally used for placements that serve as alternatives to institutionalization.

ADULT COMMUNITY CORRECTIONS – An insecure residential program operated by either the Department of Corrections or another unit of government to serve as an alternative to institutionalization, either as a diversion from institutionalization at the initial stage or at the re-entry level between institutionalization and release.

JUVENILE COMMUNITY CORRECTIONS – Same as the adult community corrections facilities but they serve juveniles.

MINNESOTA DEPARTMENT OF HEALTH

HOSPITALS – A building, or part thereof, used for the medical, psychiatric, obstetrical or surgical care, on a 24-hour basis, of four or more inpatients.

NURSING HOMES – A licensed facility or unit used to provide care for aged or infirm persons who require nursing care and regulated services in accordance with rules and regulations of the Minnesota State Board of Health.

SKILLED NURSING FACILITY – A nursing home (as defined on previous page) providing continuous nursing services on a 24-hour basis.

INTERMEDIATE CARE FACILITY – A less expensive alternative to skilled nursing homes.

BOARDING CARE HOMES – Licensed facilities or units used to care for aged or infirm persons who require only personal or custodial care and related services. A boarding care home license is required if persons need or receive personal or custodial care only. Nursing services are not required.

OUTPATIENT SURGICAL CENTER – A free standing facility organized for the specific purpose of providing elective outpatient surgery for preexamined, prediagnosed, low risk patients. Admissions limited to procedures which utilize local or general anesthesia and which do not require overnight inpatient care. Not organized to provide regular emergency services and does not include the physician's and dentist's office or clinic for the practice of medicine or the delivery of primary care.

SPECIAL SERVICE FACILITIES – Facilities established to serve particular needs including end stage renal disease services, provide outpatient physical therapy, and supply portable X-ray services. services.

SUPERVISED LIVING FACILITY – A facility to provide residential homelike setting including supervision, lodging and meals, counseling and developmental, habilitative or rehabilitative services to five or more persons who are mentally retarded, chemically dependent, adult mentally ill, or physically handicapped.

DIVISION OF VOCATIONAL REHABILITATION

SHELTERED WORKSHOPS – Facilities where any manufacturing or handiwork is carried on, and which are operated for the primary purpose of providing remunerative employment to severely disabled individuals who, as a result of physical or mental disability, are unable to participate in competitive employment.

WORK ACTIVITY PROGRAM – A program which utilizes manufacturing activities and other production work for the primary purpose of providing basic vocational skills development for the severely handicapped.

DEPARTMENT OF PUBLIC WELFARE

Facilities Regulated by DPW Rules:

Rule 1: Foster Boarding Homes (1-4 children, including family's own), and Group Foster Boarding Homes (5-10 children, including family's own).

Provide homelike residential care for children who cannot remain in their own homes.

Rule 2: Family Day Care Homes (1-4 children, including family's own), and Group Family Day Care Homes (5-10 children, including family's own).

Provide regular homelike care for periods of less than 24 hours a day to small numbers of children.

Rule 3: Group Day Care Centers (6 or more children).

Provide part-time homelike care plus an educational program.

Rule 4: Child-Placing Agencies.

Provide placement and other support services related to foster care, adoptions and in-home support to natural, foster and adoptive parents, for children and families in need.

Rule 5: Child-Caring Institutions (11 or more children).

Provide 24-hour residential care and treatment to children in need, who are usually emotionally disturbed, but may include dependent, neglected, orphaned, retarded and otherwise handicapped children as well.

Rule 6: Maternity Shelters (3 or more unmarried pregnant women).

Residential care, plus help with future plans and child-caring skills.

Rule 8: Group Foster Homes (10 or fewer children).

Residential care in a small community-based setting, providing a homelike atmosphere plus a planned treatment program individually tailored to each resident.

Rule 32: Detoxification Centers.

Provide short-term intensive medical care to inebriate and other drug-dependent persons.

Rule 34: Residential Programs – Mentally Retarded (5 of more MR).

Provide treatment programs on a 24-hour basis for individuals classified as mentally retarded or developmentally disabled, with emphasis on social skill development, behavior shaping activities and recreation programs.

Rule 35: Residential Programs – Chemically Dependent (5 or more CD).

Provide treatment programs on a 24-hour basis in a drug-free environment, designed to produce dependency-free individuals who can lead productive lives.

Rule 36: Residential Programs – Mentally Ill (5 or more MI).

Provide treatment programs on a 24-hour basis for mentally ill or emotionally disturbed individuals, with emphasis on returning patients to independent living arrangements or increasing their ability to function in non-institutional supervised living facilities.

Rule 38: Day Activity Centers for the Mentally Retarded.

Provide part-day (usually 5 hours per weekday) programming for mentally retarded or cerebral palsied individuals, both children and adults, for the purposes of enrichment, growth and training. Individual program plans are required.

Rule 80: Residential Programs – Physically Handicapped (5 or more PH).

Provide residential care on a 24-hour basis (although residents may not spend every hour in the facility), plus treatment and programming fostering growth, rehabilitation, habilitation and increased social and motor skills.

DEFINITIONS OF DEPENDENT POPULATIONS

CHILDREN (when out of their own homes) — The state accepts responsibility for regulating and assuring a minimally acceptable physical and social environment for all children consistently receiving less than 24-hour-a-day care outside their own or a relative's home (i.e., day care and school environments).

NEGLECTED AND DEPENDENT CHILDREN — Neglected child, according to Minnesota Statutes 260.021, Subd. 10, is a child:

(a) Who is abandoned by his parent, guardian, or other custodian; or
(b) Who is without proper parental care because of the faults or habits of his parent, guardian, or other custodian; or
(c) Who is without necessary subsistence, education or other care necessary for his physical or mental health or morals because his parent, guardian, or other custodian neglects or refuses to provide it; or
(d) Who is without the special care made necessary by his physical or mental condition because his parent, guardian, or other custodian neglects or refuses to provide it; or
(e) Whose occupation, behavior, condition, environment or associations are such as to be injurious or dangerous to himself or others; or
(f) Who is living in a facility for foster care which is not licensed as required by law, unless the child is living in the facility under court order; or
(g) Whose parent, guardian, or custodian has made arrangements for his placement in a manner detrimental to the welfare of the child or in violation of law; or
(h) Who comes within the provisions of subdivision 5, /"delinquent"/ but whose conduct results in whole or in part from parental neglect.

A dependent child, according to Minnesota Statues 260.021, Subd. 6, is a child:

(a) Who is without a parent, guardian, or other custodian; or
(b) Who is in need of special care and treatment required by his physical or mental condition and whose parent, guardian or other custodian is unable to provide it; or
(c) Whose parent, guardian, or other custodian for good cause desires to be relieved of his care and custody; or
(d) Who is without proper parental care because of the emotional, mental, or physical disability, or state of immaturity of his parent, guardian, or other custodian.

We also include in this category "status offenders", who are defined as a child:

(a) Who is habitually truant from school; or
(b) Who is uncontrolled by his parent, guardian, or other custodian by reason of being wayward or habitually disobedient; or
(c) Who habitually absents (runs away); or
(d) Who is "promiscuous".

These "offenses" result in adjudication as "delinquent". They constitute the traditional content of the category "status offenders". In concurrence with the National Advisory Commission on Criminal Justice Standards and Goals, appointed in 1971 by the Law Enforcement Assistance Administration of the U.S. Department of Justice and the Minnesota Task Force on Criminal Justice Standards and Goals Report (1975), we will classify such status offenders with neglected and dependent children, rather than with delinquent (criminal) children, as a more appropriate indication of their needs and condition.

CRIMINAL CHILDREN – Any person under the age of 18 years who has violated any state or local law or ordinance (except traffic offenses) which would be crimes if committed by an adult; or who has violated a federal law or a law of another state and whose case has been referred to the juvenile court.

ADULT CRIMINALS – Any person who has been convicted of a crime (misdemeanor or felony).

MENTALLY RETARDED INDIVIDUALS – DPW Rule 34, Section I. F. 10., defines mental retardation as: An individual of any age with "sub-average general intellectual functioning that originates during the developmental period and is associated with impairment in adaptive behavior".

MENTALLY ILL (and/or behaviorally disabled) INDIVIDUALS – DPW Rule 36, Section (b) (7), defines a mentally ill and/or behaviorally disabled person as:

"A person who shows an inability to interpret his surroundings in a realistic way that would lend itself to adequate coping with his life situation."

Additionally, DPW Rule 5 defines an "emotionally handicapped child" as:

". . . A child who is in the judgment of a professional social worker, psychologist, or psychiatrist is exhibiting those symptoms and behavior patterns that are determined to be of such nature that the child needs the care and treatment given in . . ." a child-caring institution.

(Note the circularity of this definition. To be in the institution, the child needs to be judged "emotionally handicapped". But, by definition, an "emotionally handicapped child" is one who needs to be in the institution.)

CHEMICALLY DEPENDENT INDIVIDUALS – DPW Rule 35, Section (b) (4), defines a drug-dependent person as: "Any inebriate person or any person incapable of managing himself or his affairs or unable to function physically or mentally in an effective manner because of the use of a psychological or physiological dependency inducing drug including alcohol".

An inebriate person, according to Rule 35, Section (b) (5), is: "Any person incapable of managing himself or his affairs by reason of habitual and excessive use of intoxicating liquors, narcotics or other drugs".

PHYSICALLY HANDICAPPED INDIVIDUALS – DPW Rule 80, Section (b) (1), defines physically handicapped as: " 'Physically handicapped' encompasses those orthopedic, incoordinative, sight, and hearing disabilities that culminate in the significant reduction of mobility, flexibility, coordination, or perceptiveness and that, singly or in combination, interfere with the individual's ability to live and function independently; that are not the result of the normal aging process; and that are considered chronic conditions".

PHYSICALLY ILL INDIVIDUALS – For purposes of this study we will define this population as including all individuals whose medical doctor considers their physical condition serious enough to warrant temporary or permanent placement in a hospital or nursing facility.

ELDERLY INFIRM INDIVIDUALS (including senility) – For purposes of this study, we will define an "elderly infirm individual" as: Persons 65 years of age or older, whose physical or mental impairments are such as to inhibit their ability to function independently, and/or who require medical or nursing supervision.

ELDERLY – For purposes of this study, we will define "elderly" as: Persons 65 years of age or older, with no physical or mental impairments, or only such impairments as do not inhibit their ability to function independently, and who do not require medical or nursing supervision.

(This population is included in our list because such people frequently end up in state licensed facilities such as boarding care or nursing homes – although they do not personally require the level of care these facilities provide – because they have no place else to go, or because such care is reimbursable while independent living is not.)

PREGNANT WOMEN – This category is included because DPW has a rule (Rule 6) for licensing maternity shelters, which are defined as "any home or institution that provides residential care for three or more pregnant women". One such home is currently licensed in Minnesota.

LIST OF STAFF PAPERS

AGENCY RESPONSES

Comments from the Department of Corrections and the Department of Health are in response to the final draft copy. The reactions of the Department of Public Welfare and the State Fire Marshal are based on an earlier draft version. References to page numbers in these responses may not correspond to pages in this report due to printing revisions.

STATE OF MINNESOTA
DEPARTMENT OF CORRECTIONS
SUITE 430 METRO SQUARE BLDG. • 7th & ROBERT STREETS • ST. PAUL, MINN. 55101

OFFICE OF THE
COMMISSIONER

612-296-3565

March 24, 1977

Bruce Spitz
Deputy Legislative Auditor
Program Evaluation
Legislative Audit Commission
Veterans Service Building
St. Paul, Minnesota 55155

Dear Mr. Spitz:

Thank you for the final copy of the Legislative Audit Commission's Report on Regulation and Control of Human Services Facilities.

We have carefully reviewed this final version, and revised the comments we wish to have included. We appreciate your attention to the comments made earlier by our Department on the rough draft report, and the clarifications and changes in recommendations which were incorporated in the final report.

If you have any questions regarding the enclosed comments, please contact the Administrative Services Division of the Department of Corrections.

Sincerely,

Kenneth F. Schoen
Commissioner

KFS:LM:lka
Enclosure

The Department of Corrections is in substantial agreement with the recommendations contained in this report. Based on initial comments made by the Department of Corrections in response to the rough draft of this report, several inaccuracies or gaps in information presented on Department of Corrections regulation activities were corrected by the authors. The following comments, which follow the structure of report chapters, indicate several remaining areas of concern about or disagreement with material presented in the report.

Introduction

Recognizing the wide range of clients and types of human service facilities in the state, the attention which could be focused on correctional facilities and regulation activities in this research was necessarily limited. Since data related to Department of Corrections regulation activities was collected from only six field supervisors/inspection and enforcement personnel and only eleven correctional facilities, the Department believes that conclusions which can be made from this limited sample should be considered as tentative.

Coverage; Department Regulatory Operations

The report accurately identifies some of the major areas of overlapping responsibility for the licensing of treatment programs for correctional clients placed in non-secure residential programs. The Department of Corrections is aware of and concerned about the ambiguity of its scope of authority over non-secure residential programs. Because of this, the Department recently requested an opinion of the Attorney General to delineate the responsibility of the Department regarding licensing of "all correctional facilities." Clarification of the existing legislation will be requested.

In the meantime, the Department is progressing with standards for facilities clearly identified by statute as subject to Department of Corrections regulatory authority. As noted in the report, this includes rules for local jails, lockups, and detention facilities. In addition, work is in various stages of completion on the drafting of standards for correctional non-secure residential facilities and local juvenile detention and treatment facilities. The necessity for coordinating such standards with other state agencies, particularly the Department of Public Welfare, is fully recognized and is being pursued.

Currently the standards drawn up by the Department of Corrections, with the assistance of an intergovernmental task force for local jails, detention facilities and lockups, are being applied as criteria for the approval or disapproval of plans for correctional facilities. These standards are being promulgated through the Office of the Hearing Examiner.

It may be noted that the Department requested three new positions for the Inspection and Enforcement Unit in its current budget to carry out the recommendations of the report. The Governor's budget as submitted to the Legislature requests two such positions.

Improving System Effectiveness

The Department of Corrections has several concerns about development of a centralized regulatory agency in addition to the implications already noted in the report.

1) The functions carried out by correctional facilities at the local level are vitally interrelated with the entire correctional process. Our goal is to develop greater integration of planning, delivery of services, monitoring and evaluation between the state and local levels. To remove regulation and inspection from the Department of Corrections may work to interrupt this process, not enhance it.

2) The ability to establish professionally qualified and experienced corrections personnel as inspectors in any agency separate from corrections is doubtful.

As a final note, it should be pointed out that the Department of Corrections (and undoubtedly other agencies) is faced with a mounting problem of the cost factor in the promulgation of standards under the Administrative Procedures Act. While it is desirable for the state to have regulatory powers in certain areas, the drafting of standards and the subsequent promulgation process are both time-consuming and costly. This may be a matter which requires further attention by the Legislature.

LM:lka
3/24/77

STATE OF MINNESOTA

DEPARTMENT HEALTH

Office Memorandum

TO : Bruce Spitz
Deputy Legislative Auditor for
Program Evaluation

DATE: March 28, 1977

FROM : Warren R. Lawson, M.D. WRL/GCA
Commissioner of Health

PHONE: 5460

SUBJECT: Final Report: Regulation and Control of
Human Service Facilities

We appreciate the opportunity to review the final report. It reflects consideration of many of the issues we raised in our initial written comments. However, some issues have been raised in the final report which were not discussed in our earlier comments. For that reason, we are submitting revised comments for inclusion in the final bound report.

Thank you.

Enclosure
cc: Ms. Brodahl

P. I-1

Coverage/Impact/Efficiency/Cost

Although these are issues which are of great importance to the Legislature, one difficult issue which the report admittedly does not address - the quality assurance effect of regulation - is as important, if not more important.

P. I-2,3

Data Sources

The rationale given for the selection of two, very narrow, areas of human services regulation as the focus of the report does not indicate that they are in no way typical of health facility regulation as performed by the Minnesota Department of Health (MDH). The MR and MI areas of human services regulation represent the smallest segment of facilities and programs regulated by MDH. The rationale for this "narrow focus" would appear to be its virtual exclusivity for coregulation by both MDH and the Department of Public Welfare (DPW). It seems inappropriate to examine these areas for problems and then to extend and extrapolate those recommendations for changes to all other segments of human services regulation. Any conclusions or recommendations based upon perceived inadequacies in the regulation of MI and MR Services should be confined to those segments of activity and in fact may not be appropriate for other health facilities.

There is a failure to recognize the fact that Boarding Care Homes (of which MDH is the primary regulator) can qualify for DPW program licensure under Rules 34 and 36. Further, it is not at all clear as to who is the primary regulator in the Supervised Living Facility field: it would be more accurate to state that MDH and DPW coregulate such facilities.

Finally, assuming all the facilities to which reference is made in this report are human services facilities, it must be recognized that there are differences in the type and scope of services delivered in different kinds of facilities. For example, hospitals may provide from 8 to 25 or more distinctly separate services which are vastly more complex than the services offered to MR and MI SLF residents. Such differences may account for variances in cost, efficiency and other factors of interest to the Legislature.

P. I-4

Agency Records

It appears unrealistic to use MI and MR facility records as indicators for purposes of determining delays in regulatory procedures. These facilities only entered the certification program in 1975. Prior to that date, they were not required to meet

the licensure and stringent Federal certification regulations already experienced by other health facilities. Thus the delays resulted from the MR and MI facilities inability to quickly and easily meet needs for corrections.

P. I-5 — Final Integrating Questions

These are, indeed, significant questions; however, the application of answers discovered by examining two particular kinds of human services facilities to the broad range of human services and health facilities suggest some caution in approach.

Chapter II: Coverage

P. II-2 — Table II-1

This table is not completely accurate. For example: facilities which provide CD programs are certifiable as ICF's, if they wish to be eligible for Title XIX funds.

P. II-3 — Federal-State Duplication

Exactly what is being duplicated is not entirely clear. Are standards duplicative? Or is there duplication of activity, i.e., multiple inspections for compliance with different standards? There may be a reason, valid or invalid, for such different standards.

JCAH accreditation (which relates principally to hospitals, not a focus of this report) is no responsibility of the state's; hospitals seek it out themselves; it is approval by a provider-controlled private entity.

Is the point which is being made that coordination of inspection and record-keeping requirements is necessary? This is very desirable, but it should be pointed out that separate Federal survey requirements will still remain separate; they cannot be unilaterally altered by the state. Furthermore, state law regarding unannounced survey visits makes coordination of inspection activities problematic at present. Finally, it should be pointed out that there are presently no proprietory hospitals in Minnesota.

P. II-5 — Local Layers

This information is somewhat misleading, because no local life safety code surveys are acceptable under the Title XIX requirements for certification (most

MR facilities are certified); the State Fire Marshal has this function.

The reference to MDH environmental health inspections has no bearing on the issues here because such inspections relate to Boarding and Lodging establishments, which are not health care human services facilities. I believe the state inspections related to food services.

P. II-6 — Recommendation II-4

This recommendation contradicts later language in the report endorsing state-level control. In any case, delegation of regulatory authorities has been historically unsuccessful. Staff recruitment, the desired uniformity of inspection approach which is so stressed in this report, etc., suffer.

P. II-7 — Money Gaps

There is no attempt here to assess if, prescinding from the question of whether regulation per se requires huge monetary outlays, any, some, or all of the regulations may not be necessary from a public health, safety or welfare standpoint.

P. II-8 — Recommendation II-7

This recommendation reflects precisely what is current MDH practice.

P. II-9 — Health Gaps

The example shown here is not a regulatory shortfall; rather, it shows an attempt at interagency coordination. Further, an implication here appears to be in error. Boarding and Lodging facilities cannot be certified for Title XIX participation because they are not health facilities; hence any rule 35 or 36 facility which wants to be federally reimbursed must be initially licensed as a health facility (i.e., SLF or higher).

Chapter III: Impact of Regulation

P. III-4 — The Drop-Out Rate

Not all MI and MR facilities contact DPW first. They may contact MDH initially. MDH has developed a form to notify DPW of a request for licensing and a descriptive form specifying for the provider the entire procedure for licensure and certification.

P. III-8 — Medical Services and Type of Resident

Why does the 3 to 1 differential necessarily indicate a difference in population served? Could there not be a failure to accurately assess need for medical services in either area?

P III-10 — Agency Records of Deficiencies

What are the parameters for "good" and "poor" facilities which are being used here?

Inspector Inconsistency

It would be helpful to see the supporting evidence for these statements.

Philosophy-Medical vs. Program

The ICF-MR regulations (which are Federal) are medically oriented. It is not surprising that DPW, which is less familiar with the medical model, would have some difficulty in perceiving deficiencies. Subsequent to the MDH surveys, the providers submitted written plans of correction thus acknowledging that the deficiencies did indeed exist. No appeals of the agency correction orders were taken.

P. III-12 — Regulation and Small Group Homes

Might there not be reasons (health, safety, well-being) which restrict small home entry into the field?

P. III-14 — Recommendation III-2

This is essentially what is being done presently by the Health Department in the revision of its existing rules.

P. III-16 — Recommendation III-5

This conflicts with earlier recommendation II-4. In any case, the recommended situation already obtains with respect to health facilities.

Chapter IV: Costs

PP. IV 1-3 — Regulatory Cost to Agencies

The meaning of these figures is difficult to determine. Nowhere is there addressed the comparability of such data, vis., whether "apples" and "oranges" are being contrasted, whether there are reasons for the variances, etc. to.

PP. IV 4-7 — Regulatory Cost to Facilities

There is little evidence here to substantiate the allocation of cost solely to efforts to comply with regulation; presumably it is available elsewhere. Furthermore, the applicability of such evidence to other types of human services providers must be examined.

Chapter V: State Department Regulatory Operations

P. V-2

Coordination with Other Agencies

These statements are not accurate. DPW issues provisional program licenses to "new" facilities even before such a facility is actually built. MDH must make on-site visits for licensing and certification purposes; hence, it takes longer for MDH to issue a license. In addition, there may not yet be a "facility" or premises to inspect. The program license can be issued on the basis of a program plan; an SLF license or ICF-MR certification must be performed in a facility ready to operate. It is thus misleading to imply that MDH delays the issuance of a program license by DPW. When the visit by MDH has been completed, orders to correct licensure violations and to submit plans of correction for certification deficiencies are issued immediately to the facility, with a copy being forwarded to DPW's Medical Assistance Division. Letters authorizing the operation of the facility are also sent to both the facility and the DPW Medical Assistance Division. The problem appears to be internal to DPW, whereby the DPW Licensing Division is not contacting the Medical Assistance Division to receive the information which it desires or requires.

DPW is not always the first agency contacted by the provider. If MDH is initially contacted, DPW is notified on a MDH form specifically developed for the purpose.

Recommendation V-2

This recommendation does not incorporate the essentials of administrative law and the requirements of the Minnesota Administrative Procedures Act.

P. V-6

Recommendation V-6

The action recommended would create a rule, under the APA, and not a policy.

Chapter VI: Improving System Effectiveness

PP. VI-2-4

Rule Stringency

There is a failure here to differentiate between increased requirements which are federal in origin (e.g., ICF-MR regulations) and increased requirements which are reflected in state rules. There is no evidence presented here to the effect that increased state requirements force existing facilities into non-compliance and present them with substantial and expensive alterations. It is most often the case that an upgrading of state requirements allows for a certain

amount of "grandfathering" and/or permits significant periods of time for facilities to come into compliance with new standards.

PP. VI-4-6 — Relevance

Rules should not obstruct desirable (from a public policy perspective) innovation. Of course, not all innovations are initially or ultimately desirable. "Broad" rules, so-called, have disadvantages. One is the likelihood that a broad rule will mean one thing to the regulated industry and another to the regulator, creating unnecessary confusion, possible unfairness, and an inability to enforce valid standards. Further, rules which are too broad can be struck down as being so vague as to be "unreasonable" under the Administrative Procedures Act.

P. VI-7 — Table VI-1

Footnote #2 should read "10" teams of 3-5 people, rather than "12," bringing annual average of facilities per team from 74 to 88.

P. VI-9 — Recommendation VI-1

Broad rules with specific, uniform interpretations would cause difficulties under the APA. These specific, uniform interpretations would very arguably constitute "rules" under that statute, and would have to go through the administrative process.

P. VI-10-12 — Inspector/Licenser Expertise

The comments here about MDH inspectors are anecdotal and subjective. We have been unable to substantiate the anecdote. It is not surprising that a provider might state that a surveyor is not "reasonable" when it is in non-compliance with a regulation. However, standards are intended and developed for purposes of consumer protection and the MDH surveyor must evaluate in accordance with these standards. Where is the supporting evidence? What are the report's parameters for making determinations of "reasonableness?"

PP. VI-15-17 — Inputs, Processes and Outcomes

Is there a failure here to differentiate between outputs and outcomes?

PP. VI-18 — Grades or Classes of Licensure

An approach to classification is being contemplated with respect to health facilities. Rather than grading facilities, however, the focus would be on identifying in rule a basic "bundle" of requirements which all such facilities must have; beyond these basic capabilities other facility services of a higher than minimal level would be separately licensed. For example, in hospital licensure it is contemplated that all hospitals offer a basic emergency medical service.

Requirements for that service would be contained in the basic facility licensure rules. For more specialized services, such as dentistry or burn units, a special, supplemental license would be issued.

P. VI-19 — Rewards for Excellence - Financial
From what source will these funds derive?

P. VI-19 — Rewards for Excellence - Status
This approach has not worked vis-a-vis JCAH accreditation and hospitals. Consumers have not made choices relating to accreditation.

P. VI-22 and P. VI-27 — Item 3
MDH has at present a technical consultation and training section which provides both staff education programs and provider assistance. The majority of workshops for providers of MR services, County Welfare Departments, Mental Health Clinics and professional associations representing the MR consumers have been initiated and presented by TC&T and the Survey and Compliance Staff of MDH with invitations to attend extended to DPW and TAP staff. TC&T staff respond to referrals from TAP staff and effect the actual consultation relating to licensure and certification.

P. VI-25 — Orientation and Value System
Whether this is a problem depends upon how one views the validity of the frankly differing standards being applied. If all such standards are valid, then the fact that as compliance with one set goes down, compliance with another set goes up should not control. It may merely be indicative of the exclusively "program" or "medical" orientation of the provider exhibiting itself in deficiencies in the area ("medical" or "program") with which the provider is least familiar. If the standards are not valid, then the rulemaking and contested case processes should be revealing them as such. Merely placing enforcement programs with differing goals, criteria and responsibilities in a centralized authority does not change the validity of these differing goals, criteria or responsibilities.

ADMIN 1000

STATE OF MINNESOTA

DEPARTMENT of Public Safety

Office Memorandum

TO : Wes Werner
State Fire Marshal

DATE: February 01, 1977

FROM : Michael F. Reber
Assistant State Fire Marshal

PHONE: 296-7641

SUBJECT: Legislative Audit Commission report on Human Service Facilities of January 18, 1977.

The conclusions drawn in this report are basically the same as those that were described in the final report of the Human Services Task Force which are the establishing of a "centralized regulatory agency" which would include all regulatory functions such as fire and life safety, health, welfare and corrections.

One special point of interest to this writer is the recommendation VI-26 on page VI-22 of this report which states "Place a centralized regulatory agency within a larger department devoted to the coordination of all human services." This recommendation is the explanation for the request for Department of Public Welfare authority as noted on pages V-2, V-3, and VI-17. It appears that the Legislative Audit Commission feels that Department of Public Welfare would be the larger department as specified in the recommendation.

As for the paragraph relating to the expansion of Department of Public Welfare's authority to command other state agencies, I feel that the State Fire Marshal's Office has always cooperated to the fullest degree possible within its manpower and funding limitations. I cite you a meeting on February 9, 1976, relating to fire/life safety inspections in daycare centers where State and local fire officials met with the Department of Public Welfare to resolve any conflicts in that specific category (which is a Human Service type facility) and the conclusions on the regulations to be used that day were accepted by all present at the meeting. The Department of Public Welfare stated they would retype the fire safety regulations (Life Safety Code #101); then there would be one final meeting before they would be implemented. To this date, one year later, no second meeting has been held on this specific category of a human service facility.

This writer takes note of the fact that Department of Public Welfare, in just recent months, is attempting to work out a single "terminology" between their rules and Life Safety Code 101 regulations, Building Code, etc.

In conclusion I feel that the State Fire Marshal's Office has always been more than willing to work out problems such as those stated in the Audit Commission report, and to state that the Department of Public Welfare needs "authority to command cooperation" is unwarranted.

MRF:jh

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55101

February 4, 1977

Mr. Bruce Spitz
Deputy Legislative Auditor
Legislative Audit Commission
Veteran's Service Building
St. Paul, Minnesota 55155

Dear Mr. Spitz:

The Department of Public Welfare has looked forward with interest to the completion of your program audit of state regulatory activities. Your draft report of January 18 reflects a thorough, comprehensive, and positive review of regulative activity. We do support the thrust of your recommendations for departmental and legislative action.

Specifically, we agree that rules should be generic whenever possible. However, our experience strongly indicates that generic rules which inherently rely on unavailable or unrealistic measurement processes create serious enforcement problems. Therefore, we urge that implementation of this recommendation weigh the potential impact of unenforceability of generic rules against the stated disadvantages of specific input rules.

The Department has supported and continues to support further coordination of all regulatory activity of state agencies, whether through a single centralized agency as your report recommends, or through another mechanism.

Your recommendation that funding available for program operation be proportional to quality desired is extremely important. There must be an increased awareness that an expectation of increased standards of quality without a consideration of costs potentially incurred in compliance, results not in improved care but in non-compliance or closing on the part of facilities.

Finally, the Department shares your concern for the professional ability of licensing personnel. These staff persons are at the critical point of enforcement, and personnel practices must support the appointment and retention of highly qualified personnel.

More detailed responses to your draft report will be found in Barbara Kaufman's memo of 1/13/77 to Martha Burt of your staff.

We look forward to close cooperation with your office during the current legislative session in pursuing implementation of these recommendations.

Sincerely,

Vera J. Likins
Commissioner

ADMIN 1000

STATE OF MINNESOTA

DEPARTMENT of Public Welfare

Office Memorandum

TO : Marty Burt
Legislative Audit

DATE: January 13, 1977

FROM : Barbara Kaufman
DPW Licensing

PHONE: 612/296-2539

SUBJECT: Chapter 6 - Report on Regulation

I have read your chapter "with great interest" and I've shared it with other Licensing staff, as well as Mike Weber. I sort of concur generally with your findings, but have problems with some of the specific recommendations.

Generic vs. Specific Licensing Regulations

Not all regs should be specific. Right! Outcome regs are better than input regs. Right again!! But I think you're underestimating the difficulty of writing outcome regulations. Especially in staff ratios, my experience has been that words like "adequate and appropriate" are not enforceable.

When writing regulations about programming, I agree too much specificity can be the kiss of death to any innovation. But I am comfortable with requiring an individualized program plan and mandating the areas to be covered by evaluation and assessments.

If you're relying on "guidelines" for specificity, you end up running into trouble with the Administrative Procedures Act. Any state policy must be in rule and regulation form when it affects other agencies or the public. So guidelines would have to be rules, and then you have, in effect, two separate rules for the same thing.

I think a waiver clause in each rule can do the same thing without so complicated a system.

Qualifications of Licensing Staff

I certainly agree that program experience is a major qualification for licensing staff. It's one of the things I look for first. But, at present, we're looking at entry level jobs (and they almost must be) with a salary structure too low to attract many "really" experienced program people -- expecially administrators. (At the present, I have four out of 11 such people on the day care staff, and three out of nine on the residential staff.)

Your suggested deployment of staff according to their particular expertise would mean an increase in staff for sure. We are doing some of that now, particularly in MR.

Broad Rules vs. Individual Program Rules

I support this completely. In day care we've had one rule for a long time covering all kinds of day care programs for children. I'd really like to have one residential rule with, perhaps, amendments for specific disability needs. But there has been great opposition from program people and advocacy groups on this issue.

"A", "B", "C" Licenses

This has been tried actually, though not in Minnesota. The results were not encouraging, as I recall. Basically, in issuing graded licenses, you're really trying to combine other functions with licensing. Remember licensing is the evaluation of programs according to a promulgated set of minimum standards. Meeting these standards permits one to operate. It doesn't guarantee funding, etc.

Corrections Group Homes

Your recommendation will not solve the problem without a change in law. The big issue is the ability of local corrections people to set up, approve, etc. local group homes which then can be used by anyone.

Your statement about "No more coordination exists....than prior to the legislation." is not accurate. There is a task force on coordination meeting. It has begun work on the common taxonomy and a single information-entry point.

If you're going to recommend including all regulators in a single regulatory "agency", then please include the Building Code too.

Thanks for the chance to comment.

EW/afgg

cc: Dave Van Wyk, Residential Licensing
Cheryl Nyhus, Nonresidential Licensing
Michael W. Weber, Assistant Commissioner, Community Services

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