# DEINSTITUTIONALIZATION OF MENTALLY RETARDED PEOPLE

Program Evaluation Division
Office of the Legislative Auditor
State of Minnesota

# Program Evaluation Division

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February 1986

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STATE OF MINNESOTA
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JAMES R. NOBLES, LEGISLATIVE AUDITOR

February 11, 1986

Senator Randolph W. Peterson, Chairman
Legislative Audit Commission

Dear Senator Peterson:

In June 1985, the Legislative Audit Commission directed the Program Evaluation Division to study the deinstitutionalization of mentally ill and mentally retarded people from state hospitals to community programs.

We are issuing two reports from this study. This report examines how state hospital programs for mentally retarded people have changed as a result of litigation and other forces. The other report examines the transition of mentally ill people from state hospitals to community care.

We received considerable help from the staff of the Department of Human Services, particularly from staff at the state hospitals. We also appreciate the assistance provided by county social service directors throughout the state.

This report was written by Allan Baumgarten (Project Manager) and Kathleen M. Vanderwall, with assistance from Deborah N. Fine and Susan T. Job.

Sincerely yours,

James R. Nobles
Legislative Auditor

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Deputy Legislative Auditor
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# EXECUTIVE SUMMARY

In the past 25 years, several forces have changed Minnesota's state hospital programs for mentally retarded people. As in many other states, litigation has been one of the most important forces. In 1972, parents of Minnesota state hospital residents successfully challenged the programs and care provided at the hospitals in a federal court suit.

The case, now known as *Welsch v. Levine*, has continued to this day. In 1980, the parties ended one phase of the case by agreeing to a consent decree. The state agreed to make program and staffing changes at the state hospitals and to reduce the number of mentally retarded residents from 2,710 to 1,850 by 1987. The decree will expire on July 1, 1987 if the state is in substantial compliance with its terms at that time.

In June 1985, the Legislative Audit Commission directed the Program Evaluation Division to evaluate the deinstitutionalization of mentally retarded and mentally ill people from Minnesota's state hospitals. In our study of programs for mentally retarded people, we asked:

- How have state hospital programs for mentally retarded persons changed since 1980?
- Has compliance with the consent decree resulted in increased spending for staff and buildings at state hospitals?
- How well have the state hospitals and the Department of Human Services complied with the consent decree? Are they likely to be substantially in compliance in 1987?
- Has the department been successful in using its new program of home- and community-based services to reduce state hospital populations and to expand the variety of services available?

## A. CHANGES IN STATE HOSPITALS

### 1. POPULATION

The population of mentally retarded persons in state hospitals peaked at about 5,800 in 1963. It then began a sharp decline five years before the *Welsch* case was filed in 1972. This decline was due to several factors, including the growing availability of community residential and educational programs for mentally retarded persons.

The population reduction requirement in the consent decree was not onerous, since it merely required the hospitals to continue the steady reduction that began in the 1960s. We found that:

- The Department of Human Services has met or exceeded its population reduction targets every year since 1981.
- The department is likely to meet the consent decree's 1987 population reduction deadline with little difficulty.

Nearly half of the residents who were discharged moved to community facilities funded through the Medical Assistance program. These are known as Intermediate Care Facilities for Mentally Retarded people, or ICFs-MR. In 1983, the Legislature decided that the state had enough ICFs-MR, and it imposed a moratorium on development of new facilities. We found no evidence that this moratorium has adversely affected compliance with the population reduction requirements of the decree.

However, the Department of Human Services has failed to comply with an important provision of the moratorium. In 1983, the Legislature also directed the department to begin reducing the total number of state hospital and community ICF-MR beds to 7,500 by July 1, 1983, and to 7,000 by July 1, 1986. We found:

- The department licensed new community facilities during 1985, even though the total number of beds exceeded 7,500. It is very unlikely that the number of beds will be reduced to 7,000 by July 1986.

### 2. STAFF

Throughout the *Welsch* case, the court has emphasized the importance of adequate staff to provide residents with a safe and humane living environment and an adequate program of habilitation. The consent decree sets standards of staff-to-resident ratios for direct care staff and supervisors and support staff. We found:

- The hospitals have generally been in compliance with the staff-to-resident ratios for direct care staff since 1983.

However, five hospitals have not reached compliance with requirements for day program supervisory and professional staff. Furthermore, the hospitals have not been able to hire and retain enough physical therapists to meet the consent decree's requirements.

### 3. EXPENDITURES

State hospital expenditures have increased sharply in the past ten years. We found that:

- After adjusting for inflation, expenditures *per resident day* for mental retardation programs increased 115 percent between 1975 and 1985.

By comparison, expenditures for mental illness programs increased 60 percent, and spending for chemical dependency programs increased by 38 percent. Most of the increase for mental retardation programs is due to the cost of maintaining staff levels required by federal standards and by the consent decree. Mental retardation programs are more staff intensive than those for other disabilities.

### 4. BUILDINGS

Between 1976 and 1985, the Department of Human Services spent about $41.9 million for building improvements and renovation at state hospitals. We calculated that nearly half of the money spent for improvements was for general maintenance (road, parking lot, and roof repairs) and equipment for service buildings.

In the past ten years, the state has renovated state hospital buildings so they would meet safety codes, to make them more homelike, and to provide more private space for individuals. Some of these improvements were required because of the *Welsch* case. However, we found:

- Compliance with the physical improvements required in the consent decree has not been expensive for the state. Only $1.4 million was spent for building improvements required by *Welsch*.

Most of the improvements made to buildings housing mental retardation programs, were needed to comply with federal regulations. Since state hospital mental retardation programs are almost completely funded by Medical Assistance, the buildings must meet federal standards to ensure continued federal funding. The hospitals have not completed all the improvements required in the consent decree, such as installing carpeting in resident living areas.

## B. COMPLIANCE ISSUES

While we found that the department has generally complied with most of the consent decree's provisions, there are three areas where the department and the hospital need to make significant improvements.

### 1. CHILDREN

The consent decree permits state hospitals to admit mentally retarded persons, including children, only if no appropriate community placement is available. Furthermore, if a child is admitted, the responsible county must develop an appropriate community placement so that the child's hospital stay does not exceed one year.

Since September 1980, at least 340 children have been admitted to state hospitals. This includes children admitted to the Minnesota Learning Center at Brainerd and children admitted for respite care. We found that:

- Of the children who were eventually discharged, 55 stayed beyond the one-year limit. As of November 1985, 16 children were in state hospitals beyond the one-year limit.

In the past, the department has not encouraged counties to plan for community placements at an early point in a child's stay. Nor has the department required counties to develop community placements for children who have passed the one-year limit. In the past few months, the department has begun to exercise the leadership needed to solve this problem. We recommend:

- The Department of Human Services and the hospitals should strictly limit the admission and length of hospital stay for children. Furthermore, they should monitor county efforts to develop community services from the day of admission and should work closely with counties which are unable or unwilling to develop services.

### 2. TREATMENT

The consent decree requires the hospitals to develop and implement individual training plans and programs for each state hospital resident. In 1984, the department organized program reviews at three hospitals. These reviews identified a number of problems, including:

- Staff lacked training and the individual programs which they developed were not adequate to teach skills to residents and solve their behavior problems, and

- Staff lacked data which would allow them to evaluate programs and determine what changes were needed.

The decree also limits the extent to which hospitals can use restraint, seclusion, or major tranquilizers to control or change residents' behavior. We found:

- Several of the hospitals have made consistent progress in limiting their use of restraint, seclusion, and major tranquilizers. However, some have recently increased their use of restraint and seclusion. At some hospitals, the average dosage and the proportion of residents receiving major tranquilizers are still quite high.

We recommend:

- The Department of Human Services should complete program reviews at the other four hospitals and should use those reviews to improve individual program plans and staff training.

- The Department of Human Services should complete the process of adopting statewide protocols for limiting the use of drugs and restraint.

### 3. APPROPRIATENESS OF COMMUNITY PLACEMENT

The consent decree requires that state hospital residents be discharged to community placements which provide *appropriate* residential and day program services. The decree does not establish a clear standard for appropriateness of placement, and this issue has emerged as a major point of conflict between the plaintiffs and the state. In allegations involving at least 35 residents of 17 group homes, the plaintiffs have questioned the ability of those homes to prepare and implement adequate individual program plans. In these cases, however, the plaintiffs have gone beyond individual cases and have raised *system-wide* questions about the performance of state and county agencies in licensing and monitoring community programs.

The appropriateness of a community placement is considered when hospital and county staff begin to plan an individual's discharge. We found:

- The Department of Human Services has been slow to establish discharge procedures which would require county and state hospital staff to consider the quality and appropriateness of community placements.

Even now, the department's standards do not establish operational criteria for concluding that a placement is appropriate. While these issues have not been formally resolved by the federal court, it seems clear that the department has not paid adequate attention to the quality of community placements and has not instituted procedures for evaluating the appropriateness of community placements before and after discharge. We recommend:

- The department should specify standards by which counties will review the appropriateness of community placements before and after discharge. It should also adopt discharge procedures which forbid placement of state hospital residents in community programs which lack the staff to develop and implement individual programs that are appropriate to residents' needs.

## C. POLICY ISSUES

We conclude that the state hospitals and the Department of Human Services have generally complied with key requirements of the consent decree. We believe that the consent decree will expire on schedule, on July 1, 1987, if the Department of Human Services and the hospitals commit themselves to solving the problems we have identified. The Legislature, the department, and the hospitals need to prepare for the "post-*Welsch* era" and to analyze what will change when the case is ended. They should address three issues:

First, the consent decree limits hospital stays only for children admitted after September 15, 1980. However, there are more than 60 children currently in state hospitals who were admitted *before* September 1980. Since the state has agreed that its hospitals are not appropriate long-term settings for children admitted after September 1980, there is no reason to continue treating children admitted before then differently.

Second, the staff-to-resident ratios for the hospitals required by the decree may no longer be adequate, and should be reexamined. As hospital populations have declined, residents who are severely handicapped and require more staff attention make up a larger proportion of the population.

Third, the consent decree has made a difference partly because it exposed the hospitals to intense, outside scrutiny. People and organizations behave differently when they know they are being watched. The Legislature should consider continuing outside monitoring of the state hospitals *and* community facilities. This is needed to ensure that the hospitals do not retreat from the progress they have made and to point out areas where improvements are needed. It is equally important to impose some outside scrutiny on community services because of the growing number of mentally retarded people in community settings dispersed across the state.

## D. MEDICAL ASSISTANCE WAIVER

In 1984, the Department of Human Services received permission to use Medical Assistance funds to pay for certain home- and community-based services for mentally retarded persons. This program, which is commonly referred to as the "waiver," was intended to help reduce the population of state hospitals and to provide services that meet individuals' needs.

Based on a survey of county and state staff, we found that almost 400 persons were receiving waiver services in December 1985. About one-third, mostly children, were receiving supportive services in their family homes. The rest were in *supported living arrangements*, including family foster homes, supervised apartments, and group homes. We found:

- Twelve group homes have been developed as waiver services.

We think that these new group homes violate the Legislature's intent in imposing a moratorium on the development of ICFs-MR. They are also inconsistent with the waiver's goal of providing services that are smaller, less restrictive, and less expensive *alternatives* to ICFs-MR.

We found that the group homes were more expensive than foster arrangements or supervised apartments. For example, the average daily rate for residential services in group homes was $47.24, compared to $28.24 for foster homes. These rates do not include room and board, which are usually paid for by foster care grants or other public assistance.

We also found that:

- ICF-MR providers dominate the provision of residential services through the waiver.

ICF-MR providers operate two-thirds of the supported living arrangements; individual foster care homes account for most of the rest. Few new providers have emerged.

Waiver services are an important part of the department's strategy for reducing the population of state hospitals. We found:

- After a somewhat rocky start, the department is close to meeting its initial goals for reducing state hospital population through the use of waiver services.

We estimate that the use of waiver services has resulted in a reduction of between 120 and 140 in state hospital population. Most of the reductions occurred after July 1, 1985.

However, the total number of persons in state hospitals, community ICFs-MR, and waiver services continues to grow. We are concerned that the number of persons entering waiver services from family settings may exceed what the department had forecast in receiving federal approval for waiver services.

We recommend:

- The Department of Human Services should continue to limit the use of waiver services for persons already in the community. It should examine the practice whereby some counties use the waiver to fund services for persons already in foster placements.

- The department should deny any new county requests for approval of waiver service group homes.

- The Legislature should reinstitute a limitation on the number of waiver clients served by one organization. The Department of Human Services should work aggressively with counties to promote the entry of new service providers into the field.

Because the department has not adopted rules for licensing supported living arrangements, these services are operating without licenses, or with licenses issued under outdated rules, such as the one for adult foster care. We recommend:

- The Department of Human Services should promulgate licensing rules for supported living arrangements.

- The department should collect and maintain additional data on clients and providers of waiver services.

# INTRODUCTION

Until the 1960s, the state was the primary *provider* of care to mentally retarded persons in Minnesota.[1] The number of mentally retarded persons in state hospitals peaked at about 5,800 in 1963.[2] Since then, the state's role in serving mentally retarded persons has steadily changed. The number of persons living in state-operated facilities has dropped dramatically. At the same time, Minnesota has invested significant resources to develop privately operated, community systems of residential care and training. The state has become a major *purchaser* of services.

As in several other states, litigation has been a major force for changing programs for mentally retarded persons. Since 1972, the Department of Human Services and the state hospitals have been defendants in a federal court suit brought over the conditions and programs in state hospitals for mentally retarded persons. That case is now known as *Welsch v. Levine*.[3]

In 1980, the state and the plaintiffs ended one phase of the litigation by entering into a *consent decree*. A consent decree is an agreement by

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[1]In this report we generally use the informal term *mentally retarded people*. However, it should be noted that the phrase *persons with mental retardation* is now used in statutes.

[2]In this report, we will refer to the system of state facilities serving handicapped people as *state hospitals*. These facilities have recently adopted new names, shown in Figure 1.2, which reflect their mission of providing treatment and human services in their regions. In tables and figures, the hospitals are generally identified by the city in which they are located.

[3]*Welsch v. Likins*, 373 F. Supp. 487 (D. Minn., 1974). The name of the case changed to *Welsch v. Dirkswager* in 1977 and to *Welsch v. Noot* in 1979 to reflect changes in the administration of the Department of Human Services. Prior to 1984, that agency was called the Department of Public Welfare.

the plaintiff and the defendant to settle a court case. Because the agreement is signed by a judge, its terms have the same force as a court order by that judge. The state agreed to make program and staffing changes at all state hospitals serving mentally retarded persons and to reduce the population of mentally retarded persons in the hospitals by about 30 percent. The decree will expire on July 1, 1987, if the state is in substantial compliance with its terms at that time.

This report builds on past research that we have done on community services for mentally retarded persons. In reports issued in 1983 and 1984, we analyzed how state agencies were planning, regulating, and financing community residences and sheltered employment programs.

We asked these questions:

- How have state hospital programs for mentally retarded persons changed since 1980?
- Has the consent decree resulted in increased spending for staff and buildings?
- How well have the state hospitals and the Department of Human Services complied with the consent decree? Are they likely to be substantially in compliance on July 1, 1987?

In our research, we reviewed records and other data from the state Departments of Human Services and Health on state hospital budgets, staff, and buildings. We analyzed reports from the hospitals and the Department of Human Services on compliance with the consent decree. We also examined court decisions and correspondence between the plaintiffs, state officials, and the federal court monitor on compliance issues. We visited each of the seven state hospitals currently serving mentally retarded persons. At each hospital, we observed the residential and day programs, and interviewed managers and staff working with mentally retarded persons.

This report is not intended to provide an exhaustive review of the department's compliance with the decree, but rather to provide the Legislature with an overview of compliance issues. Chapter 1 describes the state hospital system and its programs. In Chapter 2, we discuss how state hospital programs for mentally retarded persons have changed as a result of *Welsch* and other important forces, and we review areas where the state hospitals have generally complied with the terms of the consent decree. In Chapter 3, we examine areas where the Department of Human Services and the hospitals need to improve their performance and where their record of compliance is mixed. Finally, Chapter 4 presents a review of how the state has used the Medical Assistance "waiver" program to provide home- and community-based services to mentally retarded persons.

# MINNESOTA'S STATE HOSPITALS

## Chapter 1

### A. HISTORY

The first state hospital for mentally ill people in Minnesota opened at St. Peter in 1866. In 1881, the first state school for mentally retarded people was established in Faribault. These hospitals were the result of new thinking about care for mentally disabled people which developed during the last half of the nineteenth century. Institutions were established in response to a social reform movement which linked the therapeutic concept of "asylum" with the good of society. Social reformers advocated isolating mentally ill and mentally retarded people from the rest of society, preferably in peaceful rural settings. There, they could receive treatment and shelter from abuse and exploitation, while, at the same time, society would be protected from them.

Minnesota's system of state hospitals grew rapidly. The state hospitals were the primary providers of services to mentally disabled persons until the late 1950s. At that time, a new group of social reformers successfully argued for *normalization*, that is, disabled persons should live where they have the best opportunity to lead normal lives. The reformers further argued that community settings, rather than state hospitals, would provide the *least restrictive environment* for most people. This led to *deinstitutionalization,* a broader reform, with two main thrusts: creating a full range of new community services and reducing the population of state institutions.

Federal and state governments passed laws to encourage the development of community services and to reduce state hospital populations. In 1960, Minnesota's state hospitals had a population of about 15,400, as Table 1.1 shows. By 1970, the number was down by nearly a half, to approximately 8,400. In 1980, the population in state hospitals was 4,849, and in 1985, it was 3,903.

Between 1960 and 1980, significant changes also occurred in the population of various disability groups throughout the system, and in individual hospitals. For instance, mental illness programs were historically larger

TABLE 1.1

MINNESOTA STATE HOSPITAL POPULATION, ALL DISABILITY GROUPS
1960 - 1985

| Year | Anoka | Brainerd | Cambridge | Faribault | Fergus Falls | Hastings | Moose Lake | Rochester | St. Peter | Minnesota Security Hospital | Willmar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1960 | 1,085 | 147 | 2,001[a] | 3,096 | 1,852 | 940 | 1,108 | 1,642 | 2,111 | 239 | 1,233 | 15,454 |
| 1970 | 476 | 1,205 | 1,245[a] | 1,757 | 594 | 381 | 631 | 676 | 634 | 142 | 615 | 8,356 |
| 1980 | 362 | 543 | 527 | 807 | 550 | --[b] | 457 | 457 | 368 | 203 | 575 | 4,849 |
| 1985 | 313 | 424 | 459 | 668 | 470 | -- | 435 | --[c] | 378 | 219 | 537 | 3,903 |

Sources: Based on average daily population as reported in: Department of Human Services, Fact Book: State Hospitals and Nursing Homes, 1974 and 1983, for 1960-1980; Department of Human Services, "In-Residence State Hospital Daily Census for FY 1985," for 1985.

[a]Includes residents of Lake Owasso Annex, which was transferred to Ramsey County in 1975.
[b]Hastings State Hospital closed in 1978.
[c]Rochester State Hospital closed in 1982.

than the others. However, by the late 1960s, the number of mentally retarded residents had surpassed the number of mentally ill patients. At the same time, the number of patients treated for chemical dependency increased steadily in the 1960s and 1970s.

The Department of Human Services responded by establishing a "regional" system of mental retardation programs. As new space became available due to reductions in the mentally ill population, mental retardation programs were added at hospitals which had previously served only mentally ill or chemically dependent patients. Some people argue that this evolution has been beneficial in allowing the hospitals to provide a full range of services to all mental disability groups in different regions of the state. Others, however, contend that the actions were primarily designed to "save" hospitals whose mental illness programs and populations were steadily shrinking.

## B. PROGRAMS

At present, Minnesota operates eight state hospitals serving persons with mental retardation, mental illness, and chemical dependency. The map in Figure 1.1 shows the location of the state hospitals. Minnesota is one of the few states whose state institutions serve more than one disability group on individual campuses. As Figure 1.2 indicates, Cambridge and Faribault provide only mental retardation programs. The other six hospitals serve more than one disability group. In 1985, mentally retarded residents made up about 53 percent of the state hospital population, mentally ill patients were about 32 percent, and chemically dependent patients were about 15 percent.

Hospital service areas vary according to hospital and disability group. *Catchment area* is the term used to describe groups of counties served by individual hospital programs. As the figure also shows, special programs admit patients and residents from across the state. The programs range from the Minnesota Security Hospital at St. Peter, for patients requiring treatment or evaluation in a closed facility, to the Minnesota Learning Center at Brainerd, which serves mentally retarded or emotionally disturbed adolescents.[1]

## C. BUDGET AND STAFF

The total budget for state hospitals in 1985 was about $146.4 million. More than two-thirds ($107.1 million) was paid for by the Medical Assis-

[1]The Minnesota Learning Center has recently changed its program license. While about one-third of the beds are still licensed to serve mentally retarded youth, the others are licensed to serve "emotionally handicapped" youth.

FIGURE 1.1

MINNESOTA'S STATE HOSPITALS

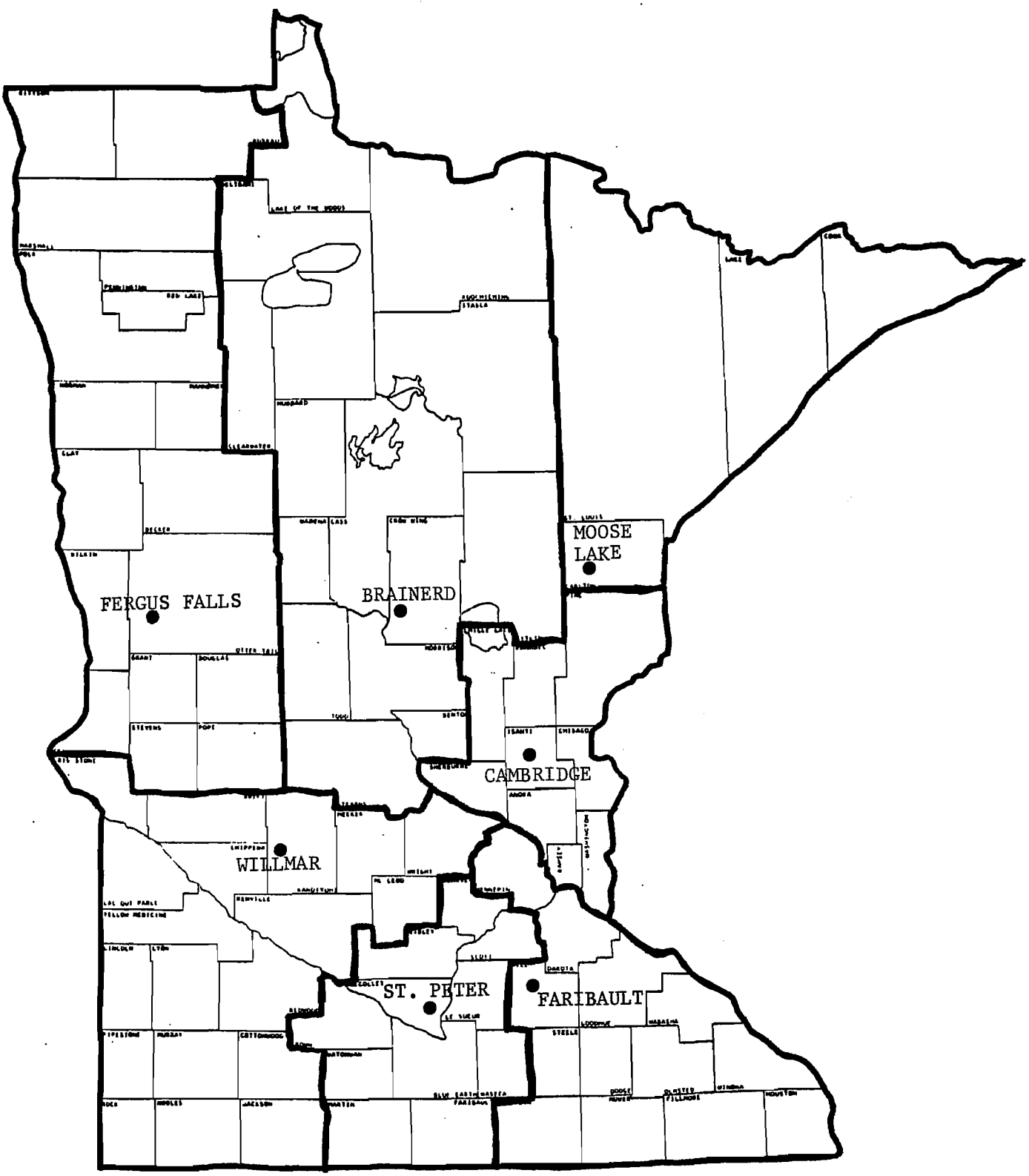

FIGURE 1.2

MINNESOTA STATE HOSPITAL PROGRAMS

| Hospital | Year Opened | Groups Served[a] | Special Programs |
|---|---|---|---|
| 1. Anoka Metro Regional Treatment Center | 1900 | MI,CD | |
| 2. Brainerd Regional Human Services Center | 1958 | MI,MR,CD | Minnesota Learning Center for adolescents who are mentally retarded or emotionally disturbed |
| 3. Cambridge Regional Human Services Center | 1925 | MR | |
| 4. Faribault Regional Center | 1881 | MR | Skilled Nursing Facility for medically fragile residents |
| 5. Fergus Falls Regional Treatment Center | 1890 | MI,MR,CD | |
| 6. Moose Lake Regional Treatment Center | 1938 | MI,MR,CD | |
| 7. St. Peter Regional Treatment Center | 1866 | MI,MR,CD | Minnesota Security Hospital; Services for hearing impaired |
| 8. Willmar Regional Treatment Center | 1912 | MI,MR,CD | Adolescent psychiatric unit |

[a]MI = Mentally Ill
MR = Mentally Retarded
CD = Chemically Dependent

tance program. Those costs are shared 52 percent, federal; 43 percent, state; and 4.5 percent, county. About 11 percent was recovered from Medicare, private insurance, charges to patients, and charges to counties. The rest was a direct state appropriation.[2]

[2]Data provided by the Department of Human Services, Reimbursement Division.

Close to 60 percent of all state hospital expenditures in 1985 were for state hospital programs serving mentally retarded people. The mental retardation program is the largest and most staff intensive of the three disability programs in the system. About 29 percent of the expenditures were for mental illness programs, and almost 12 percent were for chemical dependency programs.

In 1985, programs for mentally retarded people also employed the largest share of staff, as Table 1.2 shows. This is because mental retardation programs emphasize intensive non-professional staff contact with residents, while patients in mental illness and chemical dependency programs require less direct care, but need proportionally more professional contact. About 48 percent of all staff were assigned to mental retardation programs, compared to almost 18 percent and 6 percent, respectively, for mental illness and chemical dependency programs. General support staff made up the remaining 28 percent of the 1985 staff complement for state hospitals.

TABLE 1.2

1985 STAFF COMPLEMENT IN STATE HOSPITALS

| Hospital | Mental Retardation | Mental Illness | Chemical Dependency | General Support | Total |
|---|---|---|---|---|---|
| Anoka | -- | 176.50 | 37.56 | 164.60 | 378.66 |
| Brainerd[a] | 416.73 | 40.00 | 25.29 | 204.70 | 686.72 |
| Cambridge | 557.73 | -- | -- | 239.17 | 796.90 |
| Faribault | 850.98 | -- | -- | 242.20 | 1,093.18 |
| Fergus Falls | 290.32 | 86.00 | 87.31 | 159.25 | 622.88 |
| Moose Lake | 140.03 | 129.00 | 101.42 | 141.90 | 512.35 |
| St. Peter[b] | 207.77 | 310.00 | 30.55 | 162.40 | 712.72 |
| Willmar | 180.89 | 222.42 | 48.87 | 191.40 | 643.58 |
| TOTAL | 2,644.45 | 963.92 | 331.00 | 1,505.62 | 5,444.99 |

Source: Department of Human Services, Financial Management Division, "State Hospitals and Nursing Homes Staff Allocation Plan," July 1, 1985.

[a]Includes Minnesota Learning Center.
[b]Includes Minnesota Security Hospital.

# THE IMPACT OF THE WELSCH CASE AND OTHER FORCES

## Chapter 2

### A. BACKGROUND OF THE *WELSCH* CASE

In the early 1970s, advocates of handicapped persons followed the lead of the civil rights movement and turned to federal courts to achieve their goals. Lawsuits in many states challenged the care and treatment provided to mentally retarded persons living in state-operated institutions. These suits often succeeded and resulted in court orders to significantly improve state institutions or to reduce their population.

In Minnesota, state hospital residents and their families turned to the courts partly because of staff reductions at state hospitals. A group of parents of state hospital residents brought a suit in federal district court in 1972 against the Department of Human Services and all eight state hospitals which then served mentally retarded persons. The suit is commonly known as the *Welsch* case, after the first named plaintiffs: Patricia Welsch, a resident of the state hospital at Cambridge, and her parents.[1] During the original trial, and ever since, the plaintiffs in the suit were represented by Legal Advocacy for Developmentally Disabled Persons, a project of the Minneapolis Legal Aid Society. Figure 2.1 is a chronology of some of the important developments in the case.

The case was heard in U.S. District Court before Judge Earl Larson. He issued an initial decision in February 1974, holding that Minnesota statutes and the U.S. Constitution:

- give involuntarily committed residents a right to minimally adequate care and treatment, and
- give residents a right to be placed in the least restrictive setting appropriate to their mental and physical abilities.

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[1]Patricia Welsch was discharged from the state hospital in Cambridge in September 1982.

FIGURE 2.1

CHRONOLOGY OF THE *WELSCH* CASE

| | |
|---|---|
| 1971 | The Legislature cut the staff complement in state hospitals from 5,618 to 5,110 by the end of 1973. About 4,300 mentally retarded persons lived in state hospitals. |
| 1972 | Six mentally retarded residents of state hospitals and their parents brought suit in federal district court against the Commissioner of Human Services and the chief executive officers of the state hospitals, claiming that treatment and conditions in state hospitals violated constitutional and statutory rights. |
| 1973 | The case was tried before Judge Earl Larson in September and October. |
| 1974 | In February, Judge Larson ruled in favor of the plaintiffs and issued an injunction requiring treatment changes, building improvements, and additional staff at Cambridge. |
| 1975 | Judge Larson found that the state had not complied with the original injunction. He amended the injunction to require additional increases in staff. |
| 1976 | After the Legislature did not appropriate sufficient funds to comply with the staffing requirements, Judge Larson ordered the state to spend the money, notwithstanding constitutional and statutory prohibitions against deficit spending. |
| 1977 | On appeal by the state, the U.S. Court of Appeals for the Eighth Circuit affirmed Judge Larson's 1976 staffing orders, but it overruled the deficit spending order, giving the Legislature an opportunity to act.<br><br>In December, the parties agreed to a consent decree setting forth staffing and treatment requirements for Cambridge and requiring the Department of Human Services to prepare requests to apply those requirements to the other hospitals serving mentally retarded persons. |
| 1980 | The case returned to court. After the plaintiffs presented their case, the parties entered discussions which resulted in a new consent decree affecting all state hospitals serving mentally retarded persons. |
| 1982 | During the state's 1981-82 fiscal crisis, Judge Larson ordered the Department of Human Services to provide adequate funding to comply with the consent decree's staffing requirements. |

Furthermore, Judge Larson held that:

- The ways in which the state hospital at Cambridge used seclusion rooms, physical restraints, and medications may have violated the residents' right to be free of cruel and unusual punishment.

Judge Larson allowed the suit to be brought as a *class action*. Thus, the rulings in the case would apply to all current or new mentally retarded residents of the state hospitals, and not just to the original plaintiffs. Although the initial suit named all state hospitals serving mentally retarded persons, the decision and the court's orders until 1980 generally applied only to the hospital at Cambridge.

Those orders and the 1977 consent decree between the parties focused on *institutional reform*; that is, improving the conditions and treatment at state institutions. In the second phase of the litigation, beginning when the case returned to court in 1980, a second focus emerged: *reducing the population of state hospitals and fostering community services*. After the plaintiffs had presented their case, the parties negotiated a new consent decree, which became effective on September 15, 1980. The new decree extended the institutional reforms to all state hospitals serving mentally retarded persons. It also included a state commitment to reduce the population of state hospitals by nearly one-third and to develop appropriate community services to serve state hospital residents.

## B. WHAT FORCES HAVE CHANGED STATE HOSPITALS?

The *Welsch* case is only one of several forces which have changed state hospitals in the past 20 years. For example, the litigation is often viewed as the cause of population reductions in the state hospitals. However, the largest decline in state hospital populations came in the seven years *before* the *Welsch* case was filed, when the population fell by nearly 1,500. In our view, three other developments have been equally significant in changing state hospitals. They are:

- the participation of state hospitals in the Medical Assistance program,

- the use of Medical Assistance funds to develop community group homes, and

- the establishment of special education programs for mentally retarded children in local school districts.

In 1971, Congress authorized the use of Medical Assistance to pay for care provided to mentally retarded persons in state hospitals. By 1975, all of Minnesota's state hospital programs were certified as Intermediate Care Facilities for Mentally Retarded persons (ICFs-MR) and were eligible for Medical Assistance reimbursement. The availability of Medical Assistance resulted in a significant influx of federal funds to Minnesota and other states, since the federal government paid for more than one-half of the

cost of state hospital care. However, the federal funding was tied to standards for active treatment, health and rehabilitation services, and adequate living space. To ensure the continued flow of federal funds, states had to make substantial investments in bringing hospital facilities and programs up to these standards.

The explosive growth of community programs for mentally retarded persons has been another important factor affecting state hospitals. During the 1960s, several relatively large facilities opened in St. Paul as well as in other parts of the state. Some served more than 100 residents. These community facilities generally served children or high-functioning mentally retarded persons, often from state hospitals. The availability of community facilities made it possible for retarded persons to leave state hospitals and live in community settings. The new facilities also created options for mentally retarded persons who might otherwise have entered state hospitals.

However, it was the Medical Assistance program that really fueled the development of community facilities. Minnesota was the first state to make extensive use of the Medical Assistance program to fund *community* ICFs-MR. Between 1973 and 1980, an average of 30 new facilities opened each year. In March 1985, there were 337 community ICFs-MR with capacity for 5,180 persons.

By 1983, the Legislature concluded that enough community facilities had opened and imposed a moratorium on further development. However, it allowed exceptions for facilities already approved by the Department of Human Services and new facilities that would serve mentally retarded persons with additional handicaps. Not only did the Legislature halt new development, but it also directed the Department of Human Services to reduce the number of community group home beds by 1986. By reducing the number of persons served in group homes and state hospitals, the Legislature intended to make additional funds available for alternative home- and community-based services.

New opportunities for educational, developmental, and vocational programs in community settings have also affected state hospitals. In particular, development of special education programs to serve handicapped persons in their local school districts delayed or eliminated the need to admit some children to state hospitals. A 1957 law authorizing state aids for special education classes increased the availability of those classes. In 1971, Minnesota required school districts to provide local education programs for "trainable mentally retarded" children.

As the development of these programs enabled more mentally retarded children to stay with their families, the average age of admission to state hospitals steadily increased. According to a national study, the average age of first admission to state hospitals increased from 10.4 years in 1968 to 18 years in 1978.[2] In 1985, the average age of admission (first or otherwise) in Minnesota was 21.

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[2]K.C. Lakin, *et al*, "Changes in Age at First Admission to Residential Care for Mentally Retarded People," *Mental Retardation*, 20, p. 216-219, October 1982.

## C. POPULATION REDUCTION

### 1. GENERAL REQUIREMENTS

Part III of the consent decree requires a 30 percent reduction in the population of mentally retarded persons in state hospitals. Paragraph 12 states that, "By July 1, 1987, the population of mentally retarded persons in state hospitals and the Minnesota Learning Center shall not exceed 1,850." The decree sets a timetable for incremental reductions each year until 1987.

This requirement was not onerous given the state's past experience in reducing the population of state hospitals. The department merely had to maintain the reduction trend that had been established as early as 1968. As shown in Table 2.1, the number of mentally retarded persons in state hospitals had declined by an average of 5.3 percent annually between 1972, when the *Welsch* lawsuit was filed and 1980, when the consent decree was signed. The reduction requirement was not burdensome by comparison with court orders and consent decrees in other states, many of which required more drastic population reductions or closing certain state institutions.

We found that:

- The Department of Human Services has met and exceeded the reduction target every year since the decree took effect.
- The department is likely to meet the consent decree's 1987 deadline with little difficulty.

As of June 30, 1985, the population of mentally retarded persons in state hospitals was 2,029, ahead of the consent decree's requirement of 2,100 for that date. Given consistent reductions of 100 to 130 residents in each of the past three years, it seems unlikely that the hospitals will have any difficulty reaching the final 1987 target of 1,850.

However, the department faces other targets which will require additional population reductions. In its 1985-1987 biennial budget request, the Department of Human Services proposed to reduce the population of mentally retarded persons in state hospitals beyond the consent decree's requirements, to about 1,650 at the end of the biennium.

A key element in the department's strategy to achieve this reduction was to expand the state's program of home- and community-based services funded under a Medical Assistance waiver. (In Chapter 4, we report on services currently funded through that waiver.) Under the department's plan, the waiver services would help reduce the population of state hospitals in two ways. First, a small number of state hospital residents would be placed directly into waiver services. Second, several hundred persons now living in group homes would move into waiver services, and state hospital residents would fill those vacancies.

TABLE 2.1

AVERAGE DAILY POPULATION IN STATE HOSPITAL MENTAL RETARDATION PROGRAMS: 1965-1985

| YEAR | TOTAL | CHANGE | BRAINERD[a] | CAMBRIDGE | LAKE OWASSO | FARIBAULT | FERGUS FALLS | HASTINGS | MOOSE LAKE | ROCHESTER | ST. PETER | WILLMAR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1965 | 5,505 | -3.3% | 945 | 1,747 | 122 | 2,691 | | | | | | |
| 1966 | 5,482 | -0.4% | 1,149 | 1,569 | 124 | 2,640 | | | | | | |
| 1967 | 5,439 | -0.8% | 1,294 | 1,483 | 123 | 2,539 | | | | | | |
| 1968 | 5,117 | -5.9% | 1,290 | 1,360 | 112 | 2,355 | | | | | | |
| 1969 | 4,858 | -5.1% | 1,246 | 1,235 | 118 | 1,996 | 55[b] | 33[b] | | 12[b] | 163[b] | |
| 1970 | 4,748 | -2.3% | 1,205 | 1,137 | 108 | 1,757 | 118 | 44 | 26[b] | 14 | 339 | |
| 1971 | 4,412 | -7.1% | 956 | 1,004 | 90 | 1,592 | 204 | 63 | 51 | 78 | 374 | |
| 1972 | 4,204 | -4.7% | 831 | 887 | 77 | 1,539 | 291 | 53 | 62 | 93 | 371 | |
| 1973 | 4,012 | -4.6% | 762 | 816 | 73 | 1,443 | 319 | 33 | 68 | 133 | 353 | 12[b] |
| 1974 | 3,801 | -5.3% | 655 | 735 | 75 | 1,207 | 315 | 51 | 123 | 179 | 319 | 142 |
| 1975 | 3,541 | -6.8% | 589 | 672 | 70 | 1,099 | 297 | 53[d] | 158 | 173 | 291 | 139 |
| 1976 | 3,364 | -5.0% | 581 | 628 | 61[c] | 1,021 | 294 | 28[d] | 146 | 166 | 278 | 161 |
| 1977 | 3,085 | -8.3% | 562 | 603 | | 911 | 289 | | 148 | 160 | 237 | 175 |
| 1978 | 2,895 | -6.2% | 511 | 576 | | 856 | 288 | | 143 | 151 | 208 | 162 |
| 1979 | 2,780 | -4.0% | 470 | 553 | | 833 | 282 | | 141 | 149 | 191 | 161 |
| 1980 | 2,688 | -3.3% | 440 | 527 | | 807 | 278 | | 133 | 153 | 192 | 158 |
| 1981 | 2,524 | -6.1% | 376 | 510 | | 774 | 268 | | 129 | 129[d] | 180 | 158 |
| 1982 | 2,409 | -4.6% | 363 | 509 | | 772 | 268 | | 122 | 30[d] | 183 | 162 |
| 1983 | 2,297 | -4.6% | 352 | 503 | | 747 | 245 | | 112 | | 179 | 159 |
| 1984 | 2,179 | -5.1% | 324 | 483 | | 709 | 231 | | 107 | | 170 | 155 |
| 1985 | 2,065 | -5.2% | 298 | 459 | | 668 | 222 | | 103 | | 164 | 151 |

| | | |
|---|---|---|
| CUMULATIVE DECREASE 1965 TO 1970 | -13.8% | 757 |
| CUMULATIVE DECREASE 1970 TO 1975 | -25.4% | 1,207 |
| CUMULATIVE DECREASE 1975 TO 1980 | -24.1% | 853 |
| CUMULATIVE DECREASE 1980 TO 1985 | -23.2% | 623 |
| CUMULATIVE DECREASE 1965 TO 1985 | -62.5% | 3,440 |

SOURCE: Department of Human Services, Fact Book: State Hospitals and Nursing Homes, January 1985; also 1983, 1979, and 1974 editions; Average daily census for year.

[a] Includes Minnesota Learning Center.

[b] Mental Retardation programs were added at Fergus Falls, Hastings, Moose Lake, Rochester, St. Peter, and Willmar State Hospitals between 1968 and 1973.

[c] Lake Owasso Children's Home was transferred to Ramsey County in 1975.

[d] The Mental Retardation program at Hastings State Hospital closed in 1976. Rochester State Hospital closed in 1982.

In our view,

- The department will have difficulty achieving its accelerated schedule of reductions.

The two goals of reducing hospital population and expanding home and community- based services are closely linked. The department must accelerate reductions in order to fulfill the assurances it made when it secured federal approval for the waiver. At the same time, waiver services are needed to achieve that reduction. However, while the department proposed to provide waiver services for 1,665 persons during the 1985-1987 biennium, the Legislature approved services for only 1,000 persons. Although the department has designated most of the new service slots for persons moving out of state hospitals and community group homes, there are more demands for those slots than can be met. For example, federal authorities have threatened to decertify certain group homes. The state may also wish to decertify group homes that it considers too large or of poor quality. It is expected that waiver service slots will be needed for the current residents of those group homes. These additional demands will make it very difficult for the department to reduce the number of mentally retarded persons in state hospitals to 1,650 by July 1987.

The limited number of waiver service slots also means that certain key counties may not be able to accelerate reductions in their use of state hospitals. For example, to meet the goals set for *Welsch* compliance, Hennepin County must move 70 residents out of state hospitals by 1987, and Ramsey County needs to move 48. For 1986, the Department of Human Services allocated only 20 new waiver service slots designated for hospital reduction to Hennepin and 17 to Ramsey. These large counties will need to use other resources beyond waiver services to accomplish these reductions.

## 2. CHANGES IN COUNTY UTILIZATION OF STATE HOSPITALS

The *Welsch* consent decree did not specify population reductions for individual state hospitals or indicate how much each county should reduce its reliance on state hospitals. Originally, the Department of Human Services proposed a per capita formula to reduce county use of state hospitals. Outstate counties objected to this formula, since they were heavy users, per capita, of state hospitals. As a result, the department proposed an alternative formula requiring each county to reduce hospital use by 30 percent. Counties in the metropolitan Twin Cities area objected to this approach because they had many persons in state hospitals, though their per capita use was relatively low.

The department arrived at a compromise which combined the two formulas: half of the reduction would be on a per capita basis and half would be through a flat 30 percent reduction. The department then established non-binding, county-by-county *goals* which would actually reduce the population to 1,792 by July 1, 1987.[3]

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[3]Department of Human Services, Instructional Bulletin #81-53, July 20, 1981.

As of June 30, 1985, 35 counties had already met or exceeded their 1987 reduction targets. However, eleven counties had shown either no net reduction or an increase in utilization.

Table 2.2 compares the 1980 and 1985 rates of state hospital use in the seven catchment areas. As shown in Table 2.2, the decline has been sharpest in the Faribault catchment area, which includes Hennepin and Dakota counties, and southeastern Minnesota. Utilization rates for this region have dropped by more than half during the past five years. By comparison, utilization rates in the Fergus Falls catchment area, which includes northwestern Minnesota, have remained relatively high. The rate in this catchment area has declined by only 20.8 percent, and it is now the highest in the state.

TABLE 2.2

REGIONAL RATES OF UTILIZATION OF STATE HOSPITALS

| | Utilization Per 1,000 Population[a] | | |
|---|---|---|---|
| Catchment Area | 1980 | 1985 | Change |
| Brainerd | 0.876 | 0.591 | -32.6% |
| Cambridge | 0.488 | 0.409 | -16.1 |
| Faribault | 1.008 | 0.447 | -55.6 |
| Fergus Falls | 0.980 | 0.776 | -20.8 |
| Moose Lake | 0.731 | 0.546 | -25.4 |
| St. Peter | 0.842 | 0.624 | -25.9 |
| Willmar | 0.551 | 0.455 | -17.6 |
| State | 0.665 | 0.502 | -24.6% |

Source: Department of Human Services, Instructional Bulletin #81-53, June 20, 1981; Department of Human Services, "County Utilization of State Hospitals", July 16, 1985.

[a]Rates for 1980 are based on county populations reported from the 1980 U.S. Census; rates for 1985 are based on the 1984 estimates of population prepared by the State Planning Agency.

3. COMMUNITY PLACEMENTS

The consent decree requires state hospitals to discharge residents to "community programs which appropriately meet their individual needs." Placement must be in a family home, in a facility licensed by the state or, when appropriate, in an independent setting such as an apartment.

While the decree does not require placement in small community facilities, it does express a preference for placement in family homes or facilities serving 16 or fewer mentally retarded persons.

Tables 2.3 and 2.4 compare discharge destinations for mentally retarded people leaving state hospitals since September 1980. We found that:

- Nearly half the residents discharged from state hospitals went to community facilities funded through the Medical Assistance program.

About one-third of the residents were discharged to small community facilities (ICFs-MR) serving 16 or fewer persons. Another 13 percent were discharged to larger facilities, ranging in size from 17 to 165 residents.

The proportion of state hospital residents entering group homes with six or fewer residents has declined since 1983. However, this decline was offset in 1985 by state hospital residents entering other community settings, almost all of which served six or fewer persons.

The second largest number of discharges was to family or foster homes. In fact, nearly 60 percent of the residents of the Minnesota Learning Center at Brainerd were discharged to family or foster homes. That program provides short-term services, typically for three to nine months, to mentally retarded or emotionally disturbed adolescents who are discharged to their family homes, foster homes, or to the juvenile court system.

The 22.8 percent of discharges grouped under "Other" in Tables 2.3 and 2.4 include transfers of residents within the state hospital system and discharges to the courts. This group also includes residents of Rochester State Hospital who were transferred to other state hospitals when that facility closed in 1982.

## 4. IMPACT OF THE ICF-MR MORATORIUM

The once frantic development of new community facilities ground to a halt in 1985, as the last of the facilities approved prior to the 1983 moratorium opened. Some parties have expressed concern that the lack of new ICFs-MR will hurt efforts to reduce the population of state hospitals.

However,

- We found no evidence that the moratorium has affected compliance with the population reduction requirements in the consent decree.

As we noted above, the department has met and exceeded its population reduction requirements each year since 1980. While the number of state hospital residents discharged to small facilities (serving six or less) has declined recently, this is easily explained. First, the combined

TABLE 2.3

DISCHARGE DESTINATIONS OF STATE HOSPITAL RESIDENTS, BY HOSPITAL

September 1980 - August 1985

| | Family/Foster | | ICF-MR 6 or Less | | ICF-MR 7-16 | | ICF-MR 17-99 | | ICF-MR 100+ | | Other Community[b] | | Other[c] | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hospital | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent |
| Brainerd | 57 | 29.1% | 7 | 3.6% | 95 | 48.5% | 7 | 3.6% | 1 | 0.5% | N/A | N/A | 29 | 14.8% | 196 | 100.1%[d] |
| Minnesota Learning Center | 163 | 59.3 | 21 | 7.6 | 13 | 4.7 | 4 | 1.5 | 1 | 0.4 | N/A | N/A | 73 | 26.5 | 275 | 100.0 |
| Cambridge[a] | 47 | 32.6 | 24 | 16.7 | 29 | 20.1 | 24 | 16.7 | 5 | 3.5 | N/A | N/A | 15 | 10.4 | 144 | 100.0 |
| Faribault | 14 | 5.5 | 13 | 5.1 | 86 | 33.9 | 54 | 21.3 | 31 | 12.2 | N/A | N/A | 56 | 22.0 | 254 | 100.0 |
| Fergus Falls | 19 | 13.6 | 20 | 14.3 | 45 | 32.1 | 3 | 3.1 | 0 | 0.0 | N/A | N/A | 53 | 37.9 | 140 | 100.0 |
| Moose Lake | 5 | 10.9 | 6 | 13.0 | 11 | 23.9 | 15 | 32.6 | 0 | 0.0 | N/A | N/A | 9 | 19.6 | 46 | 100.0 |
| Rochester | 3 | 2.2 | 2 | 1.4 | 22 | 15.8 | 4 | 2.9 | 0 | 0.0 | N/A | N/A | 108 | 77.7 | 139 | 100.0 |
| St. Peter | 73 | 47.1 | 7 | 4.5 | 48 | 31.0 | 16 | 10.3 | 0 | 0.0 | N/A | N/A | 11 | 7.1 | 155 | 100.0 |
| Willmar | 21 | 21.6 | 2 | 2.1 | 40 | 41.2 | 10 | 10.3 | 9 | 9.3 | N/A | N/A | 15 | 15.5 | 97 | 100.0 |
| TOTAL | 506 | 29.4% | 114 | 6.6% | 468 | 27.2% | 168 | 9.8% | 56 | 3.3% | 24 | 1.4% | 386 | 22.4% | 1,722 | 100.1%[d] |

Source: Office of the Court Monitor, Reports of the Monitor to the United States District Court, 1981-1985.

[a] Data for Cambridge Regional Human Services Center not included for September 1980 to June 1981.

[b] Includes home- and community-based waivered services, semi-independent living settings, and juvenile group homes. Data available for January-August 1985 only. Data not available by hospital.

[c] Includes administrative discharge or transfer within the state hospital system, unauthorized absence, nursing home, and discharge to court.

[d] Does not equal 100.0 due to rounding.

TABLE 2.4

DISCHARGE DESTINATIONS OF STATE HOSPITAL RESIDENTS, BY YEAR

September 1980 - August 1985

| | Family/Foster | | ICF-MR 6 or Fewer | | ICF-MR 7-16 | | ICF-MR 17-99 | | ICF-MR 100+ | | Other Community[b] | | Other[c] | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Year | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent |
| 1980[a] | 22 | 20.0% | 3 | 2.7% | 43 | 39.1% | 19 | 17.3% | 0 | 0.0% | N/A | N/A | 23 | 20.9% | 110 | 100.0% |
| 1981[a] | 89 | 20.4 | 25 | 5.7 | 89 | 20.4 | 31 | 7.1 | 14 | 3.2 | N/A | N/A | 189 | 43.2 | 437 | 100.0 |
| 1982 | 74 | 26.7 | 26 | 9.4 | 77 | 27.8 | 33 | 11.9 | 13 | 4.7 | N/A | N/A | 54 | 19.5 | 277 | 100.0 |
| 1983 | 83 | 29.3 | 34 | 12.0 | 82 | 29.0 | 19 | 6.7 | 8 | 2.8 | N/A | N/A | 57 | 20.1 | 283 | 99.9[d] |
| 1984 | 134 | 39.5 | 14 | 4.1 | 98 | 28.9 | 35 | 10.3 | 12 | 3.5 | N/A | N/A | 46 | 13.6 | 339 | 99.9[d] |
| 1985 | 104 | 37.7 | 12 | 4.3 | 79 | 28.6 | 31 | 11.2 | 9 | 3.3 | 24 | 8.7% | 17 | 6.2 | 276 | 100.0 |
| TOTAL | 506 | 29.4% | 114 | 6.6% | 468 | 27.2% | 168 | 9.8% | 56 | 3.3% | 24 | 1.4% | 386 | 22.4% | 1,722 | 100.0% |

Source: Office of the Court Monitor, Reports of the Monitor to the United States District Court, 1981-1985.

[a]Data for Cambridge Regional Human Services Center not included for September 1980 to June 1981.

[b]Includes waivered services, semi-independent living setting, and juvenile group homes. Data available for January-August 1985 only.

[c]Includes administrative discharge or transfer within the state hospital system, unauthorized absence, nursing home, and discharge to court.

[d]Does not add to 100.0 due to rounding.

capacity of all six-person facilities in the state is less than 12 percent of the total system.[4]

Second, many residents now leaving state hospitals require the service of facilities specially licensed by the Department of Health as *Class B* facilities.[5] Since these residents are "not capable of self-preservation" in the event of an emergency, they require facilities that meet more stringent staff and fire safety standards. Placement in a small ICF-MR has never been an option for these people because there are only three Class B facilities in the state which serve six residents. None of the small ICFs-MR which opened in the past three years is a Class B facility. In fact, many of the Class B facilities best suited to serve state hospital residents serve between 30 and 60 residents. Thus, the only choices available to a county seeking to place a particularly dependent resident are large Class B ICFs-MR or specialized foster care arrangements, which may not currently exist.

The moratorium on new ICF-MR development might have had an adverse impact on state hospital population reductions if the department had complied with the moratorium's second limitation:

> In no event shall the total of certified intermediate care facilities for mentally retarded persons in community facilities and state hospitals exceed 7,500 beds as of July 1, 1983, and 7,000 beds as of July 1, 1986.[6]

The department initially complied with this limitation by decertifying 260 surplus state hospital beds. However, we found:

- The department subsequently violated the restriction in 1985 by licensing new community facilities after the total number of beds in the system had again exceeded 7,500.

As new community facilities opened, the total number of certified beds passed the 7,500 limit again. In July 1985, even after 80 more state hospital beds were decertified, there were 7,519 beds in the state. A January 1986 report from the Department of Health shows the number of beds at 7,526.

Furthermore,

- The department is unlikely to meet the July 1, 1986 limitation of 7,000 beds.

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[4]Even without the moratorium, development of six-person facilities was limited; only ten of the 47 new ICFs-MR which opened after March 1982 served six residents. The other 37 had capacity for 497 residents in facilities serving between 8 and 24 persons.

[5]Minn. Rules Part 4665.0500.

[6]Minn. Laws 1983, Chap. 312, Art. 9, Sec. 3, subd. 1.

While the department has requested decertification of 158 more state hospital beds, it is almost certain to fall short of the 7,000 bed ceiling. The department has not established, in rule, criteria for decertification of ICF-MR beds, as was required in 1983. Only 19 beds in community ICFs-MR have been decertified, although the department has reported that a number of community providers have expressed interest in decertifying some or all of the beds in their facilities.

## D. STAFF

Throughout the *Welsch* case, the federal court has emphasized the importance of adequate staff to fulfill residents' rights to a humane and safe living environment and to an adequate program of habilitation: "The most critical need at Cambridge to fullfill both of these rights is for sufficient personnel to care for, supervise, and train the residents."[7] The consent decree establishes staffing standards through staff-to-resident ratios for direct care staff and supervisors, and support staff, including doctors, therapists, and social workers.[8]

We found:

- Since 1983, the state hospitals have generally been in compliance with the staff-to-resident ratios prescribed for residential direct care staff.

- The hospitals have had difficulty hiring and retaining enough physical therapists to meet the consent decree's requirements.

Table 2.5 shows the consent decree's staffing requirements and compares them with the federal ICF-MR certification requirements. Direct care staff for residential services account for almost 60 percent of the positions where staffing ratios are established by the decree. This is the one category where the federal regulations establish specific ratios. Those ratios are equivalent to the consent decree's requirements.

Non-professional employees in the human service technician series of job classes provide most of the direct care that residents receive. A minimum staffing arrangement would be one human service technician working with eight residents during waking hours. The ratio is typically higher for day programs, when professional teachers and aides are present. Addi-

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[7]A 1962 report indicates just how inadequate staff resources were at that time: at Faribault, 394 "psychiatric" (direct care) aides were employed to work with 3,200 retarded residents. *A Report of the Governor's Advisory Committee on Mental Retardation*, October 8, 1982.

[8]The consent decree uses a more narrow definition of "direct care staff" than the department and Legislature use in allocating staff complement.

TABLE 2.5

STAFF-TO-RESIDENT RATIOS REQUIRED UNDER THE *WELSCH* CONSENT DECREE AND UNDER FEDERAL REGULATIONS

| Job Class | *Welsch* Consent Decree Ratios Required: Staff To Residents | Federal ICF-MR Regulations |
|---|---|---|
| Residential Direct Care[a] | 10.55 to 15.00 | 1 staff to 2 or 2.5 residents (equivalent to consent decree ratio) |
| Residential Supv., Prof. | 1.00 to 8.00 | Not specified |
| Daytime Direct Care[b] | 1.00 to 5.00 | Enough qualified training and habilitation staff |
| Daytime Supv., Prof.[c] | 1.00 to 6.50 | Not specified |
| Recreation Aides [d] | 1.00 to 50.00 | Enough qualified staff |
| Physicians | 1.00 to 175.00 | Not specified |
| Registered Nurses | 1.00 to 45.00 | Enough nursing staff |
| Dental | Federal Standard | Enough qualified dental personnel, support staff |
| Physical Therapists | 1.00 to 50.00[e] | Enough qualified staff and support personnel for physical and occupational therapy services |
| Physical Ther. Assistants | 1.00 to 30.00 | |
| Social Workers, Aides | 1.00 to 40.00 | Not specified |

Source: *Welsch* v. *Likins*, 373 F. Supp. 487 (D. Minn., 1974), September 15, 1980; 42 CFR 89442.440-.516.

[a]Calculated on the basis of 15 residents per household.

[b]Can include .5 direct residential care positions from each household.

[c]May count up to 3/8 of the daytime supervisory, professional staff toward daytime direct care.

[d]Included in residential and day program direct care.

[e]Non-ambulatory residents.

tional help is sometimes provided by volunteers from schools and foster grandparent programs.

While the consent decree did not require the addition of positions in the state hospital complement, it did require the Department of Human Services to "protect" staff levels, even as population declined, until the ratios had been achieved. The department also agreed to protect general and support positions at state hospitals. If any of those positions were to be eliminated, at least 45 percent would be reallocated into programs for mentally retarded persons.

Tables 2.6 and 2.7 show how the state hospitals came into compliance with required staffing ratios for direct care and supervisory positions. Note that while the state hospitals have improved staffing ratios for day program supervisors and professionals, five hospitals are still not in compliance in this category.

TABLE 2.6

COMPLIANCE WITH CONSENT DECREE RESIDENTIAL PROGRAM DIRECT CARE STAFF-TO-RESIDENT RATIOS[a]

| As of December 31, | Positions Required | Positions Filled | Percentage Filled |
|---|---|---|---|
| 1980 | 1,335.30 | 1,116.75 | 83.63% |
| 1981 | 1,684.39 | 1,419.53 | 84.28 |
| 1982 | 1,601.20 | 1,600.83 | 99.98 |
| 1983 | 1,523.03 | 1,557.67 | 102.27 |
| 1984 | 1,441.28 | 1,473.10 | 102.21 |
| 1985 | 1,318.00 | 1,375.00 | 104.30 |

Source: Office of the Court Monitor, Reports of the Monitor to the United States District Court, 1981-1985; Department of Human Services, Residential Facilities Division, 1986.

[a]Data for 1980 do not include Cambridge Regional Human Services Center.

While these data show that the state hospital *system* is largely in compliance with the decree's staffing provision, *individual hospitals* have not achieved compliance with all of the decree's staffing ratios. For example, as of January 1, 1986, two hospitals did not have sufficient day program direct care staff. The decree requires that each hospital "has positions to meet all of the staffing requirements" before the department can reduce any positions which are protected by the decree for mental

TABLE 2.7

PERCENTAGE OF POSITIONS FILLED FOR DIRECT CARE AND SUPERVISORY STAFF

| As of December 31, | Residential | | Day Program | |
|---|---|---|---|---|
| | Direct Care | Supervisory | Direct Care | Supervisory |
| 1980 | 83.60% | N/A | N/A | N/A |
| 1981 | 84.30 | N/A | N/A | N/A |
| 1982 | 99.99 | 97.20% | 95.90% | 74.60% |
| 1983 | 102.30 | 102.20 | 95.60 | 75.30 |
| 1984 | 102.20 | 98.80 | 102.70 | 83.80 |
| 1985 | 104.30 | 103.00 | 112.99 | 89.30 |

Source: Office of the Court Monitor, Reports of the Monitor to the United States District Court, 1981-1985; Department of Human Services, Residential Facilities Division, 1986.

[a]Data for 1980 do not include Cambridge Regional Human Services Center.

retardation programs. While the department has not formally eliminated positions, it has held positions vacant. A January 1, 1986 report showed 169 vacancies.

In the past five years, ratios of certain professional staff to residents have also improved. For example, there were 16 social workers at Faribault in 1982. Today, Faribault still has 16 social workers, but the number of residents at the hospital has decreased by about 13 percent.

However, the hospitals have experienced difficulties in hiring and retaining special support staff, such as physical and occupational therapists, and speech pathologists. For example, under the consent decree, the hospital at Cambridge should have three physical therapists. However, it has never had more than one in the past two years. Similarly, the hospital at St. Peter has not been able to recruit physical therapists at all and relies on consultants to provide services.

Achievement of the staffing ratios has been accompanied by some friction between the plaintiffs and the Department of Human Services. During the state's 1981-1982 fiscal crisis, the plaintiffs challenged decisions by the Department of Human Services to cut funds for mental retardation program staff. The matter was eventually decided by Judge Larson who held that the department's actions violated the consent decree's requirements that the department protect mental retardation program staff and reallocate general and support positions. In July 1982, four months after Judge Larson's order was issued, the department agreed to spend up to $1.8 million in 1983 to fill staff vacancies in the hospitals.

## E. STATE HOSPITAL EXPENDITURES

State hospital expenditures have increased sharply in the past ten years. Some people have suggested that the increase is due to costs of compliance with the *Welsch* consent decree. We examined spending by state hospitals to determine whether expenditures on programs for mentally retarded persons increased as a result of the *Welsch* consent decree. Because some have suggested that programs for mentally ill and chemically dependent persons have suffered as a result of the consent decree, we examined how expenditures on programs for mentally retarded state hospital residents have changed in comparison to expenditures for mental illness and chemical dependency programs.

For this study, we reviewed the expenditures reported by the Reimbursement Division of the Department of Human Services. The division's figures are based upon actual spending by state hospitals for items such as food, fuel, wages and salaries, and equipment.[9] In addition, building bond interest, depreciation, and administrative overhead of the Department of Human Services and other agencies are included. These costs are either identified as direct program costs for each disability group, or are assigned to the groups at each state hospital in proportion to their population.

We examined state hospital expenditures in several different ways. First, we compared total expenditures from 1975 to 1985 for each disability group throughout state hospital system. Second, we computed average per day expenditures throughout the system for each disability group. We believe that "per patient day expenditures" is a better measure of changes in spending for each group than "total expenditures", because per patient day expenditures take into account the population variations over a period of years. Finally, we reexamined these expenditures adjusting them for inflation.

### 1. TOTAL EXPENDITURES

Table 2.8 shows total expenditures by state hospitals from 1975 to 1985. We found that state hospital expenditures have grown considerably since 1975.

- Between 1975 and 1985, state hospital expenditures increased 147 percent, from $66.9 million in 1975, to $165.5 million in 1985.

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[9]The Reimbursement Division prepares expenditure reports for the purpose of requesting Medical Assistance and Medicare payments from the federal government. The Financial Management Division of the Department of Human Resources also reports expenditures by state hospitals. Figures from that division do not include interest, depreciation, or expenses of other divisions. The reports are used to account for allocations to state hospitals, and as planning tools for the department.

However, the increase has not been spread evenly over the three disability groups. Chemical dependency programs experienced the greatest percentage increase, with expenditure growth of 194 percent over the eleven-year period. Expenditures for mental retardation programs grew by 151 percent, while spending for mental illness programs increased 127 percent.

## 2. EXPENDITURES PER PATIENT DAY

Table 2.9 compares expenditures per patient day among the three disability groups served in state hospitals.[10] When we used this measure, a different trend emerged. In 1975, per day expenditures for mental retardation programs at state hospitals were lower than those for the other two disability groups. By 1978, expenditures per patient day were highest for mental retardation programs and lowest for chemical dependency programs. Between 1978 and 1985, per day expenditures for mental retardation programs remained higher, and grew at a faster rate than expenditures for other programs. Over the eleven-year period, per day spending quadrupled for mental retardation programs. Spending for mental illness programs tripled, and per day expenditures for chemical dependency programs increased two and one-half times.

## 3. EXPENDITURES ADJUSTED FOR INFLATION

In 1975, total state hospitals expenditures were $66.9 million. Expenditures in 1985 were $165.5 million, an increase of $98.6 million. Of that increase, however, $81.1 million was due to increased *prices*; that is, the same amount of goods and services was purchased, but at higher prices. Only $17.5 million represented increased *purchases*.[11]

Figure 2.2 shows adjusted expenditures at state hospitals. In constant 1975 dollars, total real expenditures for state hospital mental retardation programs increased 27.8 percent between 1975 and 1985. During the same period, expenditures for mental illness programs increased 15.5 percent, and those for chemical dependency programs increased 49.9 percent in real terms.

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[10]We computed the number of patient days by multiplying the average population of each group by 365 days. We then divided total expenditures by patient days to arrive at expenditures per patient day for each group. The per day expenditures computed here are not the same as the per diem reimbursement rates used by the state hospitals. For 1986, those rates are $147.35 for mentally retarded state hospital residents, $116.30 for mentally ill patients, and $92.30 for chemically dependent patients.

[11]Because some of the increase in state hospital expenditures has been due to increased prices, we deflated expenditures using a consumer price index prepared by the Bureau of Labor Statistics, United States Department of Labor.

TABLE 2.8

STATE HOSPITAL EXPENDITURES, BY DISABILITY GROUP

| | Mentally Retarded | | Mentally Ill | | Chemically Dependent | | |
|---|---|---|---|---|---|---|---|
| | Expenditures | Percentage Of Total | Expenditures | Percentage Of Total | Expenditures | Percentage Of Total | Total |
| 1975 | $39,322,557 | 58.8% | $21,025,399 | 31.4% | $ 6,573,796 | 9.8% | $ 66,921,752 |
| 1976 | 45,475,451 | 59.3 | 23,575,524 | 30.8 | 7,581,361 | 9.9 | 76,632,336 |
| 1977 | 51,559,857 | 57.9 | 27,827,333 | 31.3 | 9,645,683 | 10.8 | 89,032,873 |
| 1978 | 57,683,545 | 57.2 | 31,319,939 | 31.1 | 11,812,699 | 11.7 | 100,816,183 |
| 1979 | 62,507,214 | 57.8 | 33,477,597 | 30.9 | 12,206,030 | 11.3 | 108,190,841 |
| 1980 | 68,719,678 | 57.7 | 36,893,305 | 31.0 | 13,491,423 | 11.3 | 119,104,406 |
| 1981 | 74,846,692 | 57.9 | 39,409,988 | 30.5 | 15,098,712 | 11.7 | 129,355,392 |
| 1982 | 81,706,161 | 59.5 | 42,194,264 | 30.7 | 13,345,200 | 9.7 | 137,245,625 |
| 1983 | 87,278,655 | 61.2 | 40,086,070 | 28.1 | 15,298,140 | 10.7 | 142,662,865 |
| 1984 | 96,471,204 | 60.7 | 45,020,831 | 28.3 | 17,553,444 | 11.0 | 159,045,479 |
| 1985 | 98,566,710 | 59.6 | 47,632,276 | 28.8 | 19,319,141 | 11.7 | 165,518,127 |

Source: "Disbursements For All Purposes", Institutions Budget Unit, Financial Management Division, Bureau of Support Services, Department of Human Services; Title XIX Cost Settlement Reports, Reimbursement Division, Bureau of Support Services, Department of Human Services, 1975-1985.

TABLE 2.9

STATE HOSPITAL EXPENDITURES PER PATIENT DAY

| | Mentally Retarded | Mentally Ill | Chemically Dependent |
|---|---|---|---|
| 1975 | $ 30.95 | $ 33.48 | $32.36 |
| 1976 | 37.14 | 40.79 | 36.78 |
| 1977 | 45.66 | 46.90 | 44.90 |
| 1978 | 54.44 | 54.49 | 50.58 |
| 1979 | 61.43 | 58.15 | 51.95 |
| 1980 | 69.85 | 66.14 | 57.87 |
| 1981 | 80.38 | 74.47 | 62.41 |
| 1982 | 92.67 | 86.29 | 58.91 |
| 1983 | 103.82 | 84.77 | 65.62 |
| 1984 | 120.96 | 99.93 | 80.61 |
| 1985 | 130.42 | 105.38 | 87.54 |

Source: "Disbursements For All Purposes," Institutions Budget Unit, Financial Management Division, Bureau of Support Services, Department of Human Services; Title XIX Cost Settlement Reports, Reimbursement Division, Bureau of Support Services, Department of Human Services, 1975-1985.

Again, expenditure figures are more meaningful when considered on a per patient day basis. As Figure 2.3 shows, adjusted expenditures per patient day at state hospitals increased substantially.

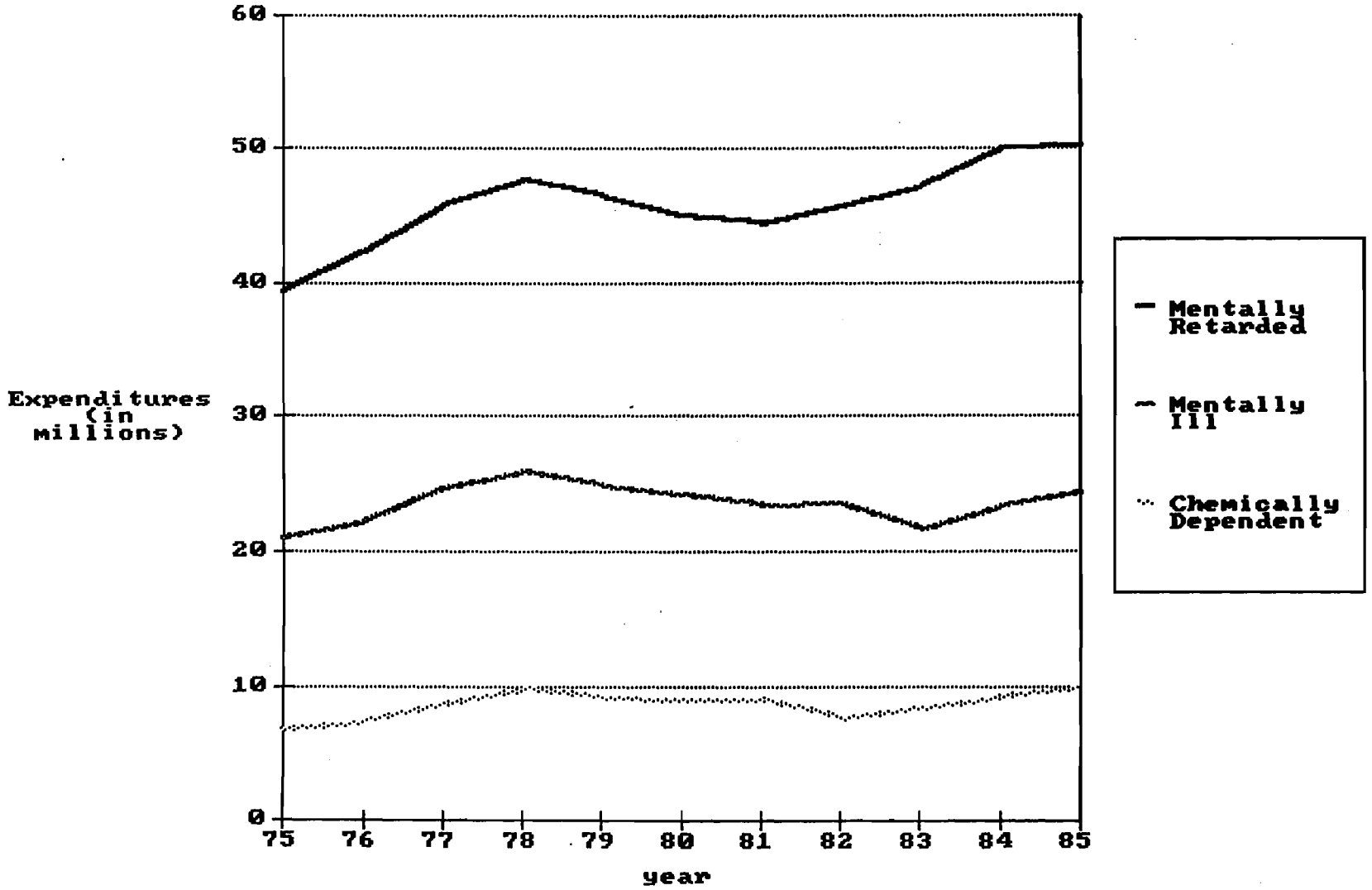
- Real expenditures per day for mental retardation programs increased 115 percent between 1975 and 1985. Per day expenditures for mental illness programs increased 60.5 percent over the period, while expenditures for chemical dependency programs grew 37.9 percent.

Between 1978 and 1980, average real expenditures per day actually decreased for mentally ill patients. Expenditures for chemical dependency programs also decreased in 1979, 1981, and 1982. During each of those years, per day expenditures for mentally retarded residents continued to increase.

## 4. CONCLUSIONS

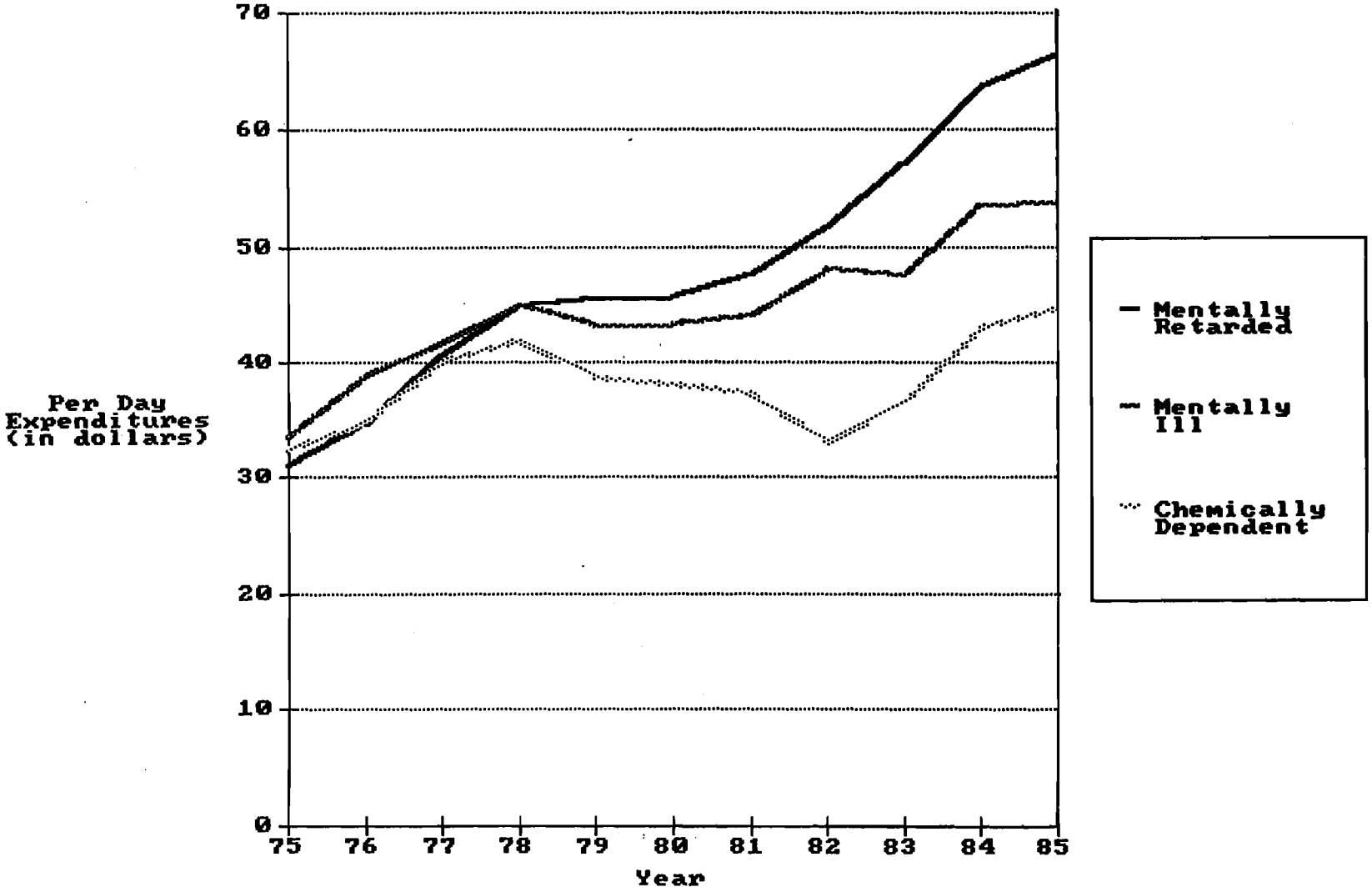
To the extent that expenditures are a measure of the state's commitment to a program, state spending since 1975 indicates a genuine attempt to upgrade programs for state hospital residents. Programs for mentally retarded residents have fared somewhat better than those for mentally ill and chemically dependent patients. While expenditures on programs for

Figure 2.2
TOTAL STATE HOSPITAL EXPENDITURES
IN REAL DOLLARS, BY DISABILITY GROUP
1975-1985




Source: Title XIX Cost Settlement Reports, 1975-1985; Reimbursement Division, Bureau of Support Services, Department of Human Services; and analysis by Office of the Legislative Auditor, Program Evaluation Division.

Figure 2.3
STATE HOSPITAL EXPENDITURES
PER PATIENT DAY, IN REAL DOLLARS
1975-1985




Source: Title XIX Cost Settlement Reports, 1975-1985; Reimbursement Division, Bureau of Support Services, Department of Human Services; and analysis by Office of the Legislative Auditor, Program Evaluation Division.

mentally retarded residents grew steadily even during periods of fiscal crises in the state, programs for the other two disability groups suffered funding cuts during those times.

## F. INVESTMENT IN BUILDINGS

We analyzed the size of Minnesota's investment in the state hospital physical plant in light of a declining patient and resident population. We also calculated the state's cost of complying with the physical plant requirements of the *Welsch* consent decree.

### 1. TOTAL EXPENDITURES

From 1976 to 1985, the Department of Human Services spent about $55 million for building improvements, renovation, and construction at state hospitals. Of that amount, $13.1 million was spent to build three new buildings at state hospitals: $1.5 million for the Chemical Dependency Center at Anoka; $9.6 million for the new Minnesota Security Hospital at St. Peter; and $2 million for the Activities Building at Willmar. Because these expenditures were for new structures, we separated them from total expenditures. After subtracting the cost of new construction, total expenditures for improvements were $41.9 million.

We compared expenditures for building improvements to the average number of licensed beds at each state hospital, in order to assess the distribution of building funds across the system. We found that:

- Building expenditures have not been evenly distributed across the eight campuses. The two facilities which provide only mental retardation programs have received a higher proportion of building funds than would be expected on the basis of their licensed beds.

From 1976 to 1985 the hospital at Cambridge had an average of 11.7 percent of all licensed beds in the system, but received 14.5 percent of improvement funds. Faribault, with an average of 17.0 percent of licensed beds, received 24.0 percent of all improvement funds. All of the other campuses received a lower proportion of building funds on the basis of their licensed beds. The largest difference was at Willmar, which averaged 11.5 percent of licensed beds over the ten-year period, but received only 7.5 percent of building improvement funds.

### 2. EXPENDITURES BY PURPOSE

We also analyzed individual improvements to shed light on the relative impact of the *Welsch* consent decree, federal certification requirements, and other factors, in determining expenditures.

In 1974, the federal government published standards which state institutions must meet in order to obtain certification as Intermediate Care Facilities for Mentally Retarded persons (ICFs-MR).[12] Certification is necessary before hospitals can receive funding under the Medical Assistance program. Federal regulations require resilient floor covering; air conditioning, or other forms of ventilation; and privacy in bathing and toilet areas. In addition, the regulations specify minimum sizes for resident bedrooms, and list furniture required for individual resident use. Buildings certified as ICFs-MR must be accessible to physically handicapped persons and must meet safety standards for emergency lighting, fire escapes, and smoke alarms.

In 1977, the parties in the *Welsch* case agreed to a consent decree which applied only to the hospital at Cambridge. This decree required certain physical plant improvements, including air conditioning in two large residential buildings; carpeting, or other resilient floor covering, in residential and program areas; and private storage space, chests of drawers, and table or desk for each resident.

A later consent decree in 1980 affected all state hospitals serving mentally retarded persons. It included some new requirements: air conditioning was to be installed in some areas of the hospital at Fergus Falls; all hospitals were required to remodel bathing and toilet areas, as necessary to provide privacy for residents; and carpeting or alternative floor covering was mandated at all hospitals in areas used by mentally retarded residents.

Dramatic changes have occurred in the arrangement of residents' living space as a result of the federal mandates and *Welsch* requirements. The number of people residing in each building has declined. Units which were once open wards with beds for 60 or more people, have been remodeled into households for 16 or fewer residents. No more than four persons may share a bedroom. Residents now dine family style in areas of their own households, rather than in large, communal dining halls. At Faribault, where four large residential buildings have not yet been remodeled, we were able to see the contrast between the old and new designs. While the remodeled units still have an institutional look, they appear warmer, more homelike, and much more comfortable than the old open wards.

However, not all of the transformations have been as successful as those in the household units. Only a few buildings were originally designed for educational activities. On some campuses, we saw former dormitories which have been converted to day programming space. We were told by staff, and saw for ourselves, that the space was inadequate for some uses, especially where industrial training, rather than classroom activities, was conducted. We learned that, in some cases, residents who could have benefited from a work-oriented program could not be accommodated because of lack of space. At the hospital in Cambridge, we saw one workshop where residents participate in a variety of projects. We were told by staff

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[12] 42 CFR §442.400 - .516.

that they would like to expand the types of projects available, both to provide more useful training for residents and to provide training for a greater number of residents. They say that they are unable to do so, however, because of the kind of space which is available.

Although the physical plant requirements of the *Welsch* consent decree are very similar to federal certification standards, we grouped them separately. We counted expenditures for items specifically mentioned in the decree as *Welsch expenditures*. We grouped any other expenditures which have been made to meet federal requirements as *certification expenditures*. We divided the remaining expenditures into three categories: *maintenance*, *equipment*, and *construction*. The maintenance category included road and parking lot repairs, roof repairs, and general renovations. Items such as kitchen equipment and lighting fixtures were included in the equipment category. The construction category included the three new buildings mentioned above.

Table 2.10 shows expenditures, by purpose, for the individual hospitals. We found that:

- *Welsch* expenditures were only about $1.4 million over the ten year period, or 3.4 percent of the total, exclusive of new construction.[13]

- Federal certification expenditures were much larger--48.2 percent of the total.

- Maintenance and equipment expenditures together were 48.5 percent of total expenditures.

3. BUILDING EXPENDITURES BY DISABILITY GROUP

We analyzed expenditures to improve buildings used by each of the three disability groups and for general campus use. In general, the Legislature and the Department of Human Services do not assign building expenditures to specific disability groups. We followed three steps in making this allocation. First, we determined which buildings were included in particular projects, and which disability groups used the buildings at the time of the project. Second, where different groups used the same building, we allocated the costs in proportion to the space in that building used by each group. Our final step was to group all expenditures for improvements to general use areas. This includes auditoriums, central kitchens, and grounds.

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[13]Note that $1.1 million has been appropriated, though not yet spent, for carpeting in state hospitals, as required in the consent decree.

TABLE 2.10

BUILDING EXPENDITURES, BY HOSPITAL, BY PURPOSE
1976-1985

| State Hospital | Welsch Compliance | Certification | Maintenance & Equipment | SUBTOTAL | Construction | TOTAL |
|---|---|---|---|---|---|---|
| Anoka | $ 0 | $ 1,016,600 | $ 1,875,300 | $ 2,891,900 | $ 1,500,000 | $ 4,391,900 |
| Brainerd | 104,000 | 3,240,300 | 1,781,210 | 5,125,510 | 0 | 5,125,510 |
| Cambridge | 290,000 | 2,772,590 | 2,877,898 | 5,940,488 | 0 | 5,940,488 |
| Faribault | 280,000 | 4,315,715 | 5,452,138 | 10,047,853 | 0 | 10,047,853 |
| Fergus Falls | 380,000 | 1,967,093 | 2,404,394 | 4,751,487 | 0 | 4,751,487 |
| Moose Lake | 65,000 | 2,945,880 | 2,038,319 | 5,049,199 | 0 | 5,049,199 |
| St. Peter | 137,000 | 2,582,432 | 2,376,776 | 5,096,208 | 9,562,000 | 14,658,208 |
| Willmar | 170,000 | 1,355,600 | 1,518,539 | 3,044,139 | 2,000,000 | 5,044,139 |
| TOTALS | $1,426,000 | $20,196,210 | $20,324,574 | $41,946,784 | $13,062,000 | 55,008,784 |

SOURCE: Project Status Reports, 1978-1985, Department of Administration, Architectural and Engineering Division, Division of State Building Construction, Design and Construction Services; Analysis by Office of the Legislative Auditor, Program Evaluation Division, October 1985.

Table 2.11 shows expenditures for improvements to buildings used by each of the three disability groups at individual state hospitals. We found that:

- The largest portion of building funds (41 percent) was used for improvements to general purpose areas.

- Much more was spent to improve buildings used by mental retardation programs than those used by mental illness or chemical dependency programs.

As the table shows, 37.3 percent of the funds went to improve buildings for mental retardation programs. Buildings for mental illness programs received 16.3 percent of total improvement funds, and 5.3 percent went to improve buildings used by chemical dependency programs.

## 4. PROGRESS TOWARD *WELSCH* COMPLIANCE

We found that:

- Compliance with the physical improvements required in the *Welsch* consent decree has not been costly to the state.

In ten years, only $1.4 million has been spent for improvements required by *Welsch*. However, we have also found that some improvements required by the consent decree were not completed on schedule. In some cases, the department has not completed projects even though the Legislature appropriated funds several years ago. This means that required improvements have not been made. For example, the consent decree required completion of improvements to the Achievement Center for the Physically Handicapped at Fergus Falls, no later than May 1983. Those improvements were not completed until October 1985. Furthermore, while allocations were made in 1984 and 1985 for floor coverings at all campuses, nothing has been installed. Finally, the decree required that bath and toilet areas be modified, as needed, by July 1, 1981, to ensure privacy. Modifications of certain buildings at Faribault did not begin until 1985.

Delays in remodelling affect residents who live in uncomfortable, unattractive institutional settings. Moreover, failure to comply with federal regulations could result in financial penalties against the state. In May 1985, auditors from the U.S. Department of Health and Human Services Health Care Financing Administration threatened decertification and financial penalties at the Faribault hospital, where four large residential buildings do not meet standards for privacy in living areas. Since then, the Department of Human Services has obtained approval to spend approximately $1 million left over from previous appropriations to renovate three of the buildings. The fourth building will be converted to non-residential use. We were told by Faribault staff that they have not received approval for these plans from federal authorities. The project will begin in January 1986, and is expected to be completed by June 1987.

TABLE 2.11

BUILDING EXPENDITURES BY HOSPITAL, BY DISABILITY GROUP
1976-1985

| State Hospital | Mentally Retarded | Mentally Ill | Chemically Dependent | General | Total[a] |
|---|---|---|---|---|---|
| Anoka | | $1,189,015 | $ 15,624 | $ 1,250,261 | $ 2,454,900 |
| Brainerd | $ 1,584,199 | 433,866 | 163,137 | 1,540,346 | 3,721,548 |
| Cambridge | 2,865,581 | -- | -- | 2,064,907 | 4,930,488 |
| Faribault | 5,304,178 | -- | -- | 4,328,675 | 9,632,853 |
| Fergus Falls | 1,061,973 | 848,784 | 350,061 | 1,751,315 | 4,012,133 |
| Moose Lake | 1,552,975 | 1,513,166 | 677,874 | 1,235,437 | 4,979,452 |
| St. Peter | 1,362,372 | 1,478,467 | 215,988 | 1,827,881 | 4,884,708 |
| Willmar | 361,462 | 637,998 | 575,640 | 1,333,039 | 2,908,139 |
| TOTAL | $14,092,740 | $6,101,296 | $1,998,324 | $15,331,861 | $37,524,221 |

Source: Project Status Reports, 1978-1985, Department of Administration, Architectural and Engineering Division, Division of State Building Construction, Design and Construction Services; analysis by Office of the Legislative Auditor, Program Evaluation Division, October 1985.

[a]Analysis based on $37,524,221, or 68.2 percent of the total expenditure of $55,008,784 which we were able to allocate. About 8 percent was not allocated.

## 5. CAPITAL PLANNING BY THE DEPARTMENT OF HUMAN SERVICES

As the populations of state hospitals have declined, more building space has become available. As a result, some buildings, or parts of buildings, have been vacated. We examined how well DHS has planned for these vacancies, and how much has been spent over the years on buildings which are now vacant, or which are likely to be vacated in the near future.

A 1984 study by the Developmental Disabilities Program of the State Planning Agency showed vacant or storage space on state hospital campuses ranging from seven percent of total building space at Moose Lake to 26 percent at Anoka. All campuses, except the one at Moose Lake, have some totally vacant buildings. In addition, many campuses have space which has been leased to other organizations, and some campuses have buildings which will be vacant within the next year or so.

The hospital at Cambridge recently consolidated several buildings. At one time, the hospital had twelve residential buildings. Currently, seven buildings and part of another are used as residences. The buildings have a total bed capacity of 446. The other five buildings were licensed for 140 residents. At present, one of them is used for day programming, one is leased to community organizations, and three are vacant. We were told by staff at the hospital that as of November 13, 1985, the day the final resident transfers were made, all residential space was filled to capacity.

- In the ten years since 1976, almost $2 million has been spent to improve buildings which are currently vacant or partially vacant.

We estimate that about five percent of the expenditure was necessary to prevent deterioration of the buildings. The remainder was used to meet federal certification requirements in buildings at the Brainerd, Cambridge, Faribault, Fergus Falls, and Willmar state hospital campuses.

## 6. CONCLUSIONS

After much delay, most of the improvements required by the consent decree are now underway. We conclude that:

- The Department of Human Services and the state hospitals should be in substantial compliance with the physical plant requirements of the *Welsch* consent decree by 1987.

We are concerned that money was spent to improve buildings that are no longer used, while buildings on other campuses have gone without necessary improvements. The department operates in a very dynamic environment which makes planning beyond the current biennium difficult. However, the department should strengthen its efforts in long-range facility planning, if only so that it can analyze the impact of deviations from its plans.

In 1982, the Department of Human Services completed a survey of state hospital buildings which detailed the physical condition of each building. We recommend that:

- The department should use its hospital building survey, in conjunction with its timetable for population reduction, in order to carefully target improvements to buildings which will be used in future years, and which can be brought up to certification standards most economically.

# COMPLIANCE WITH THE WELSCH CONSENT DECREE

## Chapter 3

In the previous chapter, we discussed four areas where the Department of Human Services has generally complied with key requirements of the consent decree. In this chapter, we will review the mechanisms for monitoring compliance with the decree and examine some of the major compliance issues that have arisen since 1980. We will then focus on three areas where the department's record of compliance is mixed, and where additional attention by the department and the Legislature is needed if the department is to be in substantial compliance in July 1987.

The three areas are:

- admission and discharge of children to state hospitals,
- treatment programs for individuals, and
- appropriateness of community placement.

### A. COMPLIANCE MONITORING AND ENFORCEMENT

#### 1. ENFORCEMENT MECHANISMS

The federal court has appointed a monitor to oversee implementation of the consent decree. The monitor's duties include periodically reporting to the court on the department's compliance with the decree and investigating allegations of non-compliance. The monitor's salary and expenses are paid by the Department of Human Services, although the monitor is independent of the department. The first court monitor was a psychologist who had previously worked in state hospitals in Minnesota and elsewhere. The current court monitor is an attorney who previously worked in special education law in other states.

The consent decree establishes procedures to be followed when the plaintiffs allege non-compliance with the decree. Allegations are submitted to the court monitor for investigation. If the monitor finds reason to

believe that the allegations are supported by fact, then he notifies the parties and requests that the department correct the situation. If the department does not act, the parties can go through a series of progressively more formal steps to resolve the issue. These steps range from informal negotiations not involving the court monitor, to a formal hearing before the court monitor. In order to implement the monitor's recommendations, one of the parties must make a formal motion to the federal court.

### 2. TRENDS IN COMPLIANCE ISSUES

In the first year after the consent decree took effect, the plaintiffs raised 858 allegations of non-compliance. Almost all of these allegations dealt with the implementation of consent decree requirements by individual hospitals. For example, 55 percent of the compliance questions dealt with the use of mechanical restraints, seclusion, and separation for residents. Many other questions related to the provision of individual treatment plans and the use of major tranquilizers. The plaintiffs raised a relatively small number of allegations (49 in all) in the area of community placements, including timeliness of post-discharge assessments and appropriateness of community residential and development services.

Since 1982, the number of non-compliance allegations has declined. The plaintiffs have shifted their attention away from compliance questions at individual hospitals and toward statewide issues such as the appropriateness of community placements.

## B. CHILDREN UNDER THE *WELSCH* CONSENT DECREE

The consent decree discourages placement of children (under 18 years) in state hospitals in two ways:

- The decree permits state hospitals to admit mentally retarded persons, including children, only if no appropriate community placement is available.

- If a child must be admitted to a state hospital, then the responsible county is required to develop an appropriate community placement so that the child's hospital stay does not exceed one year.

If difficulties arise in developing a placement for a child, the county must request an extension of the stay within nine months of the date of the original admission.

We analyzed the current status of children in state hospital mental retardation programs, and changes that have occurred since the consent decree took effect in 1980. We used data from the state hospital billing system, as well as information gained from interviews with state hospital and

Department of Human Services staff, and the plaintiffs in the *Welsch* case.[1] We examined how many children have been admitted to and discharged from state hospitals. Our analysis sheds light on the efforts being made to find community placements for children remaining in state hospitals.

## 1. COMPLIANCE WITH REQUIREMENTS FOR *WELSCH* CHILDREN[2]

State hospitals have continued to admit children since 1980, and have often discharged them only after one year has passed. We found that the Department of Human Services has not fully complied with these provisions of the decree:

- At least 340 children have been admitted to state hospitals since September 1980.

This includes many children admitted to the Minnesota Learning Center at Brainerd, as well as 37 children admitted for respite care.

- Of the 239 children who were eventually discharged, 55 had stayed beyond the one-year limit.

- Sixteen *Welsch* children in state hospitals as of November 1985 have exceeded the one-year limit.

Children are admitted to state hospitals for a number of reasons. In many cases, they are medically fragile and require intensive nursing and medical services. In other cases, the children have severe behavior problems, which also require intensive treatment. The problems of these children are sometimes referred to as *low incidence*, meaning that only a few similar cases exist. Services for such children are very expensive, and are not available in some smaller counties. When a county has only one or two children with similar needs, it may be unable to develop services for them, or may be reluctant to do so, because of the expense involved.

The *Welsch* decree states explicitly that the Commissioner of Human Services is responsible for compliance with all decree provisions. The court has found that a shortage of funds or lack of cooperation by coun-

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[1]Reports extracted by staff of the Office of the Legislative Auditor from computer records of the state hospital billing system. Reports cover years 1982 through 1985.

[2]Children admitted to state hospitals since September 15, 1980, are considered *Welsch children*, that is, affected by the one-year limitation on state hospital residency required by the consent decree. These children do not "age out". They will be included under the special provisions for children even after they reach 18 years of age.

ties does not relieve the Commissioner of his responsibilities.[3] If counties cannot, or will not, provide services in the community for mentally retarded children, then the department must see that they are provided.

Table 3.1 shows the number of admissions and discharges of children at state hospitals, and their lengths of stay. (The hospital at Moose Lake is not licensed for, and does not admit, persons under 18 years of age.) For children who were eventually discharged, lengths of stay ranged from one day to more than four years; the median stay was about eight months. We were told by state hospital staff that children are sometimes admitted for short-term observation or behavior management intervention, which may explain some very short visits.[4]

TABLE 3.1

CHILDREN ADMITTED TO STATE HOSPITALS SINCE SEPTEMBER 15, 1980

| Hospital | Non-Respite Admissions | Respite Admissions | Discharged | Length of Stay |
|---|---|---|---|---|
| Brainerd | 232 | 4 | 163 | 16 days to 50 months |
| Cambridge | 32 | 4 | 20 | 1 day to 31 months |
| Faribault | 16 | 6 | 22 | 1 day to 38 months |
| Fergus Falls | 13 | 4 | 11 | 5 days to 47 months |
| St. Peter | 2 | 8 | 8 | * |
| Willmar | 8 | 11 | 15 | 1 month to 39 months |
| TOTAL | 303 | 37 | 239 | 8 months (median) |

Source: State hospital billing system records, 1982-1985; Questionnaire completed by state hospital staff, November 1985.

*All children discharged from St. Peter had been admitted for respite visits.

[3] *Welsch v. Noot*, United States District Court, District of Minnesota, No. 4-72-Civ. 451, July 14, 1982.

[4] About 10 percent of the admissions were for *respite* care. Respite visits are designed to provide temporary care for mentally retarded persons who are normally cared for at home. The visits are limited to 180 days per year. Although an individual may have several respite visits in one year, each stay is typically short, often only for a weekend.

The majority of the children admitted to state hospitals have been residents of the hospital and Minnesota Learning Center at Brainerd. Minnesota Learning Center serves higher functioning adolescents with behavior problems, many of whom are placed there by the courts. From 1982 to 1985, 236 children were admitted to the hospital at Brainerd, and 163 were discharged. Of those eventually discharged, 31 had been residents for longer than one year. The median length of stay was about 250 days.

Table 3.2 shows the number of *Welsch* children currently residing in state hospitals, and the number who have been residents for longer than one year. Billing system records showed that 108 children have been admitted to state hospitals since September 1980, and have not yet been discharged. However, there are discrepancies between billing system and state hospital records. Twenty-four of the 108 children for whom we could find no discharge date were confirmed as still in residence by hospital staff. Seven of these children have been state hospital residents for one to two years, and nine have been residents for more than two years.

TABLE 3.2

CURRENT *WELSCH* CHILDREN
(November 1985)

| | According to Data From Billing System | | According to Data From Hospital Staff | |
|---|---|---|---|---|
| Hospital | Residents | Past 1 Year | Residents | Past 1 Year |
| Brainerd | 77 | 67 | 13 | 5 |
| Cambridge | 16 | 16 | 6 | 6 |
| Faribault | 1 | 1 | 0 | 0 |
| Fergus Falls | 7 | 7 | 2 | 2 |
| St. Peter | 2 | 2 | 1 | 1 |
| Willmar | 5 | 5 | 2 | 2 |
| TOTAL | 108 | 98 | 24 | 16 |

Source: State hospital billing system records, 1982-1985; Questionnaire completed by state hospital staff, November 1985.

Since the consent decree does permit extensions of stay, we examined whether counties had requested extensions in a timely manner. In 12 of the 55 cases, the responsible county requested an extension within nine months of admission. For 22 other children, the county's request was not timely. In the remaining 21 cases, there is no evidence that the county ever requested an extension.

b. *Case History*

A case history of one state hospital resident illustrates the types of problems which concern plaintiffs. The resident is a 15-year old boy who has been hospitalized since April 1983. In 1985, when the boy had already been in a state hospital for almost two years, a hearing was held before the court monitor to consider his responsible county's request for an extension of his stay there. The findings from the hearing include a description of the child's physical handicaps, which are partially responsible for his long stay in the institution. In addition to profound mental retardation, he suffers from epilepsy, scoliosis, myopic astigmatism, and a hearing loss. He has undergone a gastrostomy, and is fed through a tube.

The parties involved in the hearing included the child's parents, staff from his home county, staff of the state hospital and the Department of Human Services, and counsel for the plaintiffs in the *Welsch* case. The community alternative favored by all parties is a 32-bed ICF-MR which serves medically fragile children. Although a smaller facility would be preferable, none currently exists which could meet this child's needs. The larger facility was chosen because it is able to meet his needs, would provide a permanent placement, has a proven track record for caring for children with similar needs, and is close to appropriate medical services and to the parents' home. The facility would consider accepting the child in the program, but currently has no openings.

The issue which concerns the plaintiffs, then, is not where the child should be placed, but the adequacy of efforts by the county and the Department of Human Services to place him in an appropriate setting *in a timely manner*. The county did not apply for an extension of the boy's stay at the state hospital until he had been there more than one year, and not until after it had been reminded to do so by the court monitor. If the county had started the search for an appropriate placement when it should have, the child could possibly have been in his new residence as much as a year earlier. The court monitor found no evidence that the county or the department had planned for his service needs, or had made any attempt to develop or facilitate the development of a residential placement for him, as both the consent decree and state law require.

Although the monitor found that the county had made little effort to locate a community setting for this child, he placed the ultimate responsibility with the state. The Commissioner of Human Services must ensure that a child does not remain in a state hospital for more than one year, and that counties provide or develop community services. The commissioner did not fulfill his responsiblities in this case.

A second state-level issue is the department's failure to take all possible steps to provide community placements for state hospital residents. The preferred setting in this particular case is unavailable because of lack of space. At the same time, several current residents of the facility could move to a less restrictive setting, if one were available. In spite of the moratorium on new ICF-MR beds, the department could license new residential facilities for severely handicapped individuals. The

moratorium legislation permits such limited development, if the department would decertify existing programs. However, the department has refused to pursue this course. The department told us that arrangements have been made to discharge the child in this case history in February or March of 1986.

c. *Department Efforts at Compliance*

The Department of Human Services has taken several actions to implement provisions of the decree which relate to children. In April 1981, the department released Instructional Bulletin #81-31, outlining counties' responsibilities for admission of children to state hospitals. A June 1983 memorandum from the department to chief executive officers of the state hospitals *suggested* that they inform parents and county social workers of the one-year limit on state hospital stays for children. Another memorandum to state hospitals, dated May 1984, dealt with respite care for children at state hospitals. This memo said that, before admitting a child for respite care, a state hospital must receive documentation from the county explaining why community respite services were not used, and how they will be developed in the future.

Instructional Bulletin #84-29 (May 1984) outlined procedures for admitting children to state hospitals. It included the requirement that counties enter into an agreement with the state hospitals which includes a description of the county's efforts to locate or develop appropriate community services; a list of the services which will be provided for the child at the state hospital; a stipulation that the county will take any necessary action to assure that the child's stay at the state hospital does not exceed one year; and an outline of the assistance which state hospital and Department of Human Services staff will offer to the county.

As of October 1985, the department was in the process of developing a proposal to provide services for a number of medically fragile children. Under the proposal, the department would arrange community-based services for four children who have been residents of state hospitals for more than one year, and whose responsible counties have not provided community services.

The department has begun to use waiver services as placements for children from state hospitals. Because these children's service needs are often much more expensive than those usually allowed through the waiver, the department has received permission to authorize special rates for a small number of children. This has enabled counties to develop small residences with specialized support services.

Finally, in August 1985, the department announced that, as of January 1, 1986, state hospitals would no longer accept respite admissions of mentally retarded persons, except for those who are wards of the state (Instructional Bulletin #85-90). Although the ban on respite admissions applies to all mentally retarded persons, it especially affects children. The Department apparently intends to encourage the development of similar services in the community by ending this service at state hospitals.

### 3. CONCLUSIONS

We have seen several well-documented cases of children who have been residents of state hospitals for well over one year. State hospital staff agree that these children are ready for community placement, but they have not been discharged because their responsible counties are unwilling or unable to provide an appropriate community placement. The court monitor has found that the department generally does nothing to encourage counties to plan for community placements early in a child's state hospital stay. In addition, even after a child has passed the one-year limit, the department does not require the county to provide community-based services.

In the past few months, the department has begun to exercise the leadership needed in this area. It has developed new resources and, through its technical assistance staff, helped counties to utilize existing services.

## C. TREATMENT

One of the key findings in the *Welsch* court case was that residents of state institutions have a constitutional right to minimally adequate care and treatment in the least restrictive setting which is appropriate to their mental and physical needs. The court also found that some uses of seclusion rooms, physical restraints, and tranquilizing medications violated residents' Eighth Amendment right to be free of cruel and unusual punishment.

The consent decree requires that state hospital staff prepare individualized habilitation plans and programs of training and remedial services for each resident. The terms of the decree also impose limitations on the use of mechanical restraints, seclusion, and major tranquilizers to control the behavior of residents of state hospitals.[5,6]

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[5]In the decree, *mechanical restraints* refers to any device that is used to restrict the movement of an individual's body. These include restraint chairs, four-point restraint to a bed, arm boards, face masks, papoose boards, etc. The decree specifically exempts all forms of manual restraint, that is holding of a resident by another person. *Seclusion* is defined as placing a resident alone in a locked room. In the past, seclusion rooms in state hospital wards were very small, bare rooms, with an observation window in the locked door. When used today, seclusion rooms must be reasonably comfortable and free of any hazards to the resident.

[6]As defined in the decree, "*major tranquilizers* refers to medications which are phenothiazines, thioxanthines, butyrophenones, and other similar medications, which would customarily be classified as antipsychotic agents." Two measures have been used to determine whether each hospital's use of major tranquilizers is appropriate--the *propor-*

We discussed these issues with mental retardation program staff at each of the state hospitals. We asked about changes that have occurred in treating mentally retarded state hospital residents, and in particular, about changes in the use of mechanical restraints, seclusion and psychotropic drugs. We also examined reports of the court monitor for the *Welsch* case and program reviews conducted by an outside consultant at three of the state hospitals. We found:

- State hospitals are not yet in complete compliance with the treatment provisions of the *Welsch* consent decree.

## 1. REQUIREMENTS REGARDING TREATMENT PLANS

The consent decree requires that hospital staff prepare an individualized habilitation plan for each resident of a state hospital mental retardation program. This is also required by Department of Human Services Rule 34, the licensing standard for state hospital and community programs. The individual plans are to be directed toward the acquisition of skills which will enhance the resident's quality of life, improve functioning and independence, and allow him/her to move to a less restrictive environment. They must be reviewed and evaluated periodically, and altered as necessary to meet the changing needs of the individual resident.

## 2. COMPLIANCE WITH REQUIREMENTS FOR TREATMENT PLANS

In order to evaluate program efforts at state hospitals, the Department of Human Services drafted a Quality Assurance Implementation Plan in 1984. The plan requires an annual review of each state institution. To implement the plan, the department retained an outside consultant who, along with staff of the department and of state hospitals, conducted program reviews at three state hospitals: Cambridge, Faribault, and Fergus Falls. The reviews, which were conducted in July and October of 1984, examined the program plans of residents at each hospital. The reviewers focused on behavior management programs in particular.[7]

Although the reviewers were generally complimentary of the efforts that have been made at all three facilities, especially at Fergus Falls, they found that improvements were needed. They found that:

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*tion of residents* receiving the medication, and the *average dose* received. State hospitals have generally been compared to each other on these measures, although a national expert on the use of the drugs for mentally retarded persons was retained by the department to give a national perspective on their use in Minnesota's state hospital system.

[7]Several national studies have identified maladaptive behaviors as one of the major reasons for people failing in community placements and requiring readmission to state institutions. In order for many current state hospital residents to be successful in community settings, their behavior problems must be treated effectively while they are in the hospital.

- **Programs to train residents in daily living skills were often** poorly planned.

- **Direct care staff were not trained adequately and often did not understand the purposes behind the skill training and behavior modification programs they were expected to implement.**

- The hospitals did not record data on program outcomes in a manner which would allow for rational changes to be made based upon changes in residents' behavior.

The reviewers found that, while staff at Fergus Falls were generally well trained and motivated, they needed more direction to ensure that programs are provided consistently.

At both Faribault and Cambridge the reviewers found more serious problems. At Faribault, the reviewers found that programming for skill aquisition and behavior modification was simplistic and haphazard. Furthermore, most staff were not well-trained or motivated enough to develop adequate programs, especially for residents with severe behavior problems.

The reviewers found that direct care staff at Cambridge had little or no training in programming, and that poor records were kept of the programming which did occur. They found that behavior modification programs were lacking, and that maladaptive behaviors were often ignored or dealt with by tranquilizing the residents.

### 3. LIMITATIONS ON USE OF RESTRAINTS, SECLUSION, AND MAJOR TRANQUILIZERS

The consent decree prohibits use of mechanical restraints or seclusion for any mentally retarded resident of a state hospital, except when the use is authorized by a committee consisting of the chief executive officer of the institution; a licensed physician; two persons experienced in behavior management, one of whom must be a person not employed by the Department of Human Services or the state hospital; and the resident advocate at the institution. Use of restraints or seclusion may only be authorized if the use is part of a behavior management program.

When restraint or seclusion is authorized, it must be used only to affect specified behaviors which constitute a danger to the resident or to other individuals. The decree limits the amount of time a resident may spend in restraint or seclusion, and requires documentation of each use of restraint or seclusion.

Under the terms of the consent decree, major tranquilizers, also referred to as *psychotropic drugs*, may not be used for punishment of residents, for staff convenience, or as a substitute for programming. The drugs may be used only if prescribed by a licensed physician, and only to control specified behaviors which are dangerous to the resident or to others, or if it is shown that the resident's behavior interferes with implementation of his habilitation program. The decree also specifies documentation which must be maintained for any resident receiving the drugs, including

records of the incidence of behaviors which the drugs are designed to control.

Federal regulations governing Intermediate Care Facilities for Mentally Retarded individuals also limit the use of restraints, seclusion, and major tranquilizers. The requirements under those regulations are essentially the same as the *Welsch* requirements.

## 4. COMPLIANCE WITH LIMITATIONS ON RESTRAINT, SECLUSION AND MAJOR TRANQUILIZERS

We examined reports of the department and the court monitor to determine whether state hospital staff have complied with the terms of the decree relating to these matters. We found that, while some hospitals have substantially reduced their use of restraint and seclusion, others report increased use. Specifically:

- Only at Brainerd has the use of restraints and seclusion continuously declined during the five years of the consent decree.

- After two years of decline, the hospitals at Cambridge and Faribault both showed increased use of restraint and seclusion beginning in 1983.

The hospitals at Fergus Falls, Moose Lake, and St. Peter all showed declining use of restraint and seclusion initially, and no change in recent years. Staff at Willmar use manual hold techniques to restrain residents, and do not come under the requirements of this section of the decree.

The restrictions on the use of major tranquilizers in the decree originally applied only to the hospital at Moose Lake, with the possibility of extension to other facilities if the plaintiffs and monitor found it to be necessary. In 1982, plaintiffs requested that the order be extended to Cambridge, when they found that this hospital had the highest proportion of residents on using major tranquilizers (about 30 percent), and the second highest average dosage per patient. Action on the request was deferred several times, pending efforts by the hospital to analyze and address the use of major tranquilizers.

Although limitations on the use of major tranquilizers apply only at Moose Lake, each of the hospitals has initiated MED (minimum effective dose) plans. All of them have had some success, in some cases reaching zero medication for some residents.

A 1985 report by the department shows that since 1982, the *average dosage* decreased at all hospitals, except Faribault and St. Peter. The *percent of residents* receiving major tranquilizers increased at Faribault, St. Peter, and Willmar. The report also shows wide variations among the hospitals. For example, the average dosage at Willmar is nearly three times as large as at Brainerd. The percentage of residents receiving major tranquilizers ranges from ten percent at Brainerd to 31 percent at Cambridge.

## 5. CONCLUSIONS

The Department of Human Services and the state hospitals are not yet in full compliance with the treatment requirements of the *Welsch* decree. Specifically:

- The department's own program reviews show that staff at state hospitals do not always develop program plans which are appropriate for the individual, or which are implemented or updated in a timely manner.

This can mean that individuals are prevented from moving to less restrictive environments, either because they have not been taught necessary skills, or because their maladaptive behaviors have not been eliminated.

- The use of restraints and seclusion at the two largest hospitals has increased since 1983, even though the decree sharply limits their use.

- At some facilities the use of major tranquilizers is still not in accordance with acceptable standards.

Although individual hospitals may now be in compliance with the treatment requirements of *Welsch*, the system as a whole is not.

# D. APPROPRIATENESS OF COMMUNITY PLACEMENT

As we noted in Chapter 2, the consent decree requires that mentally retarded persons discharged from state hospitals be placed in community programs which meet their individual needs for residential services. Furthermore, Paragraph 26 of the consent decree establishes a similar requirement for day programs:

> All persons discharged from state institutions shall be provided with *appropriate* educational, developmental or work programs, such as public school, developmental achievement programs, work activity, sheltered work, or competitive employment. (Emphasis added)

However, the decree does not establish a clear standard for evaluating the appropriateness of community residential or developmental programs. The absence of a clear standard has emerged as a major point of conflict between the plaintiffs and the Department of Human Services. The issue has been argued on two levels. The first is the obligation of the state and the responsible county to *fund* the cost of services called for in an individual's service plan. The second level involves the obligation of county and state hospital staff to scrutinize the qualifications of community service providers and the *content and quality* of services provided to an individual.

## 1. OBLIGATION TO FUND SERVICES

This issue was settled in two cases, one decided in federal district court, the other by the Minnesota Supreme Court.[8] Both cases involved virtually the same facts: A mentally retarded state hospital resident was discharged to a community setting. His individual service plan called for five days of training each week at the local developmental achievement center. During the state's 1981-1982 fiscal crisis, the responsible county announced that it would reduce funding and only pay for three days of service. The county's decision was appealed.

Both courts held that the consent decree creates an obligation by counties to pay for services required in an individual's plan. In other words, the decree requires a county to develop an individualized plan of services for each mentally retarded individual. The services described in that plan are, by definition, appropriate, and must be provided by the responsible county. The court further held that the Commissioner of Human Services is responsible for ensuring that services are provided as required, even though the Legislature delegated certain responsibilities to county social service agencies.

## 2. QUALITY OF SERVICES

The issue of the quality of services and providers is more complex. The plaintiffs have raised numerous allegations of non-compliance based on the appropriateness or adequacy of services provided to one or more *individuals* at a given group home. In raising the allegations, however, the plaintiffs have gone beyond individual cases. They have raised *system-wide* questions about the performance of state agencies in licensing and monitoring community programs, and the work of counties in arranging and overseeing appropriate services.

The issue of whether community placements were appropriate has been the subject of allegations of non-compliance affecting at least 35 individuals residing in 17 group homes. In some of these cases, state hospital residents were discharged to facilities which the plaintiffs, the Department of Human Services, or the Department of Health had already cited for violations of licensing or certification standards.[9] In at least two cases, a resident was discharged to a group home after the court monitor had already made a preliminary finding that the home was not an appro-

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[8]The first opinion is commonly known as "Bruce L.": *Welsch v. Noot*, United State District Court, District of Minnesota, No. 4-72-Civ. 451, July 14, 1982. The second case was originally brought as an administrative appeal to the Commissioner of Human Services. *Swenson v. Minnesota Department of Public Welfare*, 329 N.W. 2d 320 (1983).

[9]On this issue, the plaintiffs have sometimes found support from state hospital staff. In our interviews, some managers expressed concern over placements that did not meet their personal standard of providing "as good or better" services as the resident received in the

priate placement for state hospital residents. In one of the cases, ownership of the group home had changed between the time of the court monitor's finding and the time of the placement.

The alleged inadequacies of these group homes fall into four broad categories:

1. *Inadequate individual plans*: The plaintiffs alleged that state hospital residents were discharged to group homes where program plans were inadequate or had not been developed, as required, by an interdisciplinary team; where progress toward goals stated in individual plans was not monitored and evaluated; and where individuals with maladaptive behaviors did not have individualized behavior programs.

2. *Inadequate staff*: State hospital residents were placed in group homes which had staffing problems, including: insufficient direct care staff to carry out programs; arrangements were not made for additional services, such as audiology and dietary consulting; and active programming was not provided during weeks when the local developmental achievement center was closed.

3. *Inappropriate use of drugs and restraints*: State hospital residents were discharged to group homes which the Department of Health had cited for violations of federal certification standards, such as improper use of prescription and non-prescription drugs, and excessive use of seclusion.

4. *Physical plant deficiencies*: State hospital residents were discharged to group homes with records of repeated violations of fire safety and building maintenance standards.

These allegations have been the subject of two lengthy hearings before the court monitor. In the first case, the parties reached a settlement. The court monitor released his report and recommendations in the second case on January 22, 1986. He concluded that three residents had been placed in a facility that was not an appropriate placement under the decree, because the facility lacked the staff and other resources necessary to develop and implement adequate individual plans. Furthermore, he found that the department had not complied with provisions of the decree because it "failed to develop and/or enforce existing standards" for evaluating the appropriateness of community placement before and after discharge.

The resolution of these cases depends on establishing an operational definition of *appropriate placement*. In the second hearing, the plaintiffs advocated a definition based on professional standards for content

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state hospital. State hospital managers are also concerned about a shift in authority for arranging community placements. In the past, they assumed much of the responsibility for identifying residents for discharge and finding suitable placements. Now county case managers are more aggressive in taking on those tasks, and state hospital managers are concerned that they are not adequately involved in the decisions.

and quality of habilitation programs. These standards are generally those found in DHS Rule 34, the program licensing rule for state hospitals and community group homes, and in the federal ICF-MR regulations.

In general, the Department of Human Services has opposed the plaintiffs' efforts to pursue the community placement issue under the decree. The Department of Human Services has argued for a narrow construction of appropriateness and has suggested two standards: one objective, the other more subjective. First, because the consent decree is silent on the licensing and certification standards in force in 1980, the department contends that the decree did not contemplate changes in those standards. Therefore, a facility or program which meets the department's licensing standards should generally be regarded as an appropriate placement.

Second, the department would look to the professional judgment of hospital and county staff to measure appropriateness on an individual basis by examining a person's needs and by considering all aspects of the placement, including factors such as the environment at the group home, safety, and proximity to family. Taking all these factors together, it would then determine whether the resident would be, or is, "better off" in the community than in the state hospital. The court monitor agreed with the plaintiffs that more vigorous enforcement of existing standards would suffice and rejected the department's "better off than" test.

The first point at which appropriateness of community placement is an issue is during the process of planning a state hospital resident's discharge to the community. We found:

- The Department of Human Services has been slow to establish discharge procedures which require county and state hospital staff to consider the quality and appropriateness of community placements.

It was not until August 1984 that the department issued uniform discharge planning standards to the counties and the hospitals. Under those procedures, the county case manager convenes a meeting of the discharge team, which includes state hospital staff, the resident and his family, and staff from the community residence and day program. The discharge planning team reviews:

> staffing ratios, professional staff availability, living unit sizes, prior placement experience with the facility, circumstances under which the facility or program has demitted residents or participants, and other considerations. . . . The county case manager and the state hospital team members shall assure that the team reaches consensus as to whether the discharge team adequately meets the resident's needs.[10]

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[10]Department of Human Services, Instructional Bulletin 84-55, August 6, 1984.

Thus while the department specifies issues for the discharge planning team to consider, it does not establish operational criteria for concluding that a placement is appropriate. Similarly, the department has provided little guidance for assessing appropriateness of placement *after* discharge. The consent decree requires that a county case manager visit the community placement within 60 days of discharge and determine whether a resident is receiving the services required in his discharge plan. The department's guidelines for that assessment only list issues that should be addressed, and do not provide criteria for evaluating the quality of the placement.

In conclusion, we view the matter on two levels. First, as a *question of law*, does the department's failure to enforce existing standards or develop new ones violate the consent decree? Although the court monitor has addressed these issues, it is likely that the matter will eventually be resolved in federal court. Because it is not our function to settle such questions, we do not attempt to reach a conclusion.

Second, as a question of good *agency practice*, has the department performed well? We think not. It seems clear that the department has not paid adequate attention to the quality of community placements and has not instituted placement procedures which adequately evaluate the appropriateness of community placements.

## E. CONCLUSIONS AND RECOMMENDATIONS

In Chapters 2 and 3, we reported on changes in state hospital programs for mentally retarded persons over the past 15 years and explained the reasons for those changes. It is clear that most of these changes have been for the good. Living quarters are more homelike and provide more private space for individuals. Hospital staff now pay more attention to planning and providing treatment and training. Inappropriate use of major tranquilizers and restraint to "control" residents has been reduced at most hospitals. Most importantly, staff-to-residents ratios are generally in compliance with consent decree standards.

### 1. *WELSCH* COMPLIANCE

We concluded that the Department of Human Services and the state hospitals have generally complied with key requirements of the consent decree. Population reductions are ahead of schedule, and staff-to-resident ratios in most areas have been achieved.

In our view:

- Compliance with the consent decree has not been expensive to the state.

For example, only $1.4 million of the $55 million spent for building construction and improvement at state hospitals since 1975 was for improvements specifically required by the consent decree. Most of the improvements made to buildings which housed mental retardation programs were required by federal Medical Assistance regulations.

Similarly, most of the large increases in operating expenditures for state hospital mental retardation programs can be attributed to compliance with federal regulations. Operating expenditures have doubled since 1975, and the increase is even larger when viewed on a per resident day basis. Yet, most of the increases can be traced to the cost of maintaining the staff-to-resident ratios required in the federal regulations.

Furthermore,

- Compliance with the consent decree has not been burdensome to the state.

First, the hospitals have had little difficulty ensuring that the steady population decline which began in the 1960s continues. Second, while the decree imposes reporting responsibilities on the hospitals and the department, much of this information is needed for the daily management of programs with an annual budget of more than $100 million, more than 2,500 employees and nearly 2,000 residents. Other data collection requirements, such as monitoring the use of drugs and restraints, were needed to meet standards of professional practice and federal regulations, as well as the consent decree.

## 2. AREAS OF NON-COMPLIANCE

While the department's overall record of compliance has steadily improved, we identified three areas where the Department of Human Services and the hospitals have a poor record of compliance and where a good deal of additional attention and commitment is needed. First, the department and the counties have collectively dragged their feet on the problem of *admitting children to state hospitals*. Several hundred children have been admitted since 1980, and many have stayed beyond the one-year limit imposed in the consent decree. It is only in the past few months that the department has indicated its willingness to develop and use the resources necessary to solve this problem and bring the department into full compliance.

Second, *use of restraint or drugs to "control" residents* is still a critical issue at some hospitals. Indeed, two hospitals have experienced recent increases in the use of restraint and seclusion. Cambridge decreased average dosages of major tranquilizers apparently by increasing the use of seclusion and restraint. Furthermore, the department faces a major task improving the quality of treatment plans and upgrading the capability of staff to develop and carry out programs.

While the department has publicly stated its commitment to implementing quality assurance programs at the state hospitals, we saw little evidence that the department is fulfilling this commitment. The department's tentative first steps toward implementing a system-wide quality assurance program through reviews of individual hospital programs came to a halt after only three hospitals were reviewed. From our discussions with state hospital managers, it is not clear that the department or the hospitals have given weight to the findings and recommendations in these reviews.

Third, the department has not scrutinized the *quality* of residential placements for state hospital residents. Its efforts to impose working standards for measuring the appropriateness of community placements have been late and inadequate. Furthermore, it has continued to allow placements of state hospital residents in community facilities with long records of inadequacies in their program, staff, and buildings, and with numerous licensing or certification violations.

## 3. ASSESSING THE IMPACT OF *WELSCH*

We concluded that the *Welsch* case has been only one of several forces changing state hospitals. As we previously noted, compliance with federal certification standards for buildings, staffing, and treatment practices, has also had a significant impact on state hospitals. The impact of these federal certification regulations will continue even after the consent decree and the *Welsch* case are finally closed.

*Welsch* has made a difference for three reasons. First, the federal court views the consent decree as a *contract* between the state and the plaintiffs; a legally binding agreement which creates rights and obligations. In some instances, the plaintiffs and the judge have enforced the contract and have prodded the Legislature, the hospitals, and the department to comply with the standards set in the decree and in federal regulations. In other cases, the consent decree has served as a shield to protect state hospital mental retardation programs from budget cuts.

Second, the consent decree has exposed the hospitals and the department to intense, outside scrutiny. People and organizations behave differently when they know they are being watched. Certainly the department and the hospitals have done some things differently, knowing that persistent plaintiffs were prepared to hold them accountable for their actions or failure to act.

Third, we think it is clear that the state hospitals' progress toward compliance with the federal regulations would have been much slower without the consent decree. The threat of federal sanctions by itself probably would not have been enough, because the threat has never been very real.

Deadlines by which state hospitals had to achieve substantial compliance with federal regulations have come and gone several times. Usually, a state could satisfy federal authorities and continue federal funds by producing a plan of corrective action. In one case, the hospital at

Faribault has housed 200 residents in four buildings which did not comply with federal requirements. Since the early 1970s, the hospital has received waivers to continue using those buildings. It was only in 1985 that federal authorities formally threatened financial penalties for continued non-compliance. After that threat was made, the department secured the money needed to begin remodeling three of the buildings.

Similarly, the Department of Human Services violated the consent decree's requirements for achieving staff-to-resident ratios in 1981 and 1982. Eventually, the department was forced to comply because of an order from the federal judge, and not because of pressure from the federal Medical Assistance authorities.

## 4. RECOMMENDATIONS

The Department of Human Services and the state hospitals need to focus their attention on the problem areas we have identified and demonstrate a commitment to solving those problems.

We recommend:

- The Department of Human Services and the hospitals should strictly limit the admission and length of hospital stay for children.

When children are admitted, the department should monitor the responsible county's efforts to develop services from the day of admission, rather than waiting until deadlines approach. If counties are unable or unwilling to develop the necessary community services, the responsibility falls on the department to coordinate development of the services.

- The department should complete program reviews at all seven campuses which serve mentally retarded residents, and use those reports to strengthen individual program planning and staff training.

- The department should also complete the process of adopting a full policy aimed at minimizing the use of major tranquilizers at all state mental retardation facilities.

The department has circulated drafts of a policy which it proposed to adopt in the spring of 1986. A system-wide policy would help to ensure that over-use of medications does not occur in any state hospital.

We recommend:

- The Department of Human Services should specify standards by which counties will review the appropriateness of community placements before and after discharge.

- The Department of Human Services should adopt discharge procedures which would forbid placement of state hospital residents

**in community facilities which lack the staff needed to develop and implement individual programs that are appropriate to residents' needs.**

## 5. PLANNING FOR THE "POST-*WELSCH*" ERA

We believe that the consent decree will expire on schedule, on July 1, 1987, if the Department of Human Services and the hospitals commit themselves to solving the problems we have identified. In exchange for ending the consent decree, we expect that the department will formally agree to maintain staff-to-resident ratios and certain other requirements of the decree for a limited period of time. In doing so, the department would agree to comply with the essential requirements of the federal regulations.

We think the Legislature, the department, and the hospitals need to prepare for a "post-*Welsch*" era, and to analyze what the end of the case will really mean. For example, we concluded that *Welsch* compliance has not been particularly costly to the state. On one hand, it is unlikely that the end of the decree in 1987 will enable the state to reap significant savings by cutting state hospital budgets. On the other hand, the end of the decree also means that the Legislature has to decide whether it will continue to support and fund the improvements that have been achieved because of *Welsch*.

There are also several policy issues which will not be resolved in 1987. These require the attention of both the Legislature and state agencies. First, the consent decree does not specifically address the issue of children first admitted to state hospitals before September 15, 1980. We estimate that there are 62 such children still living in state hospitals. Some of these residents were admitted before their first birthdays.

Since the state has agreed that its hospitals are not appropriate long-term settings for children, it should not continue to draw an artificial distinction based on date of admission. We see no difference between a child admitted to a state hospital on September 14, 1980 and one admitted on September 14, 1985. We think the Legislature and the hospitals should resolve whether the hospitals will continue to serve children, and should clarify whom the hospitals will serve in the future.

Second, the staff-to-resident ratios in the hospitals should be reexamined. The ratios established in *Welsch* were seen as as goals to strive for in providing direct care to residents. Now that the hospitals are generally in compliance with the ratios, the department has projected staff reductions in proportion to population reductions.

However, in our discussions with state hospital managers, they consistently expressed their concern that staff-to-resident ratios need to be changed because the mix of residents has changed. The *Welsch* ratios may have been appropriate when more higher functioning residents lived in

the hospitals and the hospitals could organize units of residents with a range of needs. However, state hospital managers agreed that the mix of residents and their needs has changed, now that higher functioning residents have been discharged and more severely handicapped residents have remained in the hospitals. The department should reexamine its staffing standards for the hospitals and consider increasing staff-to-resident ratios in units serving very handicapped residents.

Third, the Legislature should consider the need for continued outside monitoring and scrutiny of the state hospitals *and* community facilities and programs. The experience of the past five years suggests that this outside scrutiny is needed to ensure that the hospitals do not retreat from the progress they have made and to point out areas where improvements are still needed.

There are now three times as many mentally retarded persons in state-funded, privately operated community programs as in the state hospitals. The plaintiffs have raised troubling questions about the performance of state and county agencies in setting standards for community programs and in enforcing those standards. Given the growing numbers of mentally retarded people in community settings and the extent to which they are dispersed in the state, it is equally important to impose some outside scrutiny on community services.

Several models exist for an outside monitoring organization. The New York State Commission on Quality of Care for the Mentally Disabled is an example of such an outside monitor. That body consists of three appointed commissioners, staff, and two associated boards. It has broad responsibilties for oversight of the state Department of Mental Hygiene, and for assisting the governor in developing policies and programs to improve mental health services and ensure that care is of high quality.[11] The commission has responsibilities for oversight of programs serving mentally retarded and mentally ill people.

The commission has independent authority to investigate complaints of patient abuse or mistreatment made by patients, residents, and employees of facilities. It can assign its employees to monitor any facility which presents an imminent danger to the health and safety of the residents or employees. The Mental Hygiene Medical Review Board, a panel of professionals within the commission, examines the circumstances surrounding the death of any resident of a facility, and conducts a full investigation in cases where it considers the death to be unusual.

We think that such an agency is needed in Minnesota. It should be located outside the Department of Human Services so that it can independently review the hospitals. The Legislature may wish to consider strengthening or consolidating responsibilities for monitoring community facilities in the Departments of Human Services and Health, and the counties.

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[11]New York Mental Health Law, §45.07 (McKinney).

# MEDICAL ASSISTANCE WAIVER

## Chapter 4

In 1983, the Minnesota Legislature authorized the Department of Human Services to apply for a waiver from federal regulations to use Medical Assistance for certain home- and community-based services for mentally retarded persons.[1] The Legislature intended to expand the availability and use of individualized services that would be alternatives to state hospitals and community ICFs-MR.

We examined how the Department of Human Services and county agencies have implemented the waiver. We asked:

- Has the Department of Human Services effectively used the waiver to reduce the population of state hospitals and of community group homes?
- What services are provided under the waiver? Has the waiver fulfilled its promise of matching services to individual needs?

Although the waiver services program is new, it is important to examine what has been accomplished so far. With this information, the Legislature, the Department of Human Services, and counties can consider changes that may be needed in the program.

### A. DEVELOPMENT OF MINNESOTA'S WAIVER PROGRAM

In our 1983 *Evaluation of Community Residential Programs for Mentally Retarded Persons*, we recommended that the Legislature strengthen alternative services by ensuring stable funding and developing statewide standards for them. We suggested three changes in funding residential

[1]Minn. Laws, 1983, Chap. 312, Art. 9.

services, including use of a Medical Assistance waiver to fund home- and community-based services.[2]

The Department of Human Services submitted its application to federal authorities in January 1984, requesting approval to use Medical Assistance funds for alternative residential programs, certain day habilitation programs, and case management. The federal Health Care Financing Administration (HCFA) generally approved the state's application. However, HCFA refused to allow Medical Assistance funding for the state's Semi-Independent Living Services (SILS) program, reasoning that waiver services would not be needed to keep a person in a semi-independent living arrangement from entering a state hospital or community ICF-MR.

The department began to implement services in the summer of 1984. The program grew slowly: by June 30, 1985, the end of its first year, only about 230 persons had been served. In comparison, the state had originally projected that twice that number would be served in the first year.

A number of factors slowed implementation of the waiver. First, it was the subject of intense political debate even before it was approved. The Association of Minnesota Counties (though not several individual counties) opposed the waiver as an intrusion on county authority and an unwise fiscal policy which would increase the state's reliance on federal funding. Labor unions representing state hospital workers also opposed the waiver, fearing that continued reductions in the population of state hospitals would eliminate jobs.

The opposition of labor unions and groups in state hospital communities intensified in 1984 when the Department of Human Services proposed an expanded use of waiver services which would accelerate the reduction of the state hospital population and eliminate jobs. During the 1984 legislative session, legislators from districts containing state hospitals introduced bills to repeal the department's authority to use waiver services. Although those bills did not pass, the waiver developed a somewhat shaky image.

The second factor which slowed implementation was the need to enlist the cooperation of individual counties in carrying out their responsibilities under the waiver. Counties which had largely relied on service providers, including state hospitals, for case management and service development, were now asked to assume those responsibilities. Some counties claimed that they did not have funds to hire staff needed for those duties. They also complained that the Department of Human Services had not involved them in shaping the program. Others were concerned that the waiver might not survive, and were reluctant to develop services which might eventually require substantial county funds.

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[2]The U.S. Congress authorized such waivers in Section 2176 of the 1981 Omnibus Budget Reconciliation Act. In 1982, Minnesota applied for and received a waiver to create the Pre-Admission Screening and Alternative Care Grants programs for elderly persons considering admission to nursing homes.

Finally, the department's timetable for implementing the waiver may have simply been too ambitious. The department sought to immediately implement the mental retardation waiver statewide. By comparison, the "nursing home" waiver had started in a small group of volunteer, pilot counties, and gradually expanded statewide.

## B. ALTERNATIVE RESIDENTIAL SERVICES FUNDED THROUGH THE WAIVER

Minnesota's reliance on state hospitals and community ICFs-MR had resulted in a service system in which individuals were matched with services on the basis of what was available rather than on what was needed. A key objective of the waiver was to develop residential and habilitation programs that were tailored to the needs of individuals.

We analyzed the alternative residential programs operating under the waiver on December 1, 1985. The information reported here is based on telephone interviews with county social service agency staff and the department's eight Regional Services Specialists. These staff are responsible for working with counties in designated areas to identify individual needs and to develop waiver services.

### 1. IN-HOME SERVICES

As part of our survey, we collected a limited amount of data on "in-home" services provided under the waiver. A key objective of the waiver is to provide assistance to families whose children and adults are "at-risk" of placement in a state hospital or community ICF-MR. In-home services include respite care as well as visits from trainers, therapists, homemakers, and others. In some cases, Medical Assistance pays for the costs of making physical adaptations to homes.

We found 144 persons receiving in-home services under the waiver. More than 80 percent were identified as children. In almost all cases, waiver services were used to help keep people in their homes. However, we did find four cases where children from state hospitals or community ICFs-MR returned to family homes with the help of waiver services.

### 2. SUPPORTED LIVING ARRANGEMENTS

#### a. *Types of Arrangements*

Under Minnesota's waiver, an alternative residential service is called a *supported living arrangement*, or SLA. Our analysis is based on three categories of supported living arrangements:

1. Supervised apartments for one to four persons.

2. Foster homes for children and adults.

3. Group homes for five or six persons.

It is important to note that the difference between foster care and an apartment arrangement is not always clear. In part, this is because the department has not developed licensing rules for waiver services. For example, many services provided in apartments for between one and four mentally retarded persons are licensed under DHS Rule 51 as adult foster homes. However, in many of the waiver service arrangements licensed as adult foster homes, there is no staff person or foster family living in the apartment. For this analysis, such arrangements are considered apartments.

We found that 254 persons are in alternative residences and receiving services funded through the waiver. As shown in Table 4.1, the largest group (119) were living in apartments. Another 73 persons were in group homes, and the rest, including 22 children, were in foster homes.

TABLE 4.1

ALTERNATIVE RESIDENTIAL SERVICES FUNDED UNDER THE WAIVER
December 1985

| Arrangement | Adults Served | Children Served | Total Served | Average Per Diem Rate | Range Of Per Diem Rates |
|---|---|---|---|---|---|
| Apartment | 116 | 3 | 119 | $39.10 | $16.32-$105.37 |
| Foster Home | 40 | 22 | 62 | 28.24 | 4.25- 125.00 |
| Group Home | 73 | 0 | 73 | 47.24 | 28.76- 92.09 |
| Sub-Total | 229 | 25 | 254 | -- | -- |
| In-Home Services | 27 | 117 | 144 | n/a | n/a |
| TOTAL | 256 | 142 | 398 | -- | -- |

Source: Program Evaluation Division analysis of data supplied by county social service agencies and Regional Service Specialists of the Department of Human Services, January 1986.

Group homes, limited to six residents, are authorized waiver services. Except for their funding arrangement, they are not significantly different from ICFs-MR. In 1985, 12 group homes funded under the waiver opened. Seven of the group homes are in Hennepin County. We have two concerns about the development of group homes through the waiver. First,

- we think that development of new group homes under the waiver violates the Legislature's intent in imposing a moratorium on new ICFs-MR, and in limiting the total number of ICF-MR beds in state hospitals and community facilities.

Second,

- development of new group homes is inconsistent with the goal of developing waiver services that are smaller, less restrictive, and less expensive *alternatives* to ICFs-MR that have dominated residential programs for mentally retarded persons in Minnesota.

b. *Costs of Service*

One goal of the waiver was to contain the spiraling costs of ICF-MR care in the state. Between 1978 and 1983, the cost of community ICF-MR care increased by more than 250 percent, from $24.2 million to $56.5 million. These increases were due to the opening of relatively expensive new facilities and the rapid increase in reimbursement rates for existing facilities.

Under the waiver, Medical Assistance pays for *program costs* of supported living arrangements, but not for room and board.[3] Room and board may be paid out of the client's earnings, foster care grants, Supplemental Security Income (SSI), or Minnesota Supplemental Aid (MSA).

We asked about per diem reimbursement rates for those residential program costs.[4] As shown in Table 4.1, the highest average per diem rate for residential services was for the group homes ($47.24). Apartments and foster homes were, on average, less expensive.

We received data on room and board grants for waiver clients in Hennepin and Dakota counties. The average combined room and board and waiver service per diem for all supported living arrangements was $80.62. For group homes, the average combined cost was higher: $87.29.

c. *Providers*

The Legislature has expressed two concerns about the concentration of ICF-MR and waiver services among a few provider organizations. First, do the same organizations provide related services, such as ICFs-MR and waiver services? Second, do certain providers serve so many clients that they dominate the industry? Both concerns ask whether certain providers exert an undesirable, self-serving influence over the movement of residents between different services.

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[3]Medical Assistance can pay for the room and board costs associated with respite care.

[4]The data reported here do not include additional costs billed to Medical Assistance for day programs, county case management, or other waiver services.

We found:

- ICF-MR providers dominate the supported living arrangements funded through the waiver.

ICF-MR providers serve more than two-thirds of the clients receiving supported living arrangements through the waiver. Most of the rest are served by individual foster families not associated with any provider. Thus, few new waiver service providers have emerged.

In 1984, the Legislature imposed a temporary limit on the number of waiver clients any one provider could serve. No provider could control delivery of services to more than 50 persons, which was expected to be about ten percent of the total number served in 1985.[5]

Table 4.2 lists the ten largest providers of supported living arrangements. All but one is also an ICF-MR provider. No single provider currently operates more than ten percent of the supported living arrangements. However, five providers on this list control services to one-third of the SLA clients.

TABLE 4.2

LARGEST PROVIDERS OF WAIVER RESIDENTIAL SERVICES
December 1985

| | Provider | Provides ICFs-MR? | Residents | Average Per Diem Rate |
|---|---|---|---|---|
| 1. | Adapted Living | Yes | 23 | $40.42 |
| 2. | Dungarvin | Yes | 18 | 59.46 |
| 3. | AID Homes | Yes | 14 | 31.30 |
| 4. | REM | Yes | 14 | 56.89 |
| 5. | Polk County Homes | Yes | 14 | 56.12 |
| 6. | Clay County Developmental Services | No | 12 | 23.00 |
| 7. | Nekton | Yes | 10 | 45.91 |
| 8. | Project Independence | Yes | 10 | 44.00 |
| 9. | Residential Services of Northeastern MN | Yes | 7 | 38.66 |
| 10. | Focus Homes | Yes | 6 | 45.61 |

Source: Program Evaluation Division analysis of data supplied by county social service agencies and Regional Service Specialists of the Department of Human Services, January 1986.

[5]Minn. Laws 1984, Chap. 641, Sec. 24, subd. 2.

## 3. WHERE DO WAIVER SERVICE CLIENTS COME FROM?

The waiver has two basic purposes. First, it is intended to reduce the need for mentally retarded persons living with their families to enter state hospitals or community ICFs-MR. Second, it is intended to reduce the state's use of state hospitals and community ICFs-MR by moving residents from those settings into waiver services. Thus, clients receiving waiver services are divided into two groups:

- *Diversions* are persons who need waiver services because they are at-risk of entering a state hospital or community ICF-MR.

- *Conversions* are persons coming from state hospitals or community ICFs-MR into waiver services.

The department has limited its definition of conversions to situations which actually reduced the state's use of state hospitals or community ICFs-MR. Where a community ICF-MR vacancy was not decertified or filled by a state hospital resident, the department has labeled that a diversion. In our survey, we learned of at least 15 instances where a person left a community ICF-MR for waiver services, but the resulting ICF-MR vacancy was filled by someone in the community. The department reports that it has identified 30 such cases. In those cases, the state does not achieve a net reduction in ICF-MR utilization, and actually increases its Medical Assistance caseload.

We found:

- After a somewhat rocky start, the department has come close to meeting its initial goals for reducing state hospital population through the use of waiver services.

The department proposed that about 30 percent of the waiver service slots in the first two years would be used to reduce the population of state hospitals. We estimate that the placement of nearly 400 persons in waiver services has resulted in a reduction of between 120 and 140 in state hospital population, very close to the department's projection. The department achieved few state hospital reductions during the first year of the program. Most of the reductions occurred after July 1, 1985.

As shown in Table 4.3, 42 state hospital residents went directly into waiver services. While 108 persons went from community ICFs-MR to waiver services, not all of those placements reduced the population of state hospitals. In some cases, as we noted above, the ICF-MR vacancy was filled by someone already in the community. In other cases, the vacancy has remained open, pending decertification.

However, the department has not yet succeeded in using waiver slots to decertify community ICFs-MR, as it had projected. Thus, while 30 percent of waiver service clients simply represent a residential *relocation* for current service recipients, the other 70 percent represent an *increase* in service caseloads. The waiver services program has proven to be a popular means of funding services for persons already in the

community, most of whom came from their own homes. While 48 people left their homes to enter a supported living arrangement, 68 stayed in their homes to receive waiver services. Although we did not have information about them, we understand that most of the 70 other in-home service clients are also staying in their homes.

TABLE 4.3

RESIDENTIAL SETTING BEFORE AND AFTER WAIVER SERVICE

| | Residential Setting Under Waiver | | | | |
|---|---|---|---|---|---|
| Prior Residence | Group Home | Apartment | Foster | In-Home | Total |
| State Hospital | 16 | 16 | 7 | 3 | 42 |
| Community ICF-MR | 26 | 53 | 28 | 1 | 108 |
| Foster Home | 3 | 1 | 9 | 2 | 15 |
| Home | 17 | 25 | 6 | 68 | 116 |
| Other Licensed | 3 | 4 | 3 | 0 | 10 |
| TOTAL | 65 | 99 | 53 | 74 | 291 |

Source: Program Evaluation Division analysis of data supplied by county social service agencies and Regional Service Specialists of the Department of Human Services, January 1986.

We have two concerns about the use of the waiver to provide services for persons already in the community. First,

- The number of persons coming from their homes into ICFs-MR or waiver services may be too high.

As a result, the total number of people in state hospitals, community ICFs-MR, and waiver service continues to grow. This growth may exceed what the state had anticipated in receiving federal approval for waiver services. Given the department's slow progress in decertifying community ICFs-MR, a growing caseload will make it difficult to demonstrate that the waiver is cost-effective.

The department has recognized this problem, and it allocated new service slots for 1986 with the intent of bringing the number of conversions and diversions closer to balance. Of 298 new slots for 1986, 185 are designated for conversions. Furthermore, the department has reallocated unused slots to ensure their use by other counties.

Second,

- some counties may be using the waiver to fund services that they had previously funded themselves.

In particular, we identified counties which are providing waiver services to persons already in county-funded foster arrangements. The result may be a shift of local costs to the Medical Assistance budget.

## C. CONCLUSIONS AND RECOMMENDATIONS

While the Department of Human Services has achieved some of its initial objectives for the waiver service program, we think that mid-course corrections are needed. First, we are concerned about the growth in the service system resulting from persons in family homes entering waiver services. That growth threatens the department's compliance with federal regulations and its chances of keeping the waiver.

Therefore, we recommend:

- The Department of Human Services should continue to limit the use of waiver services by persons already in the community. It should carefully examine the practice of using waiver funding for persons already in foster placements to ensure that counties are not shifting costs to the Medical Assistance budget.

Helping to maintain mentally retarded people in their natural homes is an important goal of the waiver program. Nonetheless, the program must remain within certain limits.

Second, we think the funding of new group homes through the waiver contradicts legislative intent. The Legislature directed the department to reduce the size of the state's group home network, not expand it by allowing the development of ICFs-MR under a different name.

Therefore, we recommend:

- The Department of Human Services should deny any new county requests for approval of waiver service group homes for five or six persons.

The department might have anticipated that ICF-MR providers would seek to develop new group homes through the waiver service programs. The development of new group homes is one undesirable consequence of the domination of waiver services by community ICF-MR providers.

We think that the Legislature and the department should be concerned about the practice of ICF-MR providers branching out into waiver services.

We recommend:

- The Legislature should reinstitute the limitations on the number of waiver service clients served by one organization. It should limit providers to serving no more than ten percent of clients.

- The Department of Human Services should aggressively work with counties to promote the entry of new service providers into the field.

In 1984, the Legislature directed the Department of Human Services to study ways of avoiding concentration of waiver service providers, while promoting a wide array of provider groups. The department has not completed this study. We have heard that several counties have identified existing public agencies and private organizations which are well suited to provide waiver services, particularly for people living in their family homes.

Because the department has not adopted rules for licensing supported living arrangements, these services are operating without licenses, or with licenses issued under outdated rules. The inadequacies of the department's foster care licensing rules, particularly for adults, have been obvious to the department and to the public for many years. It is ironic that the DHS licensing rule which is most up-to-date and best describes the type of services and arrangements provided through the waiver is the rule for semi-independent living services, the only service which federal authorities refused to approve for the waiver.

We recommend:

- The Department of Human Services should promulgate licensing rules for supported living arrangements.

Because the Department of Human Services does not maintain data on individual services funded under the waiver, or on service providers, it could not provide us with much of the data we used in our analysis. During the 1985 legislative session, the department was unable to present consistent and complete data about waiver services because its two basic sources of data on waiver services are inadequate. First, data from the *screening document* for each potential waiver service client are likely to overstate the actual number of participants, because only a portion of those screened are eventually served. Second, the Medical Assistance *billing system* understates waiver service activity because of the lapse between service provision and payment.

We recommend:

- The department should collect and maintain additional data on clients and providers of waiver services. In particular, the department should collect information on room and board grants for waiver clients.

Although room and board grants are not funded by Medical Assistance, they are a key cost which the department must consider in evaluating the cost-effectiveness of the waiver.

## STUDIES OF THE PROGRAM EVALUATION DIVISION

Final reports and staff papers from the following studies can be obtained from the Program Evaluation Division, 122 Veterans Service Building, Saint Paul, Minnesota 55155, 612/296-4708.

1977

1. Regulation and Control of Human Service Facilities
2. Minnesota Housing Finance Agency
3. Federal Aids Coordination

1978

4. Unemployment Compensation
5. State Board of Investment: Investment Performance
6. Department of Revenue: Assessment/Sales Ratio Studies
7. Department of Personnel

1979

8. State-sponsored Chemical Dependency Programs
9. Minnesota's Agricultural Commodities Promotion Councils
10. Liquor Control
11. Department of Public Service
12. Department of Economic Security, Preliminary Report
13. Nursing Home Rates
14. Department of Personnel: Follow-up Study

1980

15. Board of Electricity
16. Twin Cities Metropolitan Transit Commission
17. Information Services Bureau
18. Department of Economic Security
19. Statewide Bicycle Registration Program
20. State Arts Board: Individual Artists Grants Program

1981

21. Department of Human Rights
22. Hospital Regulation
23. Department of Public Welfare's Regulation of Residential Facilities for the Mentally Ill
24. State Designer Selection Board
25. Corporate Income Tax Processing
26. Computer Support for Tax Processing
27. State-sponsored Chemical Dependency Programs: Follow-up Study
28. Construction Cost Overrun at the Minnesota Correctional Facility - Oak Park Heights
29. Individual Income Tax Processing and Auditing
30. State Office Space Management and Leasing

1982

31. Procurement Set-Asides
32. State Timber Sales
33. *Department of Education Information System
34. State Purchasing
35. Fire Safety in Residential Facilities for Disabled Persons
36. State Mineral Leasing

1983

37. Direct Property Tax Relief Programs
38. *Post-Secondary Vocational Education at Minnesota's Area Vocational-Technical Institutes
39. *Community Residential Programs for Mentally Retarded Persons
40. State Land Acquisition and Disposal
41. The State Land Exchange Program
42. Department of Human Rights: Follow-up Study

1984

43. *Minnesota Braille and Sight-Saving School and Minnesota School for the Deaf
44. The Administration of Minnesota's Medical Assistance Program
45. *Special Education
46. *Sheltered Employment Programs
47. State Human Service Block Grants

1985

48. Energy Assistance and Weatherization
49. Highway Maintenance
50. Metropolitan Council
51. Economic Development
52. Post Secondary Vocational Education: Follow-Up Study
53. County State Aid Highway System
54. Procurement Set-Asides: Follow-Up Study

1986

55. Insurance Regulation
56. Tax Increment Financing
57. Fish Management
58. Deinstitutionalization of Mentally Ill People
59. Deinstitutionalization of Mentally Retarded People

Public Employee Pensions (in progress)

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*These reports are also available through the U.S. Department of Education ERIC Clearinghouse.