Group Residential Housing Supplemental Services Program Analysis

January 2014

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $102,150.

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I. Executive Summary

The 2013 Minnesota Legislature directed the Minnesota Department of Human Services to study how Group Residential Housing (GRH) supplemental services are delivered, to review the performance of programs that deliver supplemental services, to make recommendations for rate setting and the efficient use of beds that receive the GRH supplemental service rate, and to develop requirements that ensure quality service delivery.

The department contracted with the Improve Group, an experienced provider of research and evaluation services, to conduct this study. The results of their work are included in this report. The Improve Group worked with department staff, providers, county contract managers, supplemental service recipients and other key stakeholders to inform this study. They gathered data on current service delivery practices, participant characteristics and outcomes, provider performance, county monitoring practices, efficiency of program use, and the status of service rates "banked" by counties for future development.

The department used the Improve Group's comprehensive study to develop recommendations and an implementation plan that will improve the delivery of Group Residential Housing supplemental services. Our recommendations address the following subjects:

Rate Setting

Today, GRH service rates vary among providers statewide. Many providers receive a standard rate, but many others have legislative authority to receive a higher rate. However, this study shows there is no correlation between the amount of the rate, services provided, and the level of individual need.

The department recommends that the GRH supplemental service rate should pay for a menu of core services, with an enhanced rate available for settings that offer additional or more intense services based on the needs of their target population. Providers who want an enhanced rate would submit an application to the Department of Human Services justifying their residents' need for greater services, and if approved, be subject to greater oversight and accountability. Service rate providers should receive assistance in identifying alternative sources of service funding. The supplemental service rate should be separated from the room-and-board rate so participants can continue to receive services if they leave a congregate setting. The department must also work with stakeholders to develop an appropriate method to demonstrate individual functional need for supportive services.

Performance Monitoring

Currently, counties have the primary role in performance monitoring, and hold the GRH agreement (contract) between individual counties and providers. However, they receive little state guidance or authority to clarify their compliance role or enforcement options when problems arise.

The department should promulgate standard GRH agreements and service plan templates for participants. The GRH agreements should include required monitoring activities as well as consequences for noncompliance. It should also state expectations for the frequency of

monitoring, including at least annual site visits by county staff to each supplemental service provider. Standardizing site visit monitoring practices and policies would help ensure that providers are held to the same compliance standards statewide. Department staff will provide technical assistance to county monitoring personnel in best practices and protocols for site visits and quality assurance.

Banked Beds

Since the implementation of the GRH program in its current form in 1993, there has been a moratorium on new GRH beds receiving GRH service funding. There are several legislative exceptions to this moratorium. If a GRH setting has a service rate and either closes or reduces the number of beds receiving services, those beds may be "banked" by the county in which the setting is located. These banked beds may be held for future development or given to another county.

The distribution of access to service rates across the state varies. Some counties do not have any service rate settings, or banked service rate beds for development. Providers, counties, advocates and elected officials have pursued access to banked service rate beds, without consistent success.

To accurately track availability and distribution, the state should have authority to monitor the status of banked beds. Counties should have a two-year period to redevelop their banked beds before the department redistributes them through a statewide Request for Proposal (RFP) process, which encourages regional collaboration in the use of available service rate beds.

Implementation

Program changes should recognize differences in setting types (e.g., congregate board and lodge vs. private market apartment in the community), and should be phased in gradually and through pilot projects where possible. The department should continually incorporate feedback from providers, counties and consumers into policy decisions and implementation.

The department will use this report to ensure that the Group Residential Housing supplemental service rate program continues to serve vulnerable Minnesotans in an efficient and cost-effective manner, while increasing accountability and improving outcomes.

II. Legislation

Laws of Minnesota 2013, chapter 108, article 3, section 47.

Plan for Group Residential Housing Specialty Rate and Banked Beds

The commissioner of human services, in consultation with and cooperation of the counties, shall review the statewide number and status of group residential housing beds with rates in excess of the MSA (Minnesota Supplemental Aid) equivalent rate, including banked supplemental service rate beds. The commissioner shall study the type and amount of supplemental services delivered or planned for development, and develop a plan for rate setting criteria and an efficient use of these beds. The commissioner shall review the performance of all programs that receive supplemental service rates. The plan must require that all beds receiving supplemental service rates address critical service needs and must establish quality performance requirements for beds receiving supplemental service rates. The commissioner shall present the written plan no later than February 1, 2014, to the chairs and ranking minority members of the House of Representatives and Senate finance and policy committees and divisions with jurisdiction over the Department of Human Services.

III. Introduction

The Minnesota Department of Human Services contracted with the Improve Group, an independent research firm, to conduct a study on GRH supplemental services. The data collected by the Improve Group is included in Section IV of this report, which follows this introduction.

The authorizing legislation required that the study include a plan for rate-setting criteria and an efficient use of service rate beds. To respond to this requirement, the department has included Sections V on recommendations and implementation, informed by the results of the study information compiled by the Improve Group.

IV. Group Residential Housing Supplemental Services Study

This report presents the findings of a Program Analysis of Group Residential Housing (GRH) Supplemental Services. An independent firm, the Improve Group, completed the research to support these findings and prepared this report under contract with the Minnesota Department of Human Services) from October 2013 to January 2014.

The Improve Group conducts rigorous studies to help organizations make the most of information, navigate complexity, and ensure their investments of time and money lead to meaningful, sustained impact. The Improve Group, based in St. Paul, Minnesota, provides research, evaluation, and strategic planning services to organizations locally, nationwide and internationally.

Background on Group Residential Housing and Supplemental Services

GRH is a state-funded program that pays for room-and-board costs (also called the housing rate or rate 1[1]) across the state for low-income seniors and adults with disabilities. The program goal is to reduce and prevent institutional residence and homelessness.[2]

In some cases, for those participants who cannot access service payments from other sources such as community-based waiver programs, GRH can pay for services in addition to room and board. These "supplemental services" must include, but are not limited to:

- Oversight and up to 24-hour supervision
- Medication reminders
- Assistance with transportation
- Meeting and appointment arrangements
- Medical and social services arrangements

GRH services are provided primarily by private organizations. There are GRH room-and-board providers in every Minnesota county. GRH supplemental service providers are currently located in 41 counties across Minnesota; a complete list is included in Appendix A.

Participants must meet income requirements and demonstrate a disability or disabling condition based on the criteria for Supplemental Security Income or General Assistance in order to qualify for GRH. GRH serves a wide variety of participants with needs that include physical or mental health disabilities, chemical dependency, visual impairment, and long-term homelessness.

The supplemental service rate (also known as rate 2) pays for services in addition to the provision of room and board. This study explores GRH service funding across the state, the particular services being purchased, and collects data about providers, participants and service provision.

Methodology

The Improve Group gathered data from a variety of stakeholders including the Minnesota Department of Human Services staff, county staff, supplemental service provider staff, advocacy groups and GRH supplemental service participants. The Improve Group conducted all interviews and focus groups, and administered a provider survey. The county survey was administered by the department.

Interview respondents and organizations were selected to represent the participants served and breadth of settings made available by the GRH supplemental services funding stream. A complete list is included in Appendix B. In addition, the tools used for data collection are included in Appendices D to F.

Group	Input process	Representation
Providers	Statewide survey administered to all providers Interviews	65% of all providers across the state (141 out of ~216) 14 interviews
Department staff and department data	Interviews; Advisory Committee Workshops	Policy and program experts in Chemical Dependency, Mental Health, 3 counties, and waiver services (explain; it's unclear what organization this is); data from MAXIS, the…define 4 interviews
Supplemental Service Participants	Focus Groups	3 focus groups with 21 participants from different populations with differing disabling conditions
County Contract Managers	Statewide Survey Interviews	30 (73%) of the 41 counties with supplemental service providers 5 interviews
GRH Supplemental Services Advisory Council	Workshops	4 provider staff, 2 county contract managers, 9 department staff, 1 advocacy group

Delivery of GRH Services

GRH supplemental services provide flexible funding for services to people with disabilities who are housed in a licensed or registered GRH setting. GRH recipients must qualify for GRH room and board based on eligibility for General Assistance (GA) or Supplemental Security Income (SSI) criteria and must have an illness or incapacity that prevents them from living independently. To receive the supplemental service rate, the county of residence must approve a service plan.

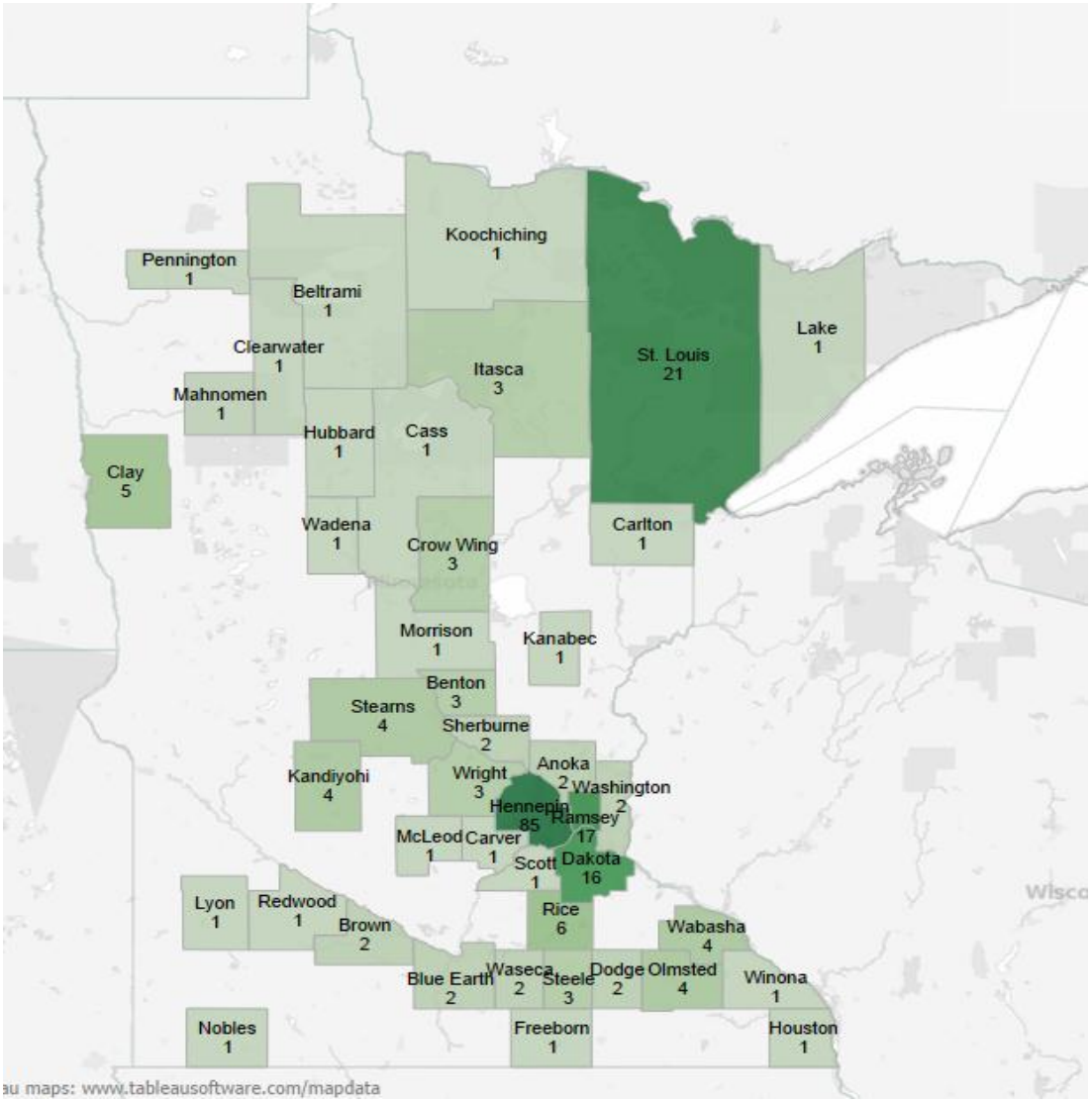
Supplemental Service Locations

At a Glance:

While almost half of Minnesota's counties have GRH service funding, the vast majority are concentrated in Hennepin, Ramsey, St. Louis and Dakota counties. Licensure or registration is required for providers and is typically obtained through the Minnesota Department of Health, but the Department of Human Services or a tribal government may also grant them. These GRH recipients most often reside in congregate settings, but apartments scattered in the community are also common.

Forty-one of Minnesota's 87 counties have GRH supplemental service providers. The settings vary among rural, suburban and urban settings. Figure 1 shows the number of settings by county at the time of the provider survey. Note that scattered site settings were each counted as single providers (based on the organization acting as a provider), as the amount of individual apartment buildings which house one or two participants would greatly inflate the number of settings for Hennepin, Ramsey and Dakota counties. As demonstrated by the map below, the greatest concentration of providers are in Hennepin, St. Louis, Ramsey and Dakota counties, with the remaining counties having between one and six providers each. Counties without GRH supplemental service settings are not shown on the map.

Figure 1 – Number of GRH Supplemental Service Rate Providers by County



GRH service providers vary immensely from large settings with several hundred residents to single apartments. Providers must hold at least one licensure or registration from the Minnesota Department of Health (MDH), Minnesota Department of Human Services or a tribal government to be eligible for funding. Some may even hold multiple licensures or registrations from these entities.

The provider survey gathered information about the type of settings providing GRH services. Overall, out of the 141 survey respondents[3], most are settings licensed or registered under the Minnesota Department of Health. The most common types of settings are board and lodging with special services[4], housing with services[5], and board and lodging[6]. See Figure 2 for more detail.

Figure 2 –GRH Provider Survey Respondents' MDH Licensures and Registrations

MDH Licensure/registration	Frequency	Percent of respondents[7]
Board and Lodging with Special Services	56	40%
Housing with Services Establishment	55	39%
Board and Lodging	37	26%
Other[8]	19	14%
Boarding Care Home	8	6%
Supervised Living Setting	7	5%
No MDH licensure	4	3%
Lodging	4	3%

It is relatively uncommon for supplemental service providers to hold licensure from the Minnesota Department of Human Services. Well over half of respondents indicated that they do not have this type of license. See Figure 3 for more detail.

Figure 3 – GRH Provider Survey Respondents' DHS Registrations

DHS Registration	Frequency	% of respondents[9]
No DHS licensure	81	62%
Other[10]	18	14%
Chemically Dependent, Rule 25	17	13%
Adult Mentally Ill, Rule 36	9	7%
Developmental Disabilities	7	5%
Adult Foster Care, Rule 203	6	5%
Semi-independent living services-Developmental Disabilities	1	<1%

Almost three-quarters of provider respondents were congregate living settings[11]; the remaining 27% were scattered site settings[12]. The size of each congregate setting varies greatly as survey respondents reported serving anywhere from 3 to 350 residents.

The provider survey also asked about ownership structure. The majority (56%) of respondents were non-profit organizations although a significant minority (43%) was for-profit[13]. Ownership structure showed no particular relationship with setting licensure or registration.

A supplemental service provider can receive the service rate reimbursement for all or just a portion of their residents. However, more settings receive these reimbursements for all of their residents (54%) than those who do not (46%). Board and lodging with special services are more likely to be serving all of their residents through GRH supplemental services than the other MDH licensed settings (which more often have a mix of residents).

Reimbursement Rates

At a Glance:

Currently, the monthly supplemental service rate is $482.84 per individual. This service rate is received in addition to room-and-board funds. The rate is paid directly to the GRH provider, and not to individuals. Although most providers receive a rate at or below the standard, there is significant variation (e.g. in SFY 2013, the range was between $42.04 and $2,925.89). In SFY 2013, GRH authorized a total of $38,161,672 in service rate payments.

The standard GRH supplemental service rate ($482.84 maximum per month) is the amount a provider receives *in addition to* the room-and-board rate ($877 per month) for qualifying residents in their settings, up to an approved number of beds. An "enhanced" supplemental service rate is a reimbursement higher than the standard $482.84 rate; all enhanced rates have been legislatively approved.

The survey revealed a lack of understanding about the current rate structure of supplemental services. For example, some respondents indicated that they had an enhanced rate and then entered their room-and-board rate ($877), or their room-and-board rate plus the standard supplemental service rate (approximately $1,350). Similarly, when asked about being approved for more than one supplemental service rate, some providers responded "yes" and then wrote in the room-and-board rate as their second rate. The rate data from the survey was cross-checked against the department records and inaccuracies were corrected prior to running the provider survey analysis included later in this report.

About half of provider survey respondents fall within the standard GRH service rate range ($400-$499[14]) and 34% receive an enhanced service rate (anything >$499 per month). The survey was representative of providers with the full range of rates across the state.[15]

Rates do not vary by:

- Setting type,
- Top four populations served (chemical dependency, mental illness, homelessness, and co-occurring disorders),
- Type of service provider,

- Additional funding, or
- Amount of services provided.

The department data show that over three-quarters (77%) or GRH providers receive reimbursements at or below the standard rate, while 23% receive an enhanced service rate. See Figure 4 for more detail. The average monthly rate in SFY 2013 for services was $500 per person although the range was between $42.04 and $2,925.89.

Figure 4 – All Minnesota GRH Service Providers' Rates by Range Categories

Rate range	Frequency	Percent of all Minnesota GRH service providers
$1-$399	39	18%
$400-$499	128	59%
$500-$699	14	6%
$700-$999	29	13%
$1,000+	6	3%

Most providers receive only one service rate at their setting. A minority of respondents, just under 20% (26 providers), are approved for more than one service rate. Of those, 14 providers are approved for two service rates, and 6 are approved for more than five.

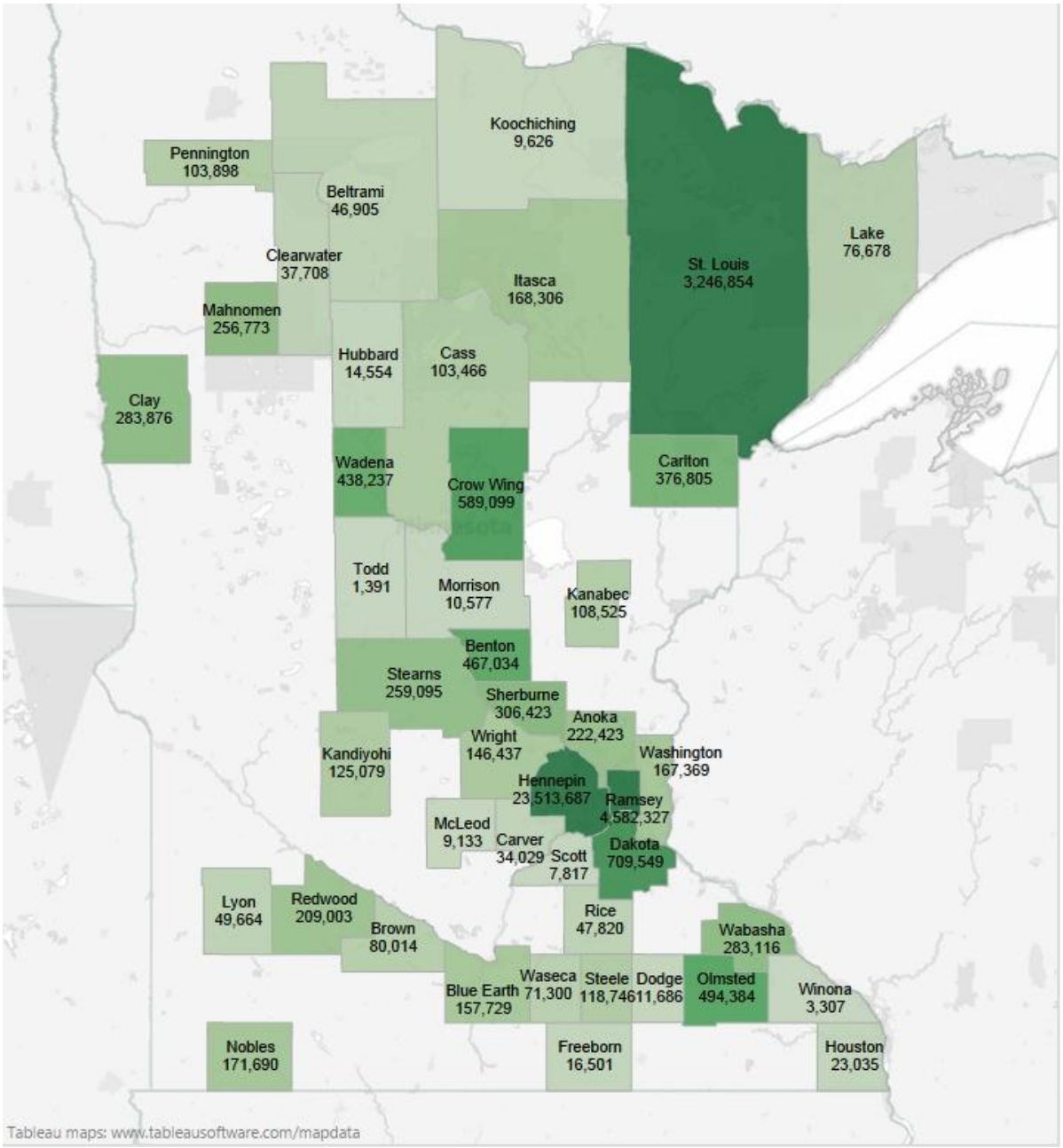
Authorized Service Payments

In SFY 2013 the total amount of authorized GRH service payments statewide was **$38,161,672**. Authorized service payments for the top six counties are shown in Figure 5. Figure 6 shows the total authorized service dollars by county on a map.

Figure 5 – Authorized Service Dollars by County of Residence

County	Total Authorized Service Dollars	% of Total
Hennepin	$23,513,687	62%
Ramsey	$4,582,327	12%
St. Louis	$3,246,854	9%
Dakota	$709,549	2%
Crow Wing	$589,099	1.5%
Olmsted	$494,384	1.3%

Figure 6 – Authorized Annual GRH Service Dollars by County of Residence



Participant Characteristics

At a Glance:

Participants must meet eligibility for either Supplemental Security Income or General Assistance to receive GRH service funding. Those who access supplemental services are most commonly single adults with mental health issues, are homeless or have chemical dependency issues. Providers identify the majority of recipients as high need, based on their frequent use of services. In SFY 2013, 29,046 unique participants were served by GRH. Of those, 9,252 (32%) received service rate funding.

To qualify for supplemental services under GRH, participants must meet eligibility criteria for either Supplemental Security Income or General Assistance. These funding streams are available to people with physical or mental disabilities, drug or alcohol addiction, older than 55 with limited work ability and insufficient income to pay for housing in the community. Participants must also have a service plan approved by the county. No other factors are used to determine eligibility. Because of these criteria, the needs of supplemental service participants are very diverse.

Participants come to GRH supplemental services in a variety of ways depending on their needs, county of residence, and the GRH setting. In interviews, providers shared that referral sources included: self-referrals, court-ordered treatment, family or friends through provider marketing, county case managers, probation officers, advertisements, Rule 25 chemical dependency housing plans, and connections to inpatient settings, street outreach and homeless shelters.

In the survey, providers reported on the populations they serve. Most commonly, they (64%) serve those with mental health issues. The other regularly served populations include the homeless, those with chemical dependency issues and those with co-occurring disorders (chemical and mental health). See Figure 7 for more detail.

Figure 7 – GRH Service Rate Participants by Population or Disability Type as Reported by Provider Survey Respondents

Population/Disability Type	Frequency	Percent of providers serving this population[16]
Mental Illness	84	64%
Homeless/Formerly Homeless	77	59%
Homeless – Long-term	73	56%
Chemical Dependency – Sobriety Model[17]	62	47%
People with a Two or More Disorders such as Mental Illness and Chemical Dependency	60	46%
Chemical Dependency – Harm Reduction Model[18]	50	38%
Elderly	35	27%
Veterans	32	24%
Brain Injury	32	24%
Chronic Medical Condition	30	23%
Developmental/Intellectual Disability	30	23%
Physical Disability	28	21%
Domestic Violence	14	11%
HIV/AIDS	14	11%
Dementia/Alzheimer's	13	10%
Other	10	8%
Parkinson's	7	5%
Deaf/Blind	6	5%
None of the Above	4	3%

Descriptions of residents from provider interviews echoed these survey responses and provided further context for how residents come to their settings. Providers specifically indicated the top factors that bring participants to their settings; those with serious and persistent mental illness, with chemical dependency, and who experience long-term homelessness or are at-risk of homelessness. Further, in these interviews providers shared that they serve participants who would have previously been housed in state hospitals.

According to provider survey respondents, residents are almost exclusively single adults. The provider survey indicated that slightly more settings serve men than women, or a mix of genders[19]. See Figures 8 and 9 for more detail.

Figures 8 and 9 – Providers Serving Participants by Gender and Population Types

Gender Served	Number of Providers	Percent of Providers[20]
Men	115	89%
Women	94	73%

Population Served	Number of Providers	Percent of providers[20]
Single Adults	121	94%
Single Parents with Children	20	15%
Adult Couples without Children	19	15%
Adult Couples with children	8	6%
Youth Alone	5	4%

High Needs Participants in Comparison to Low Needs Participants

Providers were asked to characterize the population they serve in terms of varying degrees of need by categories of high, medium and low, and to explain the differences or distinguishing characteristics (if any) of participants in those categories.[21]

The results revealed that differences between residents defined as high or low needs was not necessarily related to the *types* of services they were provided, but rather the *amount* of services they received. For example, participants needing less intense services (low needs) are independent and compliant in taking their medications and managing their relationships with the community, while participants needing more intense services require comprehensive and constant attention for managing their medications, activities of daily living, and treatment.

Provider interviews revealed that participants' needs vary greatly depending on the individual and the day. A participant who may have been stable for one period of time may suddenly relapse and require intense services, whereas another may require intense services on a daily basis. For example, chronic inebriates may go through periods of sobriety in their tenure, and then periodically relapse, requiring continuous supports to remain stable and housed through both phases.

With some recipients, needs grow greater over time, as issues that were undiagnosed or were undisclosed at intake may emerge later on. In other cases, participants have high levels of need in the beginning of their stay at a GRH setting, which may decrease over time. However, some level of services is usually still required to maintain stability.

Many providers serve a small percentage of low-needs residents. On average, providers believed that 67% of their clients were of high needs/intensity. In surveys, providers described populations who often had a higher intensity of need as those with severe and persistent mental illness and/or those with chemical dependency. Almost half of all respondents (43%) identified participants with serious and persistent mental illness as a characteristic of high needs, another 27% of providers identified chemical dependency, and 13% identified people who are at risk of homelessness.

Provider interviews confirmed that participants with co-occurring mental health and chemical dependency issues (particularly chronic users), or those with dual diagnoses (more than one medical and/or mental health diagnosis) take up the most staff time.

Conversely, provider surveys revealed, on average, few (17%) residents were low needs/intensity. Many of these residents were said to have struggled and continue to struggle with mental illness and addiction, but are now able to manage their needs, medications and treatment plans with much less intense staff assistance, and often with complete compliance. These participants may have experienced high-intensity needs previously, but were now in a stable period and were transitioning back into the community.

Type of individual need(s) is not necessarily an indicator of whether or not an individual receives GRH funding. Forty-six percent of providers reported that they have a mix of supplemental service and non-supplemental service residents.[22] Of those, 71% (42 providers) indicated their supplemental service residents do not differ from other residents in terms of need, while 17 said there was a difference between residents. When there ***was*** a difference, nearly all providers indicated that their service rate recipients had higher needs and required more intensive services than other residents.

Providers who serve a mix of participants in the same setting stated that they do not distinguish between the two populations in service delivery; they allow everyone to access the same services. In their interviews, providers also described how residents receiving GRH service funding often require assistance in more than just one area (for example, both in personal hygiene as well as making medical appointments).

Number of Participants Served

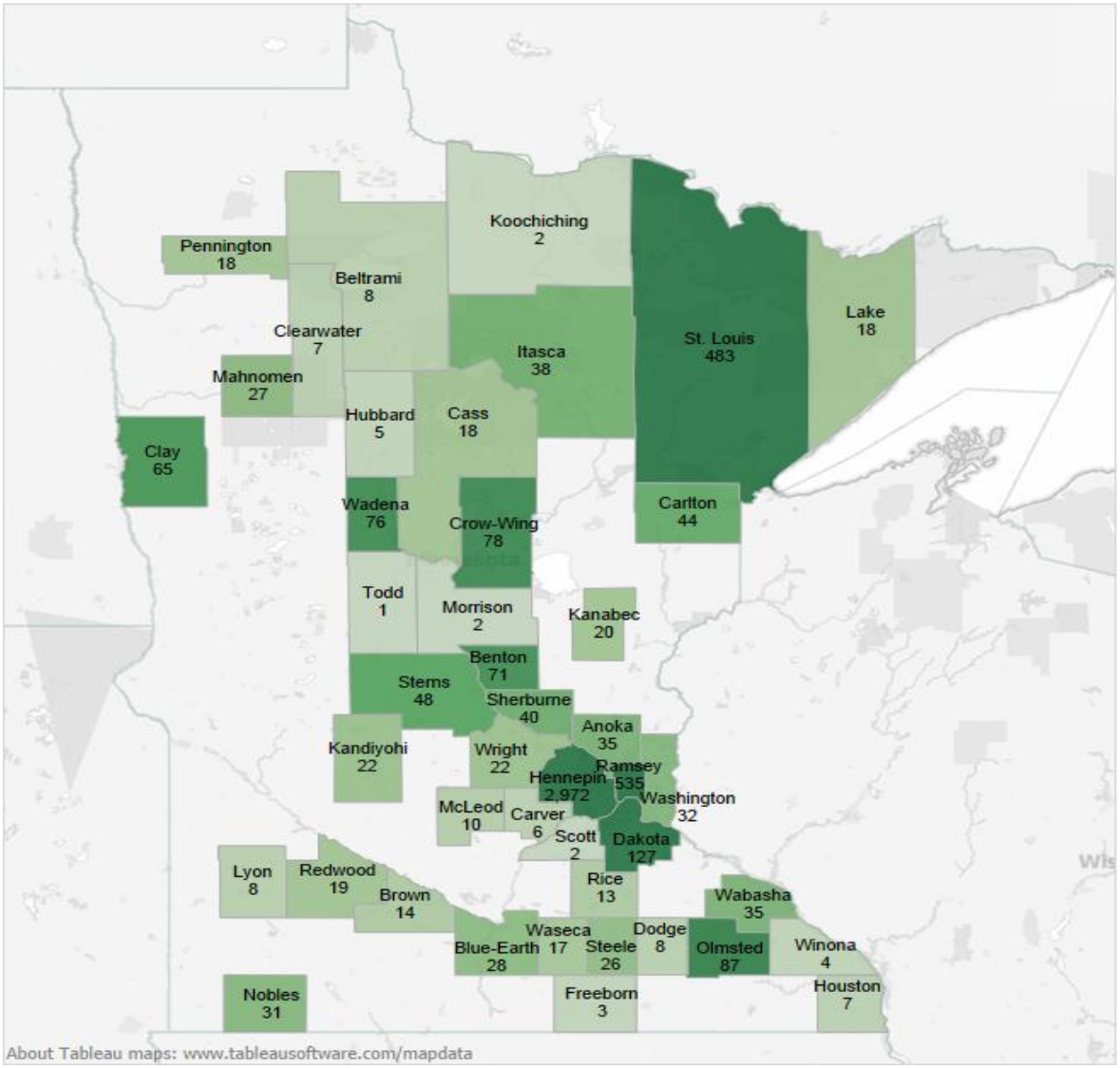
In SFY2013, **29,046** unique participants were served by GRH funding. Of those, a total of **9,252** (32%) also received a supplemental service rate. During an average month there were **5,170** supplemental service rate participants across the state.

Figure 10 and the accompanying map below (Figure 11) show the average monthly supplemental service rate participants by county. As shown, the top six counties in the state account for 85% of GRH recipients, while the remaining 35 counties account for 15%. The numbers of unique individuals served in SFY2013 compared to the monthly average shows the high rate of turnover over the course of one year. However, the rates of turnover are relatively consistent throughout the state.

Figure 10: Counties with Highest Supplemental Service Rate Usage

County	Number of unique individuals served in SFY2013	% of total unique participants served	Average Number of participants per month	Percentage of overall monthly average
Hennepin	5,455	59%	2,972	58%
Ramsey	1,048	11%	535	10 %
St. Louis	785	8%	483	9%
Dakota	290	3%	127	3%
Olmsted	178	2%	87	1.7%
Crow Wing	147	1.6%	78	1.5%

Figure 11 –Average Monthly GRH Supplemental Service Rate Participants by County



Supplemental Services Provided and Service Delivery

At a Glance:

Although GRH policy outlines services providers are required to deliver, when surveyed, 7 of every 10 providers indicated delivering a larger group of "core services." Of all supplemental services provided, they fall into four categories: social services, mental health, chemical health, and medical/health. While residents typically complete goal plans at their setting, they stay at their residences for various lengths of time. The duration of their stay is dependent on the setting and the participant.

GRH statute stipulates that, ***at a minimum***, the following services must be provided in order to receive funding: assistance with transportation, arranging meetings and appointments, arranging medical and social services, medication reminders, and up to 24 hour supervision.[23]

A wide variety of additional services are being provided in GRH settings. Nevertheless, there is some commonality across populations. At least 7 out of every 10 providers are currently delivering a core set of services. This set of services is central to meeting the needs of GRH's diverse participant population:

- Skill development (living and socialization skills)
- Community integration activities
- Treatment planning/assessment and documentation (case management)
- Service coordination and referrals (assistance arranging meetings or appointments, with benefit applications, and securing household supplies and furniture)
- Medication management (reminders, preparation and administration, and taking vital signs)
- Assistance with transportation
- Licensed nurse onsite

Social Services

The most common social services offered by providers in our survey were community integration activities, assistance with benefit application, handling or assisting with personal funds, helping with household chores, transportation assistance, appointment management, and medication reminders.[24]

Additionally, many providers work to build participants' basic life skills through assistance with budgeting and money management, healthy eating and meal preparation, basic cleaning, medicine management, navigating paperwork, job seeking, personal hygiene and health education, laundry, and interpersonal communication. See Figure 12 for more detail.

Figure 12 – Providers Offering Social Services by Service Type

All Social Services	Number of providers	% of respondents[25]
Arranging meetings and appointments*	76	92%
Assistance with application for benefits	75	90%
Arranging social services*	74	89%
Arranging medical services*	71	86%
Assistance with transportation*	71	86%
Community integration/involvement activities	67	81%
Assistance securing household supplies and furniture	58	70%
Handling or assistance with personal funds	57	69%
Assistance finding and securing housing	55	66%
Helping with household chores	53	64%
Medication reminders*	51	61%
Assistance maintaining housing, including conflict management with landlord	48	58%
Conflict resolution/mediation training	45	54%
Meal preparation	45	54%
Up to 24-hour supervision[26]*	44	53%
Group skill development	37	45%
Group coping activities	35	42%
Other	6	7%
None of the above	2	2%

Chemical Health Services

The most common chemical health services offered by providers in the survey were medication management, living skills and socialization development, community integration activities, and service coordination.

Additional common services included transportation, supervision and behavioral treatment, coordinating and fostering social activities, and assisting residents with creating connections throughout the community. See Figure 13 for more detail.

Figure 13 – Providers Offering Chemical Health Services by Service Type

All Chemical Health Services	Number of providers	% of respondents[27]
Living skills development	50	88%
Socialization skill development	47	82%
Service coordination	45	79%
Community integration/involvement activities	44	77%
Medication management	42	74%
Education on how changes in lifestyle can help maintain sobriety	41	72%
Education on chemical use	37	65%
Services that address co-occurring mental illness	34	60%
Treatment planning, assessment and documentation (including case management)	33	58%
Individual/one-on-one counseling	31	54%
Therapeutic recreation	30	53%
Employment or educational services	29	51%
Stress management	29	51%
Group counseling or group coping activities	28	49%
Transition services to integrate gains made during treatment	23	40%
Family or relationship counseling	13	23%
Other	4	7%

Medical/Health Supervision Services

The most common medical/health supervision services offered by providers in the survey were assistance in the preparation and administration of medication, medication reminders, taking vital signs, and having a licensed nurse on site.

In addition, many settings provide therapeutic diets and assistance in dressing, grooming, bathing, or walking with devices.[28] See Figure 14 for more detail.

Figure 14 – Providers Offering Medical/Health Supervision Services by Service Type

All Medical/Health Supervision Services	Number of providers	% of respondents[29]
Medication reminders	67	92%
Assistance in preparation and administration of medication (other than injectables)	62	85%
Taking vital signs	52	71%
Licensed nurse on site	52	71%
Provision of therapeutic diets	39	53%
Assistance in dressing, grooming, bathing, or with walking devices	29	40%
Providing skin care, including full or partial bathing and foot soaks	26	36%
Assistance with bowel and bladder control, devices, and training programs	18	25%
Assistance with therapeutic or passive range of motion exercises	14	19%
Assistance with eating/feeding	13	18%
Other	10	14%
None of the above	3	4%

Mental Health Services

The most common mental health services offered by providers surveyed were community integration activities and medication management. See Figure 15 for more detail.

Figure 15 – Providers Offering Mental Health Services by Service Type

All Mental Health Services	Number of providers	% of respondents[30]
Medication management	46	75%
Community integration/involvement activities	44	72%
Development of a positive behavior support plan with specific reactive or emergency strategies	38	62%
Implementation and monitoring of the behavior support plan	38	62%

Periodic reassessments and plan modifications	36	59%
Training and supervision for caregivers and direct service staff on plan implementation and monitoring	32	53%
Services that address co-occurring chemical dependency	32	53%
Individual/one-on-one counseling	29	48%
Individualized functional assessment of target behaviors	27	44%
Group counseling and other group coping activities	23	38%
Family or relationship counseling	14	23%
Other	7	12%
Occupational therapy	5	8%

Scattered site settings show a heavier focus on social services, but still provide a similar service profile in mental, chemical and health services as congregate settings. There was little variance in service types across settings with different licensure/registrations. A few providers across multiple service areas (such as mental and chemical health) indicated providing transportation.

Surveys and interviews revealed a variety of additional services offered, for example:

- Landlord mediation for scattered site housing
- Advocacy
- Resident activities such as sobriety events, recreational activities and community outings
- Building problem solving skills
- Behavioral redirection
- Education and training for residents

Staffing Levels

Providers in the survey reported a wide range of total staff[31], from 1 or 2 people to more than 21. However, 57% of respondents have 10 or fewer staff and 14% had more than 21. Case Managers[32], Registered Nurses, and Intake Workers are the most commonly used direct service staff positions, while Executive/Setting Directors, Program Directors, and Cooks rise to the top as the most commonly used indirect service staff positions. It is important to note that not all staff positions are funded with GRH service funding.

Personal Care Assistants have the highest average FTE per provider; 17 providers employ this position with an average of 19 FTE per provider. See Figures 16 and 17 for more detail.

Figure 16 – Total Number of Staff for all Provider Surveyed Respondents

Number of Total Staff	Number of Providers	% of respondents
0-5	31	29%
6-10	30	28%
11-15	12	11%
16-20	18	17%
21 or more	15	14%

Figure 17 – FTE Data for Each Staff Position as Reported by Provider Survey Respondents

Position	# of providers with this staff position	Total FTE	Average FTE per provider
Personal Care Assistant	17	322[33]	18.94
Case manager	69	306.9[34]	4.45
Other position(s) not listed here[35]	68	278.6	4.1
Certified Counselor	7	23.5	3.36
Front desk worker	44	144.3	3.28
Cook	58	176.3	3.04
Licensed Practical Nurse	21	34.75	1.65
Registered Nurse	57	76.85	1.35
Setting manager/setting or executive director	83	104.92	1.26
Clinical supervisor	17	20.05	1.18
Licensed Social Worker	20	22.45	1.12
Program/service director	81	90.56	1.12
Intake worker/coordinator	45	49.8	1.11
Licensed Psychologist	4	4	1.00
Nurse Practitioner	1	1	1.00
Licensed Marriage and Family Therapist	1	1	1.00
Dietician	11	10.25	0.93
Licensed Alcohol and Drug Counselor	14	11.7	0.84
Licensed Chemical Dependency Counselor	5	3.6	0.72
Medical Doctor	3	2.05	0.68
Occupational Therapist	0	0	0
Physical Therapist	0	0	0

Use of clinical supervisors was highest in settings addressing high medical needs such as HIV/AIDS and Parkinson's; there was also high use among those addressing chemical health issues both through sobriety and harm reduction models.

Use of registered nurses and LPNs was higher among populations with more medical needs, such as the elderly and those addressing chemical dependency issues through sobriety models.

Use of licensed social workers was higher among settings serving homeless populations and those with mental illness compared to other settings.

Length of Stay

During provider interviews, the length of stay was identified to vary greatly by setting and by participant. Some providers have specific programs and are set up primarily for individuals to stay for a period and then move on, whereas others have a combination of populations -- some who stay indefinitely and others who come for a period and transition out.

The populations most likely to stay at a setting for longer periods (more than ten years) appear to be court-ordered, elderly, and/or highly vulnerable. Programs that are functioning similar to treatment programs for chemical dependency had average resident stays from 3 to 12 months.

In participant focus groups, participants were asked about their length of stay in the GRH setting. Answers varied widely depending on the type of participant and the residency requirements (some settings require participants to have a specific length of stay, while others are indefinite). Nine respondents stated that they have been in their current place of residence for over a year, while 5 stated that they had been there between 7 and 9 months. Four have been in the GRH setting for 1 to 3 months.

Performance Review

GRH Settings Meet Participant Needs

Participant focus groups demonstrated that the biggest change in participants' lives since entering the GRH setting was increased stability. The stability they have found in GRH settings, has given participants a place for family and children to visit, opportunities to build credit, and an environment where they can work towards goals of sobriety and improved health. Participants shared general agreement that these settings are meeting their needs. They cited varied examples of helpful services and ways that staffs have assisted them with their needs.

Successes and Challenges of Meeting Participant Needs

At a Glance:

Providers report that their staff must be highly flexible in order to meet the varied needs of their participants. With such a diverse population of participants served, they maintain that this is necessary for resident success. However, providers assert that the current GRH service reimbursement is not adequate to fully meet participant needs in the areas of transportation and behavioral health. Participants also articulated this as an area in which greater services are needed.

In their interviews, providers shared the importance of always having staff available for participants in order to assist them however possible in meeting their needs, which vary greatly over the course of their residence. Providers feel that this, in combination with a menu of available services, ensures that participants feel comfortable and remain stable for as long as possible.

A key informant from a mental health advocacy organization affirmed that GRH services meet the needs of those with mental health issues. Further, the source affirmed again that the variety of services offered along with having staff available on-site is helpful since participants needs vary greatly day-to-day and over time.

In focus groups, participants described positive relationships with staff and highlighted specific examples of staff being responsive to their needs. Participants also expressed gratitude for the ways the settings have changed their lives, met their needs, and for the staff that work with them.

In their interviews, providers described areas in which they are challenged to meet certain needs, often because the service rate reimbursement was not adequate to fully cover needed services. Many noted transportation as a critical need that allows residents to access services and behavioral health supports, and described additional services they thought would be beneficial, but were not financially feasible now, including:

- Aggression control therapy
- Having a therapist on staff or other mental health services regularly available
- Transportation

Participants in focus groups agreed that the largest unmet need they have is transportation, with respondents specifically stating that they have difficulty getting to appointments, or find that appointments only scheduled for an hour take up entire days due to transportation complications.

Providers echoed that some of their residents are not able to access public transportation options, where they exist, without assistance or supervision for various reasons including mental health concerns.

In two focus groups, participants felt as though they could not gain employment without risking their funding, and have therefore avoided employment or have quit their jobs in order to maintain the services offered at their GRH setting.

Accessing Services Outside of GRH Supplemental Services

At a Glance:

Most providers work to ensure that residents who are provided with supplemental services do not receive services that duplicate those they receive through other funding streams. They also help participants access additional services outside of their GRH setting.

Surveys and interviews indicated that supplemental service participants also receive support from many services in addition to those provided through their GRH setting. In their interviews, providers shared that they are careful not to duplicate services that participants are receiving through other funding streams such as Adult Rehabilitative Mental Health Services (ARMHS) workers, Personal Care Assistants (PCA), or an Assertive Community Treatment (ACT) team which also assist with activities of daily living.

Several providers specifically described that that they assist in referring residents to these and other services, and assist in facilitating that connection. In surveys, providers described services most frequently provided outside of GRH services. These include:

- ARMHS services (identified by 7 providers)
- Nursing / medical services (identified by 10 providers)
- Case managers (identified by 6 providers)
- Mental health services (identified by 5 providers)

In focus groups, participants identified a wide variety of services through outside agencies and/or community activities that help them, including:

- Alcoholics Anonymous
- Community centers and churches
- ARMHS
- Volunteer work
- Health coordinators

In their interviews, providers shared that trust is a major barrier participants face when accessing services. Once trust has been established, the participant is more likely to access the appropriate services. In order to facilitate this for outside services, many providers have established relationships with programs through partnerships. For example, a few mentioned bringing licensed chemical dependency treatment providers into the setting to hold groups and work with residents. One provider shared that this practice has increased the number of residents accessing treatment and decreased substance usage. Others have partnerships with pharmacies, food shelves, foot care specialists, and public health nurses through the county. A few providers shared that they have built strong relationships with law enforcement. For example, police officers will notify them of any issues or concerns involving their residents.

Relationship between Services, Funding Sources, Rates, Disability Type, & Level of Need

At a Glance:

There is little connection between the proportion of GRH participants with high needs, and those receiving an enhanced supplemental service rate (in other words, having higher needs does not guarantee that a participant will receive a higher service rate). Similarly, the proportion of the sites receiving enhanced/not enhanced rates is fairly similar across the different service areas (e.g. chemical versus mental health service areas). So, certain service areas or needs do not get higher rates than others. A majority of sites provide a high number of chemical health and social services, regardless of whether they receive the standard or an enhanced service rate.

The standard supplemental service rate is set by the State Legislature. In order to receive an enhanced service rate, a provider must obtain a legislative exemption. This study set out to uncover if there are relationships between supplemental service rates and the type or amount of supportive services provided, populations served, or setting type.

While the GRH service funding is an individual income supplement, payments are associated with the GRH settings and are not received directly by individual residents. Because of this, it is crucial to understand what relationship, if any, exists between the characteristics of residents and the services provided in their GRH settings.

Enhanced Rates & Amount of Services Provided

Settings appear more likely to have an enhanced rate if all of their residents receive GRH services. Almost 50% of settings where ALL residents receive the service rate have an enhanced rate, compared to 13% for settings with a mix of residents.

Many providers across the state are offering their participants comprehensive service packages but are not currently reimbursed for all of those services. They often supplement GRH funding with other funding sources to cover all service costs.

Thirty-five percent of providers in our survey receive funding through other sources than GRH in order to provide services.[36] However, outside funding does not appear to have a relationship

with service rates, as 36% of providers that do receive additional funding have an enhanced service rate compared to 32% of providers that do not receive additional funding.

Figure 18 below explores the relationship between the kinds of services offered and whether or not sites are receiving an enhanced service rate. Survey data show that settings with a non-enhanced rate have slightly lower rates of providing chemical and mental health services.

Figure 18 – Providers with Enhanced or Non-Enhanced Service Rates across Service Areas

Service Area	Number of providers	Enhanced Rate	Number of providers	Non-enhanced Rate
% offering chemical health	18	60%	39	41%
% offering mental health	18	60%	46	49%
% offering medical/health supervision	20	67%	53	56%
% offering social services	20	67%	66	70%

In terms of the needs of participants, there is no relationship between the portion of a provider's high or low needs residents and whether or not that provider receives an enhanced rate. See Figure 19 for more detail.

Figure 19 – Providers with an Enhanced or Non-Enhanced Rate by Participant Need

Service Rate	Number of providers	Settings with over 50% of participants being HIGH NEED	Number of providers	Settings with over 50% of participants being LOW NEED
% providing services with the standard rate or lower (<$499)	47	69%	8	73%
% providing services with an enhanced rate (>$499)	21	31%	3	27%

The survey data also demonstrate that the number of different supplemental services offered is not necessarily related to the amount of high or low need participants served, but instead to service area. As shown in the table below, the amount of different services being provided does

not vary much between settings with large proportions of high or low need residents. See Figure 20 for more detail.

Figure 20 – Number of Different Services Provided by Participant Need

Number of Different Services Provided	Number of providers	Settings with over 50% of their population being HIGH NEED	Number of providers	Settings with over 50% of their population being LOW NEED
% offering 9+ services in chemical health	32	66%	6	67%
% offering 9+ services in mental health	33	27%	5	20%
% offering 7+ services in medical/health supervision	45	29%	5	20%
% offering 10+ social services	30	74%	7	71%

Scattered Site vs. Congregate Settings

At first glance, the table below (Figure 21) may indicate that there are some significant differences between service rates at congregate and scattered site settings. However, a closer analysis reveals that 79% of congregate settings receive the standard rate or less compared to 84% of scattered site settings, which is a minimal difference.

Figure 21 – Rate ranges for Congregate versus Scattered Site Settings

Rate Ranges[37]	Number of providers	Congregate Settings	Number of providers	Scattered Site Settings
$0 – $399	23	24%	0	0%
$400 – $499	53	55%	31	84%
$500 – $699	5	5%	1	3%
$700 – $999	12	13%	5	14%
$1000+	3	3%	0	0%

There is a difference between services provided at congregate settings compared to scattered site. Congregate settings are much more likely to provide medical services and slightly more likely to provide mental health services. Nearly every scattered site setting in our survey offers social services compared to just over half of congregate settings. See Figure 22 for more detail.

Figure 22 – Comparing Services Provided by Service Area in Congregate and Scattered Site Settings

Service Area	Number of providers	Congregate Settings	Number of providers	Scattered Site Settings
% offering Chemical Health services	39	45%	14	42%
% offering Mental Health services	47	55%	12	36%
% offering Medical/Health Supervision services	64	74%	6	18%
% offering Social Services	52	61%	31	94%

In terms of amount of different services, none of the scattered sites in our survey offer more than seven medical/health supervision services, contrastingly, over one-third (34%) of the congregate sites do offer more than seven. In addition, while scattered sites have high rates of providing social services generally, they do not provide as many when compared to congregate settings. See Figure 23 for more detail.

Figure 23 – Comparing the Amount of Different Services Provided by Service Area in Congregate and Scattered Site Settings

Amount of Different Services	Number of providers	Congregate Settings	Number of providers	Scattered Site Settings
% offering 9+ services in chemical health	23	59%	8	57%
% offering 9+ services in mental health	13	29%	3	25%
% offering 7+ service in medical/ health supervision	22	34%	0	0%
% offering 10+ social services	45	88%	13	45%

Participant Outcomes

At a Glance:

Individual goal setting with participants is not a requirement of the current GRH supplemental service system. However, because documentation of this is required by many other outside organizations, many providers do provide this service. When goals are set, they vary from getting healthier to finding employment. County staff and providers feel that supplemental service funding is critical to keeping people from homelessness, medical emergency, and inebriation, saving public money in the long run.

In their interviews, most providers reported that participants regularly set goals and staff regularly monitor their progress and work to achieve them, both through formal and informal processes. However, providers varied greatly in their approach to goal setting; for example, some focused on helping participants stay sober while others asked participants to set goals in major areas of finance, education, employment and social involvement.

Overall, 70% of providers surveyed reported documenting outcome goals for residents receiving Supplemental Service funding. Of those, 92% monitor progress on resident outcome goals internally. In addition, progress is often either monitored by or reported to an outside organization. Providers indicated reporting to counties (65%), the State (22%), private foundations (20%), and Homeless Management Information Systems (HMIS) (20%). Other reporting systems used for monitoring outcomes include Mental Health Information Systems (MHIS), County Veterans' Administration, probation officers, Hennepin County Citrix Database, and Federal Home Loan Bank.

These providers shared that information from systems such as HMIS is not useful for them internally and they cannot generate any useful reports.

In the survey, providers were asked to select which outcome best characterized the goal for their setting. The results are in Figure 24 below.

Figure 24 – Treatment Goals as Reported by Provider Survey Respondents

Treatment Goals	% of Providers	Highlights
Long-term stay with improved stability	50%	43 of the 65 providers who selected this response serve participants with mental illness, 39 serve long-term homeless participants, 38 serve homeless/formerly homeless, 30 serve participant with co-occurring disorders.
Transitioning residents to independent living	27%	25 of the 54 providers with this goal serve participants with chemical dependency in a sobriety model and 26 serve participants with mental illness.

Residents transitioning to housing with less intensive services	9%	Of the 11 providers who selected this option, seven serve homeless/formerly homeless individuals
Other	14%	Of the 18 who selected other, five providers identified assisting residents to secure long-term housing, while others largely stated that treatment goals were to become more independent and involved in communities. Two providers identified risk reduction for sex offenders, independence from chemicals, and assisted living.

Participants in focus groups confirmed an emphasis on goal setting. Over half of participants identified using a goal list and working on that list with a staff member. These goals varied depending on the participant, but specific themes were gaining employment, making steps towards physical health, and medical management (making doctor's appointments, etc.). Other goals listed were getting a case manager, applying for disability insurance, developing budgeting skills, and finding an apartment.

Transitioning Out of the GRH Setting

In interviews and the survey, providers shared reasons participants leave their settings. These varied from being evicted, to transitioning to independent living, and entering treatment or jail. In cases where a setting has a very fixed program, participants may finish the programming requirements and transition out. In addition, providers noted that there are a very small percentage of people at each setting who successfully transition to independent living, as most cannot find or sustain employment that pays enough to afford market rate housing, and because they frequently face barriers or issues that prohibit them from living independently.

Providers also shared that, in general, participants who wish to transition off the program will self-identify as being interested in pursuing work and independent living options. The provider will then work with the individual to create a transition plan and meet their goals in order to successfully make the transition. Participants with the highest likelihood of success are those who receive sufficient Supplemental Security Income or who access public housing. Some larger providers who have multiple setting types will start an individual off in the group residential housing setting, and then as they are ready, transition them to scattered site housing, and eventually to independent living.

Preventing Negative Outcomes through Supplemental Services

To gain insight into the impact of GRH, providers, county staff, participants and advocacy groups were asked what would happen to participants if their setting and/or GRH supplemental services did not exist. Respondents felt that participants would end up homeless, in shelters, living in public spaces, incarcerated, in detox, in nursing homes, using drugs or alcohol on the streets, in emergency rooms, dead, in intensive residential treatment service (IRTS) settings, in state commitment, and/or off of their medications with unpredictable behaviors. During focus

groups, participants confirmed this impression, anticipating that they would be homeless, in shelters, or a few would be staying with family members if they did not have access to this setting.

Providers shared that if the funding did not exist the public cost would be significantly higher than the cost of GRH supplemental service funding. County staff felt the most likely outcomes would be increases in the homeless population, incarceration rates, demand for emergency services, and for waivered services (which already have some supply limits). All of these services are costly and crisis driven options compared to the longer-term stability offered by GRH settings.

Performance Monitoring Practices

Counties currently have varying degrees of oversight for GRH service providers, creating a situation of uncertainty as to which providers are performing well and which ones are falling short of meeting the needs of their residents.

Licensure and Registration

While GRH settings must meet certain requirements to receive an MDH, the department, or tribal government licensure or registration, oversight requirements for maintaining them vary. MDH requires settings who have health related services to provide this through a licensed home care provider or a licensed nurse.[38] The department has no specific requirements or state-required oversight specifically related to the service rate.

In general, licensures or registrations are renewed on an annual basis, which includes completing a form each year. There is little else in the way of requirements across jurisdictions.

GRH Agreements

At a Glance:

In order to receive GRH funding, providers are required to have a GRH agreement with the county where they are located. This agreement reflects the current GRH rate for which they are approved, along with basic information about the provider. GRH agreements look quite different from county to county, and vary in the frequency at which they are updated.

Content

In order to receive GRH funding, each provider is required to have a GRH agreement with the county where they are physically located, which reflects the current GRH rate (updated every July). Yet, there are no additional guidelines or requirements for content of the agreement specifically related to the service rate. So, while some counties have provider expectations and required practices related to monitoring in their agreement, others have no such language.

Overall, almost all counties are in compliance with this basic policy. In the county contract manager's survey, 93% of counties with GRH service providers have a GRH agreement on record with each provider (27 out of 29 counties who responded). Almost half (47%) of the counties with GRH service providers monitor providers' compliance with specific terms of their GRH agreements as needed (when there are concerns), and 13% monitor yearly.

The example of several metro county agreements illustrates how much these forms can diverge. In one metro county, congregate GRH providers are required to offer 4 hours of nursing per week. The rationale is to provide a focus on medication management, as this can be a key factor in the stability and safety of many GRH service rate participants who have substance use, mental health, or co-occurring disorders.

Nurses also provide education to residents on a variety of health issues. Another metro county has even more required services and specifications for the program (i.e. increasing independent living skills, healthy social and recreational opportunities to promote community integration). For example, instead of "24-hour care" which is an MDH requirement, this county's language reads:

> *"…Supervision by trained staff, volunteers, or interns. Clients will not be unattended at the site for more than 120 minutes at a time and an emergency responder will be on-call at all times when clients are unattended."*

A third metro county's agreement requires semi-annual data reporting, allows for unannounced site visits, notification within ten days if someone exits, and return of overpayment within thirty days.

Counties often specify first access to available units, and may require providers to notify the county first and in advance in the event of openings.

Frequency of Updates

In addition, counties may or may not update their GRH agreements on a regular basis, as seen in Figure 25 below. In counties with GRH service funding, most updates are occurring when there is a new provider, a change in provider information, or a change in rates. For those updating their agreements at other times, many are doing it annually (other than July 1st when GRH rates currently change). Others are doing updates every 2 or 5 years.

Figure 25 – How Often GRH Service Rate Counties Update their GRH Agreements

How often do you update your GRH agreements?	Number of GRH service rate counties (n=29)	% of respondents
When there is a new provider	22	73%
When a provider changes their address or number of beds	21	70%
When there is a rate change	21	70%
Every July 1	16	53%
Other	8	27%

Participant Service Plans

At a Glance:

GRH service recipients are required to have some sort of service plan in order to receive funding and should be monitored annually. Nevertheless, like the GRH agreements, the frequency with which service plans are reviewed varies from county to county.

Under Minnesota statute, counties must approve a current plan for service rate eligibility for each participant. The policy assumption is that these plans should be updated annually; however, in practice this does not necessarily occur.

In total, 30% of counties with GRH service providers monitor individual ***eligibility determinations*** as needed for supplemental service providers, another 10% monitor monthly or yearly, while 7% monitor every six months.

Over 33% of counties with GRH service providers monitor ***individual budget determinations*** (financial eligibility) as needed for participants, and another 13% monitor it monthly, with 7% monitoring it every six months.

One metro county's service plans are updated annually with a financial review, but the county does not meet with each individual participant.

Another metro county's service plan includes required services available at the residence, the client's disability needs, and sometimes their goals. If the client has a self-sufficiency account, discharge is also part of their plan.[39]

This county recommends that providers update the service plan after 90 days for participants with chemical dependency issues, and every 30 days for all participants in order to report income data to a financial worker. They also prefer to authorize 180 days for GRH participants coming out of chemical dependency treatment settings, and have previously done 90 days in order to motivate people to think about moving.

One rural county's service plans are updated annually to detail the participant's needs and how the participant and case manager plan to meet those needs. In addition, these GRH service rate participants are matched with case managers.

County Monitoring

At a Glance:

Further monitoring beyond the oversight of the GRH agreement and participant service plans varies greatly by county. Larger counties like those in the metro have more robust systems in place to do regular monitoring of providers, while smaller counties with fewer GRH service providers rely on relationships to maintain oversight. Currently, counties are not required to conduct regular site visits or provide case management unless service rate participants qualify for it under a different program. Most providers do not complete accountability reports on GRH participants aside from the annual service plan update. About 40% of county staff work with providers on an as needed basis for oversight. Furthermore, training and educational opportunities for supplemental service providers is sporadic; only 40% of staff said their county has ongoing support in this area.

County survey respondents were asked about their current GRH monitoring practices and interviews were completed with 5 of the counties to gather more in depth information and perspectives.

Practices for provider performance monitoring vary greatly by county. Some counties, such as those in the metro, have a lot of processes and structures in place, whereas other counties do not and rely instead on relationships with providers.

In total, 37% of counties with GRH service providers shared that their county monitors the concurrence of GRH Agreement information with MAXIS information on an as needed basis for supplemental service providers, while 20% monitor this yearly, and 3% not at all. Yearly monitoring for complete and up-to-date providers' licenses/registration is done by 37% of counties with service rate providers and 23% monitor this as needed.

In total, 63% of the counties with GRH service providers monitor for potential fraud or financial exploitation by providers for supplemental service providers on an as needed basis. While only 7% of the counties shared that their county conducts monthly monitoring of overpayments and overpayment collection for supplemental service providers, 53% monitor this as needed.

Almost half (43%) of counties with GRH service providers monitor the cleanliness and safety of GRH settings for supplemental service providers as needed, with another 17% monitoring yearly, and 3% not monitoring this at all. Sixty-three percent of the counties with GRH service funding monitor incident and adult maltreatment reports for supplemental service providers on an as needed basis.

In total, 43% of the counties with GRH service providers monitor existence and enforcement of house rules for supplemental service providers as needed, although 10% do not monitor this at all, and 7% monitor annually.

Verifying validity of client complaints can be a challenge for counties. In one rural county, providers are highly encouraged to contact the county staff if they believe a complaint is likely to

be made by a participant in order to explain the situation and assist the county in understanding the problem. The most common complaints are centered on miscommunication of house rules, which this county keeps a copy of for their two GRH service providers.

This county also shared that communicating different expectations for participants with the GRH housing rate only as opposed to those with GRH services to case managers can also lead to challenges, as case managers may suggest that a provider is not meeting expectations when in reality there is no expectation of service delivery with the GRH housing rate.

In order to ensure supplemental service providers are implementing their required services, 47% of counties with GRH service providers monitor Minnesota statutory requirements on an as needed basis, 7% do not monitor this, 3% monitor monthly, and another 3% are yearly.

Almost half (43%) of the counties with GRH service providers monitor providers' resident case files for supplemental service providers as needed, although 10% do not conduct any monitoring in this area, and 3% monitor this yearly. Around 37% of counties with GRH service providers monitor the amount of funds spent on food and food preparation for supplemental service providers as needed, 17% monitor this yearly, and 10% never monitor this.

Site Visits

License requirements specify that drop-in visits may be completed; however, not all GRH providers are licensed settings. Some settings are registered Housing with Services settings with the Minnesota Department of Health (MDH) and are not required to have site visits. For board and lodge with special service establishments to be licensed with MDH, they must first have an initial site visit by a county or state official to acquire the Food, Beverage and Lodging Establishment license. Yet, this initial site visit may be targeted towards food-related amenities and physical plant specifically, but not necessarily the provision of room, board, or services.

County level GRH oversight practices vary. Two metro counties were the only respondents that reported having a monitoring policy for supplemental service sites (out of the 31 respondents).

Some counties complete regular site visits to GRH service providers, while others shared in interviews that they do not have the staff capacity or time to complete visits or do not know what aspects to monitor.

The largest counties in the state conduct annual site visits. Drop-in visits are also conducted if there have been complaints or if there is an issue a provider is working to resolve. For scattered site housing, one metro county no longer visits apartments because the program has outgrown staff capacity for that level of monitoring; however providers are required to conduct annual housing qualification standard inspections. Another metro county also relies on providers to complete drop-in visits to resident apartments.

In one rural county, drop-in site visits are completed as needed if there are complaints. In addition, quarterly GRH provider meetings take place at one of the two service rate providers in the county, and will usually include a tour of the setting.

Case Management

In general, counties do not provide case management for GRH supplemental service rate participants, unless they qualify for case management under another program such as targeted mental health case management. This limits the capacity for county engagement with participants receiving the GRH service rate. However, financial workers at counties are required to annually verify financial eligibility for GRH. This is further evidenced by county surveys, where 77% of staff from counties with service rate providers reported collaborating with County Financial Assistance on a regular basis. The rest of the county staff collaborates on an as needed basis.

Cross-Department Collaboration

The majority (61%) of staff from counties that have GRH service providers collaborate with Public Health on an as needed basis; fewer (25%) collaborate regularly. For example, in one rural county, public health officials conduct annual visits to each site for licensure, and at times they may also request that a county staff person involved with GRH attend the visit with them due to complaints or concerns. This county provides additional enforcement and consequences if issues are not resolved in a timely manner.

Case managers within another rural county visit their GRH settings in the context of serving participants through other programs, and will report any issues to the Social Services supervisor.

Accountability Reports

While reporting requirements vary by county, 27% of the counties with GRH service providers monitor GRH recipient outcomes as needed, with 17% monitoring this annually and 13% not monitoring outcomes.

One metro county requires provider data reporting biannually. These reports vary by setting type and include things such as participant demographics, numbers of participants admitted, whether participants left voluntarily or were asked to leave, identifying housing barriers, disabilities, and criminal records.

Providers in one metro county working with people who have long histories of homelessness report on the outcome of housing stability for a year or more, and can add additional outcomes. The county reviews one case file for each case manager per site visit in order to look at how often they visit participants in scattered site housing (one in-home visit per week is required when participants first enter the program, and an average of one visit per month over a year after the initial period).

Another metro county requires quarterly reporting from providers, including census data, demographics, length of stay, number of new admissions, total number of participants served for the period, number of cases closed, and reasons for discharge.

A third metro county has a GRH evaluation report that includes total number of participants admitted, how many left on positive terms, on negative terms, number of emergency vehicle

responses to the site, numbers of participants whose sobriety and employment stabilized or improved, and how many exited to permanent housing.

One rural county in the study does not require providers to submit reports about GRH service rate participants, but recommended that a service plan with a checklist of services be developed for these participants.

A second rural county's staff shared in an interview that they do not have the capacity to review reports, nor a method for addressing situations in which reports were not submitted. This is likely the case for many smaller counties around the state without dedicated staff positions for GRH.

In surveys and interviews, most providers reported that they do not currently complete accountability reports on GRH participants aside from the annual service plan update, in some instances these plans are updated only when a participant moves in, and then again if they change settings. One provider uses a mix of questions to assess quality of life and housing stability on a quarterly basis. Many providers shared that they do their own monitoring and evaluation processes or hire external evaluators for things such as participant satisfaction surveys, but only use those findings internally. One provider has an annual review process conducted by Minnesota Housing Finance Agency as they received the money to construct their setting and an operating subsidy from that agency.

Training and Supports Available

Most staff from counties with supplemental service providers work with providers on an as needed basis (46%) or regularly (43%). However, only 40% of staff surveyed from counties with GRH service providers shared their county has ongoing education/training opportunities for supplemental service providers, while the rest do not. Of those counties who provide education/training for GRH supplemental services providers, 38% offer it as needed/by request and a quarter provide it monthly or quarterly, while another 12.5% have the education/training available online. The department does not currently offer training for counties or providers on GRH services.

Additional support or resources for GRH service providers is provided consistently by 30% of counties; 40% do not have other ongoing support in place. Overall, 78% of staff from GRH service rate counties shared that their county does not orient new service providers, while 17% do.

Two metro counties have regular meetings between county staff and providers to cover policy changes and updates. Also there are meetings as needed on planning and development, and meetings for particular interest groups. One of these counties has a GRH Step Down group and a provider's council that meet monthly. The other county has a citizens' advisory council that provider staff often attend. This county also shared that their placement unit staff are on the phone with providers every week and other specific meetings are scheduled as needed.

In one rural county in our study, GRH provider meetings are conducted quarterly and are provider driven. These GRH meetings create a setting in which providers see one another as peers and can learn from one another, and are voluntary unless it is determined by the county that

the meetings should become mandatory. County staff will have additional meetings after the quarterly GRH provider meeting if it is determined that the provider needs additional assistance, and this scenario creates an opportunity for mentoring providers as they navigate complexities. A second rural county in the study does not hold regular meetings due to a lack of staff capacity and time.

One metro county offers periodic training to providers on topics such as: financial eligibility, bed bug training, case management, and through Metro-wide Engagement on Shelter and Housing (MESH). A second metro county offers provider trainings when changes are made, and financial assistance offers training as needed. This county's staff also shared relevant publications and resources with providers.

Contract Managers in one rural county shared in an interview that trainings are conducted during quarterly meetings as well as on an individual level to redirect behaviors if the county receives a complaint. The county suggested that a mandatory training that could be completed independently by providers could be beneficial. Another rural county shared that they do not conduct trainings due to a lack of staff capacity and time.

County Perspectives on the Department's Role and GRH Improvements

At a Glance:

County staff are split on whether or not the department should be more involved in monitoring and oversight of providers, and eligibility determinations. Yet, in suggestions for improvement from county staff, most opinions revolved around the department providing minimum performance monitoring standards and activities. Similarly, the most frequently cited area for improvement was in clarifying and communicating detailed expectations for all parties involved (e.g. county staff, providers, the department GRH staff). Counties also asked for regular and accessible trainings on GRH housing and service rate funding.

Overall, 53% of county staff surveyed felt that the department should assume a greater role in administering the MN statutory requirement to ensure supplemental service providers are implementing the required services. Also, 51% of county staff believed that the department should assume a greater role in oversight of potential fraud or financial exploitation by providers, as well as ensuring that providers' licenses/registration are complete and up-to-date. Additionally, 50% of counties think the department should provide more oversight with provider compliance on specific terms of their GRH agreements.

Conversely, 47% of staff from counties felt that the department should not be involved in oversight of individual eligibility determinations, and 46% did not think they should be involved in individual budget determinations. 29% of county staff did not believe the department should be involved in the existence and enforcement of house rules, although 25% of county staff did think they should provide oversight. Overall 27% of staff felt that the department should provide more oversight on providers' resident case files and an equal number felt that they should not have a role.

Two metro counties' staff recommended regular data reporting and annual site visits by county staff to providers as minimum performance monitoring practices. One of these counties conducts a participant survey every two years and their staff recommended that the department develop standards or performance measures for providers. In their interview, a second metro county indicated that they do not have time for participant surveys or interviews to monitor provider performance.

During an interview with contract managers, one rural county stated that performance monitoring activities would need to be created with an understanding of the county's ability to carry out the process as well as clearly defined purposes for the activities. Annual site visits would be especially valuable for settings without licensure from another regulatory body. Also, monitoring activities should clearly define payments and expectations for GRH housing and service funding, and should take into account the public rates for apartments versus the allowance the department pays per bed.

Another rural county noted that if performance monitoring activities were required, they encounter challenges with staff capacity and resources needed to complete these activities. The

county has had previous challenges in accessing support for processing issues as they are raised with other monitoring methods.

Of county staff that provided suggestions for GRH improvements on the survey, the most frequently cited area was in clarifying and communicating detailed expectations for all of the parties involved. Six people felt that GRH should have a uniform or template contract for GRH Agreements. Others (7) said they would like to see clear monitoring requirements for settings and providers, some noting that there should be consequences listed for non-compliance. Six individuals mentioned that they would like clear expectations for provider roles and standards. A few wanted to better understand county staff roles.

The desire for the department to provide regular and accessible trainings on GRH was also mentioned frequently. These trainings were seen as helpful for county staff and providers. Similarly, a few wanted designated GRH staff to answer questions if they had them. Others said that the department GRH staff had been very helpful answering questions and clarifying policy.

Efficiency of GRH Service Funding Usage and Banked Beds

Current Status of Banked Beds

At a Glance:

There are around 190 banked beds across the state, reflecting service settings that have either closed or downsized. There is little to no relationship between the number of beds a provider is approved for, and their actual capacity to serve participants.

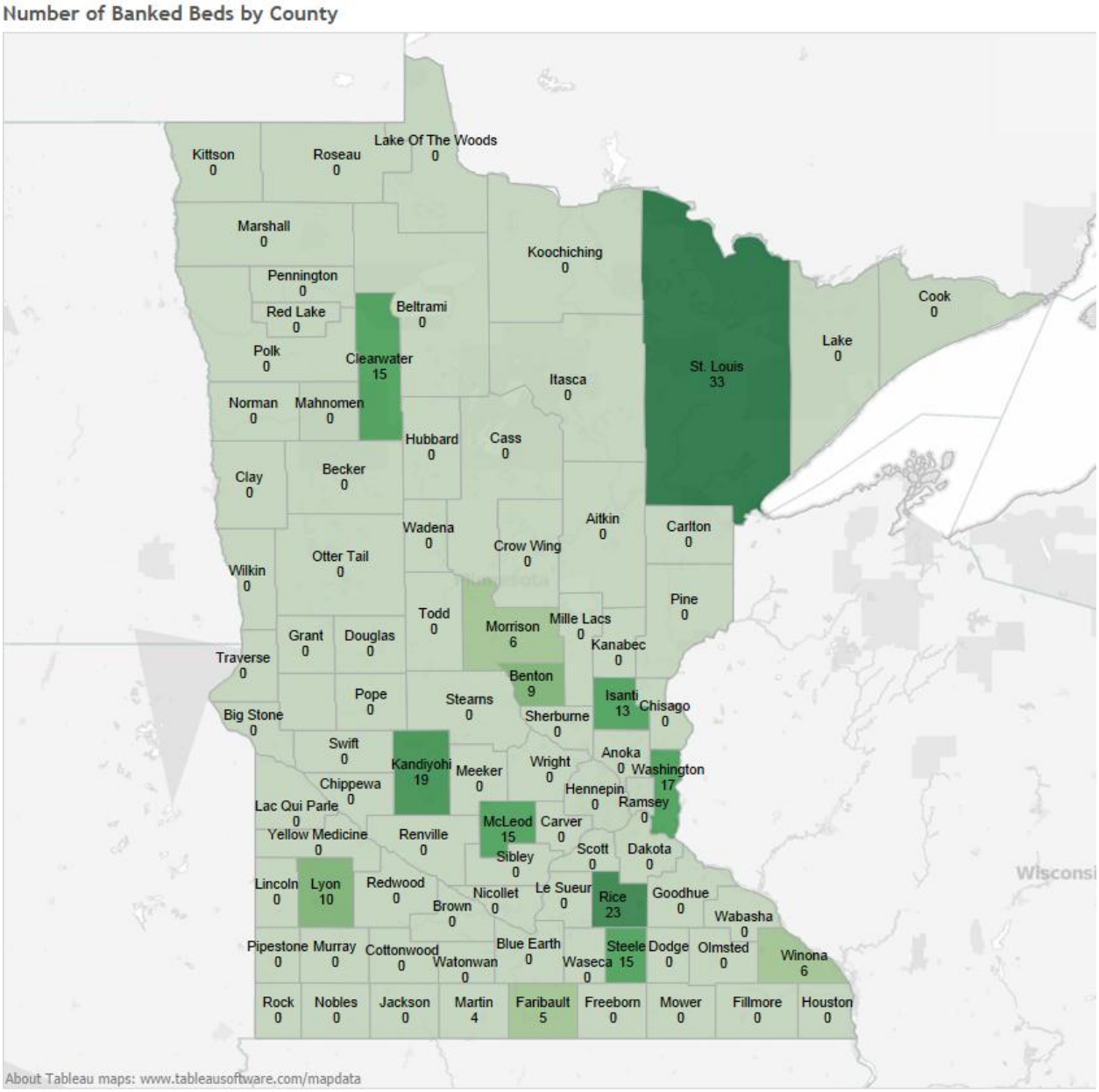
Due to the moratorium on the development of new supplemental service rate beds in place at the time GRH was implemented in 1993, counties have been limited to the number of beds they have at the time, with no room for growth aside from legislative exception.

When a GRH setting that receives a supplemental service rate closes or downsizes, the beds that are "lost" in that process may be "banked" by the county in which they were located. Banked beds[40] are considered "banked" until they are contracted to a provider. Beds that have been approved for a provider but have never been used are not "banked". This study has revealed in discussion with the department that the number of beds a provider is approved for, in many cases, has little to no relationship with their capacity to serve participants. GRH agreements designate the maximum number of beds that can receive payments at any given time with no relationship to actual utilization. Thus, this report does not include totals for "approved" beds across the state.

The map below (Figure 26) shows the number of banked beds currently available for development across the state by county. There are a total of **190 banked beds across the state** per the department data. The tracking of banked beds has largely been informal through the knowledge of the department and county staff. There is no formal state-wide system in place to track banked beds or for counties to verify the number of banked beds as statute does not require counties to report banked beds to the department.

County survey respondents varied in their assessment of whether the department counts matched their own records; further, these respondents also showed some uncertainty about the definition of "banked" beds. It should be noted that Faribault and Martin counties have a combined human services agency with a total of nine banked beds.

Figure 26 –Current Number of Banked Beds by County



Map based on Longitude (generated) and Latitude (generated). Color shows sum of Banked GRH Rate 2 Beds. The marks are labeled by County and sum of Banked GRH Rate 2 Beds.

The transfer of available beds from one county to another can only occur by the agreement of both counties.[41]

In interviews, county staff shared differing experiences in requesting and transferring banked beds when needed in collaboration with other counties, some counties have been quite willing, whereas others are more reluctant in case they need them for future development.

Two metro counties reported being in need of every bed they can access, given the high need for services in their counties; their primary reason for having banked beds is the lead time it takes to develop new provider sites.

One region pooled their banked beds together to develop a setting serving individuals with serious mental illness. Similarly, one rural county borrowed banked beds from neighboring counties for a development to benefit residents of the area. It is unknown how many of the banked beds across the state are in the process of being redeveloped.

Barriers to Providers Accessing GRH Service Funding

At a Glance:

Because of the moratorium on GRH service funding in Minnesota, there are few options for providers seeking to be approved for the supplemental service rate. Providers can use banked beds, where available, or seek a legislative exemption. Another exception allows residents of certain homeless shelters to relocate from the shelter to registered Housing With Services settings in the community.

Due to the moratorium on supplemental service rate beds in the state, providers who are trying to access the GRH supplemental services rate for their residents have limited options. If the county they are located in has banked GRH service rate beds they may enter negotiations with the county, or they may appeal to their legislator to seek a legislative exemption.

In their interviews, counties shared that without banked GRH service rate beds there is nothing they can to do help providers who want to access the rate; the exception was one rural county in the study. This county assists providers by holding a request for proposals, building connections with existing providers as well as making connections with other counties in order to borrow banked beds, and helping them to initiate legislative processes.

Accessing GRH service funding is very difficult for providers when their county does not have banked beds and their attempts at a legislative exception have been unsuccessful. In an interview, one provider who has been trying to access GRH service funding described these difficulties and noted that they are already providing services that are nearly identical to those offered by many GRH service providers around the state.

There is another exception to the moratorium. A legislative exemption allows persons who have resided in certain homeless shelters to relocate to an authorized setting in the community.[42] This legislative exemption has allowed many persons with histories of long-term homelessness to access scattered-site housing in the community while still receiving supportive services that help them maintain their independence.

This study sought to better understand the state of need for GRH. However, the data presented below is imperfect as it presents a snapshot of opinions from various groups. No systems currently gather or hold data about individuals looking for placement who cannot find a bed; moreover, since the supplemental services serve such a broad set of populations, it is not possible

to extrapolate potential need from other data sources. A statewide needs assessment could help to determine where the gaps in services exist for participants who are not currently being served.

Reallocation of Banked Beds and Provider Qualifications

Counties often reallocate banked beds through the use of RFP processes when settings close. County staff were asked in surveys what qualification criteria they would use to select providers if new supplemental service rate beds were available. The responses varied from an explanation of the RFP process to the description of the need for compliant and licensed providers. County staff identified quality of service and qualifications to be important factors for provider selection, in addition to meeting standards such as sufficient liability insurance. County staff also expressed interest in providers who have identified willingness to address unmet needs, such as transportation, as well as those serving certain (underserved) populations.

Bed Usage

At a Glance:

Most providers said they have not had a single GRH service rate bed go unused in the past six months. For those that have had beds go unused, providers report that they are often a result of high turnover and not for lack of demand.

The majority of providers shared that they have not had a single supplemental service bed go unused in the past six months (61%). In interviews, providers shared that they infrequently have vacancies and generally have either an informal waiting list or knowledge of other individuals waiting to be served.

Of the 53 providers who reported empty beds, the number ranged from 0 to 120 beds that were unoccupied at some point over the course of the year, for a total of 479 beds. The median number of beds unoccupied per provider was 3. Providers were asked to estimate the average amount of time beds went unused at their setting in the past year. The responses varied from 1 to 365 days with a median response of 30 days. Providers and our advisory group members shared that if someone goes into treatment or is arrested, they will hold their place, leaving the bed unused. This means an empty bed may not actually be available for a different participant.

In settings with high rates of turnover, they may consistently have one or two beds open, given the regular turnover of participants; however, there is always demand for the beds. Newer programs may be authorized for additional beds and in the process of slowly scaling up the size of the program to fill them. Providers have established networks and relationships to ensure a steady stream of participants to fill beds as they become available.

Survey respondents reported the most common reasons for beds to go unused were a lack of eligible residents/ a lack of referrals (54% of those with a vacancy in the past 6 months), a resident leaving without giving notice (52%), and that the provider asks a resident to leave (32%). Less common reasons were preparing the room for a new tenant (15%) and administrative delays (7%). The transition between residents was listed by 3 different providers,

some citing the screening as the reason there is a gap between two residents. Other reasons include beds being filled by alternate funding sources, residents not always wanting roommates, short-term medical care, and competition in the area to keep beds full.

Unmet Need Statewide

At a Glance:

There is currently no formal way to know the degree of need for GRH (beyond current use of the funds). A statewide needs assessment could help determine this. Many county staff reported in the survey that people with mental illness have the highest rates of unmet need for supplemental services. Others felt that people with co-occurring disorders have the highest rates of unmet need.

This study sought to better understand the state of need for GRH. However, the data presented is imperfect as it presents a snapshot of opinions from various groups. No systems currently gather or hold data about individuals looking for placement who cannot find a bed; moreover, since the supplemental services serve such a broad set of populations, it is not possible to extrapolate potential need from other data sources. A statewide needs assessment could help to determine where the gaps in services exist for participants who are not currently being served.

Providers and county staff have noted that waiting lists are not an accurate picture of unmet need as they vary significantly by provider, many providers do not maintain them, and there is no official process for accessing a waiting list as the referral process can vary greatly by participant. However, interviewees described high unmet needs across the state. Around one quarter (26%) of staff surveyed from counties with GRH service funding believed that people with mental illness have one of the highest rates of unmet need for supplemental services in their county. Next, 17% felt that people with co-occurring disorders had one of the highest rates of unmet need, while 13% responded that people with chemical dependency (harm reduction or sobriety) or were homeless/formerly homeless had one of the top three highest rates of unmet need.

A representative of one Tribal Nation discussed the large unmet need in the community for supportive housing, particularly for those who face issues such as chemical dependency, mental illness and barriers to housing such as bad rental histories and criminal records. While the Tribal Nation is working to expand their supportive housing options, they have not made substantial efforts to access GRH as a funding stream. Currently, this Tribal Nation's settings are funded by a mix of tribal funds, HUD funding for long-term homeless placements and MA billable services. They received Minnesota Housing funding to build the settings.

Findings

Rate Setting

This study demonstrates that the current approach to rate setting is not based on any documented alignment between the costs to provide services and the service rates. This can raise questions about accountability, fairness, and the efficient allocation of resources according to need.

Key findings related to rate setting for GRH service funding include:

1. By definition, GRH services is not a "program"; it is an income supplement that was not designed to serve a specific population or particular set of needs, however, all GRH service participants require some level of support to maintain day-to-day stability. Because of the lack of "programming" structure, GRH services became a "catch all" for individuals with varying degrees of disabling conditions and parameters around service delivery, monitoring, and accountability were not standardized across the system, resulting in the inconsistent nature of service rates and accountability measures experienced today.

2. A great variety of services are provided, but there is some commonality in certain services being provided across populations. At least seven out of every ten providers are currently delivering a core set of services that are critical to meeting the needs of GRH's diverse participant population:[43]

    - Skill development (living and socialization skills)
    - Community integration activities
    - Treatment planning/assessment and documentation (case management)
    - Service coordination and referrals (assistance arranging meetings or appointments, with benefit applications, and securing household supplies and furniture)
    - Medication management (reminders, preparation and administration, and taking vital signs)
    - Assistance with transportation
    - Licensed nurse onsite

3. Many providers serve few participants with low needs. Further, participant needs are often variable and changing – for individuals and at the broader population level. For example, participants who may have been stable for a period of time can suddenly relapse and require intense services, while others' needs grow greater as they age or face life challenges. In addition, issues that were undiagnosed or were undisclosed at intake may emerge, or participants may improve over time and need different types of services to maintain stability.

4. Individual assessments are difficult to reliably administer within this population due to the various underlying conditions requiring different types of tools and the presence of some conditions lacking the tested tools to determine and assess need appropriately. In addition, establishing a standardized cycle for conducting and refreshing individual assessments would negate the fact that there is often a lack of clear trajectory for improvement due to large variations in the disabling conditions.

   Providers and advocates using other state funding streams that serve similar populations and utilize individual assessments have often found them to be burdensome, lacking transparency, and particularly unsuccessful for people with mental illness in combination with other disabilities. Consequently, implementing an individual assessment of need would require intense collaboration and approval of a standard form, as well as additional funding and administrative support.[44]

5. There is no consistent justification for enhanced rates in the current system.

Performance Monitoring

Counties play the primary role in performance monitoring for GRH because they hold the GRH agreement with the provider. Currently, counties vary in their staff capacity and oversight practices; a minimum standard across the state would require that every county provide a basic level of oversight and consistent management practice. In their interviews, County staff shared that they would like to see the department play a role in providing guidance and consequences for provider expectations.

Counties have practices that vary, particularly in regard to the frequency of updating GRH Agreements and service plans. Several providers across the state have impressions that they are only permitted to provide the five required services set out in GRH policy. Other providers shared that case management is not an allowable service under GRH supplemental services funding.

Currently, not all counties require annual eligibility updates and instead provide them on an as-needed basis. It is not clear that all GRH service rate participants are sufficiently screened for eligibility on an annual basis.

Counties are also unclear regarding the role of a participant service plan. There is no standardized service plan template or policy to guide its use or implementation. However, several counties or providers have created forms to use as a documented reference point if complaints arise or the provider is not meeting the service expectation.

There is currently no performance monitoring appeal processes for providers who disagree with county or state decisions. The development of an appeals process for providers is desired among some counties who are having issues with underperforming providers to gain state support in implementing sanctions, closure, or additional resources.

Banked Beds

Counties who have banked beds are aware of their scarcity and worry about the department taking control of this resource. However, the current system is not as efficient as it could be because the moratorium created a landscape where there is increased unmet need and inequitable access to GRH service funding across the state. Furthermore, confusion over the definition of a banked bed and the lack of a tracking system has rendered the current banked beds system rife with errors.

Efforts are currently underway by the department to reconcile state records with county counts with the voluntary cooperation of counties. There is no current policy to require every county to notify the department if a GRH service rate setting closes or downsizes.

V. Minnesota Department of Human Services Recommendations and Implementation Strategies

It is a priority of the department to ensure that the GRH supplemental service funds serve vulnerable Minnesotans in an efficient and cost-effective manner. The Improve Group's research demonstrates that there is currently no relationship between the amount of a GRH service rate and the needs of residents. In addition, it is clear that current GRH service rates do not fairly address the unmet need for services across congregate or scattered site settings. This does not align with the intent of the funding or policy goals of the department. **Therefore, the department recommends changing the current structure of the GRH supplemental service rate.**

Rate Setting

- To align with the goals of Minnesota's Olmstead Plan, and policy direction of the department, it is **our recommendation that the GRH supplemental service rate be separated from the room-and-board rate**. This would allow participants to continue receiving services if they choose to transition out of a congregate setting and/or no longer require the room-and-board rate.

- The department **recommends that service rate setting criteria establish a menu of core services by target population and setting type**. Further analysis is necessary to identify a core set of services distinct for congregate setting vs. scattered-site settings in the community, as the nature of these setting structures impact service delivery in both staffing and feasibility.

- We **recommend rate setting criteria based on an individual's needs and established rates for individual services performed**. Everyone eligible for the GRH room-and-board rates today must demonstrate a disability or disabling condition through a General Assistance or Supplemental Security Income basis of eligibility. The core service rate will require an individual to also demonstrate the same disability or disabling condition basis of eligibility plus a need for housing services. For individuals with needs not met by the core service rate, the department would develop an application process to authorize eligible providers to provide additional services for identified higher-need target populations.

In order to meet the identified unmet service need for GRH settings statewide, the department **intends to pursue federal Medicaid reimbursement** where possible. To obtain federal approval from the Centers for Medicaid and Medicare (CMS) it will be necessary to demonstrate functional need at an individual level, not by program. To do this, it will be necessary to work closely with stakeholders to develop an appropriate method.

Additional implementation considerations include:

- **Pilot the new service rate model** across rural, metro, scattered, and congregate settings, along with a representative mix of populations served. This would allow for troubleshooting and model adjustments before rolling out system-wide.

- **Phase in changes to rates and include a "hold harmless" clause,** For example, with the new Waiver Rate Frameworks, rates are being implemented over the course of five years with a graduated change scale.

- Many providers across the state seek more information about the full range of service funding options available to them today. **A targeted technical assistance effort by the department could help providers review their financing model to determine the most appropriate service funding for their setting**, including Medicaid. The department's Housing Work Group would identify a process for such an effort.

Performance Monitoring

Counties play a primary role today regarding performance monitoring, as they hold the GRH agreement (contract between county and provider) regarding GRH funds. As described in the Improve Group study, counties vary in terms of capacity and level of monitoring.

The department recognizes the need to increase its training curriculum for county staff, including contract managers, social services, and financial workers. In addition, the department is working to develop training resources for providers directly, to reinforce basic standards and requirements for quality performance. Online trainings or webinars would be available to minimize the burden on financial and staff resources.

The department **recognizes that additional legislative authority** will be necessary to support a standard response to performance monitoring:

- Further define basic expectations for GRH funds, including the provision of room and board.
- Require use of a GRH agreement template that supports the enforcement of provider compliance and county monitoring. Examples include:
    - The right to unannounced site visits,
    - Expectations around setting cleanliness and provider responsibility to maintain cleanliness,[45]
    - Expectation of participant centered care and flexibility in meeting participant needs,
    - Basic services to be provided at a minimum; enhanced services if a provider receives an enhanced rate, and
    - Reporting requirements.
- Authorize the department to terminate a GRH Agreement if necessary for the health and safety of residents.
- Require minimum provider qualifications.
- Identify minimum training requirements for providers.

Banked Beds

- The department **recommends that the department be granted authority to require notification of all closures and reduction in authorized GRH service rate beds** to effectively track the number of banked beds available for development. Many counties are well positioned to identify community need and have development plans for their banked beds.

- The department **recommends giving counties two years to develop these beds or demonstrate a reasonable development plan**. After two years, the department would assume responsibility for the distribution of banked beds, with the following priority of serving specific target populations or geographic areas that have been underserved.

The department recognizes that continued monitoring and further evaluation of the Group Residential Housing program will be necessary upon implementation of these recommendations.

Appendix A: List of Counties with GRH Service Funding

Counties with GRH Service Funding	
Anoka	Lake
Beltrami	Lyon
Benton	McLeod
Blue-Earth	Mahnomen
Brown	Morison
Carlton	Nobles
Carver	Olmsted
Cass	Pennington
Clay	Ramsey
Clearwater	Redwood
Crow-Wing	Rice
Dakota	St. Louis
Dodge	Sherburne
Freeborn	Sterns
Hennepin	Steele
Houston	Wabasha
Hubbard	Wadena
Itasca	Waseca
Kanabec	Washington
Kandiyohi	Wright
Koochiching	Yellow Medicine

Appendix B: Consumer and Provider Qualitative Data Sources

This project was designed with a mixed-methods approach. Quantitative data were gathered from internet-based surveys and the department's MAXIS database. These data were analyzed in Excel and SPSS. Frequencies and cross-tabulations were used to describe the GRH supplemental service system and determine relationships between variables.

Qualitative data were gathered from interviews and participant focus groups. These data were analyzed using a multi-step process that follows the constant comparison/grounded theory model. Steps in this methodology included preparing and organizing the data in an Excel spreadsheet by responses to key evaluation questions, and analyzing and reorganizing data into themes.

These multiple sources of data ensured that we had a comprehensive picture of supplemental services across the state. The quantitative data helped us understand the breadth and prevalence of different factors, and relationships between different issues. The qualitative data helped us clarify, verify, and determine the relative importance of different issues.

	Need/Service Context	Organization	Location
Consumer Focus Groups and interviews	Mental health services focus – Metropolitan area	Guild Inc.	Saint Paul
	Homelessness focus	Higher Ground, Catholic Charities	Minneapolis
	Chemical dependency focus	New San Marco, Center City Housing	Duluth
	Mental health services focus – Rural	Youngdahl Living	Owatonna
Provider Interviews	High enhanced rate, high need population	Andrew Residence	Minneapolis
	Medical service focus – Rural	Cummings Care Center	Sauk Rapids
	Current GRH provider that wants to provide Supplemental Services but cannot access the rate	Dodge Board and Lodge	Kasson
	Scattered setting, metro demo , and special grant funding for services	People Inc.	Twin Cities
	Chemical dependency focus with homeless populations	St. Anthony Residence,	St. Paul

		Catholic Charities	
	Scattered site housing	St. Stephens	Minneapolis
	Chemical dependency focus – sober living setting(s)	Supportive Living Solutions MN Teen Challenge	Twin Cities Minneapolis/ Brainerd/Duluth
	Medical service focus - Metropolitan area	Transition Homes	St. Paul
	Would like to explore using GRH service funding, but does not have access to the funding stream	White Earth Resources and Supportive Services	White Earth
County Contract Manager Interviews	Rural county with GRH service rate providers	Clay County	Clay County
	High user of GRH service funding	Hennepin County	Hennepin County
	Rural county with GRH service rate providers	Olmsted County	Olmsted County
	High user of GRH service funding	Ramsey County	Ramsey County
	Other counties	Winona County Community Services	Winona County
	Advocacy group	MN Coalition for the Homeless	Statewide
	Advocacy group	National Alliance on Mental Illness (NAMI)	Statewide
Rate Setting Key Informants	Difficulty of Care	Anoka County	Anoka County
	Chemical Dependency	the department	Saint Paul
	Customized living tool	the department	Saint Paul
	Disability Waivers Rate System	the department	Saint Paul
	Mental Health	the department	Saint Paul
	Difficulty of Care	Olmsted County	Olmsted County
	Difficulty of Care	Washington County	Washington County

Appendix C: Provider Survey Respondents' Supplemental Service Rates by Range

Rate range	Number of respondents	Percent of respondents
$0-$399	23	17%
$400-$499	85	62%
$500-$699	6	4%
$700-$999	19	14%
$1,000+	4	3%

Appendix D: Survey Protocols

Provider Survey

Group Residential Housing (GRH) Supplemental Services Survey

The Minnesota Legislature commissioned a program analysis to inform the development of a new rate setting criteria for Group Residential Housing (GRH) Supplemental Services. GRH Supplemental Services is also known as Rate 2 or Service Rates. The Supplemental Services rate is the GRH money you receive on top of the Room and Board rate for select residents in your setting who qualify for additional services.

Learning about each setting's residents and the Supplemental Services available to them will be critical to informing the rate setting criteria and program decisions made by the Legislature.

The information you provide in this survey will provide the Legislature with the most complete picture of this program, which is necessary for implementing effective and appropriate program changes given the diverse range of GRH Supplemental Service consumers.

The Improve Group, a private firm, is managing this survey. The Improve Group will ensure your individual responses remain confidential. If you have questions about this survey, please contact Danielle Hegseth at danielleh@theimprovegroup.com or 651-315-8906. This survey should take approximately 25 minutes to complete.

Survey Instructions:

If you wish to exit the survey, just click SAVE. You will be prompted for your e-mail address and sent a unique link which you can use when you are ready to begin again.

To navigate between pages, use the BACK and NEXT buttons at the bottom of each page.

DO NOT USE THE BACK ARROW ON YOUR BROWSER.

What is the name of your GRH setting? [Note: "Setting" refers to the residence or single building where your consumers live, for scattered site housing vendors, please consider all individual sites together as one "setting".]

_____

_____

What MN Department of Health licensure/registration does your GRH setting currently hold? [Select all that apply]

- ❑ Lodging
- ❑ Board and lodging
- ❑ Board and lodging with special services
- ❑ Board and lodging with special services - Homeless
- ❑ Housing with services establishment

- ❑ Boarding care home
- ❑ Supervised living facility
- ❑ Hotel/restaurant
- ❑ Metro demo
- ❑ No MDH licensure
- ❑ Other

If other, please specify:

_____

_____

What MN Department of Human Services licensure/registration does your GRH setting currently hold? [Select all that apply]

- ❑ SILS-DD
- ❑ DD
- ❑ Adult Mentally Ill, Rule 36
- ❑ Adult Foster Care, Rule 203
- ❑ Pregnant Women Shelter, Rule 6
- ❑ Physically Handicapped, Rule 80
- ❑ Child Foster Care, Rule 13
- ❑ Chemically Dependent, Rule 25
- ❑ No the department licensure
- ❑ Other

If other, please specify:

_____

_____

In which county or counties does your GRH setting operate? [To select more than one county, hold down your control/Ctrl key and select each county.

- ❑ Anoka
- ❑ Beltrami
- ❑ Benton
- ❑ Blue-Earth
- ❑ Brown
- ❑ Carlton
- ❑ Carver
- ❑ Cass
- ❑ Clay
- ❑ Clearwater
- ❑ Crow-Wing
- ❑ Dakota
- ❑ Dodge
- ❑ Freeborn
- ❑ Hennepin
- ❑ Houston

- ❑ Hubbard
- ❑ Itasca
- ❑ Kanabec
- ❑ Kandiyohi
- ❑ Koochiching
- ❑ Lake
- ❑ Lincoln, Lyon, Murray
- ❑ McLeod
- ❑ Mahnomen
- ❑ Morison
- ❑ Nobles
- ❑ Olmsted
- ❑ Pennington
- ❑ Ramsey
- ❑ Redwood
- ❑ Rice
- ❑ St. Louis
- ❑ Sherburne
- ❑ Sterns
- ❑ Steele
- ❑ Wabasha
- ❑ Wadena
- ❑ Waseca
- ❑ Washington
- ❑ Winona
- ❑ Wright
- ❑ Yellow-Medicine

What is your provider ownership structure?

- ❑ Nonprofit organization
- ❑ For profit
- ❑ Public Agency

Do all of the individuals in your setting receive the GRH Supplemental Service rate?

- ❑ Yes
- ❑ No

In total, how many individuals are currently housed at your GRH setting?

_____

How many individuals at your GRH setting are currently receiving a Supplemental Service rate?

_____

Over the last six months, have you had one or more Supplemental Service beds go unused in your GRH setting?

- ❑ Yes
- ❑ No

Over the last six months, how many of your Supplemental Service beds have gone unused for more than one day in your GRH setting?

_____

On average, how many DAYS did a bed go unused in your GRH setting over the last six months?

_____

What are the TWO most common reasons for a bed to go unused? [Select two]

- ❑ People leave without giving notice
- ❑ Lack of eligible residents/lack of referrals
- ❑ We ask a resident to leave
- ❑ We are preparing the room for a new tenant
- ❑ City is holding up the administrative process (financial dispute, etc.)
- ❑ County is holding up the administrative process (contract problems, etc.)
- ❑ Other

If other, please specify:

_____
_____

Is your GRH setting currently approved for more than one Supplemental Service rate?

- ❑ Yes
- ❑ No

Is your GRH setting currently approved to receive an ENHANCED Supplemental Service rate (more than $482.84 per month, per resident)?

- ❑ Yes
- ❑ No

What is your GRH setting's approved Supplemental Service rate (round up to the nearest dollar)?

_____

How many Supplemental Service rates does your GRH setting currently receive?

- ❑ 2
- ❑ 3
- ❑ 4
- ❑ More than 5

Please enter your GRH setting's Supplemental Service rates (round up to the nearest dollar):

_____ _____

Please enter your GRH setting's minimum and maximum Supplemental Service rates (round up to the nearest dollar):
Minimum rate _____

Maximum rate _____

Are those you serve through Supplemental Services at your GRH setting: [Select all that apply]
- ❑ Men
- ❑ Women
- ❑ Transgender

Are those you serve through Supplemental Services at your GRH setting: [Select all that apply]
- ❑ Adult couples, no children
- ❑ Adult couples with children
- ❑ Single parents with children
- ❑ Single adults
- ❑ Youth, alone

Does your GRH setting specialize in serving any of the following population/disability types? [Select all that apply]
- ❑ Brain Injury
- ❑ Chemical dependency - harm reduction
- ❑ Chemical dependency - sobriety
- ❑ Chronic Medical Condition
- ❑ Co-occurring disorders
- ❑ Deaf/Blind
- ❑ Dementia/Alzheimer's
- ❑ Developmental/intellectual disability
- ❑ Domestic violence
- ❑ HIV/AIDS
- ❑ Homeless/formerly homeless
- ❑ Homeless - Long-term
- ❑ Mental Illness
- ❑ Physical Disability
- ❑ Parkinson's
- ❑ Elderly
- ❑ Culturally specific groups (e.g. Refugees, American Indians, etc.)
- ❑ Veterans

- ❑ None of the above
- ❑ Other

If other, please specify:

_____
_____

Do the residents in your GRH setting who receive the Supplemental Service rate differ in any way from the residents who do not receive the Supplemental Service rate?

- ❑ Yes
- ❑ No

In general, how do the NEEDS of residents in your GRH setting who are receiving the Supplemental Service rate compare to the NEEDS of the residents who do not receive the Supplemental Service rate?

- ❑ The Supplemental Services residents have higher needs/more intensity of services needed
- ❑ The Supplemental Services residents have lower needs/less intensity of services needed
- ❑ The Supplemental Services residents have about the same level of need

In what other ways do your GRH setting's Supplemental Service recipients differ from your residents who do not receive the Supplemental Service rate?

_____
_____
_____

How are Supplemental Services provided at your GRH setting? [Check all that apply]

- ❑ By staff from the GRH setting
- ❑ By an outside provider
- ❑ By multiple outside providers
- ❑ A combination of both the GRH setting and outside provider(s)

Please list the type(s) of service(s) being provided by outside provider(s):

_____
_____
_____

Please list the KEY CHARACTERISTICS of the Supplemental Service residents in your GRH setting that you consider High Need (requiring the highest level of services and staff time):

_____
_____
_____

In general, what PERCENT of the Supplemental Service residents you serve would fall into this category at any given time? [Please enter a whole number, no percentage sign needed]

_____

Please list the KEY CHARACTERISTICS of the Supplemental Service residents in your GRH setting that you consider Medium Need (requiring a moderate level of services and staff time):

_____
_____
_____

In general, what PERCENT of the Supplemental Service residents you serve would fall into this category at any given time? [Please enter a whole number, no percentage sign needed]

_____

Please list the KEY CHARACTERISTICS of the Supplemental Service residents in your GRH setting that you consider Low Need (requiring the lowest level of services and staff time):

_____
_____
_____

In general, what PERCENT of the Supplemental Service residents you serve would fall into this category at any given time? [Please enter a whole number, no percentage sign needed]

_____

How do the services residents at your GRH setting receive differ by their Supplemental Service rate? (For example, those receiving higher rates receive slightly more services, there is no difference in service delivery, money is pooled, etc.)

_____
_____
_____

Which of the following service types does your GRH setting provide to residents receiving the Supplemental Service rate? [Check all that apply]

- ❑ Chemical Health services
- ❑ Mental Health services
- ❑ Medical/Health Supervision services
- ❑ Social Services

What Chemical Health services are provided to residents receiving the Supplemental Service rate at your GRH setting? [Select all that apply]

- ❑ Treatment planning and documentation
- ❑ Individual/one-on-one counseling
- ❑ Family or relationship counseling
- ❑ Group counseling or group coping activities
- ❑ Medication management
- ❑ Living skills development
- ❑ Socialization skill development
- ❑ Community integration/involvement activities
- ❑ Employment or educational services
- ❑ Education on chemical use and its impact on health, including information on HIV, other STDs, drug and alcohol use during pregnancy, hepatitis, and tuberculosis
- ❑ Education on how changes in lifestyle can help maintain health and sobriety
- ❑ Therapeutic recreation
- ❑ Stress management
- ❑ Transition services to integrate gains made during treatment into daily living and to reduce reliance on the license holder's staff for support
- ❑ Services that address co-occurring mental illness
- ❑ Service coordination to help the client obtain the services and to support the client's need to establish a lifestyle free of the harmful effects of substance
- ❑ None of the above
- ❑ Other

If other, please specify:

_____

_____

On average, how many hours of overall staff time PER WEEK is needed to meet resident needs under each Chemical Health service area? **Please enter the number of hours needed per service area.**

Treatment planning/assessment and documentation (case management) _____

Regular or ongoing counseling, including: one-on-one, group, family, etc. _____

Skill development classes/groups (e.g. living skills, social skills, community involvement etc.) _____

Referrals to external resources or supports, including: employment or educational services, other therapies, transition services, etc. _____

Medication management _____

Crisis intervention, including planning _____

Other areas not covered here? _____

If other areas, please describe:

_____

What Mental Health services are provided to residents receiving the Supplemental Services reimbursement at your facility? [Select all that apply]

- ❑ Individualized functional assessment of target behaviors
- ❑ Individual/one-on-one counseling
- ❑ Family or relationship counseling
- ❑ Group counseling and other group coping activities
- ❑ Community integration/involvement activities
- ❑ Development of a positive behavior support plan with specific reactive or emergency strategies
- ❑ Implementation and monitoring of the behavior support plan
- ❑ Training and supervision for caregivers and direct service staff on plan implementation and monitoring
- ❑ Periodic reassessments and plan modifications
- ❑ Medication management
- ❑ Services that address co-occurring chemical dependency
- ❑ Occupational therapy
- ❑ None of the above
- ❑ Other

If other, please specify:

_____

On average, how many hours of overall staff time PER WEEK is needed to meet resident needs under each Mental Health service area? **Please enter the number of hours needed per service area.**

Treatment planning/assessment and documentation (case management) _____

Regular or ongoing counseling, including: one-on-one, group, family, etc. _____

Skill development classes/groups (e.g. living skills, social skills, community involvement etc.) _____

Referrals to external resources or supports, including: employment or educational services, other therapies, transition services, etc. _____

Medication management _____

Crisis intervention, including planning _____

Other areas not covered here? _____

If other areas, please describe:

_____

What Medical/Health Supervision services are provided to residents receiving the Supplemental Services reimbursement at your GRH setting? [Select all that apply]

- ❑ Assistance in preparation and administration of medication (other than injectables)
- ❑ Medication reminders
- ❑ Provision of therapeutic diets
- ❑ Taking vital signs
- ❑ Assistance in dressing, grooming, bathing, or with walking devices
- ❑ Assistance with eating/feeding
- ❑ Assistance with bowel and bladder control, devices, and training programs
- ❑ Assistance with therapeutic or passive range of motion exercises
- ❑ Providing skin care, including full or partial bathing and foot soaks
- ❑ Licensed nurse on site
- ❑ None of the above
- ❑ Other

If other, please specify:

_____

On average, how many hours of overall staff time PER WEEK is needed to meet resident needs under each Medical/Health Supervision service area? **Please enter the number of hours needed per service area.**

Treatment planning/assessment and documentation (case management) _____

Preparation and administration of medication (other than injectables), including reminders _____

Therapeutic work, including therapeutic diet preparation _____

Crisis intervention, including planning _____

Intermittent care, including: dressing, grooming, bathing, skin care, eating, bathing, etc. _____

24 hour care, including: bowel and bladder control, devices, feeding tubes, etc. _____

How many hours is a licensed nurse required on site? _____

Other areas not covered here? _____

If other areas, please describe:

_____

What other Social Services are provided to residents receiving the Supplemental Services reimbursement at your GRH setting? [Select all that apply]

- ❑ Medication reminders
- ❑ Up to 24-hour supervision
- ❑ Group skill development
- ❑ Group coping activities
- ❑ Community integration/involvement activities
- ❑ Conflict resolution/mediation training
- ❑ Assistance with transportation
- ❑ Assistance with application for benefits
- ❑ Arranging meetings and appointments
- ❑ Arranging medical services
- ❑ Arranging social services
- ❑ Handling or assistance with personal funds
- ❑ Helping with household chores
- ❑ Meal preparation
- ❑ Assistance finding and securing housing
- ❑ Assistance securing household supplies and furniture
- ❑ Assistance maintaining housing, including conflict management with landlord
- ❑ None of the above
- ❑ Other

If other, please specify:

_____

On average, how many hours of overall staff time PER WEEK is needed to meet resident needs under each Social Service area? **Please enter the number of hours needed per service area.**

Treatment planning/assessment and documentation (case management) _____

Transportation services _____

Service management and coordination, including: assistance with applications, scheduling meetings, medical appointments, social appointments _____

Group work/skill development activities , including: coping, conflict resolution training, community involvement, etc. _____

Tenancy support services _____

Meal preparation _____

Medication reminders _____

Other areas not covered here? _____

If other areas, please describe:

_____

How many meals does your GRH setting PROVIDE DAILY to Supplemental Service rate residents?

- ❑ 0
- ❑ 1
- ❑ 2
- ❑ 3

Are resident outcome goals documented for those receiving the Supplemental Service rate?

- ❑ Yes
- ❑ No

Is progress on these resident outcome goals monitored by GRH setting staff?

- ❑ Yes
- ❑ No

If available, please upload the form(s) or tool(s) (a blank copy) you use to monitor progress on resident outcome goals at your GRH setting.

_____

Is progress on resident outcome goals monitored by or reported to any of the following organizations, external funders, or oversight bodies? [Select all that apply]

- ❑ Private foundation
- ❑ External service provider(s)
- ❑ City
- ❑ County
- ❑ HMIS
- ❑ Health plans
- ❑ State
- ❑ Progress on resident outcome goals is not monitored or reported externally
- ❑ Other

If other, please specify:

_____

If available, please upload the form(s) or tool(s) (a blank copy) used to report progress on resident outcome goals externally.

_____

Which of the following best describes your program/GRH setting's treatment goal for your residents?

- ❑ Transitioning to independent living
- ❑ Long-term stay with improved stability
- ❑ Transitioning to housing with less intensive services
- ❑ Other

If other, please describe:

_____

How many total staff does your GRH setting currently employ (including contract workers)?

_____

How many of the following staff POSITIONS does your GRH setting currently employ (including contract workers)? [Note: If a position is split, **for example:** a front desk worker also conducts intakes, you would indicate .5 FTE for each role they fulfill, and so on.]

Case manager _____

Certified Counselor _____

Licensed Social Worker _____

Licensed Psychologist _____

Licensed Marriage and Family Therapist _____

Licensed Chemical Dependency Counselor _____

Licensed Alcohol and Drug Counselor _____

Medical Doctor _____

Personal Care Assistant _____

Occupational Therapist _____

Physical Therapist _____

Nurse Practitioner _____

Registered Nurse _____

Licensed Practical Nurse _____

Dietician _____

Cook _____

Intake worker/coordinator _____

Front desk worker _____

Site manager/facility or executive director _____

Program/service director _____

Clinical supervisor _____

Other position(s) not listed here _____

If other, please specify:
_____

What training/supports does your direct service staff currently receive? [Select all that apply]

- ❑ Benefit assistance training (SOAR or something similar)
- ❑ Continuing Education
- ❑ Other courses or trainings
- ❑ Conferences
- ❑ Support groups
- ❑ Other

If other, please specify:
_____

What are the TOP THREE most common reasons a Supplemental Services resident leaves your GRH setting? [Please select three]

- ❑ Decreased needs/when they show improvement
- ❑ Increased needs/services can no longer be met in this setting
- ❑ Resident's decision
- ❑ Resident's change in funding eligibility
- ❑ Eviction
- ❑ Death
- ❑ Other

If other, please specify:
_____

Does your GRH setting have a waiting list?

- ❑ Yes
- ❑ No

How many people are currently on that list?

_____

Given your current rate of turnover, how long do you estimate it would take to house everyone on your waiting list?

- ❑ Less than 1 month
- ❑ 1 to 6 months
- ❑ 6 months to a year
- ❑ 1 to 3 years
- ❑ More than 3 years

Do you receive funding through any other source specifically for service provision at your GRH setting?

- ❑ Yes
- ❑ No
- ❑ I don't know

Please list the additional funding sources for service provision at your GRH setting:

_____

If there anything else you would like to say about GRH Supplemental Services?

_____

_____

Thank you for your time!

County Survey

Greetings!

We at the department would like to identify and share successes in Counties' Group Residential Housing (GRH) programs to develop statewide Quality Assurance measures for GRH Room and Board (Rate 1) and Supplemental Service (Rate 2) programs. Each County administers GRH in a way that works best for their community, and we're curious to learn what each County has tried and learned.

Please take 15-20 minutes to respond to the questions in this survey. We will compile the results and report them back to you with our action plan in six weeks.

Along with this survey, we hope to create a forum for communicating GRH updates, trainings and opportunities to engage with the department, Counties and Vendors. At the end of this survey, you will have the opportunity to provide your email address to stay connected.

Survey Instructions:

A navigation toolbar located at the bottom of each page of this survey will help you as you complete the survey:

* To navigate between pages, use the BACK and NEXT buttons at the bottom of each page.

* Click the RESET button to reset answers on the current page in the survey.

* If you wish to exit the evaluation, just click SAVE. You will be prompted for your e-mail address and sent a unique link which you can use when you are ready to begin again.

* When you have completed your response, be sure to click SUBMIT at the end of the last screen.

* If you would like to open a blank PDF version of the questionnaire so you can review the questions before beginning the questionnaire, click HERE.

Information about you

Q1	**County:**	_____
Q2	**First Name:**	_____
Q3	**Last Name:**	_____
Q4	**Title:**	_____
Q5	**Phone:**	_____
Q6	**Email:**	_____

Q7 **I am a:**

- ☐ Social Services Worker
- ☐ Financial Assistance Worker
- ☐ Contract Management Worker
- Manager/Supervisor

Information about your county's GRH program

Q8 **In your County, how many staff work on or are regularly involved with GRH?**

Social Services _____
Financial Assistance _____
Contract Management _____
Manager/Supervisor
Other _____

Q9 **Does your GRH staff collaborate with any of the following?**

	On a regular basis	As needed	No
Public Health	☐	☐	☐
County Social Services	☐	☐	☐
County Financial Assistance	☐	☐	☐
Provider / Vendor Collaboratives	☐	☐	☐
Contract Management	☐	☐	☐
Other	☐	☐	☐

Q10 **You chose Other in the previous question, please enter the type of group you collaborate with:**

_____

Information about your county's GRH program

Q11 **Do you have a GRH Agreement on record with each GRH Vendor in your county?**

☐ Yes
☐ No

NOTE: Service Contracts for Home and Community Based Services waivers will change January 1, 2014, but GRH Agreement requirements will remain.

Q12 **How often do you update your GRH Agreements? (Check all that apply)**

☐ When there is a new vendor
☐ When a vendor changes their address or number of beds
☐ When there is a rate change
☐ Every July 1
☐ Other

Q13 **You chose Other in the previous question, please enter how often you update your GRH agreements:**

_____

Information about your county's GRH program

Q14 **How often do you monitor the following elements for settings that receive GRH Room and Board (Rate 1) funding:**

		Monthly	Every 6 months	Yearly	As needed/When concerns	Never	Other
Q13a	Concurrence of GRH Agreement information with MAXIS information (e.g. # of GRH beds, license #s, # of licensed beds, payment rates, Vendor #s)	☐	☐	☐	☐	☐	☐
Q13b	Vendors' licenses/registrations complete and up-to-date	☐	☐	☐	☐	☐	☐
Q13c	Individual eligibility determinations	☐	☐	☐	☐	☐	☐
Q13d	Individual budget determinations	☐	☐	☐	☐	☐	☐
Q13e	Vendors' compliance with their GRH Agreements	☐	☐	☐	☐	☐	☐
Q13f	Amount of funds spent on food and food preparation	☐	☐	☐	☐	☐	☐
Q13g	Potential fraud or financial exploitation by Vendors	☐	☐	☐	☐	☐	☐
Q13h	Overpayments and overpayment collection	☐	☐	☐	☐	☐	☐
Q13i	Cleanliness and safety of GRH settings	☐	☐	☐	☐	☐	☐
Q13j	Incident and adult maltreatment reports	☐	☐	☐	☐	☐	☐
Q13k	Existence and enforcement of house rules	☐	☐	☐	☐	☐	☐
Q13l	Vendors' resident case files	☐	☐	☐	☐	☐	☐
Q13m	GRH Recipient Outcomes (e.g. exits, employment, etc.)	☐	☐	☐	☐	☐	☐

How often do you monitor the following for Room and Board (Rate 1) settings:

Q15 Concurrence of GRH Agreement information with MAXIS information (e.g. # of GRH beds, license #s, # of licensed beds, payment rates, Vendor #s) _____

Vendors' licenses/registrations complete and up-to-date _____

Individual eligibility determinations _____

Individual budget determinations _____

Vendors' compliance with their GRH Agreements _____

Amount of funds spent on food and food preparation _____

Potential fraud or financial exploitation by Vendors _____

Overpayments and overpayment collection _____
Cleanliness and safety of GRH settings _____
Incident and adult maltreatment reports _____
Existence and enforcement of house rules _____
Vendors' resident case files _____
GRH Recipient Outcomes (e.g. exits, employment, etc.) _____

Information about your county's GRH program

Q16 **Does your county have a monitoring policy for Room and Board (Rate 1) services?**

- ☐ Yes - I will email our county's monitoring policy to sophat.jesci@state.mn.us.
- ☐ Yes - I would like to enter our county's monitoring policy in this survey.
- ☐ No

If you are entering your county's monitoring policy in this survey, please give us a general description of how you monitor the elements listed below.

☐Concurrence of GRH Agreement information with MAXIS information (e.g. # of GRH beds, license #s, # of licensed beds, payment rates, Vendor #s)
☐Vendors' licenses/registrations complete and up-to-date
☐Individual eligibility determinations
☐Individual budget determinations
☐Vendors' compliance with their GRH Agreements
☐Amount of funds spent on food and food preparation
☐Potential fraud or financial exploitation by Vendors
☐Overpayments and overpayment collection
☐Cleanliness and safety of GRH settings
☐Incident and adult maltreatment reports
☐Existence and enforcement of house rules
☐Vendors' resident case files
☐GRH Recipient Outcomes (e.g. exits, employment, etc.)

Q17 **Please enter your county's monitoring policy for Room and Board (Rate 1) services:**

_____
_____

Information about your county's GRH program

Q18 **How do you manage complaints from GRH Room and Board (Rate 1) residents and vendors?**
(Check all that apply)

- ☐ Refer to the State Office of Ombudsman
- ☐ Refer to the Long-Term Care Ombudsman
- ☐ Refer to a Regional Resource Specialist
- ☐ Refer to the Minnesota Department of Health
- ☐ Refer to the Department of Human Services Licensing
- ☐ Refer to the Office of Inspector General

- Refer to another agency
- Manage internally
- Other

Q19 **What agency do you refer your county's complaints from GRH Room and Board (Rate 1) residents and vendors?**

_____

Q20 **How does your county manage complaints from GRH residents and vendors?**

_____

_____

_____

Information about your county's GRH program

Q21 **Do you use a standardized needs assessment to approve the Difficulty of Care payment for Adult Foster Care?**

- Yes
- No
- We do not have Difficulty of Care in our county

Q22 **How frequently does your county use a standardized needs assessment to approve the Difficulty of Care payment for Adult Foster Care?**

- At intake
- Annually
- Other

How often does your county use a standardized needs assessment to approve the Difficulty of Care payment for Adult Foster Care?

_____

Q23 **Do you have minimum qualifications for approval of new GRH Vendors who provide Room and Board (Rate 1)?**

- Yes
- No

Q24 **Does your County have ongoing education/training opportunities for GRH Vendors who provide Room and Board (Rate 1)?**

- Yes
- No

Q25 **[ROUTED from Q24] How frequently do you offer these education/training opportunities for GRH Vendors who provide Room and Board (Rate 1)?**

- Monthly
- Bi-monthly
- Quarterly
- Annually
- As needed/by request
- Always available online

Q26 **Do you provide GRH orientation for new Room and Board (Rate 1) vendors?**

- ☐ Yes
- ☐ No
- ☐ Sometimes

Banked Beds

Bed Counts

The department has been tasked by the legislature with reviewing "the statewide number and status of group residential housing beds with rates in excess of the MSA equivalent rate, including banked supplemental service rate beds" (MN Law 2103, Chapter 108, Article 3, Section 47).

Q27 **the department' Inventory of {Q1} County's banked Supplemental Service (Rate 2) beds**

_____

Q28 **Does this number match your current Supplemental Service (Rate 2) inventory?**

- ☐ Yes
- ☐ No, please explain_____
- ☐ No, our county does not have any GRH vendors that receive funding to provide Supplemental Service (Rate 2)
- ☐ Don't know, please explain_____

(If your response to the question above is "No" or "Don't know," the department will contact you to clarify.)

Information about your county's GRH Supplemental Service (Rate 2) providers

Q29 **Do any GRH Vendors in your county receive funding to provide Supplemental Services (GRH Rate 2)?**

- ☐ Yes
- ☐ No

Q30 **Does your county have a monitoring policy for Supplemental Services (Rate 2) providers?**

- ☐ Yes - I will email our county's monitoring policy to sophat.jesci@state.mn.us.
- ☐ Yes - I would like to enter our county's monitoring policy in this survey
- ☐ No

Q31 **If yes, please enter your county's Supplemental Services (Rate 2) monitoring policy:**

_____

Q32 **How often do you monitor the following elements for Supplemental Service (Rate 2) providers:**

	Monthly	Every 6 months	Yearly	As needed/When concerns	Never	Other

Q32a	Concurrence of GRH Agreement information with MAXIS information (e.g. # of GRH beds, license #s, # of licensed beds, payment rates, Vendor #s)	☐	☐	☐	☐	☐	☐
Q32b	Vendors' licenses/registrations complete and up-to-date	☐	☐	☐	☐	☐	☐
Q32c	Individual eligibility determinations	☐	☐	☐	☐	☐	☐
Q32d	Individual budget determinations	☐	☐	☐	☐	☐	☐
Q32e	Vendors' compliance with specific terms of their GRH Agreements	☐	☐	☐	☐	☐	☐
Q32f	Amount of funds spent on food and food preparation	☐	☐	☐	☐	☐	☐
Q32g	Potential fraud or financial exploitation by Vendors	☐	☐	☐	☐	☐	☐
Q32h	Overpayments and overpayment collection	☐	☐	☐	☐	☐	☐
Q32i	Cleanliness and safety of GRH settings	☐	☐	☐	☐	☐	☐
Q32j	Incident and adult maltreatment reports	☐	☐	☐	☐	☐	☐
Q32k	Existence and enforcement of house rules	☐	☐	☐	☐	☐	☐
Q32l	Vendors' resident case files	☐	☐	☐	☐	☐	☐
Q32m	GRH Recipient Outcomes (e.g. exits, employment, etc.)	☐	☐	☐	☐	☐	☐
Q32n	Minnesota statutory requirement to ensure Supplemental Service (Rate 2) providers are implementing the required services	☐	☐	☐	☐	☐	☐

If other, how often do you monitor the following for Supplemental Service (Rate 2) providers:

Q33a	Concurrence of GRH Agreement information with MAXIS information (e.g. # of GRH beds, license #s, # of licensed beds, payment rates, Vendor #s)	_____
Q33b	Vendors' licenses/registrations complete and up-to-date	_____
Q33c	Individual eligibility determinations	_____
Q33d	Individual budget determinations	_____
Q33e	Vendors' compliance with their GRH Agreements	_____

Q33f	Amount of funds spent on food and food preparation	_____
Q33g	Potential fraud or financial exploitation by Vendors	_____
Q33h	Overpayments and overpayment collection	_____
Q33i	Cleanliness and safety of GRH settings	_____
Q33j	Incident and adult maltreatment reports	_____
Q33k	Existence and enforcement of house rules	_____
Q33l	Vendors' resident case files	_____
Q33m	GRH Recipient Outcomes (e.g. exits, employment, etc.)	_____
Q33n	Minnesota statutory requirement to ensure Supplemental Service (Rate 2) providers are implementing the required services	_____

Q34 **If new Supplemental Service (Rate 2) beds were available in your county, what qualification criteria would you use to select a vendor/provider?**

_____

Q35 **Does your County have ongoing education/training opportunities for Supplemental Service (Rate 2) providers?**

- ☐ Yes
- ☐ No

Q36 If **yes**, how frequently do you offer these **education/training opportunities for GRH for Room and Board (Rate 1) services**?

- ☐ Monthly
- ☐ Bi-monthly
- ☐ Quarterly
- ☐ Annually
- ☐ As needed/by request
- ☐ Always available online

If yes, how frequently do you offer these education/training opportunities for GRH Supplemental Service (Rate 2) providers?

- ☐ Month
- ☐ Bi-monthly
- ☐ Quarterly
- ☐ Annually
- ☐ As needed/by request
- ☐ Always available online

Q37 **Do you provide any other ongoing support or resources for Supplemental Service (Rate 2) providers?**

- ☐ Yes
- ☐ No
- ☐ Sometimes

Q38 **Do you provide orientation for new Supplemental Service (Rate 2) providers?**

- Yes
- No
- Sometimes

The following questions are designed to help us understand what role GRH supplemental services presently play in meeting the needs of your county's residents, and what needs remain unmet.

Q39 If GRH Supplemental Service (Rate 2) did not exist in your county, what alternative programs would be available?

_____

Q40 If there was a reduction in GRH Supplemental Service (Rate 2) funding in your county, what would be your TOP THREE concerns?

- Increase in homeless population
- Increased use of Emergency Room
- Increased demand for waivered services
- Increased demand for emergency social services
- Increase in county jail population/incarceration rates
- Increase in detox use
- Other

Q41 If other, please specify

_____

Q42 Which population/disability type(s) have the highest rate(s) of unmet need for GRH Supplemental Service (Rate 2) in your county? Please select UP TO THREE.

- Brain Injury
- Chemical dependency – harm reduction
- Chemical dependency – sobriety
- Chronic Medical Conditions
- Deaf/Blind
- Co-occurring disorders
- Dementia/Alzheimer's
- Developmental/intellectual disability
- Domestic violence
- HIV/AIDS
- Homeless/Formerly Homeless
- Homeless – long-term
- Mental Illness
- Physical Disability
- Parkinson's
- Culturally specific groups (e.g. Refugees, American Indians, etc.)
- Elderly
- Veterans
- Other

Q43 If other, please specify

_____

Q44 What GRH Supplemental Service (Rate 2) settings would best meet the needs of the population/disability type(s) with the highest rates of unmet need(s) in your county? Please select UP TO THREE.

- Settings that encourage continued sobriety
- Settings that incorporate a harm reduction model
- Therapeutic settings with intermittent supervision/care
- Therapeutic settings with 24 hour supervision/care including therapeutic diet preparation
- Semi-independent living settings
- Independent living with supportive services

Other

Q45 If other, please specify

_____

Follow-Up

If the State/the department was to assume a greater role in administering the GRH program, what program elements would you most like to see the State/the department have oversight over?

	DHS should have a role	DHS should not have a role
Concurrence of GRH Agreement information with MAXIS information (e.g. # of GRH beds, license #s, # of licensed beds, payment rates, Vendor #s)		
Vendors' licenses/registrations complete and up-to-date		
Individual eligibility determinations		
Individual budget determinations		
Vendors' compliance with their GRH Agreements		
Amount of funds spent on food and food preparation		
Potential fraud or financial exploitation by Vendors		
Overpayments and overpayment collection		
Cleanliness and safety of GRH settings		
Incident and adult maltreatment reports		
Existence and enforcement of house rules		
Vendors' resident case files		
GRH Recipient Outcomes (e.g. exits, employment, etc.)		
Minnesota statutory requirement to ensure Supplemental Service (Rate 2) providers are implementing the required services		

Q46 **What are the most important changes you would recommend to the GRH Program, if any?**

_____

_____

Follow-Up

Q49 **Please enter the email addresses of those who would like GRH policy, training and engagement updates:**

_____
_____
_____

Q50 **Do you need to enter more email addresses for those who would like GRH policy, training and engagement updates?**

- ☐ Yes
- ☐ No

Q51 **Continue entering the email addresses of those who would like GRH policy, training and engagement updates:**

Thank you for taking the time to respond to the Survey!

******If you would like a copy of your responses, please click on the print button below PRIOR to submitting your survey.**

Remember: you must press the **SUBMIT** button in order for your responses to be submitted to the department.

Appendix E: Interview Protocols

County Contract Manager Interview Protocol

As you may know, the Minnesota Legislature commissioned a program analysis of Group Residential Housing (GRH) Supplemental Services. The program analysis will inform the development of a new rate setting criteria for supplemental services, a final report, and program recommendations, all of which will be given to the State Legislature in early 2014.

The Improve Group, a private consulting firm that has been hired as an independent contractor to undertake this work. As a part of this process, we would like to gather insights from counties with Supplemental Services through one-on-one interviews in addition to the survey you have been asked to take.

During this interview we will ask about your county's GRH setting's supplemental service processes, and performance monitoring. The interview will last approximately 1 ½ hours.

---

1. What's your position and how long have you been working with GRH? Can you explain a little about how you are involved with GRH?

2. What information is included on the service plan for each individual receiving the GRH supplemental service rate? Could you please email us a copy? Who currently completes the form? How often are plans updated? Are they verified? Does someone from the County meet with the consumer at any point in time?

3. Are providers in your county required to submit any information regarding GRH supplemental service rate consumers? Such as progress or outcomes, or any reporting? Do county staff and/or providers set outcome expectations for consumers receiving supplemental services? If so, how are outcomes determined and/or measured and tracked?

4. Are there providers in your county that are interested in Rate 2 but have not been able to access it? What's their situation? Is there anything that your county does to help them access the rate?

5. We want to learn more about how your county monitors GRH supplemental service provider performance. I have a list of particular areas that we are interested in that I'll go through one by one, if you could please share if it's used at all, explain the process briefly, share which staff positions are involved in it at the county, and the frequency at which it's done. **Additionally, if you do not currently use a certain method, please tell me about any challenges you would face if it became required.**
    a. Do providers submit any regular reports to the county?
    b. Do county staff complete site visits? At what frequency? Who at the county does this?

   c. Do you have regular meetings between county staff and providers to see how things are going?
   d. Does the county do any GRH supplemental service consumer surveys or interviews that include questions about provider performance?
   e. Does the county do any GRH supplemental service surveys of county staff that include questions about provider performance?
   f. Does the county offer trainings to GRH supplemental service providers? Which subjects in particular?
   g. Are there other things that the county does to monitor provider performance?

6. What challenges or barriers does your county face with performance monitoring? Which methods (if any) present larger challenges than others?

7. In what ways does the monitoring process vary at all from GRH providers that only provide room and board?

8. If the department were to require counties to complete certain performance monitoring activities what do you think they should keep in mind? What things should they consider? What are the processes that you feel are more effective than others? In what ways?

9. We have been asked to make recommendations for the efficient use of banked (supplemental service rate) beds across the state. What things do you think we should keep in mind as we consider this issue? Does your county currently have banked beds? If another county needed the beds is your county likely to "loan" them out for development?

10. Could you please email me a copy of your county's GRH agreement?

Advocacy Group Interview Protocol

The Department of Human Services is beginning an exploration of the Group Residential Housing Supplemental Services program and its rate structure. I am with the Improve Group, a private consulting firm that has been hired as an independent contractor to undertake this work. The evaluation will result in rate setting criteria, a legislative report, and policy recommendations for the program. As a part of this process, we would like to gather feedback from consumer advocates through one-on-one interviews.

During this interview we will ask about your observations regarding Supplemental Services. The interview will last approximately 1 hour.

---

1. What do you know about the Supplemental Services (Rate 2) program for GRH? What have you heard about it?

2. From what you know or heard, how well would you say do the services offered through GRH Supplemental Services meet the needs of its consumers? Can you comment specifically on what about the program and its services are a good fit for the particular needs of the population you represent?

3. In what ways do you think the current approach that GRH settings use to get services to consumers needs improvement? What are some of the common complaints from residents in these settings?

4. In general, what are some of the gaps in or challenges of getting the appropriate services to meet consumer needs?

5. What is unique or valuable about GRH Supplemental Services compared to other options for meeting consumers' needs? If these services did not exist, what would the consumers you represent do? Where else would they live, what other services would they use? What would likely outcomes be?

6. In your experience, what are common outcome goals for the populations living in these GRH settings represented by your organization? (e.g. moving towards independent living, step down, stability within their setting) Are these usually appropriate to their needs? Why or why not?

7. Are you familiar with any assessment tools or approaches that would help a county or the state determine level of service need for a GRH Supplemental Services resident? What are the pros and cons of this/these method(s)?

8. In your opinion, what strategies or policies would improve GRH Supplemental Services for consumers?

9. What are some key considerations you want us to know as we think about setting or changing the reimbursement rates for GRH Supplemental Services?

Providers without Access to GRH Supplemental Services Interview Protocol

As you may know, the Minnesota Legislature commissioned a program analysis of Group Residential Housing (GRH) Supplemental Services. The program analysis will inform the development of a new rate setting criteria for supplemental services, a final report, and program recommendations, all of which will be given to the State Legislature in early 2014.

The Improve Group, a private consulting firm that has been hired as an independent contractor to undertake this work. As a part of this process, we would like to gather insights from Supplemental Service providers through one-on-one interviews in addition to the survey you have been asked to take.

During this interview we will ask about your GRH setting's supplemental services, impact on clients, and how the system has been working overall. The interview will last approximately 1 ½ hours.

---

1. Do you currently receive GRH funding for room and board? If yes, Could you please talk a little bit about your residents and the types of needs they have? How did your residents come to live there? How was it determined that they would be a good fit for this GRH setting?

2. What types of services, if any, are currently provided to residents in your GRH setting? How would accessing the supplemental service rate change the services you provide, if at all?

3. Are you hoping to access the supplemental service rate for all of your residents? If no, please describe the difference in need with the consumers who would be eligible?

4. What has the process been like for you in trying to access the supplemental service rate? What have you done so far? What barriers have you faced in accessing the supplemental service rate for your residents?

5. Is there anything that would help you to access the supplemental service rate?

6. Do residents' service needs change over time? How? Why? How do you respond to these changing needs?

7. What services do you feel confident are meeting resident needs? Why?

8. Are there services residents need that are difficult for you to provide here? What are they and why? How could these services be provided more effectively, in your opinion?

9. How do you manage the varying degrees of need that your residents experience?

10. What residents/what are the characteristics of the residents that require the most staff time and resources in order to have their needs met? Please describe what staffing and resources are needed for them. How much of your population fits in this category? How do these staffing and resource needs compare to other resident needs?

11. Does your GRH setting staff set outcome goals for residents? [If yes:] What kinds of outcomes are often planned? How is this monitored?

12. How long do consumers often stay here? Do you track why they leave? What can you share from your records about why they leave? Do any Supplemental Service rate recipients have step-down plans/ever transition out because their needs decrease?

13. What other sources of funding do you have here (including social insurance options)? Are these sources more or less attractive than GRH for your setting? Why?

14. Has the number of beds filled by Supplement Service residents remained relatively stable over time? Why or why not? When is the last time you had Supplemental Service vacancies?

15. How does the process work for filling empty GRH beds with GRH Supplemental Service rate residents: do they require county approval and/or oversight? Other monitoring or reporting requirements?

16. What is the unmet need in your community in terms of what can be accessed with the Supplemental Service rate? What are the most common needs of people who cannot access services or programming like that offered in this GRH setting? If these services did not exist, where else would people live, what other services would they use? What would likely outcomes be?

17. Do you have to conduct assessments or prepare reports for other programs at this setting (outside of GRH Supplemental Services)? If so, what are they and how well are those processes working?

18. What are some key considerations you want us to know as we develop this Supplemental Service rate setting criteria?

19. Do you have any other suggestions for improving the GRH program more generally?

Difficulty of Care Interview Protocol

The Department of Human Services is beginning an exploration of the Group Residential Housing Supplemental Services program and its rate structure. The Improve Group is a consulting firm that has been hired as an independent contractor to undertake this work. The evaluation will result in a rate setting tool, legislative report, and policy recommendations for the program. To begin this process, we are gathering feedback from a variety of stakeholders through one-on-one interviews and a survey.

During this interview we will ask you about how the Difficulty of Care assessment impacts or informs service rates and how the system has been working overall. Your responses will be a part of the final legislative report, and while you will not be identified by name, your program will be. If there is anything you want to say anonymously, please let us know.

---

1. How does the DOC assessment inform/determine provider rates? *What factors are taken into account? Are any other assessments used to inform provider rates? How do the rates vary by client need? Do they vary by geographic area? By setting or provider type? By service frequency? Sources of information to inform rates?*

2. What are the key strengths of the DOC tool/system? Unanticipated impacts?

3. What are the main weaknesses or gaps in the DOC tool/system? Unanticipated impacts?

4. How do these rates compare to the private pay system? Any issues here?

5. How often are clients/participants assessed? One time upon entry, on a regular assessment schedule, when needs change, other? How is this monitored?

6. Please describe the functions of the counties versus that of the vendors/providers – *For example, what are the communication mechanisms between the two? Are there instances where the county conducts an assessment but the vendor/provider determines the rate? How do the roles of case managers, financial workers, etc. impact service rates?*

7. Are the same services available under this funding mechanism across the state or do they vary by county? What are these services? Can you email us a list of specific services (and if available relevant/example rates)?

8. Do counties and/or providers set outcome expectations for these services? If so, how are outcomes determined and/or measured?

9. Any other resources we should know about as we develop GRH's rate setting tool/methodology?

The department Waiver Rate Setting Interview Protocol

The Department of Human Services is completing an exploration of the Group Residential Housing Supplemental Services program and its rate structure. The Improve Group is a consulting firm that has been hired as an independent contractor to undertake this work. The evaluation will result in a rate setting tool, legislative report, and policy recommendations for the program. To begin this process, we are gathering feedback from a variety of stakeholders through one-on-one interviews and a survey.

During this interview we will ask about your program's components, outcomes, and how the system has been working overall. Your responses will be a part of the final legislative report, and while you will not be identified by name, your program will be. If there is anything you want to say anonymously, please let us know.

---

1. What data was used to inform the process to develop the rate setting system? Who was involved in the process in a general sense? Counties? Providers?

2. Can you please describe how the rates are calculated? What factors are taken into account? Are there variations by client need? By geographic area? By setting or provider type? By service frequency? Is there variation by program?

3. How did the implementation of the rate setting system impact the overall budget (statewide) for these services? What did you forecast? How well did your forecast match reality? Were there unanticipated impacts?

4. What are the key strengths of this tool/system? Unanticipated impacts?

5. What are the main weaknesses or gaps in the tool/system? Unanticipated impacts?

6. How do these rates compare to the private pay system? Any issues here? Were there unanticipated impacts?

7. What assessment tools are used to inform provider rates?

8. How often are clients/participants assessed? One time upon entry, on a regular assessment schedule, when needs change, other? How is this monitored?

9. Please describe the functions of the counties versus that of the vendors/providers – *For example, what are the communication mechanisms between the two? Are there instances where the county conducts an assessment but the vendor/provider determines the rate? How do the roles of case managers, financial workers, etc. impact service rates?*

10. Are the same services available under this funding mechanism across the state or do they vary by county? What are these services? Can you email us a list of services (and if available relevant rates)?

11. Do counties and/or providers set outcome expectations for these services? If so, how are outcomes determined and/or measured?

12. Any other resources we should know about as we develop GRH's rate setting tool/methodology? Or other things you feel we should take into consideration?

Appendix F: Focus Group Protocols

Consumer Focus Group Protocol

The Department of Human Services is beginning an exploration of the Group Residential Housing, or GRH, and the Supplemental Services program. They want to learn more about how services are provided in different settings and about the value of these services for residents. The evaluation will result in recommendations for the program. We are asking for you to participate in a focus group to help us learn about residents' experiences with Group Residential Housing.

Participating in this focus group is voluntary, but we really hope you will take the time to share your feedback with us. Information from these focus groups will play a critical role in the rate setting criteria and any program recommendations we make to the legislature. Your responses will remain confidential. Your participation is greatly appreciated and important to this project!

---

1. How long have you lived here? *Potential prompts: where were you before you came here (describe if they found that setting helpful (if appropriate – i.e. not jail or homelessness)*

2. How did you find this place? Was it hard to make arrangements to move in?

3. When you think back to how things were before you moved in here, what have been the biggest changes in your life since you moved in?

4. Do you feel that this setting is a good fit for your needs? Why? *Prompt for details about what kinds of help staff offer to them, how that is helpful and ask if there are other ways for them to get this help if they lived elsewhere.*

5. What kinds of needs did you have when you came here? Have these changed over time?

6. What are some of the challenges in getting the services you need at this facility?

7. What other needs do you have that you feel are not being met/addressed here? *Prompts: Have you tried to get some help for that here or elsewhere? Why do you think that didn't that work well for you here? What have you found helpful elsewhere? What difference would it make for you to have that service here?*

8. Do you meet with anyone here to set goals for the future? [If yes] Can you share some examples of goals you have set? What types of things do you do in order to meet these goals? How do you know when you are making progress on your goals?

9. What would you say your (and residents in general) relationships are like with staff on site here? Do you feel these staff are responsive? Understanding? Supportive? Respectful? How about property management staff?

10. Are you using other services or programs outside of this setting? [If so] How much time in a typical week do you spend there? How did you find out about those services? How do you get to and from those services/service providers?

11. What else would you like to say about the services you receive here? Would you like to say anything else about your experience overall at this GRH setting?

[1] A significant portion of GRH recipients who do not receive the supplemental service rate access services through home and community based waivers.
[2]http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_002549
[3] Surveys received from 141 of approximately 216 unique supplemental service providers across the state. Survey respondents were generally representative of the 41 counties, with a slightly lower response rate from one large metro county.
[4] Board and lodging with special services is defined as an establishment that provides supportive services or health supervision services. Supportive services include supervision and minimal assistance with independent living skills, as well as minimal medication management. Health supervision services include taking vital signs, assistance with activities of daily living, and preparation and administration of medications other than injectables. Please see: Minn. Stat. §157.17
[5] Housing with services is defined as an establishment with sleeping accommodations to one or more adult residents, with 80% of the residents being 55 years of age or older. This establishment also charges a fee to offer or provide one or more regularly scheduled health-related services or two or more supportive services on a regular basis. Please see: Minn. Stat. §144D
[6] Board and lodging establishments are defined as those which provide care to customers requiring only personal or custodial care, who are aged or infirm persons. Please see: Minn. Stat. §157.15
[7] Since respondents could hold more than one licensure or registration, they were allowed to pick "all that apply"; thus, the "percent of respondents" column will total more than 100%.
[8] Of the write-in responses, 14 providers identified as Class F Home Care Providers, with another provider identifying as Nursing Setting Boarding Care.
[9] Since respondents could hold more than one licensure or registration, they were allowed to pick "all that apply"; thus, the "percent of respondents" column will total more than 100%.
[10] Of the write-in responses, 3 identified as serving long-term homeless populations, and 2 identified as Rule 31. Other write-in responses were Children's Residential Setting, Aged 55 and over, EW, CADI, and DD waivers, HIV/AIDS, and FLH, LLH-19 rooms.
[11] Congregate housing is a type of housing in which each resident has a private bedroom or living quarters, but shares common areas with other residents (dining room, living room, recreational room). The resident does not have a lease agreement, but may have a type of household agreement; a license or registration is required for the provider.
[12] Scattered-site housing is a type of housing in which each resident has a lease agreement for an apartment or home setting integrated into the private market; a license is not required. Respondents that are Housing First settings and Metro Demos were counted as scattered site settings in this report.
[13] Two providers identified as public agencies (Gateway Gardens and the HSPHD- Parent Support Program).
[14] In this report's service rate data tables the standard service rate is considered to be between $400-$499. This was done to account for slight variations in rate amounts around $482.84 while ensuring a fair analysis of settings with enhanced versus non-enhanced service rates.
[15] A table of provider survey respondents by rate range is included in Appendix C.
[16] Since respondents could serve more than one type of population, they were allowed to pick "all that apply"; thus, the percent of respondents column will total more than 100%.
[17] Sobriety models are settings where any chemical use is prohibited, and enforced through policies which discourage use such as zero tolerance or allowing three strikes prior to eviction.
[18] While each provider is likely to have their own definition of a harm reduction model, Minnesota Alternatives defines this as: "The essence of this model is the pragmatic recognition that treatment must meet active substance users 'where they are' in terms of their needs and personal goals. Thus, harm reduction approaches embrace the full range of harm-reducing goals including, but not limited to, abstinence. This means that small incremental positive changes are seen as steps in the right direction." http://mnalternatives.com/harm-reduction.html
[19] The survey did ask for three gender categories: men, women, and transgender. We were concerned with the validity of the transgender response and subsequently chose to remove that data from this report.
[20] Since respondents could serve more than one type of population, they were allowed to pick "all that apply"; thus, the percent of respondents' column will total more than 100%.
[21] A copy of the provider survey is available in Appendix D. 123 out of the 141 respondents answered questions concerning high need categories, and 121 respondents detailed low need categories.
[22] Residents who do not receive the Service Rate could be receiving services funded through other programs than GRH such as Home and Community Based Waivers, or could be private pay residents.
[23] See Minn. Stat. §256I.03, subd. 3
[24] Most common denotes more than 70% of providers offering this service
[25] Since respondents could serve more than one population type, they were allowed to pick "all that apply"; thus, the "percent of respondents" column will total more than 100%.
[26] Although this is a required service, the low percentage of providers indicating offering this service may be due to misinterpretation as being strictly 24 hour supervision.

[27] Since respondents could serve more than one population type, they were allowed to pick "all that apply"; thus, the "percent of respondents" column will total more than 100%.
[28] Source: Group Residential Housing (GRH) Overview, Power Point Presentation delivered by the department on October 3, 2013.
[29] Since respondents could serve more than one population type, they were allowed to pick "all that apply"; thus, the "percent of respondents" column will total more than 100%.
[30] Since respondents could serve more than one population type, they were allowed to pick "all that apply"; thus, the "percent of respondents" column will total more than 100%.
[31] Note: providers were asked to document all staff, not just those whose are paid for in whole or in part with GRH Supplemental Service funds. It isn't assumed that the GRH service rate alone pays for these positions.
[32] Case manager is a general term used in the industry and in this context does not necessarily refer to county-contracted or Medicaid funded case managers.
[33] One setting employs 102 FTE personal care assistants; excluding them lowers the overall average FTE to 13.75. Another provider employs 58 FTE, and the remainder employ 25 FTE or fewer.
[34] One setting employs 33 case managers, another has 30, but most have 5 or fewer.
[35] The most common write-in ("other") staff position was facilities/maintenance staff (20 responses) and administrative assistants (9 responses). Overnight staff (6 responses) and security and cooking (3 for each) were the next most-common, with some other positions being employment specialists, activities coordinators and women's advocates.
[36] The majority of this additional funding came from private funding sources (14 responses), HUD (5 responses), MHFA funding (4), and the United Way (2 responses).
[37] Analysis conducted using rate data from the provider survey.
[38] A complete list of health-related services can be found here: http://www.health.state.mn.us/divs/fpc/profinfo/lic/fpc926_1.pdf
[39] This is a state policy.
[40] Beds are banked if the additional beds are only a replacement of beds with rates in excess of the MSA equivalent rate [room and board rate] which have been made available due to closure of a setting, a change of licensure or certification which removes the beds from group residential housing payment, or as a result of the downsizing of a group residential housing setting. For more information please see: Minn. Stat. §256I.04, subd. 3
[41] As per Minn. Stat. §256I.04, subd. 3, 10b
[42] Most of these shelters are in the Twin Cities metropolitan area. Please see Minn. Stat. §256I.05, subd. 1g.
[43] As previously noted, less than 70% of providers indicated offering up to 24 hour supervision, possibly due to confusion with the survey language. Based on provider interviews and the fact that this is currently a required service, up to 24 hour supervision is likely offered by more providers than the survey results indicate. Subsequently, this service could be added to the core set of services, and into any future Medicaid funded service offerings considered by the department.
[44] State staff are exploring options to have these services covered by Medicaid. This would require some assessment of need on an individual level. There is some potential for this to be focused on the need for housing or housing stability as a qualifier as opposed to an individual needs assessment.
[45] This is not specific to the service rate, but it is one of many expectations around the provision of room and board that needs to be clarified in order to address gaps between the GRH agreement and what is covered by the building's licensure to better ensure health and safety of residents.