Department of Public Welfare's Regulation of Residential Facilities for the Mentally Ill

Program Evaluation Division
Office of the Legislative Auditor
State of Minnesota

Program Evaluation Division

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February 1981

Program Evaluation Division
Office of the Legislative Auditor
State of Minnesota

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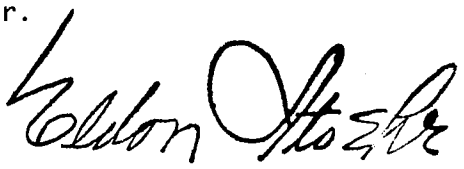
PREFACE

In June 1980, the Legislative Audit Commission directed the Program Evaluation Division to conduct an evaluation of the Department of Public Welfare's program to license residential facilities for the mentally ill. Because only a few facilities had ever been licensed, legislators were concerned that the mandates given the department in 1971 and reiterated in 1976 were not being implemented. Accordingly, our study has sought to determine why so few facilities for the mentally ill are currently licensed, how the department has managed its licensing program, and what have been the consequences of a partially operating licensing program.

We would like to thank employees of the Department of Public Welfare, the Department of Health, and the State Fire Marshal's Office for their assistance. In addition, we are grateful to employees in all of the state's 87 county welfare offices for supplying us with data and to the facility directors of more than 550 nursing homes, boarding care facilities, hospitals, and other residential facilities for responding to our questionnaire.

This study was directed by Roger Brooks. Major research components were conducted by Jack Benjamin, Senior Program Evaluator, and Joanne Dahl, a graduate student intern from the University of Minnesota, Duluth. Additional assistance was provided by Robert Grams, Peter King, and Marie Scheer.



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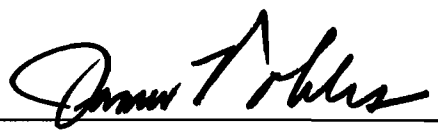

James Nobles, Deputy Legislative Auditor for Program Evaluation

February 23, 1981

PROGRAM EVALUATION DIVISION

The Program Evaluation Division was established in 1975 to conduct studies at the direction of the Legislative Audit Commission (LAC). The division's general responsibility, as set forth in statute, is to determine the degree to which activities and programs entered into or funded by the state are accomplishing their goals and objectives and utilizing resources efficiently. A list of the division's studies appears at the end of this report.

Since 1979, the findings, conclusions, and recommendations in Program Evaluation Division final reports and staff papers are solely the product of the division's staff and not necessarily the position of the LAC. Upon completion, reports and staff papers are sent to the LAC for review and are distributed to other interested legislators and legislative staff.

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EXECUTIVE SUMMARY

Since 1971 the Department of Public Welfare has been required by law to license residential facilities for the mentally ill. Although DPW did establish licensing standards in 1974 under DPW Rule 36, the rule is not currently being enforced and only 10 licenses are now in effect. The department's position is that licensure under Rule 36 would jeopardize the availability of Medicaid funds used by many persons in residential facilities, making licensure impractical until an adequate and stable funding base can be established.

However, while we agree that the funding problems associated with Rule 36 are serious and complex, we think that the department's position has only limited validity. Medicaid regulations remain unclear and DPW has not determined how many facilities or residents might be affected given alternative interpretations of those regulations. Although the department claims that these funding problems impede implementation of the licensing law, DPW has not shown initiative in proposing a solution to the Legislature in a timely fashion. The department's current request for $4.9 million to cover program costs in licensed facilities may not constitute such a solution since the proposed funds would not be used to supplant or reduce existing facility funding. We think that adequate funding must be ensured for residential facilities serving the mentally ill or the state's licensing program should be abandoned as unworkable.

In the meantime, DPW has not fulfilled its mandate to license and regulate residential facilities for the mentally ill. Nor has it sought to establish, in lieu of immediate licensing, a program to identify and monitor facilities subject to licensure. Legislative directives have been clear and persistent, but DPW's response has not been adequate.

This report presents our evaluation of DPW's performance. Our research strategy was designed to address the following questions:

- Minnesota's Mental Health System: How has the trend to rely more on noninstitutional, community-based settings for treating the mentally ill affected state hospital populations?
- Minnesota's Mental Health Policy: What is the state's policy regarding the proper setting for treating the mentally ill?
- DPW Compliance With State Policy: To what extent has DPW complied with the legislative mandate to license residential facilities for the mentally ill?
- Zoning Issues: How does DPW monitor the neighborhood concentration of residential facilities for the mentally ill?
- Funding Issues: In what way does state licensure as a facility for the mentally ill affect the ability of a residential facility to obtain funds needed for operation?

- A Survey of Residential Facilities: To what extent are unlicensed facilities for the mentally ill in compliance with state laws and relevant administrative rules?

Our findings and conclusions are noted below; our specific recommendations for improving the program to license residential facilities for the mentally ill conclude this summary.

A. FINDINGS AND CONCLUSIONS

1. MINNESOTA'S MENTAL HEALTH SYSTEM

In all parts of the country over the past two decades there has been less reliance on large, traditional institutions to care for the mentally ill and more reliance on community-based residential settings, such as halfway houses and nursing homes. Many factors, including new tranquilizing drugs, altered funding priorities, and a general movement toward reform, have encouraged this process of "deinstitutionalization." In Minnesota, there have been dramatic changes in the number of persons receiving mental health care in state institutions:

- Consistent with national trends over the past 25 years, Minnesota's state hospital population has declined by two-thirds; the state hospital population of mentally ill persons has declined by 87 percent.

- Over one-half of state hospital admissions of mentally ill persons today are readmissions rather than new admissions. Over one-half of these persons are admitted from, and discharged to, their own homes or those of relatives or friends.

Increasingly, it appears that many persons are receiving care and treatment for mental disabilities in a variety of community-based settings.

2. MINNESOTA'S MENTAL HEALTH POLICY

Despite the sweeping changes that have occurred recently in the state's system of care for the mentally ill, no public body has yet articulated a formal and comprehensive policy to shift from an emphasis on large state institutions to one on care in community-based settings. Nevertheless, a fragmented policy to place greater reliance on community-based facilities has evolved:

- The 1957 Community Mental Health Services Act provided opportunities for aftercare for persons who have been in state hospitals.

- The Hospitalization and Commitment Act was amended in 1967 to ensure consideration of alternatives to state hospitals prior to judicial commitment.

- Various court cases have endorsed the right of mentally ill persons to receive treatment in the "least restrictive" setting possible.

- In an action to encourage adequate housing financing, the Legislature declared in 1976 that the mentally ill are better served through a community-based system of treatment and care.

The Legislature has declared that all residential facilities serving the mentally ill should be licensed by DPW. The 1976 Public Welfare Licensing Act--echoing similar legislation from 1971--declares that:

- no "day care or residential facility [may operate] unless licensed to do so by the commissioner."

DPW Rule 36 was promulgated in 1974 to carry out this licensing program.

3. DPW COMPLIANCE WITH STATE POLICY

DPW is identified in statute as the lead agency to carry out the Legislature's mandate to license facilities for the mentally ill. We assessed DPW's compliance with the state's policy to license facilities and found that:

- Nearly five years passed between the enactment of the initial licensing mandate and the issuance of the first license. It took DPW nearly three years to promulgate Rule 36. A revision of the rule has been recently prepared, but it has not yet been promulgated even though almost five years have passed since the enactment of the new licensing law.

- The law requires DPW to license residential "facilities" for the mentally ill; DPW's Rule 36 specifies licensure for all residential "programs." The difference in language implies that facilities without programs are exempt from licensure, a meaning apparently unintended by the Legislature.

- Only 10 facilities, including two state hospitals, currently are licensed under Rule 36; at the program's peak in 1977, 19 facilities had licenses. DPW has estimated that more than 150 residential facilities, plus a considerable portion of the state's 400 nursing homes, may be eligible for licensure under Rule 36.

DPW claims that state licensure as a facility for the mentally ill jeopardizes a facility's ability to obtain needed funding since Medicaid regulations prohibit the expenditure of funds for persons in

"institutions for mental diseases," even for services rendered outside the facility. Accordingly, DPW suspended its full-scale licensing program under Rule 36 in 1977 and has, since that time, licensed only those facilities specifically requesting licensure. Despite these problems with the licensing program, we have found that:

- DPW has not directly addressed the funding problem that it claims is an obstacle to licensing. While it has recently requested $4.9 million for FY 1981-83 to cover program costs in licensed facilities, it has indicated that these proposed funds will not be used to replace those Medicaid funds which it claims will be lost upon facility licensure. Therefore, even if the Legislature approves the department's request, the Medicaid dilemma will remain.

- The department has, however, taken steps to revise Rule 36 to bring it more into line with current law. A Task Force to revise Rule 36 has worked over the past year to prepare a new draft of the rule.

- In the meantime, DPW has not kept track of residential facilities serving the mentally ill which it believes are eligible for licensure. In fact, aside from a "resource directory" developed in mid-1980, it has little information on what facilities exist or whether they are in compliance with relevant laws and administrative rules.

4. ZONING ISSUES

To assess the controversy which has been raised concerning neighborhood concentration of residential facilities we reviewed the legal requirements, DPW's procedures, and local practices regarding zoning. We found that:

- The law prohibits DPW licensing of a facility if it is within 1,320 feet of another residential facility unless a waiver is granted by the local zoning authority.

- DPW notifies local authorities that a license application has been received, but does not inform the authority of the provisions in state law. Unless specifically informed otherwise by the local authority within 30 days, DPW assumes compliance with state law and proceeds to issue a license.

- Local zoning authorities are often unaware of the provisions of state law and even when aware of the spacing requirement many assume that DPW is monitoring compliance.

- Many facilities cannot meet the state's zoning requirements and would have to obtain local waivers in order to become eligible for a Rule 36 license.

5. FUNDING ISSUES

Since funding issues are the primary reason given by DPW for not implementing the licensing program more aggressively, we have examined federal and state funding programs providing money to support mentally ill persons in residential facilities. From our review we have found that:

- Although there is a multitude of public funding sources available to needy persons, there are numerous restrictions governing eligibility and services covered which limit their use for mentally ill persons in residential facilities.

- State funds for mental health programming in non-medical community-based facilities have been limited and experimental in nature.

- Current funding mechanisms create incentives for counties to place mentally ill persons in state hospitals rather than in less institutional settings, contrary to the trends in state policy noted above.

- According to federal regulations, Medicaid funds cannot be paid on behalf of individuals aged 22 to 65 who reside in "institutions for mental diseases" (IMDs), even though they may receive otherwise reimbursable services outside the facility.

- However, it is unclear what types of facilities are IMDs. Medicaid administrators have interpreted federal regulations to mean that licensure under Rule 36, among several other factors, is evidence that a facility is an IMD. But the question is controversial and currently the subject of appeals.

- We have determined that fewer than 20 of the residential facilities to which county welfare agencies refer mentally ill persons in Minnesota are now certified to receive Medicaid funds. There are additional community-based facilities with residents who receive Medicaid benefits for services delivered elsewhere, such as in hospitals or private psychologists' offices. Aside from these facilities, all other facilities serving the mentally ill could be licensed--even under current federal interpretations--without jeopardizing any source of funding.

6. A SURVEY OF RESIDENTIAL FACILITIES FOR THE MENTALLY ILL IN MINNESOTA

Because DPW was unable to provide comprehensive information regarding those residential facilities for the mentally ill which are unlicensed, we conducted our own survey to determine the nature of conditions in those facilities and to determine whether applicable laws

and administrative rules were being observed. We asked Minnesota's 87 county welfare agencies to supply us with the names of facilities to which they sometimes refer mentally ill persons. We sent a questionnaire to the 150 facilities thus identified, plus to an additional 454 facilities which may also provide care to the mentally ill, including all of the state's nursing homes and hospital psychiatric units.

Among the 150 facilities, 93 percent answered our survey. We found that:

- Approximately 1,570 mentally ill persons live in residential facilities which are unlicensed by DPW.

- Although most facilities have state or local health licenses, only 42 percent have had any fire inspection in the past two years.

- 82 facilities house five or more mentally ill persons, making them eligible for Rule 36 licensure.

- Although Rule 36 licensure may jeopardize federal funding for Medicaid certified facilities, 64 of the 82 facilities considered eligible for licensure are not certified to receive Medicaid funds and therefore could be licensed without jeopardy to their funding sources.

- Among those 64 facilities not certified, however, at least 13 do have residents who are receiving Medicaid benefits for services delivered outside the facility. Licensing these 13 facilities might jeopardize this funding. Although these data are not definitive, many of the remaining 51 facilities could presumably be licensed without jeopardizing individual residents' Medicaid benefits.

- Fewer than one-half of the 82 facilities offer private counseling sessions, less than one-third offer group counseling or therapy sessions, and less than 15 percent offer psychotherapy by a licensed professional. Only one-half of the facilities offer instruction in independent living skills, 56 percent offer help in finding or keeping a job, and nearly 70 percent provide help with dressing or bathing.

- Fewer than one-half of the 82 facilities keep all of the resident records required by Rule 36.

- Approximately 60 percent of the current residents of the 82 facilities eligible for Rule 36 licensure have been patients in a state hospital.

- For the 82 facilities, the largest sources of estimated annual revenue are Minnesota Supplemental Aid (24.3 percent), Medicaid (12.6 percent), General Assistance (9.8 percent), and Supplemental Security Income (9.2 percent).

- The eight community-based facilities licensed under Rule 36 have significantly different patterns of funding than the other 74 facilities eligible for licensing. For licensed facilities, Title XX, "social services," provides 59.5 percent and General Assistance 10.4 percent of total revenues; for unlicensed facilities, Minnesota Supplemental Aid provides 31.3 percent and Medicaid 16.9 percent of total revenues.

More than 90 percent of the additional 454 facilities (mostly nursing homes and hospitals) responded to our survey. Among this group we found that:

- The number of mentally ill residents may exceed 7,000, more than one-half of whom have been in a state hospital.

- 251 facilities claimed to have six or more mentally ill residents, and may therefore be eligible for Rule 36 licensure. Some nursing homes and hospitals may be exempt from licensure, but definitions in state law make this unclear.

- Fewer than 30 percent of responding facilities provide group counseling or therapy sessions, instruction in independent living skills, or psychotherapy by a licensed professional; and fewer than 15 percent provide help in finding a job. More than 90 percent of these facilities provide help with dressing or bathing, help with medication, or recreation programs; more than 85 percent provide help with personal or financial affairs; and more than two-thirds provide help in using community resources.

- Nearly all facilities keep all of the resident records required by Rule 36.

- 90 percent of the facilities reporting six or more mentally ill residents are Medicaid certified, and could have their Medicaid funding jeopardized if licensed under Rule 36. Of the remaining 10 percent, most have residents who receive Medicaid benefits outside the facility. These funds, too, might be jeopardized if the facilities were licensed under Rule 36.

B. SUMMARY OF RECOMMENDATIONS

Following is a summary of our major recommendations:

- DPW should ascertain the number of facilities which face Medicaid and other funding problems, and should seek statutory authority which would authorize the department to implement a phased licensing program. Facilities unlikely to lose Medicaid funds could be the first to be licensed, while licensing for other facilities could be waived for the period of time specified in statutory amendments.

- DPW should actively seek out and license eligible facilities rather than licensing only those facilities which request licensure.

- DPW should conduct its licensing activities in a manner which does not exempt any residential facility that is not explicitly exempted by the Public Welfare Licensing Act. All residential facilities serving five or more mentally ill persons are subject to licensure and must establish and maintain treatment programs in compliance with the licensing act and Rule 36.

- DPW should carry out an ongoing program to locate and monitor facilities which the department determines are eligible for licensure to ascertain whether minimum standards are being observed. This monitoring program could operate in lieu of full-scale licensing, until funding and other problems are resolved.

- DPW should prepare a legislative proposal to clarify the provisions in the Public Welfare Licensing Act which exclude from licensure some nursing homes and hospitals.

- DPW should revise Rule 36 to address matters dealt with in the licensing act but not in the current rule, including procedures for suspending, revoking, and making licenses probationary; conditions for facility exemption from licensure; procedures for inspections; standards to ensure adequate living conditions at a facility; conditions under which fines may be levied; and, guidelines for the location of residential facilities.

- DPW should systematically inform local zoning authorities of applicable statutory zoning requirements. The department should ensure that those requirements are met before issuing a license.

- DPW should take steps to ensure that the entire licensing process is completed within 90 days of receiving a completed application in accordance with licensing law.

- DPW should improve its record-keeping procedures by recording the number of license application requests received according to the type of facility involved.

- DPW should produce a workable proposal which alters the current county financial incentives to make referrals to state hospitals and other high cost facilities.

INTRODUCTION

In 1971, the Minnesota Legislature passed laws requiring the Department of Public Welfare (DPW) to license residential facilities for the mentally and physically disabled.[1] Subsequently, the department promulgated several administrative rules, each designed to regulate the licensing of residential facilities for a specific disability group, such as the mentally retarded or the chemically dependent. In 1974, DPW promulgated Rule 36 which sets licensing standards for residential facilities for mentally ill adults. It ensures that in addition to providing residents with room and board, facilities will offer programmatic services aimed at achieving recovery and maximizing a resident's ability to function independently. The rule requires such facilities to obtain a license from DPW.

The 1976 Public Welfare Licensing Act reconfirmed the Legislature's intent to have facilities licensed, clearly stating that no facility shall operate "unless licensed to do so by the commissioner" of DPW.[2] To operate without a license was deemed a misdemeanor, punishable by a fine of not more than $300.

Recently, however, DPW has come under increasing criticism that it has licensed only a fraction of those residential facilities which currently serve the mentally ill and which are eligible for licensure. At present, only ten Rule 36 licenses are in effect--two of them for state hospitals. Many facilities, it has been assumed, are operating in violation of existing law. Because of this, DPW has been criticized for not carrying out its legal obligation to license residential facilities for the mentally ill and to ensure that minimum program standards are being observed.

The Legislative Audit Commission directed the Program Evaluation Division to investigate these circumstances. In response, we have attempted to determine:

- the nature of the obligations placed on DPW by the Legislature;
- the nature and sequence of responses by DPW;
- how many facilities are eligible for Rule 36 licensure;
- how many facilities are licensed;
- the character of programs currently operating in licensed and unlicensed facilities for the mentally ill; and

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[1] Minn. Laws (1971), ch. 627 and ch. 229.

[2] Minn. Stat., ch. 245.

- the sources of funding currently used by residential facilities for the mentally ill in Minnesota.

The regulation and licensing of residential facilities for the mentally ill has become an issue largely because of the national trend to "deinstitutionalize" those persons with mental disabilities who, in an earlier era, might have received care and treatment in a state hospital. Consequently, in studying Rule 36, we have tried to consider the broad historical and philosophical context within which events have unfolded in Minnesota.

In Chapter I we examine deinstitutionalization in Minnesota and describe the nature of the state's mental health care system. Chapter II explains the evolution of state policy regarding deinstitutionalization and the provision of residential care for the mentally ill. In Chapter III we describe the program for licensing residential facilities as established by DPW and we examine the extent to which DPW has complied with the specific requirements of state policy. In Chapter IV we examine issues related to zoning and the location of residential facilities, and in Chapter V we review the major funding issues which have complicated the implementation of Rule 36. Finally, Chapter VI summarizes the results of our statewide survey of facilities which provide services to mentally ill adults. Our principal recommendations for improving the state's system for licensing residential facilities are found in Chapter III.

How a society cares for its mentally disabled may be considered a measure of the character and depth of its civilization. In our society, approaches to the problem have varied greatly from generation to generation and from locale to locale. But at no time or place has the problem appeared simple or the solutions easy. In this study we recognize that the issues surrounding Rule 36 in Minnesota are only a part of a much bigger, more complex national situation. Nevertheless, we hope that this report will be useful to the Legislature and to the Department of Public Welfare as they address the issues dealt with herein.

I. TRENDS IN MINNESOTA'S MENTAL HEALTH SYSTEM

In the 19th century, the development of asylums--large state institutions where the mentally ill could receive systematic care and treatment--was considered a great progressive reform. These institutions, or state hospitals, soon became the mainstay of every state's mental health care system, growing in importance in the 20th century, and reaching a peak in the 1950s. Many social reformers, however, became increasingly disillusioned with the quality of care in large institutions isolated from the social mainstream. Consequently, a new reform movement--deinstitutionalization--began in the 1950s and achieved a reversal of the trends begun in the last century.

Over the past 25 years, state hospital populations, in Minnesota and in the nation, have declined dramatically. Many persons who were once cared for in state hospitals, or who would have been referred to such institutions, found themselves in any of a variety of community-based settings instead. Those requiring short-term care have been treated increasingly often in general hospitals or through community mental health centers; those requiring long-term care have often been referred to nursing homes or group homes.

In this chapter we consider deinstitutionalization and its causes, show to what degree state hospitals in Minnesota have become depopulated, and describe the elements of the state's system of care for the mentally ill. It is our intention in this chapter to provide the general background information needed to gain a fuller understanding of the Rule 36 issue.

A. DEFINING DEINSTITUTIONALIZATION

In considering the problems related to licensing Minnesota's residential facilities for the mentally ill, it is necessary to understand the meaning of deinstitutionalization. As a concept, deinstitutionalization is complex; as a social practice, it is controversial. In layman's terms, deinstitutionalization involves a preference for mental health care in group homes and other community-based facilities instead of treatment in a traditional state hospital. It has been more formally defined as:

> the eschewal of traditional institutional settings, particularly publicly operated facilities, for mentally handicapped persons, and the concurrent expansion of community-based settings for the care of these individuals.[1]

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[1] Leona Bachrach, "The Concept of Deinstitutionalization," Sharing (A Publication of Project Share), vol. 4, no. 5 (July/August 1980), p. 5.

Deinstitutionalization may be considered both a process and a philosophy. As a process, it involves the actual movement of people from one care setting to another. In this sense, it is amenable to measurement and description. As we shall see below, it can be shown that deinstitutionalization is a process that has been occurring in Minnesota and in the rest of the nation over the past 25 years.

As a philosophy, deinstitutionalization may be likened to a social reform movement. Those who encourage the process of deinstitutionalization consider community alternatives preferable to state hospitals. Some are convinced that the quality of care is better in community settings, while others think that noninstitutional care is cheaper.

The U.S. General Accounting Office has defined deinstitutionalization as the process of preventing unnecessary admission to or retention in institutions; developing community alternatives for treatment, rehabilitation, housing, and other basic needs; and improving conditions for persons who continue to require institutional care. The underlying principle is that "mentally disabled persons are entitled to live in the least restrictive environment necessary and lead their lives as normally and independently as they can."[1]

In a similar vein, a 1978 Minnesota Governor's Task Force considered deinstitutionalization to involve an increase in a person's ability to function independently. The task force took a positive view of deinstitutionalization, adding that "reduced accessibility to society's resources, reduced opportunity for choice, reduced protection of individual rights and the impact on the person of prolonged reductions in these areas are often . . . characteristics of an institutional environment."[2] According to this orientation, release from a state hospital to a community location, or from a large to a small facility, may or may not constitute deinstitutionalization. The key is the extent to which the environment, regardless of the institution's size or location, promotes independence and reintegration into the community.

These definitions indicate that deinstitutionalization may have enormous policy implications, including the expectation that community alternatives will be available, that care at all levels will be improved, and that the maximum possible reintegration into the community will be achieved. The desire to realize these expectations in Minnesota led directly to the creation of a program to license residential facilities serving the mentally ill. The development of deinstitutionalization policy in Minnesota and the activities of DPW to implement that policy are described in the next two chapters.

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[1]U.S. Comptroller General, Returning the Mentally Disabled to the Community: Government Needs to Do More, U.S. General Accounting Office (January 7, 1977), p. 1.

[2]Mental Health Task Force Report to the Commissioner, Department of Public Welfare (May 1978), p. 33.

B. ORIGINS OF DEINSTITUTIONALIZATION

There are many theories to explain the trend toward deinstitutionalization. According to one writer, deinstitutionalization has been supported both as a "humanitarian reform" and as an "economic necessity."[1] Others contend that after World War II a "reassessment of the delivery of psychiatric services" was prompted by several interrelated social, economic, and medical developments, including:

- increasing evidence and concern regarding deteriorating conditions in state hospitals, which generally had declined since the early 1900s;

- rejection from military service in World War II of nearly two million draftees because of mental disorders, which prompted national awareness of the prevalence of mental disabilities;

- development and rapid acceptance of tranquilizing or "psychotropic" drugs in the early 1950s, which made possible new forms of treatment of mentally ill persons;

- concern among states about the increasing costs of upgrading and operating state hospitals at a time when additional funds were not available;

- growing federal involvement, including congressional action establishing the Joint Commission on Mental Illness and Health in 1955; the Commission's publication of Action for Mental Health in 1960, setting forth national policy objectives; President Kennedy's 1963 address to Congress urging a "bold new approach" embracing prevention, manpower increases, and community-based programs; and, passage of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 promoting community-based centers and promising federal funding;[2]

- actions of the Minnesota Legislature, including enactment in 1957 of the Community Mental Health Services Act, authorizing community mental health programs and providing grants for their support; and enactment of the Hospitalization and Commitment Act in 1967, which required careful consideration of alternatives to state hospital commitment; and

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[1] Stephen M. Rose, "Deciphering Deinstitutionalization: Complexities in Policy and Program Analysis," Milbank Memorial Fund Quarterly/Health and Society, vol. 57, no. 4 (Fall 1979), p. 435.

[2] 42 USC §2689.

- congressional enactment of Medicare and Medicaid programs in 1965, which have authorized substantial federal expenditures for inpatient and nursing care for elderly, disabled, and low-income persons including mentally ill persons.[1]

Acceptance of deinstitutionalization was accompanied by increased concern about state hospital conditions, the prevalence of mental disorders, and the costs of maintaining state hospitals. The availability of tranquilizing drugs has made it possible to treat many persons in noninstitutional settings. Finally, certain federal and state funding programs have provided incentives encouraging care in community-based facilities instead of state hospitals.

C. STATE HOSPITAL POPULATIONS

As we have indicated, state hospital populations have declined steadily since the mid-1950s. Nationwide, the number of mentally ill, mentally retarded, and chemically dependent persons in state hospitals has dropped by two-thirds over the past 25 years:

- For the nation as a whole, state hospital populations declined from a peak of 559,000 in 1955 to approximately 150,000 in 1978.[2]

- During the same period, Minnesota's state hospital population dropped from 16,000 to about 5,100.

- Minnesota's mentally ill population in state hospitals declined even more dramatically over this time, from 11,500 in 1955 to approximately 1,500 in 1978, an 87 percent decrease.[3]

As shown in Figure 1, Minnesota state hospital populations declined most dramatically in the mid-1960s with the trend leveling off by the late 1970s. Between 1955 and 1979, state hospitals serving the mentally ill have become much less crowded; some, most notably at Hastings, have closed. Table 1 indicates the numbers of mentally ill persons in Minnesota's state hospitals in 1955 and 1979.

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[1]Many of these developments are discussed in Ellen Bassuk and Samuel Gerson, "Deinstitutionalization and Mental Health Services," Scientific American, vol. 238 (February 1978), p. 47. See also Gary Clarke, "In Defense of Deinstitutionalization," Milbank Memorial Fund Quarterly/Health and Society, vol. 57, no. 4 (Fall 1979), pp. 467-472.

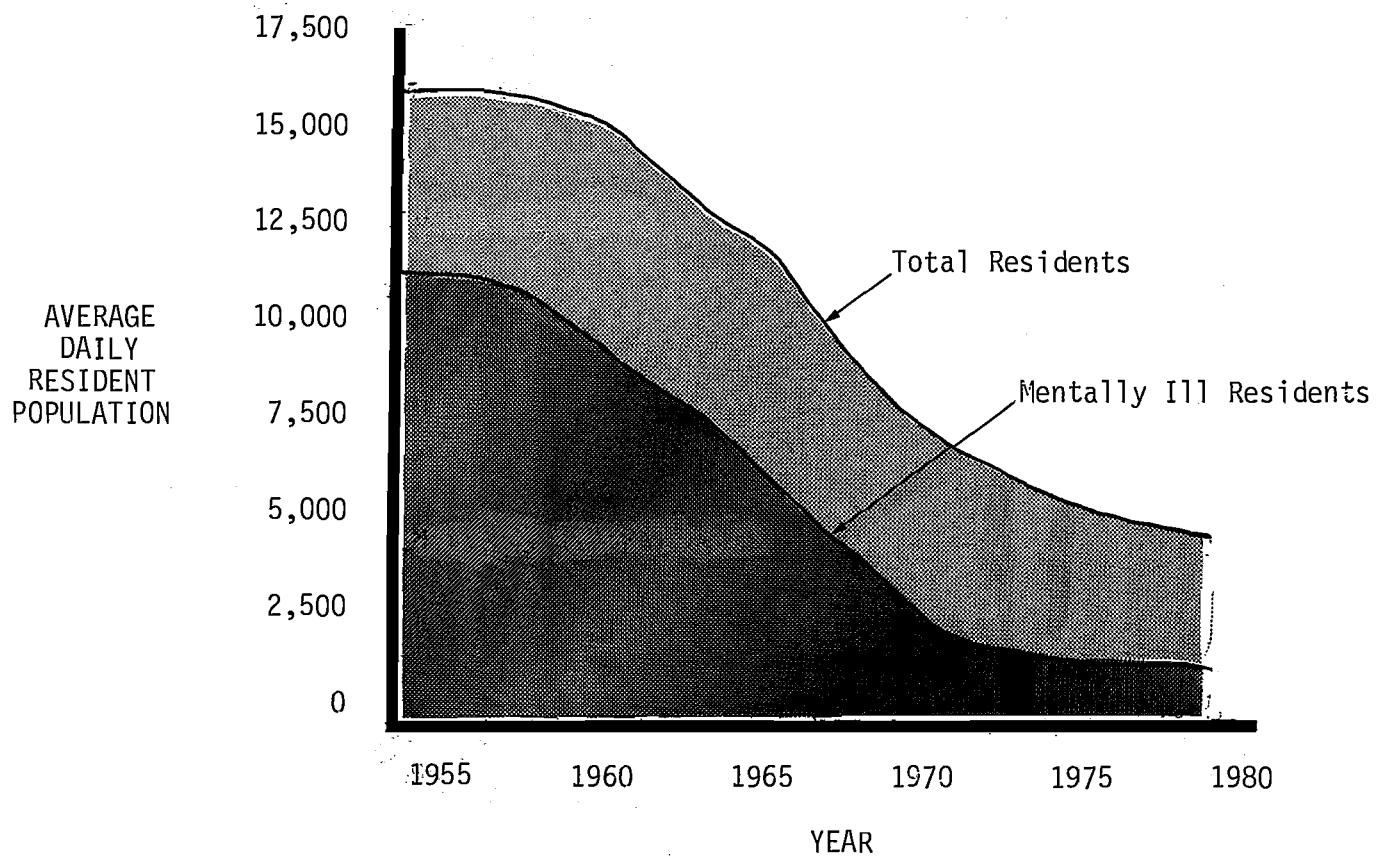
[2]According to Dr. James Thompson, Research Psychiatrist, National Institute of Mental Health (Telephone conversation, December 23, 1980).

[3]DPW, Research and Statistics, Biennial Reports.

FIGURE 1

MINNESOTA STATE HOSPITALS: AVERAGE DAILY RESIDENT POPULATIONS

(FY 1955-1980)



Source: DPW Research and Statistics

As state hospital populations have declined, nearly all institutions have begun to serve more than one mental disability group. Moreover, staff-to-patient ratios at Minnesota's state hospitals have improved dramatically. Between 1960 and 1980, hospital staff serving all disability groups increased by 30 percent, from 4,341 to 5,677, while patients decreased by two-thirds, from 15,800 to 4,849. Staff-to-patient ratios, therefore, were 1 to 3.6 in 1960 and 1 to .85 in 1980.

TABLE 1

MINNESOTA STATE HOSPITALS SERVING THE MENTALLY ILL: AVERAGE DAILY POPULATIONS OF MENTALLY ILL PATIENTS, 1955 AND 1979

Hospital	Number of Mentally Ill in 1955	Number of Mentally Ill in 1979
Anoka	1,149	281
Brainerd	a	72
Fergus Falls	1,922	142
Hastings	981	b
Moose Lake	1,289	155
Rochester	1,768	267
St. Peter	2,488[c]	335[d]
Sandstone	454	b
Willmar	1,483	321
TOTAL:	11,534	1,573

Source: DPW, Research and Statistics.

[a]Opened after 1955.

[b]Closed before 1979.

[c]Includes 255 mentally ill persons at the Minnesota Security Hospital.

[d]Includes 198 mentally ill persons at the Minnesota Security Hospital.

As we have suggested, the reasons for declining state hospital populations are complex and varied. However, Bassuk and Gerson suggest that this decline is primarily attributable to shorter periods of hospitalization rather than lower rates of hospital admissions.[1] More and more, Minnesota has come to depend on noninstitutional settings for mental health care. In the next section we describe the noninstitutional settings most commonly used for mentally ill persons.

D. COMMUNITY-BASED ALTERNATIVES TO STATE HOSPITALS

The mental health care system is a complex maze of facilities and services which are regulated, funded, and operated by combinations of federal, state, local, and private entities. There is no single classification system for types of residential facilities which serve the mentally ill. Terms such as "group home" and "halfway house" are often used to describe facilities which provide varying levels of care and treatment. Other terms, such as "board and lodging," "boarding care," and "nursing home" refer to Minnesota Department of Health (MDH) licenses, although these terms are also used generically.

Mental health professionals have developed the concept of a "continuum of care" for residential facilities and other mental health programs. This concept was defined by the Governor's Mental Health Task Force as "the availability to clients in a geographic area of a comprehensive array of preventive, emergency, diagnostic, treatment, and rehabilitative mental health services which offer varied amounts of support and care depending on the individual client's needs."[2] The continuum ranges from facilities in which residents receive minimal supervision and use mental health services outside the facility to "institutional" facilities which provide 24-hour care and intensive in-house treatment programs. In addition, of course, there are some "non-care" facilities such as hotels and apartment houses where many mentally ill people live.

There is no one-to-one correspondence between the health license a facility holds and the type of mental health program it provides. However, since MDH has a well-established licensing program with clear definitions for types of facilities, the following MDH classification system is used to describe residential facilities serving the mentally ill:

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[1] Bassuk and Gerson, "Deinstitutionalization and Mental Health Services," p. 49.

[2] Mental Health Task Force Report to the Commissioner, DPW (May 1978), p. 11.

- Board and Lodging - This licensing category applies to all facilities which provide rooms and/or meals such as restaurants, hotels, and boarding houses. These facilities are inspected for safety and sanitation standards, but they are not licensed to provide any type of medical or health care. In general, these facilities do not provide mental health programs, although some provide limited activity programs and assist their residents in using community resources. Most of these facilities were not specifically established to provide housing for the mentally ill. However, it is not unusual, especially in the cities of Minneapolis and St. Paul, to find that the majority of persons in these facilities have a history of hospitalization for mental illness. We estimate that there are approximately 94 board and lodging facilities in the state to which mentally ill persons are referred by county welfare departments.[1]

- Supervised Living Facility (SLF) - This health licensing category was specifically designed for facilities also licensed under DPW's residential program rules for the mentally retarded (Rule 34), chemically dependent (Rule 35), mentally ill (Rule 36), and physically handicapped (Rule 80). Facilities holding an SLF license are often referred to as "halfway houses." The distinctive feature of these facilities is that they provide "in-house" rehabilitation or treatment programs. We estimate that only eight facilities for the mentally ill hold an SLF license.[2]

- Boarding Care - This type of license is held by facilities which provide personal and custodial care as well as supervision of medications to persons not requiring more intensive care. Often these facilities provide care for both elderly and mentally ill persons, although some are specifically advertised as facilities for the mentally ill. As with board and lodging facilities, some boarding care homes sponsor activity programs, but very few provide mental health rehabilitation or treatment programs. We estimate that there are 37 boarding care facilities in the state to which mentally ill persons are regularly referred.

- Nursing Home - These facilities are licensed to serve persons who require continuing nursing care as well as personal care and supervision. There are two groups of persons in nursing homes who might need mental health services. The first group consists of persons who were discharged from state hospitals to nursing homes in the mid-1960s when Medicaid funds became available. The second group includes elderly persons who suffer from organic brain disorders associated with advancing age. There are approximately 400 nursing homes or convalescent nursing units in the state.

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[1] See Chapter VI.

[2] Ibid.

- General Hospital Psychiatric Unit - Some general hospitals have inpatient psychiatric units which provide acute, short-term care. For MDH licensing purposes, these are considered specialized units of a general hospital, and are not licensed separately unless they are located on separate premises. There are approximately 30 general hospitals with specialized units for psychiatric care in the state. In addition, two veterans hospitals in the state have specialized units for psychiatric care. Many other general hospitals admit persons experiencing psychiatric crises or provide "holding facilities" for persons awaiting judicial commitment proceedings.

Persons who are discharged from state hospitals may be referred to any of these types of community-based residential facilities--or they may go home. DPW was able to supply us with state hospital patient admission and discharge information only for 1977.[1] These data, presented in Table 2, provide a general picture of the referral system by which patients come to state hospitals and their initial destinations upon leaving state hospitals. Although only limited generalizations can be formulated from such data, several significant points should be made:

- More than one-half of all patients were admitted from or discharged to the patient's own home. Regarding discharges, this suggests that there may be a shortage of other residential alternatives.

- More than one-fourth of all patients were admitted from psychiatric or medical hospitals, while less than 4 percent were discharged to these settings.

- Less than 5 percent were admitted from or discharged to group or foster homes.

- 7 percent of all patients admitted and nearly one-fourth of all those discharged were accounted for simply as "other" or "unknown." This indicates a serious gap in DPW's knowledge about the movement of patients to or from state hospitals.

A significant feature of recent state hospital population movement hidden by average daily population statistics is that many admissions to Minnesota state hospitals are actually readmissions. Table 3 shows that this readmission rate varied somewhat from one state hospital to another in 1977, the highest being at Hastings, which has subsequently closed. The overall readmission rate for mentally ill patients--52 percent--was higher than for other disability groups in 1977. For the mentally retarded and chemically dependent, readmissions accounted for approximately 42 percent of all admissions.

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[1]We have found inadequacies in the state's patient-tracking and management information systems. Appendix A discusses these problems.

TABLE 2

MINNESOTA STATE HOSPITALS: ADMISSIONS AND DISCHARGES OF MENTALLY ILL PERSONS, BY SOURCE OR DESTINATION

(FY 1977)

Source or Destination	Admissions: Number	Admissions: Percent	Discharges: Number	Discharges: Percent
Own Home	1,746	56.2%	1,834	56.6%
Group, Foster Home, or Related	33	1.1	160	4.9
Nursing Home	130	4.2	234	7.2
Veterans Facility	7	0.2	62	1.9
Medical Hospital	275	8.8	66	2.1
Psychiatric Hospital	542	17.4	40	1.2
Correctional Facility	149	4.8	80	2.5
Other	90	2.9	57	1.8
Unknown	136	4.4	707	21.8
TOTAL:	3,108	100.0%	3,240[a]	100.0%

Source: Adapted from Patient Oriented Information System summary in Mental Health Task Force Report to the Commissioner, DPW (May 1978), p. 17.

[a]Does not include 22 deaths.

Although the data in Table 3 represent only one year's activities, they are generally consistent with reported national findings:

- A large proportion of admissions to state hospitals across the country were readmissions--in 1972, 64 percent of admissions were readmissions.
- About one-half of all persons discharged from state hospitals are readmitted within one year.
- Admissions to state hospitals increased from 178,000 in 1955 to a peak of 433,000 in 1975, declining to 390,000 in 1978.

Bassuk and Gerson suggest that these trends reflect a "new philosophy of short-term hospitalization,"[1] and the "lack of a fully effective community-based support system."[1]

[1]Bassuk and Gerson, "Deinstitutionalization and Mental Health Services," p. 49.

TABLE 3

MINNESOTA STATE HOSPITALS:
FIRST ADMISSIONS AND READMISSIONS OF MENTALLY ILL PERSONS

(FY 1977)

Facility	First Admissions: Number	Percent	Readmissions: Number	Percent	Total Admissions
Anoka	240	49.6%	244	50.4%	484
Brainerd	145	49.0	151	51.0	296
Fergus Falls	130	45.8	154	54.2	284
Hastings	105	38.7	166	61.3	271
Moose Lake	151	43.4	197	56.6	348
Rochester	352	45.2	427	54.8	779
St. Peter	170	62.0	104	38.0	274
Willmar	208	52.8	186	47.2	394
TOTAL:	1,501	48.0%	1,629	52.0%	3,130[a]

Source: DPW.

[a]Not including 78 unspecified cases.

While these data alone cannot confirm or disconfirm the inadequacies of the noninstitutional care system as it has developed over the past 25 years, some in Minnesota have questioned whether the alternative care system has developed fast enough to accommodate the influx of patients from state hospitals. The 1978 Governor's Task Force report observed:

> Judging by the large number of readmissions (over 50 percent of the admissions are readmissions), one cannot help but wonder what is happening to these individuals in their own homes after being discharged from state hospitals . . . . The data raise serious questions about the availability and quality of after-care and follow-up services . . . and about the screening and treatment available in the community to prevent hospitalization or rehospitalization.[1]

The licensing program for residential facilities set up by DPW Rule 36 was designed to ensure compliance with minimum standards in order to encourage quality programs for persons who required noninstitutional care for mental disabilities. The program is more fully described in the next two chapters.

[1]Mental Health Task Force Report, pp. 17-18.

II. MINNESOTA'S MENTAL HEALTH POLICY

Chapter I documents the dramatic decline in state hospital populations in Minnesota, consistent with the trend in the rest of the nation. It is unclear, however, what role state mental health policy played in causing that trend in Minnesota. In general, public policy is an objective desired from government action, or a plan of action to achieve an objective, which provides focus for public decision-makers and administrators. However, public policy is not always articulated clearly or attributable to a single event or actor.

We examined existing legislation, administrative rules, agency studies, and task force reports to determine the content of Minnesota's policy regarding deinstitutionalization and residential care for the mentally ill. In this chapter we discuss several significant indicators of that policy. We demonstrate that although in many respects the state's policy is fragmented, it seems to endorse deinstitutionalization.

A. DEINSTITUTIONALIZATION POLICY

In May 1978 the Commissioner of DPW wrote to the Governor, "It is my opinion that the State of Minnesota has operated too long without a mental health policy."[1] Despite the sweeping changes that have occurred over the past 20 years in the system of care for the mentally ill, no public body has yet articulated a formal, comprehensive statewide policy on deinstitutionalization in Minnesota, nor on the larger question regarding the most effective and most humane way of providing treatment for the mentally ill. Nevertheless, through actions by the Legislature, the Department of Public Welfare, and the courts, a kind of policy has evolved. Although fragmented, it has provided guidance to state agencies and the public, and it has affected much of the change experienced since the mid-1950s. In this section we present some of the most important fragments making up that policy.

1. COMMUNITY MENTAL HEALTH SERVICES ACT

By enacting the Community Mental Health Services Act in 1957, the Minnesota Legislature preceded by six years the comparable landmark legislation passed by the U.S. Congress in 1963.[2] Minnesota's legislation authorized the establishment of community mental

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[1] Commissioner Edward Dirkswager to Governor Rudy Perpich, in a letter accompanying the report of the Mental Health Task Force, May 17, 1978.

[2] Minn. Laws (1957), ch. 392.

health services programs and provided for state grants-in-aid to assist in establishing and operating these programs. More specifically, the act authorized the Commissioner of DPW to promulgate rules, to approve community mental health programs, and to make grants. It also specified procedures and limitations for the allocation of funds and required the establishment of community mental health boards.

In setting up these programs, there was a general expectation that some of the kinds of mental health services provided in state hospitals could be offered in community-based settings as well. As former state hospital patients became reintegrated into the community, the act sought to improve the quality of aftercare. Services provided by approved programs have included those to prevent psychiatric disabilities, to provide informational services to the general public and professional groups, and to provide outpatient diagnostic, treatment, and rehabilitative services. DPW Rule 28 was promulgated under this statute to regulate the establishment and operation of the community mental health centers.

Although the act does not mandate deinstitutionalization of the mentally ill, it does provide opportunities for aftercare for persons who have been in state hospitals, and it does provide outpatient services for persons who might otherwise have been referred to state hospitals. In these ways, the act may well have accelerated the process of deinstitutionalization.

2. HOSPITALIZATION AND COMMITMENT ACT

The 1967 Hospitalization and Commitment Act outlines procedures for voluntary hospitalization, emergency hospitalization, and judicial commitment for persons legally determined to be mentally ill, inebriate, or mentally deficient.[1] The act also defines the "rights of patients," establishing limits on the use of restraints, protecting the right to uncensored correspondence, and requiring each patient to have written treatment and discharge plans.

According to the act, involuntary commitment can be ordered by a court only when necessary for "the welfare of the person and the protection of society," or more specifically when the person's conduct clearly shows:

> (i) that he has attempted to or threatened to take his own life or attempted to seriously physically harm himself or others;
>
> (ii) that he has failed to protect himself from exploitation from others; or
>
> (iii) that he has failed to care for his own needs for food, clothing, shelter, safety, or medical care.

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[1] Minn. Stat., ch. 253A.

Perhaps most significantly, the act requires that before commitment is ordered there must be "careful consideration of reasonable alternative dispositions," such as outpatient care, voluntary hospitalization, appointment of a guardian, or dismissal of the petition. Commitment to a state hospital, then, should be considered a last resort, the act seems to imply. Although this act, too, does not explicitly mandate deinstitutionalization, the force of its requirements is clearly compatible with deinstitutionalization. According to the act, involuntary hospitalization cannot be ordered without specific reasons supported by factual evidence. Moreover, less restrictive alternatives to involuntary hospitalization must be considered, and commitment may be ordered only when no suitable alternative exists.

3. WELSCH V. LIKENS

The U.S. District Court, District of Minnesota, affirmed in 1974 in Welsch v. Likens[1] that "mentally retarded persons civilly committed to the state's institutions have a constitutional right to treatment and care in the least restrictive practicable alternative to hospitalization and to a humane and safe living environment."[2] That decision led to a 1978 consent decree which spelled out numerous staffing and other operating standards to be met at Cambridge State Hospital. In 1980 litigation, the standards were applied to all state hospitals caring for mentally retarded persons. This settlement also spelled out a timetable for the release of mentally retarded persons from state hospitals.

Although Welsch v. Likens pertained to care for mentally retarded persons, its implications are widely assumed to extend to other disability groups, and comparable legal issues may be raised in cases specifically pertaining to care for the mentally ill. This case followed by only a few years the landmark Wyatt v. Stickney decision in 1972 by the U.S. District Court in Montgomery, Alabama.[3] The U.S. General Accounting Office characterized Wyatt v. Stickney as:

> the first class-action suit successfully brought against a state's entire mental health system. The court ruled that the mentally ill and the mentally retarded had a constitutional right to treatment in the least restrictive setting necessary . . . [and] imposed minimum constitutional standards for adequate habilitation.[4]

These two court cases have clearly established a policy requiring that care be provided in the least restrictive setting possible. They have caused state hospitals in Minnesota and elsewhere

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[1] Welsch v. Likens, 373 F. Supp. 487 (D. Minn., 1974).

[2] U.S. Comptroller General, Returning the Mentally Disabled to the Community, p. 216.

[3] Wyatt v. Stickney, 334 F. Supp. 1341 (D. Ala., 1971).

[4] Ibid., p. 213.

to establish specific operating requirements, and they undoubtedly strengthened the already accelerating trend to deinstitutionalize the mentally disabled throughout the country.

4. HOUSING POLICY

In 1976 the Minnesota Legislature incorporated into the state's Housing Finance Agency law certain provisions pertaining to the development of community-based residential facilities for mentally ill and other disabled persons. This legislative action represents perhaps the clearest single statement of legislative intent with regard to deinstitutionalization. The Legislature stated that the welfare of mentally ill and other specified persons needing residential care is:

> better served through the development of a comprehensive, community based system of treatment and care which requires the availability of adequate financing for the construction, renovation, or rehabilitation of residential care facilities as well as sufficient funds for their operational startup costs.[1]

Although no new money was appropriated to accomplish this development, this provision represents a clear endorsement by the Legislature of the principle of deinstitutionalization. It also broadens the authority of the Housing Finance Agency to encourage the development of community-based residential care facilities for the mentally ill. However, no loans have been made for facilities serving the mentally ill because of uncertainties that facilities can pay back mortgages.

B. STATE POLICY ON LICENSING RESIDENTIAL FACILITIES

While Minnesota's policy on deinstitutionalization is fragmented, the state's policy on licensing residential facilities for the mentally ill is not. Although, as we shall point out in Chapter III, there are some inconsistencies between the policies established by the Legislature and the administrative rule promulgated by the Department of Public Welfare to implement that policy, it is clearly the policy of the State of Minnesota to license residential treatment facilities serving the mentally ill. The following elements comprise that policy.

1. LICENSING ACT OF 1971

In 1971 the Legislature enacted a law authorizing the Commissioner of Public Welfare to "license and regulate day care and

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[1]Minn. Stat., ch. 462A, §2, subd. 9.

residential facilities and services for the mentally ill, inebriate, and physically handicapped."[1] The law required the commissioner to hold public hearings to establish necessary rules setting forth minimum standards for operating these facilities. It also stipulated that no residential facility or service for five or more persons was to operate without a license and that, after due process, licenses could be revoked by the commissioner for failure to comply with the operating standards set down in rule.

The law went on to require that all mentally ill persons "under the care and supervision of any county welfare department and who need placement in residential, aftercare or day care facilities shall be placed only in facilities licensed in accordance with this act." (Our emphasis.) Without ambiguity, therefore, this act authorized facility licensure, prohibited facility operation without a license, and specifically required county welfare agencies to make placements only in duly licensed facilities.

Although the 1971 legislation placed the chief burden for developing a licensing program and for promulgating the rules under which it would operate on the DPW commissioner, the act gave the commissioner the right to delegate any of the powers and duties granted by the act to county welfare boards. This presumably meant that the licensing program itself might have been turned over to the counties for their supervision and development. This provision was dropped, however, when this legislation was superseded by the 1976 Public Welfare Licensing Act described below.

2. RULE 36

In February 1974, DPW promulgated Rule 36 "for the licensing and operation of all residential programs for adult mentally ill persons."[2] The purpose of the rule, which had been authorized by the 1971 licensing act, was to "aid in the development of a system of residential programs for the mentally ill that," among other things, "provides appropriate treatment and rehabilitation programs" in a homelike atmosphere. The rule also sought to ensure that:

- residents of community-based facilities are provided appropriate care and services;
- residents receive sufficient information about the facility and its programs;
- specific criteria are established to enable DPW to evaluate the facility's programs; and
- careful and realistic individual planning is done in all facilities.

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[1] Minn. Laws (1971), ch. 627.

[2] 12 MCAR §2.036.

The rule requires that "every residential program must have a current and valid license or provisional license to operate in the State of Minnesota." The rule defines a "residential program" as "a planned purposeful set of conditions and events for the treatment and rehabilitation of five or more mentally ill adults on a 24-hour basis for more than three consecutive days."

In addition, Rule 36 requires licensed facilities to develop and carry out a written treatment plan for each resident which defines specific problems to be overcome and provides the means of resolving them. It also requires:

- designation of an administrator, a program director, and a volunteer coordinator on the facility's staff;
- program staff with demonstrated knowledge in the area of human relations;
- a staff development program;
- space adequate for program activities required by individual treatment plans;
- a program plan describing intake policies and documenting the availability to residents of necessary services, including medical, psychiatric, financial, and rehabilitation services; and
- an individualized written record for each resident which includes a treatment plan, a medical and social history, progress notes, a discharge summary, a signed statement concerning expectations, responsibilities, and legal rights, and consent for the release of information.

As we explain in subsequent chapters, the department has encountered many difficulties in implementing the licensing program mandated by the Legislature and outlined in Rule 36. The most serious difficulties have involved funding. The licensing program places additional burdens on a facility to meet the standards specified in Rule 36. However, no new money has been appropriated to help facilities meet expected increased costs. More significantly, a Rule 36 license has been taken as prima facie evidence by administrators of the federal Medicaid program that a facility is an "institution for mental diseases" and therefore ineligible to receive Medicaid funds. For these reasons, the department has decided to suspend the licensing program outlined in Rule 36 for all facilities except those that specifically request a license. These issues are more fully discussed in Chapters III and V.

In the meantime, the department has taken steps to revise Rule 36 and to request funds for residential facilities from the Legislature in 1981. These activities are discussed later in this chapter.

3. PUBLIC WELFARE LICENSING ACT

In 1976 the Legislature enacted the Public Welfare Licensing Act which superseded and clarified the earlier licensing legislation.[1] Records of committee and subcommittee hearings indicate the chief author's hope that the legislation would "unify pre-existing laws into one licensing statute which would more clearly and more flexibly define the department's licensing function" and remove inequities from statutes. Subcommittee members expressed interest in avoiding "disparate mandates being sent out by different state agencies" and avoiding an unenforceable licensing law. The act clearly made DPW the lead agency in the licensing program, specifying that all state agencies "which are involved in the investigation and review of a facility or an applicant's qualifications shall direct their employees to report directly to the commissioner [of DPW] on these matters and shall be subject to the rules promulgated by the commissioner with respect to the coordination of licensing and inspection functions."

Like the statute it replaced, the licensing act required DPW to license "residential facilities" for various dependent groups in order "to regulate the provision of care and services and to assure protection, proper care, and the habilitation and rehabilitation necessary to health, safety, and development." The act set out in detail the procedures for facility licensure, including procedures for application and inspection, as well as license revocation or denial. In addition, the act directed the Commissioner of Public Welfare to promulgate rules governing the licensing of residential facilities and mandated consultation during this process with other appropriate state agencies, service users, service providers, advocacy groups, and experts from related professions. Any rules promulgated under previous statutes--including Rule 36--could remain in effect until expressly superseded by those newly promulgated under the Public Welfare Licensing Act. A review of rules was to take place at least every five years.

Many specific types of facilities were excluded from the requirements of the act, most significantly any residential facility which served "fewer than five" handicapped adults, and any nursing home, hospital, or boarding care home unless it had "an identifiable unit" which provides care for "more than five" handicapped persons.[2] The act did not elaborate on what "an identifiable unit" was.

As indicated earlier, a key provision of the licensing statute declares that:

> No individual, corporation, partnership, voluntary association, or other organization may operate a day care or residential facility or agency unless licensed to do so by the commissioner.

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[1] Minn. Laws (1976), ch. 243.

[2] See also p. 77 of this report.

A "day care facility" is defined by the act as any public or private facility which "provides one or more persons with care, training, supervision, habilitation, rehabilitation, or developmental guidance on a regular basis for periods of less than 24 hours per day, in a place other than the person's own home." This definition expressly includes daytime activity centers and day treatment programs. A "residential facility" is defined as any public or private facility which "provides one or more persons with a 24 hour substitute for care, food, lodging, training, education, supervision, habilitation, rehabilitation, and treatment they need, but which for any reasons cannot be furnished in the person's own home." This definition expressly includes state institutions under the control of the Commissioner of Public Welfare, residential treatment centers, group homes, and residential programs.

The Public Welfare Licensing Act, therefore, reiterated and strengthened the mandate to DPW to set standards for licensing residential facilities for the mentally ill and to establish an active licensing program. Later we examine the extent to which the department has complied with the requirements of the act.

C. RECENT POLICY DEVELOPMENTS

The licensing acts passed in 1971 and 1976 and Rule 36 have defined the formal policy of the state with regard to licensing residential facilities for the mentally ill. However, a full understanding of the context within which the licensing program has developed requires an examination of several subsequent policy developments. In this section we describe the activities of DPW to study the state's mental health system, the Legislature's enactment of the Community Social Services Act, and the department's efforts to revise Rule 36 and prepare a funding proposal for presentation to the 1981 Legislature.

1. MENTAL HEALTH TASK FORCE

In February 1978 the DPW commissioner, at the direction of the Governor, appointed a 21-member task force representing a "diversity of interests and expertise" to make recommendations regarding "the delivery of mental health services in Minnesota." The goals of the task force were to describe the state's mental health system, to highlight its inadequacies, and to make recommendations to improve the system. More generally, the task force accepted the charge of recommending "clear direction for a state mental health policy."

Based on a three-month study, the task force[1] issued a report outlining a recommended state mental health policy. A summary of the report, delivered to the Governor in May 1978, listed 12

[1] Mental Health Task Force Report to the Commissioner, DPW (May 1978).

major findings concerning inter-governmental relations, accountability, placements, and problems with the state's residential care system. Specifically relating to this last point, the task force found that:

- the absence of strong state leadership in mental health has created a lack of commitment at the state and local level to solving problems in the mental health delivery system; and

- standards of program quality for the mentally ill, such as DPW Rule 36, have not been fully implemented primarily because of the absence of adequate and stable funding sources.

The summary also identified seven policy goals and outlined what actions were necessary for their accomplishment. Among the goals were the following:

- The state needs a coordinated and accountable local mental health system.

- The state should give high priority to the needs of the mentally ill.

- The mental health system should be adequately funded using both public and private resources.

Finally, the report endorsed the principles of deinstitutionalization by recommending the adoption of policy for the State of Minnesota which ensures that "a balanced mental health system which provides the most appropriate care in the least restrictive setting and which relies on the strengths of both the public and private sectors shall be available to all its citizens."[1]

2. COMMUNITY SOCIAL SERVICES ACT

The second recent development affecting the state's policy on mental health and deinstitutionalization was the passage of the Community Social Services Act in 1979.[2] This act has significantly shifted the responsibility for planning and implementing human service programs from the state level to the local level. The stated purpose of the act was to establish "a system of planning for and providing community social services administered by the boards of county commissioners of each county under the supervision of the commissioner of public welfare." The act requires biennial plans at both the state and county levels. The state is responsible for coordinating plans in areas such as housing, health, corrections, employment, education, and mental health. The act also establishes a formula for allocating state and federal funds--including Title XX, "Social Services" funds--to counties for the administration and provision of community social services included in the plan.

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[1] Summary of Mental Health Task Force Report to the Commissioner, DPW (May 16, 1978).

[2] Minn. Laws (1979), ch. 324.

A major implication of this act for mental health policy was that it amended the Community Mental Health Services Act of 1957. The most significant change was the transfer of authority for these programs from DPW to the counties. Other provisions of the act which apply to mental health programs include the following:

- County boards may make grants to public or private agencies to establish and operate local mental health programs.

- Any city, county, town, or combination thereof--irrespective of population--may establish a community mental health services program.

- Any city, town, or public or private corporation may apply to a county board for assistance in establishing and funding a mental health services program.

- An experimental statewide program was established to assist counties in providing services to chronically mentally ill persons in community-based facilities. The Commissioner of DPW was directed to make grants to counties to "establish, operate, or contract with private providers to provide services designed to help chronically mentally ill persons remain and function in their communities." Programs established under this provision are discussed in subsequent chapters of this report, and are referred to as "Rule 14 programs."

3. DPW'S RESIDENTIAL CARE STUDY

In August 1979 the Commissioner of DPW transmitted to the Governor a summary of a report on the state's system of residential care for the mentally ill and other disabled groups.[1] The report, which resulted from a two-year study requested by the Governor, attempted to assess the future role of state-operated and community-based facilities. The report made several recommendations relevant to mental health policy and deinstitutionalization, contingent on the appropriation of funds sufficient to permit the growth of adequate community-based facilities, and provided that various "proposed policy changes are reviewed and acted upon" by the Legislature. Perhaps most significantly, the report "recommends diverting from state hospitals all admissions which can be appropriately served in community-based programs and reducing the length-of-stay of mentally ill state hospital residents." The report estimated that the cost of these community services would amount to nearly $850,000 in state funds and $1.2 million in county funds. These costs, however, would be

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[1]Office of Policy Analysis and Planning, Residential Care Study (Executive Summary), Department of Public Welfare (March 1979).

more than offset, according to the report, by savings of approximately $3.3 million from the state hospital system. The report recommends, therefore, "a fiscal relief program which would effectively transfer a portion of those savings to the counties in order to assist in the funding of community residential and support services."[1]

A significant characteristic of the department's Residential Care Study, then, is that it endorses deinstitutionalization on the condition that funding issues are resolved. Although it does not, in and of itself, determine state policy, the report reflects the thinking of those in the executive branch who share with the Legislature the chief responsibility for shaping mental health policy in the future.

4. DPW TASK FORCE TO REVISE RULE 36

On April 21, 1980 the DPW Commissioner formally invited persons to participate in a task force to propose revisions in Rule 36. Task force members included employees of DPW, MDH, and other state agencies, employees of Hennepin County and other local governments, facility operators, consumers, advocates, and members of professional organizations. The task force met for the first time on May 6, 1980 and met as a whole approximately six times by December 1, 1980. The task force also worked in four subcommittees assigned to funding, data, standards, and program issues, which met approximately 35 times in total. By early October 1980 the task force had produced a draft for revisions in Rule 36.

The third draft of the revision of Rule 36 prepared by the task force included these features:

- A statement identifying the rule's purpose to be the establishment of "minimum standards for the development, operation, and maintenance of residential programs for the adult mentally ill" and a "means of ensuring the human rights of adult mentally ill persons" through their enforcement.

- Establishment of three levels of care--category I for a mental health residential program within a nursing home; category II for a mental health residential facility providing active treatment on a regular basis; and category III for a semi-independent living facility offering in-house and community-based service.

- Specification of licensing procedures including written application; documentation by the applicant of compliance with "all building codes, fire/safety codes, health regulations, zoning ordinances" and other regulations; and payment of a fee.

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[1] Ibid., see pp. 122-124.

- A specific requirement that "every residential program shall have a current and valid license or provisional license to operate in the State of Minnesota," valid for up to two years.

- Specific staff qualifications and staff/patient ratios, facility capacity limits, specific MDH license to be maintained, types of program services to be offered, and resident records to be kept.[1]

Recently, DPW modified the September 1980 third draft of Rule 36 by deleting Category I pertaining to nursing homes and adding the requirement for a need determination mechanism to be based on guidelines set by the commissioner. A date for public hearings is not yet set.

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[1]Rule 36, Third Draft (September 1980).

III. THE DEPARTMENT OF PUBLIC WELFARE'S COMPLIANCE WITH STATE POLICY ON CARE FOR THE MENTALLY ILL

As we have demonstrated, Minnesota's policy on care for the mentally ill lacks coherence. However, a policy endorsing care in the "least restrictive" setting clearly exists. Moreover, it is undeniable that state hospitals have become dramatically depopulated over the past two decades and that an increasing number of persons requiring care for mental disabilities have turned to community-based residential facilities.

Through legislation enacted as early as 1971 the Legislature placed the chief responsibility for regulating and licensing community-based facilities for the mentally ill on the Department of Public Welfare. In this chapter we examine DPW's compliance with state policy on care for the mentally ill as outlined in the previous chapter. Specifically, we try to establish whether DPW has set up a licensing program as required by law, how well that program works, and how extensively residential facilities for the mentally ill are licensed. At the conclusion of each section in this chapter, we make recommendations for improvement in the state's system of regulating residential facilities.

A. PROCEDURAL COMPLIANCE

In this section we examine whether DPW's procedures in responding to the licensing legislation of 1971 and 1976 have been in compliance with the requirements of that legislation. Most of our analysis focuses on DPW's Mental Illness Program Division and its Licensing Division (see Figure 2). In general, we conclude that although DPW has promulgated a rule as required, it did not do so in a timely fashion and in many ways the rule does not respond adequately to DPW's legislative mandate. In addition, we think there is confusion about whether legislation requires licensing of residential "facilities" or, rather, residential "programs."

1. THE MANDATE TO PROMULGATE RULES

The licensing law of 1971 required DPW to promulgate rules for regulating residential facilities for the mentally ill:

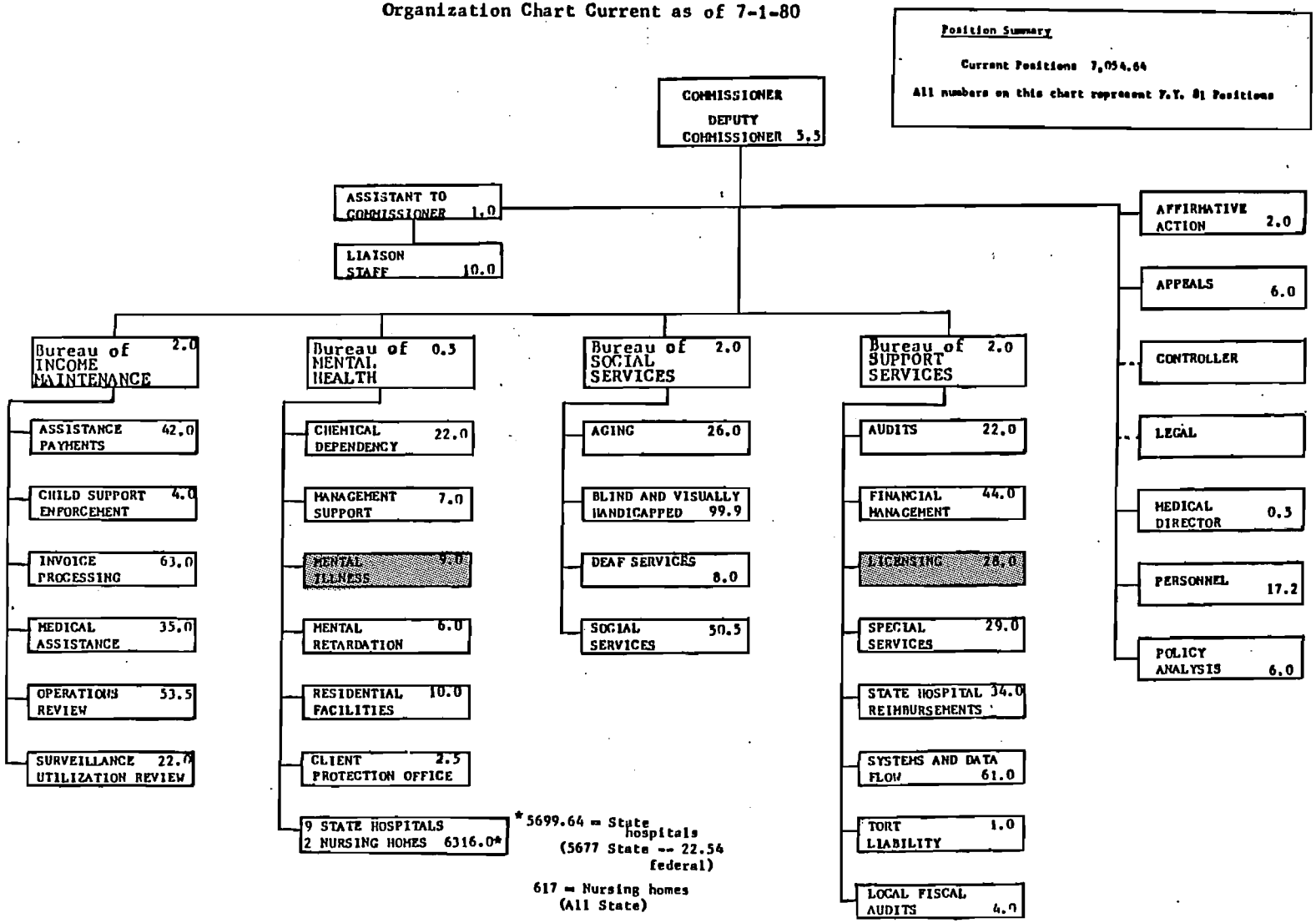
> The Commissioner of Public Welfare shall establish rules, regulations, and guidelines after public hearings for the licensing and operation of day care and residential facilities and services for the mentally ill, inebriate and physically handicapped.[1]

[1] Minn. Laws (1971), ch. 627.

FIGURE 2

DEPARTMENT of PUBLIC WELFARE

Organization Chart Current as of 7-1-80



Source: Detailed Biennial Budget Proposal, 1981-83.

Rule drafting began in mid-1972 and was completed approximately one year later. After a public hearing, the rule was formally promulgated on February 4, 1974.

- Nearly three years passed between the initial licensing authorization and the promulgation of Rule 36. More than four years have passed since the enactment of the Public Welfare Licensing Act (1976) and DPW has not yet promulgated a revision of Rule 36.

According to DPW staff, two factors contributed to the delay in the initial promulgation of Rule 36. The first was that the department had several related mandates to respond to at the same time. Through various legislative actions in 1971, including the licensing law to which we have already referred, DPW was required to promulgate rules to regulate residential facilities for mentally retarded, chemically dependent, physically handicapped, and mentally ill persons. According to DPW employees, the department gave priority to the administrative rule for licensing facilities for the mentally retarded (Rule 34) in part because of pressure from strong advocacy groups. In addition, federal funding for residential facilities serving the mentally retarded was contingent on these facilities first obtaining a program license. DPW licensing therefore eased the flow of federal money for facilities for the mentally retarded. In contrast, there was no comparable funding source for facilities serving the mentally ill, and therefore no equivalent incentive to give high priority to Rule 36. Rules 34 and 80 (physically handicapped) were promulgated in November 1972; Rule 35 (for the chemically dependent), like Rule 36, was not promulgated until February 1974.

A second factor contributing to delay may have been more explicitly organizational. According to a DPW administrator, there were two DPW employees assigned to mental illness programs and no distinct mental illness program unit when the original licensing law took effect. The law did not provide funding or staff to implement its provisions. DPW secured federal funding for a staff position to draft and facilitate implementation of Rule 36. DPW personnel records show that that person was assigned to Rule 36 development activities from August 1, 1972 to September 5, 1973.

Separate legislation in 1971 created a mental retardation division in DPW with a director whose responsibilities included maximizing "the availability of federal or private moneys for programs to assist mentally retarded and mentally deficient persons."[1] A Mental Health-Behavioral Disabilities Division was not created until May 1, 1974 through a departmental reorganization. That division is now known as the Mental Illness Program Division.

Once promulgated, Rule 36 did fulfill the mandate of the 1971 licensing act requiring DPW to set forth "minimum qualifications for operators of facilities." The rule established standards for various administrative procedures, qualifications and numbers of program

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[1]Minn. Laws (1971), ch. 486, §1.

staff, content of treatment plans required for each resident, and personnel and management procedures. Examples of these requirements in the current rule include the following:

- Each residential program is to have a designated administrator, a program director, and a volunteer coordinator.

- Every resident is to have a written treatment plan detailing the types of care planned by the resident, program director, and others to meet specific rehabilitation goals.

- A confidential record is to be maintained for each resident to include the individual treatment plan, signed statement concerning legal rights, medical and social history, and discharge summary.

However, the current rule did not fulfill the requirement of the 1971 licensing act that DPW set forth "standards for determination of local need which shall be a prerequisite for licensure." The rule recognized the issue of local need determination only in that it provided that "the need for the program shall be determined under Area Board coordination" prior to licensure. However, DPW did not issue guidelines pertaining to the determination of need and did not, prior to 1976 when the provision was dropped from the law, make the issuance of licenses conditional on Area Board approval.

The Public Welfare Licensing Act, passed by the Legislature in 1976, was far more explicit than the original licensing legislation in outlining what should be included in administrative rules. Matters covered in the act which are not dealt with in the current version of Rule 36 include the conditions under which facilities may be exempted from the licensing requirement, the manner and frequency of inspections, the steps to be taken to ensure adequate living conditions at a facility, the conditions under which fines may be levied, the requirements regarding zoning and the permissible geographic setting for a facility, and the requirement for rules for "suspending, revoking, and making licenses probationary."

Although the department has worked to revise Rule 36 over the past year, a revision has not yet been promulgated and the department therefore has not yet fulfilled many specific requirements of the 1976 law.

2. THE MANDATE TO LICENSE FACILITIES

Our review of Rule 36 and the legislation which mandates a licensing program leads us to conclude that:

- DPW's Rule 36 is designed to license only those facilities with programs for the mentally ill even though the licensing legislation appears to give a more general mandate to license all facilities for the mentally ill.

As we outlined in Chapter II, the original licensing legislation required a rule for the licensing and operation of "day care and residential facilities." It further specified that no one "shall operate a day care or residential facility or service for the mentally ill . . . without a license." The Public Welfare Licensing Act of 1976 echoed these requirements, clarifying the definitions of "day care facility" and "residential facility" to make it clear that facilities which fell under the act were to be licensed.[1]

In contrast, Rule 36 makes reference to "residential programs." Instead of using the language in the licensing legislation, the rule specifies that:

> Every residential program must have a current and valid license; [and]
>
> Each residential program shall hold or have applied for a facility license from the Minnesota Department of Health. (Our emphasis.)

This last excerpt from Rule 36 indicates that a distinction is meant between a program license from DPW and a facility license from MDH, a distinction which is not made in the licensing legislation. This distinction takes on more significance when we note, as we do below, that DPW has issued only a few "program" licenses since 1974 although perhaps as many as 150 to 160 "facilities" specifically serving the mentally ill exist in Minnesota. There are many reasons why more licenses have not been issued, but at least some DPW staff may be unaware that the rule is written in a way to exclude some facilities--those without "programs"--which the law requires to be licensed.

This raises, of course, a significant question. Did the Legislature intend to license all facilities which serve five or more mentally ill persons or just those which have treatment programs? We have been unable to resolve this question satisfactorily. However, it does appear to us that the law currently requires DPW to license and regulate all residential facilities--even those without programs--except those specifically excluded by the 1976 Public Welfare Licensing Act.

3. RECOMMENDATIONS

- As a result of the above analysis, we recommend that DPW conduct its future licensing activities in such a way that does not exempt any residential facility from the licensing program that is not explicitly excluded by the Public Welfare Licensing Act.

Subject to clarification by the Attorney General or by the Legislature, this means that any residential facility serving five or more mentally ill persons should be subject to licensure and must, according to the provisions of the licensing act and Rule 36, establish and maintain a satisfactory program of treatment for its residents.

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[1] See Chapter II, p. 22.

Before a revised Rule 36 is promulgated, DPW should ensure that its scope of applicability is consistent with the Public Welfare Licensing Act. As a practical matter, this means that DPW should revise Rule 36 so that it reflects the legal requirement that all residential facilities must obtain a license to operate. In addition, the revised rule should address those matters which are incorporated in the licensing act but not covered in the current rule. These include procedures for suspending, revoking, and making licenses probationary; conditions for facility exemption from licensure; procedures for inspections; standards to ensure adequate living conditions at a facility; the conditions under which fines may be levied; and guidelines relating to the location of residential facilities.

B. THE SCOPE OF DPW'S LICENSING PROGRAM

In this section and the next, we examine DPW's licensing program for residential facilities serving the mentally ill. These activities take place in the Licensing Division of the Bureau of Support Services. Our principal conclusion is that since only a few facilities have actually been licensed over the past decade, DPW has not fulfilled its responsibilities under the law. Those facilities which are operating without licenses are violating the provisions of the Public Welfare Licensing Act.

1. LICENSES ISSUED

The 1971 licensing act was unequivocal in its requirement that all facilities serving the mentally ill had to obtain a license in order to operate:

> No person, organization or association shall operate a day care or residential facility or service for the mentally ill . . . after such date as the commissioner shall establish without a license as provided by this act.[1]

When Rule 36 was promulgated in 1974, it repeated the licensing requirement:

> Every residential program must have a current and valid license or provisional license to operate in the state of Minnesota.[2]

In 1976 the Legislature reiterated its mandate:

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[1] Minn. Laws (1971), ch. 627.

[2] 12 MCAR §2.036.

> No individual, corporation, partnership, voluntary association, or other organization may operate a day care or residential facility or agency unless licensed to do so by the commissioner.[1]

Furthermore, the 1976 act declared that operation of such a facility for the mentally ill "without a license is a misdemeanor punishable by a fine of not more than $300." The commissioner was empowered to seek an injunction against such a facility if its "operator has willfully failed to apply for a license" or if the facility is in violation of the licensing law or administrative rules. In addition, the act declared that "any individual who advertises a facility [which is] required to be licensed" is guilty of a misdemeanor.

Despite the apparent clarity of this policy,

- DPW officials acknowledge that no residential facility for the mentally ill in the State of Minnesota is currently being licensed without the operator's consent.

DPW issues licenses only to those facilities specifically requesting licensure. In response to inquiries, DPW licensing staff members inform operators that having a Rule 36 license may jeopardize any Medicaid funding which they receive, and that licensure is voluntary.

DPW estimated in 1976 that more than 150 facilities were eligible for a Rule 36 license. In addition, a certain number of nursing homes which had identifiable units regularly providing care to six or more mentally ill persons were presumed to be eligible.[2] Although DPW cannot now produce tangible evidence of its activities, department staff members are said to have systematically compiled lists of facilities potentially eligible for licensure, and surveyed approximately 110 facilities to determine the number of mentally ill persons then being served and the nature of their diagnoses. Facility operators were apparently informed of the requirements of the licensing law.[3]

DPW began to issue licenses under Rule 36 in February 1976, nearly five years after the first legislative mandate to license facilities for the mentally ill. Rice Memorial Hospital in Willmar was the first to receive a license. DPW's license files show that:

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[1]Minn. Laws (1976), ch. 243.

[2]Testimony of DPW Assistant Commissioner Michael Weber before the Minnesota House Committee on Deinstitutionalization (May 17, 1976).

[3]According to former DPW staff member Craig Brooks, now employed by Winona County. Unfortunately, no record of the survey or list of facilities could be produced by DPW.

- At the program's peak, in November 1977, 19 facilities had licenses. Just 10 facilities--including two state hospitals--currently hold licenses.

Table 4 shows the number of valid Rule 36 licenses at certain intervals over the past four years.

TABLE 4

RULE 36 LICENSES IN EFFECT, JULY 1977-NOVEMBER 1980

Date	Rule 36 Only	Joint Rule 36 and Another Rule[a]	Total
July 1, 1977	13	3	16
November 1, 1977	15	4	19
March 1, 1978	13	4	17
July 1, 1978	14	3	17
November 1, 1978	15	3	18
March 1, 1979	11	3	14
July 1, 1979	10	3	13
November 1, 1979	7	3	10
March 1, 1980	7	3	10
July 1, 1980	7	3	10
November 1, 1980	7	3	10

Source: DPW Licensing Division.

[a]Joint licenses authorize a facility to serve mentally ill persons under Rule 36 as well as another disability group, such as mentally retarded under Rule 34.

The first real signs of trouble arose soon after the licensing program got under way. Three facilities--Andrew Care Home, Birchwood Care Home, and Hoikka House--were informed that since regulations prohibited the use of Medicaid money in "institutions for mental diseases," they could no longer receive such funds. Federal administrators declared that a Rule 36 license was prima facie evidence that a facility was such an institution.[1] In addition, federal regulations specified that persons who reside in "institutions for mental diseases" cannot receive Medicaid reimbursement for services rendered elsewhere, such as in hospitals or private psychologists' offices. However, persons in the three facilities were permitted to continue receiving Medicaid benefits for services off the premises pending the outcome of an administrative appeal on the facility disallowance. In the meantime, DPW suspended the licensing program for all facilities but those specifically requesting licensure. To do otherwise, DPW officials now contend, would have seriously crippled the

[1]For a further discussion of the funding situation, see Chapter V.

ability of facilities to acquire the public funding they needed to operate. Since there was little state money available to replace the anticipated loss of Medicaid funds, DPW officials decided against actively enforcing the licensing law (and Rule 36) in order not to risk the loss of federal support.

We have found that:

- despite the department's claim that Medicaid funding has created problems for the Rule 36 licensing program, DPW has not determined how many facilities or individuals would be affected if Medicaid funds were denied to facilities licensed under Rule 36. In fact, as we demonstrate in Chapter VI, there may be as many as 50 facilities whose funding would be unaffected by licensure.

Some Medicaid money is currently being used for mentally ill persons in facilities eligible for licensure.[1] However, DPW has not undertaken to determine which, or even how many, facilities eligible for licensure may be in this funding quandary.

Moreover, we have found that:

- DPW has not directly addressed the funding problem that it claims is an obstacle to licensing. While it has recently requested $4.9 million for FY 1981-83 to cover increased programming costs imposed by licensure under Rule 36, it has specified in its legislative proposal that these proposed funds will not be used to replace those Medicaid funds which may be lost upon facility licensure. Therefore, even if the Legislature approves the department's funding request, the Medicaid dilemma will remain.

Finally, we have found that:

- the department has not undertaken, in lieu of active licensing, to monitor existing residential facilities serving the mentally ill.

The department cannot provide accurate and comprehensive information regarding the number of residential facilities which serve the mentally ill in Minnesota, where they are, how many persons reside in such facilities, what programs for the mentally ill are operating, what physical conditions exist, and whether the laws and administrative rules governing the operation of such facilities are being observed. During the summer of 1980, however, the department produced a "resource directory" containing names, addresses, and other information about many residential and nonresidential facilities which provide

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[1] In addition, most nursing homes depend heavily on Medicaid.

services to the mentally ill in Minnesota. While not comprehensive, this directory represents a significant first step in establishing a meaningful monitoring program. It also should be of interest to agencies involved in referring persons needing services. In addition, the data subcommittee of the Task Force to Revise Rule 36 produced a report in mid-1980 which summarized the department's information on types of facilities, levels of care, and numbers of mentally ill persons. This effort has been of considerable help to the department in establishing the level of need for services throughout the state. However, it is not currently part of an ongoing monitoring program. In Chapter VI we summarize the results of our own investigation of these matters.

2. RECOMMENDATIONS

Presumably, a fully operational licensing program would provide DPW with detailed information about the state's residential care system and would enable the department to fulfill its statutory obligation to oversee the operation of residential facilities for the mentally ill. But the obstacles to a comprehensive licensing program--however insurmountable they may seem in a practical sense--do not preclude other activities by which the department could comply with the spirit of the statutory licensing requirement.

We think that:

- an ongoing monitoring program could help DPW ascertain whether minimum standards were being observed while the problems connected with funding and licensing were being resolved. We recommend such a program--perhaps an extension of the resources directory described above--to locate and monitor those facilities which DPW may ascertain are eligible for licensure under Rule 36.

A more serious problem, of course, is the nearly dormant licensing program itself. While the Medicaid funding problems are real, we do not think that they affect all--or even a majority--of the facilities which are eligible for licensure. However, should DPW proceed to license only those facilities unaffected by the Medicaid quandary, its treatment of facilities would be inequitable under the current law. In any case, DPW would still not be in full formal compliance with the law.

Ultimately, in our opinion:

- a solution must be found for the funding dilemma or the state's licensing program for facilities serving the mentally ill must be abandoned as unworkable.

To find an acceptable solution is, naturally, more difficult than discovering that a problem exists. However, a way to fund those individuals and facilities which will be rendered ineligible for Medicaid must be found. Additional money may come from new or expanded state or federal programs which specifically target the mentally ill in

residential settings. Alternatively, it may be obtained from existing funding programs--such as the Title XX, "Social Services," program. There is some evidence that licensed facilities have been successful in obtaining Title XX funds.[1] However, some problems connected with the use of Title XX funds are discussed in Chapter V.

In any case,

- we think the problem should be resolved this year. There have been too many delays in DPW's licensing program. It was nearly five years after the first licensing law was passed before the first license was awarded. Five more years have passed while DPW has tried to sort out the problems related to funding.

The department needs to bring this issue before the Legislature and develop a workable solution to reconcile the state's licensing program with the realities of facility funding.

In order to provide an interim solution:

- we recommend legislation which would empower the Commissioner of DPW to waive for a specified limited period the licensing requirement for any facility which he thinks may be adversely affected in its ability to attract needed funds for its regular operation.

The department then could proceed to render assistance to those facilities in order to find a substitute source of funding. In the meantime, facilities without funding problems could be licensed by the department under the existing licensing program.

C. THE NATURE OF DPW'S LICENSING PROGRAM

Because of DPW's relative inactivity, the department's licensing program lacks a "track record" of sufficient length to permit a normal program evaluation. Nevertheless, in this section we attempt to outline the nature of the licensing program, insofar as it exists, and make suggestions for its improvement.

1. THE LICENSING PROCESS: AN OVERVIEW

The Public Welfare Licensing Act provides only a sketchy guide as to the process of licensing facilities for the mentally ill:

> Application for license . . . shall be made in the manner . . . the commissioner prescribes. The commissioner shall offer consultation, assistance

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[1] See Chapter VI.

> and information to all applicants including information regarding regulations and requirements of other state agencies and departments which affect the applicant, and shall assist applicants and operators to meet and maintain requirements for licensure . . .. Failure of the commissioner to approve or deny an application within 90 days of receipt of a completed application shall be deemed to be an approval of license . . .. In exercising the powers of licensing . . . the commissioner shall study and evaluate operators and applicants for a license . . .. Authorized representatives of the commissioner may visit a residential facility . . . at any time during the hours of operation for purposes of the study and inspection.

Rule 36 is even less explicit:

> Prior to the issuance of a license or provisional license, the following steps shall be completed: (a) The need for the program shall be determined under Area Board coordination . . ., (b) A completed application shall be submitted to the Commissioner, (c) A written report with recommendations about licensing or not licensing the prospective program shall be submitted to the Commissioner by the review team, (d) The fee for license shall be paid . . ..

However, given these guidelines, DPW's licensing process generally fulfills the letter, if not always the spirit, of the licensing law and Rule 36. DPW has developed a Rule 36 licensing process which is similar to that used for other residential facilities licensed by the department. The sequence varies and few Rule 36 applications have moved beyond the initial steps; however, an application which results in licensure would generally follow these steps:

- Upon request from a prospective applicant, DPW mails an information packet which includes a copy of the rule, application instructions, forms, and the name of the assigned licensing consultant.

- The applicant makes the initial contact with the licensing consultant after receiving the information packet or by mailing back the application form. Upon initial contact, the licensing consultant points out the continuing funding uncertainties for Rule 36 facilities (discussed above and in Chapter V). He also mentions the required MDH license and indicates that clearance is needed from the State Fire Marshal (SFM), building code authorities, and local zoning authorities. Finally, he recommends contact with the local mental health board for endorsement of need.

- When DPW receives an application the licensing consultant informs the MDH, SFM, and local zoning authority of that fact by means of form letters. DPW licensing and program staffs begin their review of the application, including an on-site inspection to determine compliance with various requirements.

- MDH notifies DPW that an applicant has been cleared for facility licensure, including SFM and building code clearance. If the local zoning authority does not otherwise act within 30 days, DPW assumes that the applicant meets all applicable zoning requirements (discussed in the following chapter). DPW no longer uses local review teams although they are specified in Rule 36, and it does not make area mental health board endorsement a necessary condition for licensure, as noted previously.

- When DPW receives notification of MDH licensure, and when the local zoning authority has not objected within the 30 days provided, and when DPW licensing and program staff recommend approval, then DPW issues a license. The license states provisions or limitations where applicable and identifies the operator's name, the facility's location, and the authorized number of residents. A license fee of $150 is paid.

2. RECOMMENDATIONS

While these procedures are in general compliance with the law and the rule, we think there is room for improvement. Specific problems which deserve attention include the following:

First, an interested facility, and not DPW, initiates the process by requesting licensing information. Facilities which choose not to contact DPW continue to operate without the license required by statutes and administrative rule. The voluntary, response-oriented nature of DPW's licensing process contributes to the inadequate licensing record achieved under Rule 36, as discussed in the previous section. Therefore,

- we think DPW should actively seek out those facilities which are eligible for licensure and initiate the licensing process.

Clerical staff in the licensing office record only the total number of licensing information packets mailed out, without regard to whether the inquiry was from a facility for the mentally ill or another disability group. To aid in record keeping,

- we recommend a simple log entry to record which rule is involved, to provide useful subtotals.

Third, the form letter with which DPW informs the local zoning authority that the department has received an application is

inadequate, primarily because it does not provide sufficient information regarding state law and local responsibilities, as discussed in the following chapter. So that legal responsibilities are clearer,

- we think this form letter should include at least a summary of the zoning requirements in state law which are applicable to residential facilities for the mentally ill.[1]

Fourth, DPW has not complied with the requirements in Rule 36 which pertain to Area Boards and review teams. As noted above, DPW has not issued guidelines pertaining to the role of Area Boards in determining need, and it does not require Area Board endorsement as a necessary condition for licensure. Rule 36 requires the commissioner to appoint a review team of at least five persons, staffed by DPW, to examine applications for licensure and submit written recommendations to the commissioner. DPW made limited use of review teams in the earliest phases of the Rule 36 licensing program. However, the department discontinued using review teams, largely on grounds that orienting review team members required excessive DPW staff time, and from a general concern about "licensing by committee." Therefore,

- if DPW considers these aspects of the current rule unworkable or counterproductive we think DPW staff should propose changes in the rule.

Finally, regarding the requirement in the law that DPW approve or reject a completed application within 90 days, the department rather arbitrarily considers an application complete only when all clearances from other agencies have been submitted to DPW. Therefore, the time between the initial submission of an application, and ultimate licensure or denial, can require considerably longer than the 90 days which the statute would imply as a limit. We recommend that:

- as the lead agency in the licensing process, DPW should assume responsibility to ensure that the entire licensing process is completed within 90 days as required by law.

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[1] See Chapter IV.

IV. ZONING AND THE LOCATION OF RESIDENTIAL FACILITIES FOR THE MENTALLY ILL

A certain amount of controversy has arisen in some communities over the issue of overconcentration of residential facilities for the mentally ill and other disabled persons. In this chapter we examine the legal provisions regulating the location of new residential facilities and the manner in which DPW and local authorities have responded to those provisions.

A. LEGAL REQUIREMENTS

The 1976 Public Welfare Licensing Act places clear limits on DPW in its ability to newly license residential facilities which are located close to already existing facilities:

> No license . . . shall be granted when the issuance of the license would substantially contribute to the excessive concentration of residential facilities within any town, municipality or county of the state . . . under no circumstances may the commissioner newly license any group residential facility pursuant to this act if such residential facility will be within 1,320 feet of any existing community residential facility unless the appropriate town, municipality or county zoning authority grants the facility a conditional use or special use permit.[1]

The key provisions of the law are as follows:

- DPW may not grant a license which would contribute to the excessive concentration of residential facilities in a given area.
- The term "residential facility" here applies only to those facilities under the jurisdiction of DPW, hence excluding any facilities regulated only by the departments of Health, Education, and Corrections.
- To determine excessive concentration, DPW is to consider the population and size of the community, the number and size of public and private community residential facilities already in the area, and several other factors.

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[1] Minn. Laws (1976), ch. 243.

- With limited exceptions, DPW may not license a residential facility which is within 1,320 feet (one-quarter mile) of existing residential facilities, unless the local zoning authority issues a conditional use or special use permit.

- By statute, a licensed residential facility serving six or fewer persons is "considered a permitted single family residential use of property for the purposes of zoning." And unless otherwise provided in local zoning ordinances, a licensed facility serving more than six and less than 17 persons is a permitted multi-family use of property.

- Zoning authorities may require a permit to assure proper maintenance and operation of a facility. Except for those necessary to protect the health and safety of the residents of the facility, no conditions may be imposed which are more restrictive than those applied to other conditional or special uses of property in the same zone.

The 1980 Legislature added to the law the provision that the 1,320 foot distance requirement applies to all licensed residential facilities in cities of the first class. The only facilities excluded from the 1,320 foot requirement are foster family homes. These changes in the law were made in response to concerns expressed over facilities in Minneapolis being located close to one another but exempted from regulation because they served six or fewer residents. The general exemption for facilities serving six or fewer persons continues to apply throughout the rest of the state.

B. COMPLIANCE AND MONITORING

This section examines the extent to which DPW is in compliance with current legal requirements and describes local activities relating to the placement of facilities for the mentally ill. As we indicated in the last chapter, DPW routinely notifies the local zoning authority that an application for a Rule 36 license has been received. Unless notified to the contrary within 30 days, DPW assumes that there is no local objection to the application and that spacing requirements in state law have been met. However, we have found that:

- DPW does not inform local authorities of the current statutory provisions relating to the location of proposed facilities, does not determine how well local zoning procedures respond to the requirements of state law, and does not monitor the spacing of residential facilities.

Therefore, DPW in effect, has delegated its responsibility without notification to local authorities.

In order to determine whether monitoring of the 1,320 foot spacing requirement occurs at the local level, we contacted city planning departments in St. Paul, Minneapolis, Duluth, Rochester and St. Cloud. Among these cities we found that some zoning authority

employees were unaware of the spacing requirements in state law. Others knew about those requirements but considered them the responsibility of the state to monitor.

1. ST. PAUL

The City of St. Paul has developed a conditional use permit process which requires minimum distances between residential facilities. St. Paul has required a 1,320 foot distance between facilities for the past five years. City planning staff have mapped the location of existing facilities and have monitored proposed locations of new facilities.

The St. Paul zoning ordinance was amended in 1980 to make it consistent with recent changes in state legislation and to reflect concerns expressed by neighborhood residents and facility operators. This ordinance incorporates the state's provision permitting single family use for facilities of six or fewer persons. It also specifies permitted uses in all other zoning districts and attaches certain conditions to these uses, such as off-street parking requirements, lot size, and number of residents allowed. The recent amendments revised the definition of "community residential facility" to include some facilities not regulated by the Public Welfare Licensing Act. This includes correctional facilities and room and board houses recognized by the county as "resources, eligible for public reimbursement, or for providing residential services to persons who are mentally ill or chemically dependent."

The distance requirements of St. Paul's zoning ordinance apply only to facilities which were established within the past five years, after these requirements took effect. However, facilities established more than five years ago were not subjected to any local spacing requirement. Therefore, should DPW begin to enforce Rule 36 and to license residential facilities, facilities established more than five years ago would be subject for the first time to the state spacing requirement. A facility within 1,320 feet of another facility would need to obtain a special use permit from the City of St. Paul before DPW would give them a license. The Ramsey County Community Human Services Planning Department has prepared a map showing the exact location of all community residential facilities. The majority of Ramsey County's residential facilities are located in the Summit-University and Crocus Hill areas. A study of the department's map shows that approximately 15 facilities serving mentally ill persons--most of which do not have conditional use permits--are within 1,320 feet of some other community residential facility. According to city planning staff members, the City Planning Commission would probably grant these facilities conditional use permits to avoid undue hardship, unless there were complaints raised by neighborhood residents. It is difficult to predict the effect Rule 36 enforcement would have on facilities in St. Paul because the issue has not yet been brought to the attention of the City Planning Commission.

Acceptance of these facilities by neighborhood residents could determine whether they will be granted conditional use permits. Therefore, in St. Paul newer facilities do meet the state spacing requirement although facilities more than five years old may not.

2. MINNEAPOLIS

The Minneapolis zoning code specifically regulates "group homes" and requires a conditional use permit if they house seven or more residents and meet at least one of the following conditions:

- program staff are on the premises;
- funding goes to the organization, not the client;
- transportation is arranged or provided for residents; or
- at least some of the residents are in the facility during the day.

However, many facilities such as board and lodging homes may not meet these conditions and therefore are not regulated under the Minneapolis zoning code.

In order to receive a conditional use permit, group homes must meet the following criteria:

- one-half mile spacing between facilities;
- one parking space per staff member, plus additional spaces as required by the City Council; and
- periodic public reviews by the City Council and City Planning Commission.[1]

Exceptions to the one-half mile spacing requirement may be granted by the City Council when:

- program effectiveness is closely tied to cultural resources in a community;
- two programs would be effectively separated by a natural or man-made barrier; or
- there is strong neighborhood support for the facility.[2]

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[1]Minneapolis City Planning Department, Community-Based Residential Facilities in Minneapolis, (December 1980), p. 7.

[2]Minneapolis Zoning Code: Requirements for Social Welfare Facilities, §538.140(8).

Should Rule 36 licensing begin, many facilities in Minneapolis would be required to obtain conditional use permits because they do not meet the spacing requirements set by state law. Of the 43 boarding care or board and lodging facilities which serve the mentally ill in Minneapolis, 40 are within the one-half mile limit set by the City of Minneapolis and 33 are within the one-quarter mile limit set by the state. Since few of these facilities are covered by the Minneapolis zoning code, few have current conditional use permits. Most residential facilities serving the mentally ill in the city are in the Powderhorn Planning District.

These facilities would be subject for the first time to the state spacing requirement should DPW begin to enforce Rule 36. According to a Minneapolis Planning Department study, facilities for the mentally ill are more often the subject of neighborhood complaints than other types of facilities and may therefore encounter difficulties in obtaining conditional use permits.

3. DULUTH

In Duluth, there is no monitoring of the concentration of facilities by planning and zoning officials. Inspections are made for building and housing code compliance, and the city attorney reviews the facility's plans to ensure compliance with zoning regulations. Duluth has not set up any specific process for granting special or conditional use permits to residential facilities. The city planning department assumes that the state is monitoring the spacing requirements of the licensing law.

4. ROCHESTER

The City of Rochester has developed specific procedures for permitting facilities to locate in the various zoning districts. The city requires all residential facilities to obtain a conditional use permit, regardless of where they are located. The City Planning Commission's policy is to grant this permit if certain minimal conditions are met, such as lot size and building setback. The question of distance from other facilities is not considered in the process. City planning officials assume that the state is monitoring its law requiring the 1,320 foot spacing. If a facility does not meet the requirements for a conditional use permit, a more thorough review is made through a "planned unit development" process. This process involves four public hearings and encourages neighborhood participation. The decision to grant or deny exceptions to zoning regulations is based on this review process, and the city may attach special conditions to approvals of these exceptions. Again, in this process compliance with the state law is not monitored by the local government.

5. ST. CLOUD

In St. Cloud, city planning officials closely monitor the location of residential facilities. They have mapped the location of

existing facilities and are actively attempting to prevent overconcentration. However, staff members of the Planning Department were not aware of the 1980 legislation which requires facilities for the mentally retarded to meet the 1,320 foot spacing requirement. They were monitoring the location of these facilities on the basis of the earlier legislation, which required only a 300 foot distance between facilities for the mentally retarded. This change in state law could affect zoning decisions in St. Cloud because two facilities for the mentally retarded have recently been sited there over the opposition of neighborhood groups. Staff members of the City Planning Department explained to us that they thought it was the responsibility of state officials to notify them when changes were made in state laws affecting zoning of residential facilities.

C. CONCLUSIONS

In summary, DPW has neither enforced state spacing requirements nor monitored local zoning activities. DPW has, in effect, delegated to local authorities all responsibility for implementing the spacing requirements contained in state law. DPW has done so without formal notice specifying the requirements of state law or the specific responsibilities of local zoning authorities. The only communication between DPW and the local zoning authority is the form letter by which DPW gives notice that a facility has applied for a Rule 36 license. If DPW receives no response from the local authority, the department assumes that the spacing requirement has been met and that its responsibility has been fulfilled. However, we believe that:

- DPW is not free of its responsibility to determine if a facility is within 1,320 feet of another facility until the local authority informs DPW that a conditional use permit has been issued.

As we discussed above, local zoning activities vary considerably. Although some cities have no spacing requirements pertaining to residential facilities, others require specific minimum distances and conditional use permits for every facility. Local zoning authorities are not always aware of the requirements of state law in this area, and often assume that the state is monitoring compliance with its own licensing statutes. In addition, issuance of a conditional use permit fulfills only the procedural requirements of state law, but provides no assurance that facilities are not, in fact, overconcentrated.

Given the assumptions made by state and local officials that some other governmental unit is monitoring the spacing requirement, we have found that Rule 36 licenses may be issued with no attention to the issue of overconcentration. The intention of the Legislature to prevent excessive concentration of residential facilities, therefore, has not been effectively implemented due to confusion regarding state and local responsibilities.

The location and zoning requirements pose a potential "Catch-22" licensing problem. These requirements are a part of the licensing process. However, because DPW has not actively enforced Rule 36, many residential facilities are operating without licenses, and therefore with no state enforcement of the law regarding facility concentration. Should DPW begin to enforce Rule 36, it is possible that facilities which have been operating without a license could be unable to obtain a license if they are located within one-quarter mile of another residential facility and are unable to obtain a conditional use permit from the local zoning authority. Since, as we have suggested, the concentration which state law seeks to control may already have occurred, difficult choices may have to be made when Rule 36 enforcement begins.

In an attempt to prevent zoning problems for existing residential facilities, DPW is now proposing changes in the Public Welfare Licensing Act as part of a bill authorizing grants to counties for Rule 36 facilities. Subdivision 4 of this bill proposes to amend Minn. Stat. §245.812 by adding a subdivision as follows:

> Subd. 7. Residential facilities for the adult mentally ill established on or before July 1, 1980 shall be exempt from the requirements of this section for a period not to exceed three years. The Commissioner shall develop a mechanism for ensuring full compliance with this section by residential facilities for the adult mentally ill by July 1, 1984.

In effect, DPW has recognized the licensing problem which Rule 36 enforcement could create.

V. FUNDING ISSUES

As we have suggested, funding issues are central to the problem of licensing facilities for the mentally ill. They are important in understanding the factors which encourage and inhibit deinstitutionalization. They are important, too, in understanding some of the frustrations experienced by DPW in trying to implement the Rule 36 licensing program. In this chapter, we examine these money-related issues. We describe current funding mechanisms, explore the financial incentives at work, and examine the difficulties in the use of Medicaid and Title XX, "Social Services," funds for persons in facilities for the mentally ill. Although it was not a goal of our study to determine the adequacy of current or potential funding for persons in residential facilities for the mentally ill, this brief discussion may help to inform such a debate.

A. CURRENT FUNDING MECHANISMS

In addition to using money from their own families and from their own personal resources, persons in residential facilities for the mentally ill currently rely on a multitude of public funding sources. Unlike persons who have other disabilities, such as chemical dependency or mental retardation, however, the mentally ill have not been able to qualify for many funding programs. To the extent possible, they have depended on general purpose entitlement programs, such as those which make up the federal Social Security program. Among the most important sources of general purpose funds which can be used to support mentally ill persons in residential facilities are:

- Social Security (OASDI)--federal payments to the elderly, disabled, or survivors of insured persons, based on individual earnings history; Title II of the Social Security Act.

- Supplemental Security Income (SSI)--federal payments to low income elderly and disabled persons; Title XVI of the Social Security Act.

- Medicare--federal health insurance for elderly and certain disabled persons; Title XVIII of the Social Security Act.

- Medicaid (Medical Assistance)--health coverage provided to low income persons, supported from federal, state, and county funds; Title XIX of the Social Security Act.

- Social Services (Title XX)--federal funds for authorized social services in categories designated by federal or state regulations; Title XX of the Social Security Act.

- Minnesota Supplemental Aid (MSA)--payments to supplement SSI funds for low income elderly and disabled persons, supported from state and county funds.

- General Assistance (GA)--payments to low income persons who do not qualify for any of the programs authorized by the federal government; supported from state and county funds.

- General Assistance Medical Care (GAMC)--health coverage for low income persons not eligible for other health care programs; supported from state and county funds.

To support persons who receive care for mental illness in residential facilities, a funding "package" is put together--usually by the county welfare office where the person resides--drawing upon these and other resources. The specific elements in this package are determined by the type of facility and by the individual's eligibility to receive various monies.

Each program has restrictions governing type, length, and amount of benefit provided as specified in its regulations. Persons requiring health care present to the provider their proof of eligibility for health coverage under Medicare, Medicaid, or GAMC. The responsible federal, state, or county agency reimburses the provider for services. To receive Medicare or Medicaid reimbursement a facility must be certified to provide medical services, ranging from nursing care in boarding care and nursing homes, to acute care in general hospitals. Long-term residents in medically-oriented facilities who have some personal source of income generally pay part of the cost of care themselves but the bulk of the cost in these settings (e.g., boarding care, and nursing homes) typically is paid by Medicare, Medicaid, or GAMC.

Title XX funds are paid to facilities by counties for program or treatment costs for eligible recipients. Federal regulations prohibit use of Title XX funds for room and board costs. Social Security and SSI cash grants are mailed to eligible persons from regional federal offices; MSA and GA cash grants are mailed to eligible persons by counties. These cash grants are intended to cover basic living needs, including room and board and other services in residential facilities.

State cash grant programs generally do not pay for mental health programming in residential facilities. MSA and GA are significant sources of funding for many persons in community-based facilities which are ineligible for federal Medicaid funding. However, regulations for these two programs allow payment only for basic maintenance needs such as food, shelter, clothing, and personal needs but do not include medical care or mental health program services.

A close examination of state funds appropriated to support mental health programming in non-medical residential facilities leads us

to the conclusion that such monies have been piecemeal, temporary, or experimental in nature. Recent examples include the following:

- Rule 14--The Community Social Services Act included "an experimental statewide program to assist counties in providing services to chronically mentally ill persons," and appropriated $2 million for this purpose.[1] To implement this program, DPW promulgated a temporary rule--Rule 14--effective December 27, 1979 to govern grant applications and the approval and allocation of grants. Twenty-nine programs were funded, including seven residential programs, and services included community support, day treatment, crisis homes and safe houses, and socialization programs. DPW requested $6 million for 1981-83 to continue current projects and fund new projects under Rule 14. The department has recently issued an evaluation report on this program.

- Rule 21--In 1976 the Legislature authorized Dakota, Washington, and Ramsey counties to establish non-residential pilot programs to rehabilitate mentally ill persons, and appropriated $350,000 for this purpose.[2] To implement this legislation DPW promulgated Rule 21, effective October 24, 1976. The program known as "Sharing Life in the Community" (SLIC) resulted. SLIC essentially provided intensive counseling and support services to help persons who were discharged from state hospitals remain in the community. Although Rule 21 pertains to non-residential services it is relevant here because the authorizing legislation emphasizes enabling persons who might otherwise be hospitalized to live independently in the community. DPW has proposed termination of this appropriation at the beginning of the 1981-83 biennium as part of its overall plan to discontinue categorical funding programs and to increase Community Social Services block grants to the counties. DPW recommends that counties continue to fund this program from the block grants.

- Rule 22--DPW promulgated Rule 22, effective October 24, 1976 to govern the use of funds appropriated for deinstitutionalization. The original appropriation was targeted to the area formerly served by Hastings State Hospital (Ramsey, Dakota, and Washington counties), which was closed in 1978. Subsequent appropriations were designated for statewide use. For FY 1981, grants totaling $898,000 were awarded to 11 community programs, including five residential programs. Examples of services funded include day treatment, crisis intervention, vocational training, and halfway houses. DPW has proposed ending this separate appropriation at the conclusion of the current biennium.

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[1]Minn. Laws (1979), ch. 324.

[2]Minn. Laws (1976), ch. 327.

Programs could be continued if counties chose to fund them with their Community Social Services block grants. DPW recommends this.

- Rule 36--Although no funds have been appropriated yet to implement Rule 36, DPW has requested $4.9 million for the 1981-83 biennium. According to the request, these funds would be available to ensure that mentally ill persons in licensed facilities are "provided with treatment and training in the independent living skills necessary to function in society."

This review suggests the complexity and fragmented nature of state and federal funding programs covering residential services for the mentally ill.

B. FINANCIAL INCENTIVES IN MAKING REFERRALS

It is important to recognize the role of the county welfare office in making placement decisions regarding the mentally ill. The state's Hospitalization and Commitment Act specifies that counties will--after consulting with physicians and community mental health personnel--draw up discharge plans for persons leaving state hospitals. For other persons who have not been in state hospitals, county welfare offices commonly take the responsibility for referrals, particularly when welfare funding of the kind described above is required. This responsibility exercised by counties is generally endorsed by the state's Community Social Services Act.[1]

Some counties have a philosophy of using community-based care whenever possible. This philosophy is consistent, of course, with state policy regarding deinstitutionalization and placement of mentally ill persons in the least restrictive setting suitable for the individual. In addition, placement decisions are affected by the availability of space in specific facilities. However, our study of the funding patterns for residential facilities and of the financial role of the county in providing funding has led us to the conclusion that counties have a clear financial incentive to place mentally ill persons in state hospitals, not community-based facilities. The county share of costs to support persons in state hospitals is fixed at a miniscule level while its share for persons in community-based facilities is sometimes substantial. Table 5 illustrates typical funding patterns for care for eligible mentally ill persons in different types of facilities. Although the data cited in the table are accurate only for the specific facilities selected, we have found these patterns to be typical.

Current Minnesota law fixes at $10 per month the charge to counties for state hospital care received by their residents.[2] This

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[1]See Chapter II, pp. 23-24.

[2]Minn. Stat. (1978), ch. 246, §54.

TABLE 5

SOURCES OF PUBLIC PAYMENT FOR RESIDENTIAL CARE OF MENTALLY ILL PERSONS FOR SELECTED FACILITIES[a]

TYPE OF FACILITY	State Hospital	Psychiatric Unit General Hospital	Supervised Living Facility	Nursing Home	Boarding Care	Board and Lodging
FACILITY NAME	Anoka State Hospital	Hennepin County Medical Center	Wellspring Therapeutic Communities	Willows Central Nursing Home	Andrew Care Home	Hennepin County Level II Facilities
TOTAL COST PER PERSON PER DAY	$ 74.05	$199.95	$ 27.70	$ 40.00	$ 32.21	$ 9.03
FEDERAL SHARE (% of total)	--	$111.25[b] (55.7%)[b]	--	$ 22.26[b] (55.7%)[b]	$ 6.93[c] (21.5%)[c]	--
STATE SHARE (% of total)	$ 73.72 (99.6%)	$ 79.82[b] (39.9%)[b]	$ 22.86[e] (82.5%)[e]	$ 15.97[b] (39.9%)[b]	$ 20.22[c] (62.8%)[c]	$ 6.32[d] (70.0%)
COUNTY SHARE (% of total)	$ .33[f] (0.4%)[f]	$ 8.88[b] (4.4%)[b]	$ 4.84[e] (17.5%)[e]	$ 1.77[b] (4.4%)[b]	$ 5.06[c] (15.7%)[c]	$ 2.71[d] (30.0%)[d]

[a]Although the examples in this table are typical, actual amounts paid may vary because rates vary between facilities, counties, etc., for each category; and, because different clients in a facility may be eligible for different funding sources. For example, the boarding care example assumes only SSI/MSA funding and the board and lodging example assumes only GA funding; the cases could be reversed or mixed which would change the relative shares and percentages of the total cost accordingly. Also, the figures assume that clients have no income to contribute, other than SSI/MSA or GA which they may receive. Per diem costs do not include expenses for outpatient care.

[b]Denotes use of Medicaid, and reflects the current 55.7 percent federal, 39.9 percent state, and 4.4 percent county Medicaid funding shares.

[c]Denotes use of maximum SSI and MSA for the balance; effective January 1, 1981 MSA is 80 percent state and 20 percent county funded; actual amounts and percentages may vary in accord with note (a).

[d]Denotes use of GA only; effective January 1, 1981 GA is 70 percent state and 30 percent county funded; actual amounts and percentages may vary in accord with note (a).

[e]Denotes use of GA for room and board costs and state experimental grant funding under DPW Rule 14 for the program costs; actual amounts and percentages may vary in accord with note (a). Most of the state's share would be borne by the county in the absence of the Rule 14 funds.

[f]Minn. Stat. §246.54 requires that counties pay $10 per month for their residents in state hospitals.

amount is less than one percent of the total cost per capita (which exceeds $2,200 monthly). Virtually all of these costs, then, are paid by the state. Moreover, DPW does not even bill counties for this $10 monthly payment because billing costs may exceed the revenues which the state would recover. This practice makes state hospital placement even more attractive to counties. In contrast, the county share of nursing home costs in our example approximates $53 per month, or more than five times the county cost of state hospital placement. Similarly, county costs for board and lodging, boarding care, and supervised living facility placements are substantially higher than county costs for state hospital placements. Of course, comparisons of county costs must take into account the likely length of stay in different types of facilities.

The department has drafted legislation for consideration during the 1981 session to decrease financial incentives which presently encourage county referrals to state hospitals. This legislation would remove the statutory $10 monthly charge to counties for each state hospital placement, requiring instead that counties pay 10 percent of the real per capita rate for such placements. Referring to Table 5, this change would increase county costs under the Anoka State Hospital example from 33¢ per day to $7.40 per day at the current daily rate.

C. FEDERAL FUNDING ISSUES

1. MEDICAID

As we have indicated, federal regulations severely limit the use of Medicaid funds for the mentally ill. Medicaid funds are specifically prohibited to persons who are "inmates of public institutions," including state hospitals, and to "individuals under age 65 who are patients in an institution for tuberculosis or mental diseases unless they are under age 22 and are receiving inpatient psychiatric services." An institution for mental diseases is defined in regulations as one that,

> is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.[1]

These regulations, however, remain unclear and federal authorities have attempted to clarify their meaning. In internal memos from 1975 and 1976, the Department of Health, Education and

[1] U.S. Code, Title 42, ch. 4, §435.1008 and §435.1009.

Welfare specified that an institution is characterized as "primarily" one for mental diseases if:

- it is licensed as such;
- it is advertised as such;
- more than 50 percent of the patients have a diagnosis of mental disease;
- it is used by mental hospitals for alternative care;
- it accepts patients directly from the community who could have entered a mental hospital;
- it is within 25 miles of a state mental institution;
- its patients show an age distribution uncharacteristic of nursing home patients; or
- the basis for Medicaid eligibility for patients under age 65 is due to mental disability.[1]

In a 1978 letter to DPW, the Regional Medicaid office confirmed that this description included "nursing homes which were recently or are now licensed under Minnesota DPW Rule 36 . . .."[2] However, these clarifications, while helpful, do not have the legal force of regulations and many of these points are being challenged by affected parties around the country.

The regulations themselves do apparently preclude the use of Medicaid funds on behalf of persons aged 22 to 65 who reside in "institutions for mental diseases" [IMDs], even though they may receive otherwise reimbursable services outside the IMD. Therefore, federal Medicaid funding for services in a residential facility is jeopardized when that facility is judged to be an IMD. In addition, Medicaid funds used by persons who reside in IMDs is jeopardized even though the service itself is delivered by a certified vendor. In no case, however, are Medicaid funds in jeopardy for persons aged 65 or over.

In 1979 HEW disallowed federal Medicaid participation for services in three Minnesota residential facilities which HEW determined to be IMDs. In early 1977 Andrew Care Home in Minneapolis had appealed to HEW an adverse decision by DPW regarding certain per diem payments. This appeal and HEW's investigation resulted in the federal agency's recognition that Medicaid funds were being used by

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[1] HEW Field Staff Information and Instruction Series [FSIIS] #76-44 (November 7, 1975) and #79-97 (May 3, 1976).

[2] Letter from Regional Medicaid Director Bryant to DPW Assistant Commissioner Baird (January 18, 1978).

Andrew Care Home and other residential facilities considered ineligible according to Medicaid regulations. In correspondence with both regional and national HEW offices, DPW disputed HEW's finding of Medicaid ineligibility for Andrew Care Home, Birchwood Care Home, and Hoikka House. DPW's position included the argument that HEW "had never notified states of the criteria to be used in determining what constituted a facility for the treatment of mental illness."[1]

On December 29, 1977 Andrew Care Home notified DPW that it wished "to voluntarily withdraw from the Minnesota Department of Public Welfare Rule 36 licensure program" and that the sole reason was "to protect its funding under the Medical Assistance Program." Birchwood Care Home chose not to renew its Rule 36 license when its initial license expired in February 1978. Hoikka House withdrew its Rule 36 application during the same period. Nevertheless, HEW verbally notified DPW in February 1978 of a forthcoming disallowance and notified DPW in correspondence dated February 5, 1979 and April 3, 1979 that a total of $896,000 of federal financial participation was disallowed for services provided by these three facilities during the period of July 1, 1977 through September 30, 1978. Following verbal notification from HEW, DPW notified Hennepin and Ramsey counties in March 1978 that state participation in Medicaid payments to these facilities would end, effective July 1, 1978. However, DPW diverted $57,129 to Ramsey County and $263,704 to Hennepin County from "deinstitutionalization" funds appropriated under Rule 22 (see above). DPW provided these funds to reimburse Ramsey and Hennepin counties for the higher costs of having to use funding requiring higher county participation (i.e., MSA and GA) to replace lost Medicaid funding. DPW made these special payments from FY 1978 and 1979 appropriations, and no further payments were made from this source for this purpose after fiscal year 1979.

DPW has challenged HEW's action and the issue is still awaiting a decision by HEW's (now Health and Human Services) Departmental Grant Appeals Board. Possible outcomes of this challenge include federal repayment of the disallowed amounts, or a more thorough survey by federal authorities to determine whether other Minnesota facilities are receiving Medicaid funding for services which are not covered.

In the meantime, DPW has taken the position that it will not fund any Rule 36 facilities from Medicaid because of the risk of future federal disallowances. In addition, DPW has claimed that these funding difficulties preclude the effective operation of its Rule 36 licensing program and, as a result, it has virtually suspended all licensing of facilities for the mentally ill.

A possible solution being considered by DPW involves Medicaid regulations which authorize federal financial participation for "personal care services" prescribed by a physician. These services are intended to prevent inappropriate institutionalization, and may include health care services (including help with medications and

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[1]Letter from DPW Deputy Commissioner Hiniker to Ramsey County Welfare Department Director Edmunds (March 2, 1978).

specialized physical activities), self-care services (including bathing and dressing), support and safety services (including laundering and financial management), and community support services (including transportation). In order for persons in residential facilities to be covered, the services must be provided by persons not on the facility's staff. The DPW subcommittee investigating funding problems associated with Rule 36 has expressed in a draft report its belief that "the personal care provisions of the federal Medical Assistance program allow sufficient room for state initiative and development of programming for services to clients in Rule 36 facilities." New York has apparently implemented one version of this approach.

Finally, a change in regulations may authorize federal financial participation for services for persons who can be defined to be "developmentally disabled" because their mental illness initially occurred prior to adulthood. Other states have explored this approach to fund services for mentally ill children. The personal care services and developmental disabilities approaches would require increases in state and county Medicaid expenditures.

2. TITLE XX

As we have explained, under federal regulations some Medicaid funds can be used for the mentally ill in residential facilities. For the most part, however, persons who have been discharged from state hospitals into community-based facilities for the mentally ill, or those who are referred directly to such facilities, must rely on other sources of financial support. In addition to those limited state funds for "deinstitutionalization" described earlier in this chapter, one important alternative source of funds is federal "Social Services" or Title XX funds. These monies are available to support specific social services designated by the state for low income persons. The State of Minnesota has authorized 22 specific services, including residential care for the mentally ill. As we shall see in Chapter VI, these funds have become important for those residential facilities which already have Rule 36 licenses. However, three problems may limit the expanded use of these funds for residential care for the mentally ill.

First, Congress has placed a ceiling on the amount of federal funds provided for social services. Within this limit funds are allocated to each state in proportion to total state population; Minnesota's fiscal year 1981 allocation was approximately $54 million. This ceiling has contributed to a trend whereby state and county percentages of the total cost of Title XX social services have increased and the federal percentage has decreased.

Second, Title XX funding for residential care for mentally ill persons is provided as a sub-category termed "Halfway House--Chemically Dependent and Mentally Ill." Under this category approximately $1.5 million federal Title XX funds have been allocated in the 1980-81 services plan to support halfway house services "provided as a transition environment for persons returning to the community,"

targeted for approximately 2,748 chemically dependent and mentally ill persons. However, we have been unable to determine the allocation of these funds between services for chemically dependent and for mentally ill persons. Also, there are no other categories of Title XX services funding residential services to mentally ill persons, suggesting that only halfway houses can technically receive these funds.

Third, "in Minnesota, the decisions about services to be provided are made at the local level, within limits established by the State Welfare Department . . .. Certain services are required to be available in all counties. The other services are optional or priority services and the decision to provide them is made by the county commissioners or the county welfare department."[1] County discretion regarding how much Title XX funding to allocate to which social services is generally consistent with the local decision-making emphasis of Minnesota's recent Community Social Services Act. However, this feature diminishes the state's ability to ensure the maximum use of Title XX funding for services in facilities which should be licensed under Rule 36. The service category "Halfway House--Chemically Dependent and Mentally Ill" is classified as a priority service rather than a mandatory service, and currently receives only 3 percent of the state's federal Title XX allocation. A federal ceiling, federal funding categories, and county decision-making authority complicate the state's ability to target federal Title XX funding to residential care for mentally ill persons.

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[1] DPW, Final Comprehensive Annual Services Program Plan, October 1, 1979 to September 30, 1980, p. 2.

VI. A SURVEY OF RESIDENTIAL FACILITIES FOR THE MENTALLY ILL IN MINNESOTA

In Chapter III we criticized the Department of Public Welfare for failing to establish, in lieu of active licensing, an on-going program to monitor existing residential facilities serving the mentally ill in Minnesota. In 1976-77 the department reportedly took steps to identify and survey facilities believed to be subject to the Public Welfare Licensing Act. However, the department cannot now produce the list of facilities developed nor the data it gathered on those facilities. In addition, the data subcommittee of the Task Force to Revise Rule 36 gathered information from many sources to make estimates of the number of mentally ill persons and the number of residential facilities in the state. However, these efforts did not involve an identification of specific facilities or a determination of the services offered therein. The department cannot ascertain whether relevant laws and rules are being observed.

The absence of an active licensing program for facilities serving the mentally ill indicates that DPW is not in compliance with the Public Welfare Licensing Act; we consider DPW's failure even to monitor programs for the mentally ill an additional breach of its responsibilities. As a result, the Legislature lacks the minimum information needed to judge the adequacy of the state's system of residential care for the mentally ill. In addition, the department itself lacks the data it needs to evaluate the Rule 36 licensing program and to plan improvements in the system of care.

Accordingly, we have taken steps to gather certain data on residential facilities and on persons residing in such facilities. We have gathered this information in order to:

- determine the nature of the state's system of residential care for the mentally ill;
- answer questions about the sources of financial support presently used by persons in residential facilities;
- determine the validity of DPW's rationale for not carrying out a more aggressive licensing program; and
- provide evidence as to whether, in the absence of an active licensing program, the law and Rule 36 are being observed by residential facilities.

In this chapter we present a summary of the results of our efforts. A full report on our survey of residential facilities for the mentally ill will be published in a separate staff paper subsequent to this report.

This chapter is divided into two parts. In the first part we present information on those facilities which, in our judgment, comprise the primary community-based residential care system for

mentally ill persons. These are the facilities to which county welfare agencies refer persons requiring care for mental illness. In the second part we present information on a second group of health care facilities which normally provide care to persons with various kinds and degrees of physical and mental disabilities. Most of these are nursing homes or convalescent units or psychiatric care facilities affiliated with general hospitals. Although this section is brief, we present these data in more detail in our staff paper.

A. FACILITIES IDENTIFIED BY COUNTY WELFARE AGENCIES

1. FACILITIES TO WHICH MENTALLY ILL PERSONS ARE REFERRED

Only eight community residential facilities and two state hospitals are now licensed under Rule 36 by the Department of Public Welfare. The vast majority of residential facilities for the mentally ill--the exact number of such facilities is unknown--are unlicensed by DPW. In order to develop a list of such facilities for our study, we contacted the 87 county welfare offices in Minnesota and asked them to supply us with the names and addresses of community-based facilities in their county to which persons with mental disturbances or persons discharged from a state hospital for the mentally ill might be referred. We believed county welfare offices to be good sources for this information since the state's Hospitalization and Commitment Act requires that county welfare offices "establish a continuing plan of aftercare services," including psychiatric treatment, for all patients discharged from a state hospital.[1] We were, therefore, reasonably confident that the resulting list of facilities was comprehensive.

Using these procedures we were able to compile a list of 150 facilities. The map shown in Figure 3 indicates the distribution of these facilities by county. Hennepin leads with 43 facilities, followed by Ramsey with 17 and St. Louis with 13. These three counties account for nearly one-half of all residential facilities we were able to identify by these procedures.

For each of these 150 facilities we tried to determine:

- whether they had ever been licensed by DPW under Rule 36 as a facility for the mentally ill;
- whether they had been issued a health license by the Minnesota Department of Health or by a local unit of government; and
- how recently a fire inspection had been completed by the State Fire Marshal or by a local fire inspection authority.

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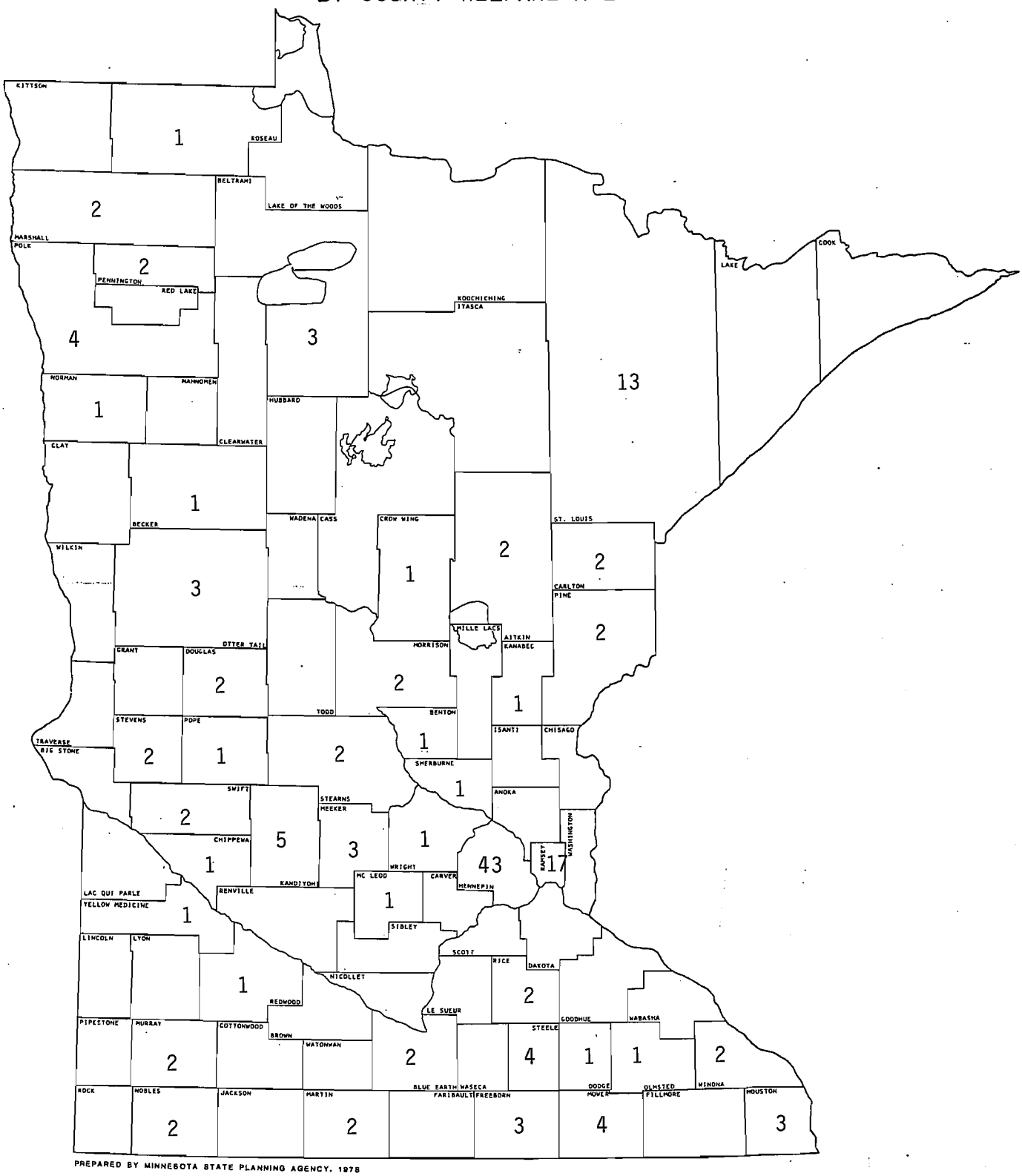
[1] Minn. Stat., ch. 253A.15, subd. 12.

FIGURE 3

DISTRIBUTION OF RESIDENTIAL FACILITIES IDENTIFIED BY COUNTY WELFARE AGENCIES



PREPARED BY MINNESOTA STATE PLANNING AGENCY, 1978

Through our investigation we were able to confirm that only eight of the 150 facilities were licensed by DPW under Rule 36 to care for mentally ill adults. Eleven other facilities reported having been licensed previously by DPW but have subsequently dropped their Rule 36 license. Our inspection of the records of health facility licensing authorities, including MDH, revealed that most facilities among the 150 on our list had at least one health license. However, we found no health licenses for five facilities. Moreover, as Table 6 shows, more than 62 percent of all facilities on our list held only a state or local board and lodging license. As explained in Chapter I, this type of facility generally provides no medical or rehabilitative services.

TABLE 6

HEALTH LICENSES CURRENTLY HELD BY FACILITIES TO WHICH MENTALLY ILL PERSONS ARE REFERRED

Type of License	Number of Facilities	Percent of All Facilities
Boarding Care (MDH)	37	24.7%
Supervised Living Facility (MDH)	8	5.3
Nursing Home (MDH)	10	6.0
Board and Lodging (MDH)	44	29.3
Board and Lodging (local authority)	50	33.3
None	5	3.3
TOTAL:	154[a]	101.9%[a]

Source: Minnesota Department of Health and local licensing authorities.

[a]Some facilities had multiple licenses.

In addition, we examined the State Fire Marshal's records to determine how many facilities had had recent fire inspections. For those cases in which state fire inspections had not been done, we contacted local fire inspection authorities. We were able to confirm that only 42 percent of all facilities on our list had had even minimal fire inspections within the last two years. Another 26 percent had undergone inspections more than two years ago. We could find no evidence of fire inspections for the remaining 32 percent.

State law mandates that all nursing homes, hospitals, lodging houses, and hotels conform to the state's uniform fire code.[1] However, the State Fire Marshal is mandated only to inspect hotels.

[1]Minn. Stat., ch. 299F.391.

Other types of facilities are inspected by the Fire Marshal upon specific request by another agency, such as MDH or DPW. Facilities not licensed by either MDH or DPW therefore may never come to the attention of fire inspection authorities.

Of those facilities whose inspection records we could locate, relatively few had long lists of "deficiencies" or code violations identified by inspectors. But there were 20 facilities which had not been reinspected for the last two years although at least some "deficiencies"--whether trivial or serious--had been found at the time of the most recent inspection. These data are displayed in Table 7.

TABLE 7

FIRE INSPECTIONS OF FACILITIES TO WHICH MENTALLY ILL PERSONS ARE REFERRED

Months since last inspection	Number of Facilities having: No deficiencies	1 - 5 deficiencies	More than 5 deficiencies	Deficiencies not ascertained	TOTAL FACILITIES
Up to 12 months	43	8	3	--	54
13 - 24 months	5	3	1	--	9
25 - 36 months	9	8	1	--	18
37 - 48 months	2	7	1	--	10
More than 48 months	6	1	2	2	11
No record of inspection found	--	--	--	48	48
TOTAL:					150

Source: State Fire Marshal or local fire inspection authorities.

We conclude from these facts that some mentally ill persons are referred by county welfare agencies to residential facilities which are not uniformly monitored by state agencies for compliance with health, program, and safety standards. Most are monitored for compliance with food service health standards, but for many that is the only monitoring which takes place.

These facts, by themselves, do not prove that minimum program, health, and safety standards are unmet in these facilities. However, the lack of comprehensive state monitoring means that the

state has little information on the conditions which exist in residential facilities for the mentally ill. Despite this lack of information, the state and the counties have continued to implement a policy of deinstitutionalization for the past two decades.

2. FACILITIES SERVING FIVE OR MORE MENTALLY ILL PERSONS

In order to describe the state's system of residential care for the mentally ill and thereby determine the consequences of DPW's inactivity in licensing under Rule 36, it was necessary for us to generate additional data by contacting facilities directly. In September 1980 we mailed a six-page questionnaire to those facilities which we had earlier identified through our contacts with county welfare agencies. This questionnaire (reprinted in Appendix B of this report) was designed to determine:

- the number of mentally ill persons residing in the facilities which we had identified;
- the number of facilities serving at least five mentally ill persons and therefore required by law to have a license under Rule 36;
- the amenities and services available to mentally ill persons in these facilities;
- the sources of referral for residents;
- the numbers and types of staff at the facilities; and
- the sources of funding used by residents to pay for their expenses at these facilities.

All 150 facilities were sent our questionnaire.[1] As a result of multiple mailings and personal call-backs, 140 facilities (93 percent) replied.

The key question in determining whether a facility is operating within the terms of the Public Welfare Licensing Act involves the number of mentally ill residents currently in the facility. As previously noted, no facility is permitted to operate without a license if it serves five or more physically or mentally handicapped adults. The licensing law does not define "mentally handicapped" nor does it indicate when a resident may be regarded as mentally ill. However, Rule 36, promulgated by DPW to regulate the licensing of residential facilities for the mentally ill, defines a "mentally ill and/or behavioral disabled person" as one "who behaviorally shows an inability to interpret his surroundings in a realistic way that would lend itself to adequate coping with his life situation."[2]

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[1] In addition, questionnaires were mailed to all nursing homes, convalescent units, and psychiatric units in hospitals--some 454 facilities. See Section B of this chapter.

[2] 12 MCAR 2.036.

Due to the ambiguity implicit in this definition and what we regarded as the difficulties in applying it for the purposes of securing an accurate count of mentally ill persons in residential facilities, we sought the advice of experts in arriving at a definition which could be applied relatively unambiguously in a variety of settings. We learned that there is little agreement among experts as to what constitutes mental illness. We did learn, however, that there are certain common indicators which, while not infallible, can be used to identify persons who require care for mental disturbances.

Accordingly, we devised a definition which incorporated these indicators. For the purposes of our survey, we asked facility administrators to count all persons who met at least one of the following criteria:

(a) diagnosed as mentally ill or psychotic by a qualified professional; or

(b) has received treatment for mental illness at a state hospital or private psychiatric hospital within the past five years; or

(c) is currently being treated with psychotropic medication (e.g., Thorazine, Prolixin, Mellaril), excluding common sedatives.

We recognize that this definition is broad and that it would include many persons suffering from organic brain disorders brought on by old age and not always considered mentally disturbed. Nevertheless, even these persons require care for a mental incapacity and most would fit the general definition provided in Rule 36, "an inability to interpret his surroundings in a realistic way."[1]

Of the 140 facilities which replied to our questionnaire, 82 (more than 58 percent) claimed to have five or more residents who fit our operational definition of mental illness. We presume that these 82 facilities fall under the terms of the Public Welfare Licensing Act and all should be licensed by DPW. Throughout the remainder of this section, we shall address the status of these 82 facilities. Figure 4 illustrates the relationship of these 82 facilities to the 150 originally identified.

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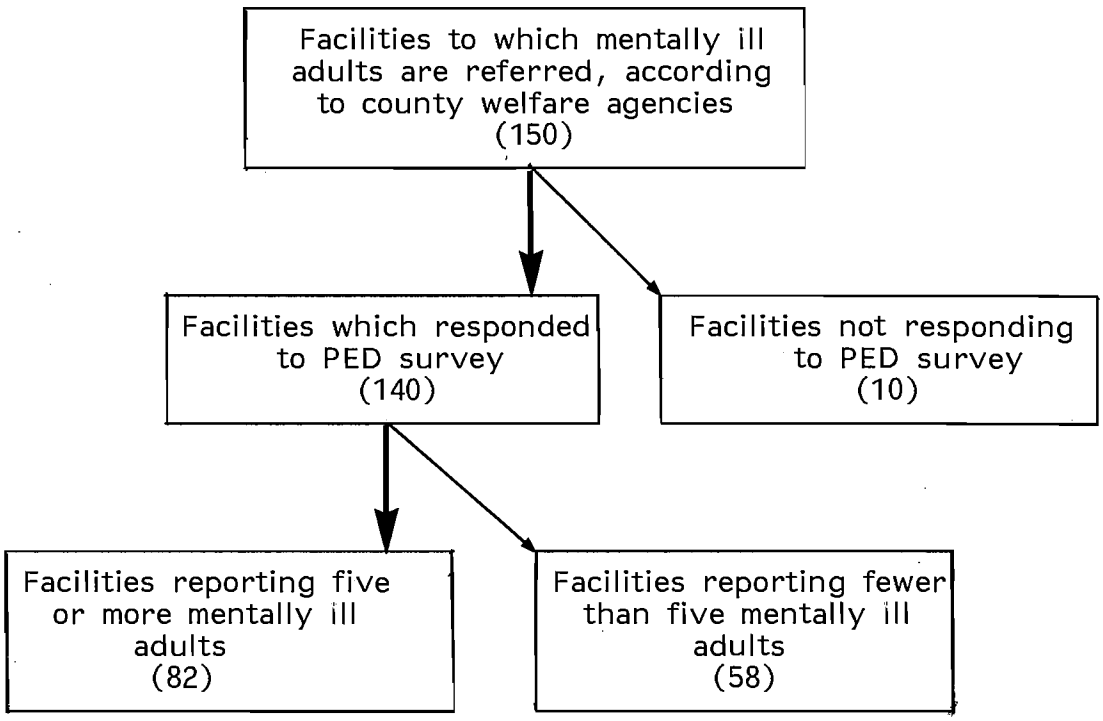
[1]The Department of Health, Education and Welfare defined a "mental patient" as one "with mental disability necessitating nursing home care who has no significant physical problems," or a "patient with physical problems that would not independently necessitate nursing home care, but who has a mental disability that would preclude his proper handling of his physical problem outside a nursing home." FSIIS 76-156 (October 28, 1977).

FIGURE 4

PRIMARY RESIDENTIAL CARE FACILITIES STUDIED BY THE PROGRAM EVALUATION DIVISION



a. Licensing and Inspections

According to the Public Welfare Licensing Act, no residential facility serving five or more mentally handicapped adults shall operate "unless licensed to do so by the commissioner" of Public Welfare. Our survey reveals that 74 facilities are currently operating in apparent violation of this provision. Ten of these reported previously having Rule 36 licenses but do not at present.

Nearly all facilities have current health licenses; only two lack any state or local health license. However, as shown in Table 8 nearly 60 percent are licensed only as board and lodging facilities.

TABLE 8

HEALTH LICENSES CURRENTLY HELD BY FACILITIES SERVING FIVE OR MORE MENTALLY ILL PERSONS

Type of License	Number of Facilities	Percent of All Facilities
Boarding Care (MDH)	23	28.0%
Supervised Living Facility (MDH)	6	7.3
Nursing Home (MDH)	5	6.1
Board and Lodging (MDH)	16	19.5
Board and Lodging (local authority)	33	40.2
None	2	2.4
TOTAL:	85[a]	103.5%[a]

Source: Minnesota Department of Health and local licensing authorities.

[a]Some facilities had multiple licenses.

Our review of fire inspection records for facilities serving five or more mentally ill persons reveals that only 39 facilities have had state or local fire inspections within the last two years. Another 23 facilities had inspections more than two years ago. There were no records of fire inspections for 20 facilities--nearly 25 percent of all those which serve five or more mentally ill persons. As shown in Table 9, 11 facilities had not been reinspected within the last two years although some deficiencies had been identified at the time of the last inspection.

TABLE 9

FIRE INSPECTIONS OF FACILITIES SERVING
FIVE OR MORE MENTALLY ILL PERSONS

Months since last inspection	Number of facilities having: No deficiencies	1 - 5 deficiencies	More than 5 deficiencies	Deficiencies not ascertained	TOTAL FACILITIES
Up to 12 months	24	5	3	--	32
13 - 24 months	4	2	1	--	7
25 - 36 months	5	3	1	--	9
37 - 48 months	--	5	1	--	6
More than 48 months	5	--	1	2	8
No record of inspection found	--	--	--	20	20
TOTAL:					82

Source: State Fire Marshal or local fire inspection authorities.

b. Description of Facilities

According to our survey, most residential facilities for the mentally ill are in urban settings and more than 80 percent are in neighborhoods consisting predominantly of single and multi-unit dwellings. The location of residential facilities for the mentally ill, as well as for other disability groups, is often controversial, and we have addressed the issue of zoning and location of facilities in Chapter IV.

In terms of size, services offered, and programs operated, residential facilities vary considerably. Our survey has shown that total facility capacity may range from only a few people to more than 100. A total of 3,106 persons currently reside in the 82 facilities in our study group. This represents an average residential population of 37.9 persons per facility. The average number of sleeping rooms per facility is 23.8.

The numbers and kinds of amenities available to residents on the premises is also variable. Table 10 shows that most facilities we studied report having lounges and full food services, but fewer than one-half having meeting or therapy rooms and only 38 percent report providing kitchen privileges for their residents. Rule 36 currently requires space adequate for "program activities" and requires that residents have access to a dining room and kitchen. The rule also requires that "residents shall have free use of all space within the unit, with due regard for privacy."

TABLE 10

AMENITIES AVAILABLE TO MENTALLY ILL RESIDENTS OF FACILITIES SERVING FIVE OR MORE MENTALLY ILL PERSONS[a]

Amenity	Facilities claiming the amenity: Number	Percent
Lounge	77	93.9%
Dining Room/Full Food Service	75	91.5
Semi-Private Sleeping Rooms	75	91.5
Laundry Facilities	69	84.1
Recreation Room	52	63.4
Private Sleeping Rooms	51	62.2
Sleeping Rooms for three to five Persons	39	47.6
Meeting or Therapy Room	38	46.3
Private Bathrooms	32	39.0
Kitchen Privileges	31	37.8
Library	30	36.6
Snack Bar/Vending Machines	29	35.4
Sleeping Rooms for More Than five Persons	2	2.4

[a]N = 82 facilities.

Although Rule 36 was designed to "aid in the development of a system of residential programs for the mentally ill that [among other things] provides appropriate treatment and rehabilitative programs, relatively few facilities we studied actually operate treatment programs on the premises. As shown in Table 11, fewer than one-half of all facilities report offering private counseling sessions and less than one-third report offering group counseling or therapy sessions. Only 13 percent report offering psychotherapy by a licensed professional on the premises. However, many facilities apparently provide their residents help with personal or financial affairs, help with medications, or help in using community resources. It should be remembered that we have not independently confirmed these claims made by facility directors.

TABLE 11

SERVICES AVAILABLE TO THE MENTALLY ILL IN FACILITIES SERVING FIVE OR MORE MENTALLY ILL PERSONS[a]

Service	Facilities claiming to have the service: Number	Percent
Help with Personal or Financial Affairs	75	91.5%
Help in Using Community Resources	73	89.0
Help with Medications	69	84.1
Recreation Programs	62	75.6
Help with Dressing or Bathing	57	69.5
Help in Finding or Keeping a Job	46	56.1
Instruction in Independent Living Skills (cooking, cleaning, etc.)	41	50.0
Private Counseling Sessions	38	46.3
Group Counseling or Therapy Sessions	25	30.5
Psychotherapy by a Licensed Professional	11	13.4
No Special Services	3	3.7

[a]N = 82 facilities.

Rule 36 requires facilities to maintain for each resident individual and confidential records, including a written treatment plan, a medical and social history of the resident, progress notes, and a discharge summary. According to our survey, only 48.8 percent of all facilities keep all of these records as required in Rule 36. Table 12 shows how many facilities maintain each kind of individualized record for their residents.

Rule 36 currently requires that programs for the mentally ill designate staff members to act as administrator, program director, and volunteer coordinator. According to our survey a total of 1,981 full-and part-time persons, or about 24.2 per facility, are employed in residential facilities for the mentally ill. These numbers include all administrative personnel, counselors, nurses, food service workers, and maintenance personnel. However, our survey reveals that seven facilities (8.5 percent of those with five or more mentally ill) report no administrative staff. In addition, 64 facilities (78.0 percent) report not having any full-time or part-time counselors. Moreover, among those not having any counselors, 45 (54.9 percent of the whole) have no other program staff. One facility reported having no paid staff at all, while six others claimed to have between one and three paid staff. These data show that many facilities serving the mentally ill and eligible for licensure operate with minimal staff.

TABLE 12

TYPES OF CLIENT RECORDS KEPT BY FACILITIES SERVING FIVE OR MORE MENTALLY ILL PERSONS[a]

Type of record	Facilities keeping records: Number	Percent
Information on Notification in Case of Emergency	75	91.5%
General Medical Information	65	79.3
Information on Financial Eligibility	63	76.8
Medication Record	62	75.6
Social History	60	73.2
Progress Notes	55	67.1
Discharge Summary	52	63.4
Current Treatment Plan	50	61.0
No Client Records Kept	2	2.4

[a]N = 82 facilities.

c. Description of Residents

Because so many facilities do not keep systematic and individualized records, many had difficulty supplying us with accurate data regarding their residents. In some cases, especially for facilities in Hennepin County, we sought additional information on residents from the county welfare office and added the data to what we already had received from the facility itself. As a result of these difficulties, we must regard these data describing residents of facilities for the mentally ill as close approximations.

As reported to us in our survey, the total residential population in facilities serving five or more mentally ill persons is 3,106. Of these, 1,748 (or about 56 percent) were identified as mentally ill. Facilities licensed under Rule 36 have a total mentally ill population of 178; unlicensed facilities have a total mentally ill population of 1,570. The number of mentally ill persons in a facility varies greatly. Our survey has identified 23 facilities which have between 5 and 10 mentally ill residents, 34 facilities with 11 to 20 mentally ill residents, 11 facilities with 21 to 30 mentally ill residents, and 14 with more than 30 mentally ill residents.

About two-thirds of all residents fall into the 22 to 64 year age bracket, with about 10 percent aged less than 22 years and almost 25 percent aged 65 and over. All of those in the oldest group live in facilities unlicensed under Rule 36. About 25 percent of all residents are recent arrivals in their facilities, having arrived less than six months ago. Nearly 44 percent have resided at their facility for more than two years.

Finally, to the extent that reliable information is available, it appears that many mentally ill residents--approximately 60 percent--are former patients of a state hospital. However, only about 20 percent of all mentally ill residents were referred to the facility directly from a state hospital. Another 11 percent were from private hospitals and 39 percent were referred by county welfare agencies.[1] Physicians and families each account for about 6 percent of all referrals.

d. Medicaid Certification

As we reported in Chapter III, one significant reason given by DPW officials for not actively licensing facilities for the mentally ill under Rule 36 over the past six years is that issuing a license may jeopardize a facility's source of federal funding under Title XIX of the Social Security Act (Medicaid). Irrespective of the precise legalities of this position, this argument has a certain inherent validity. As we have indicated, some facilities have been challenged by the federal administrators of Medicaid on the ground that they were licensed by the state as facilities for the mentally ill.

On the other hand, DPW's position lacks cogency when applied to facilities which are not certified to receive Medicaid payments or which do not have residents receiving Medicaid benefits for services delivered elsewhere. Our survey reveals that out of 82 facilities serving five or more mentally ill persons only 18--with a total of 682 residents--are now certified to receive Medicaid funds. Licensing these facilities would presumably jeopardize any Medicaid funds currently being paid on behalf of their residents aged 22 to 65. Of the remaining 64 non-certified facilities, we have identified 13 facilities with a total of 98 residents who are receiving Medicaid benefits for services delivered outside the facility. Licensing these 13 facilities--there may well be more which are not identifiable through our survey--might jeopardize many of these Medicaid benefits. Although these data are not definitive, many of the remaining 51 facilities could presumably be licensed without jeopardizing individual residents' Medicaid benefits.

e. Funding

In our survey of residential facilities we sought information on the level and variety of funding currently used to pay for the living expenses and program costs of residents. Based on data supplied to us by facility directors, we estimate that the total annual revenue for all 82 facilities in our study group combined is approximately $15.7 million. However, since facilities vary considerably in size and in other factors affecting finances, annual facility revenues

[1] Since county welfare agencies handle discharge plans for patients from state hospitals, many of these referrals may actually have been from state hospitals.

vary markedly across those in our study group. Table 13 shows that a majority of facilities have annual revenues amounting to less than $100,000, but that nearly 10 percent have revenues exceeding $300,000.

TABLE 13

ANNUAL REVENUES FOR FACILITIES SERVING FIVE OR MORE MENTALLY ILL PERSONS

Annual Revenues	Number of Facilities	Percent of Facilities
Up to $50,000	21	25.6%
$ 50,000-$ 99,999	22	26.8
$100,000-$149,999	13	15.8
$150,000-$199,999	10	12.2
$200,000-$249,999	6	7.3
$250,000-$299,999	2	2.4
$300,000-$349,999	4	4.9
$350,000 or More	4	4.9
TOTAL:	82	99.9%

As we suggested in Chapter V, residential facilities serving the mentally ill depend on a variety of sources of funds to continue operating. No federal program exists exclusively to support the mentally ill in residential settings, although the funds from several federal programs may be used, under certain conditions, for that purpose. State programs to facilitate deinstitutionalization have been relatively small and most funds to support the mentally ill in residential settings have come from general federal or state/county welfare programs. Our data suggest that among the facilities in our study group, the largest single source of funds is Minnesota Supplemental Aid, with an estimated $3.8 million reported as annual revenues. Other important funds include Medicaid with nearly $2 million annually, General Assistance with $1.5 million annually, and federal Supplemental Security Income (SSI) monies amounting to approximately $1.4 million per year. Table 14 shows monthly revenues as reported by the 82 facilities in our study group and indicates estimated annual revenues by funding source.

One of our aims in conducting the survey of facilities was to determine how the sources of funding for Rule 36 licensed facilities differ from those for unlicensed facilities. However, the small number of licensed facilities makes any generalizations tentative. Because one licensed facility primarily serves children, and its revenue sources reflect its special clientele, we have excluded its financial data from the table below.[1]

[1]Only 11 of the facility's 42 mentally ill are over 18 years old and the bulk of its funding comes from sources which do not support adult mentally ill persons.

TABLE 14

ESTIMATED COMBINED REVENUES FOR ALL RESIDENTIAL FACILITIES SERVING FIVE OR MORE MENTALLY ILL PERSONS, BY SOURCE OF REVENUE

Revenue Source	Estimated Monthly Revenue	Estimated Annual Revenue
Supplemental Security Income (SSI)	$ 120,202	$ 1,442,424
Minnesota Supplemental Aid (MSA)	$ 316,233	$ 3,794,796
Medicare	$ 4,907	$ 58,884
Medicaid	$ 164,928	$ 1,979,136
Title XX	$ 85,461	$ 1,025,532
General Assistance (GA)	$ 128,150	$ 1,537,800
General Assistance/ Medical Care (GAMC)	$ 7,210	$ 86,520
Resident's Personal Funds	$ 77,594	$ 931,128
Resident's Family	$ 42,891	$ 514,692
Other	$ 357,841	$ 4,294,092
TOTAL:	$1,305,417	$15,665,004

Our data suggest that facilities licensed under Rule 36 have significantly different patterns of funding than unlicensed facilities. While unlicensed facilities depend primarily on Minnesota Supplemental Aid, Medicaid, General Assistance, and Supplemental Security Income monies, licensed facilities depend overwhelmingly on Title XX ("Social Services") money. Table 15 shows the estimated mean monthly revenues for residential facilities by funding source. Although this table represents a composite picture--no facility's finances look exactly like it--it can give a rough idea of the average level of funding that licensed and unlicensed facilities receive from various sources. While unlicensed facilities report that on the average approximately 18 percent of their monthly revenues come from Medicaid, no licensed facilities are currently receiving Medicaid funds. Approximately 59 percent of the revenues for these facilities comes from Title XX. The reason that licensed facilities can qualify for Title XX funds may be due, in part, to the fact that the program is designed specifically to cover social service program costs. Since licensed facilities are required to have such programs, they may be more likely to qualify for Title XX eligibility. Our data show that well over one-half of all residents are funded, at least in part, from the Title XX program.

TABLE 15

ESTIMATED MEAN MONTHLY REVENUES FOR RESIDENTIAL FACILITIES SERVING FIVE OR MORE MENTALLY ILL PERSONS, BY SOURCE OF REVENUE

Revenue Source	Facilities With Rule 36 License	Facilities Without Rule 36 License
SSI	$ 999	$ 1,530
MSA	$ 1,469	$ 4,134
Medicare	$ 0	$ 66
Medicaid	$ 0	$ 2,229
Title XX	$ 9,646	$ 162
General Assistance	$ 1,686	$ 1,572
General Assistance/ Medical Care	$ 370	$ 62
Self	$ 371	$ 1,013
Family	$ 76	$ 373
Other	$ 1,594	$ 2,057
TOTAL:	$16,211	$13,198
	N = 7	N = 74

Although licensed facilities--being largely dependent on Title XX funds--exhibit funding patterns that are far less balanced than those for unlicensed facilities, their overall level of financial support compares favorably to unlicensed facilities as a whole. Average monthly revenues for licensed facilities are approximately $16,200; for unlicensed facilities they are about $13,200. In addition, mean monthly revenues per resident are somewhat higher among licensed facilities ($405 per resident per month) than among unlicensed facilities ($352 per resident per month.

We must reiterate that these data are tentative. According to our survey, nearly half of all facilities in our study group have never been audited by a certified public accounting firm or by a government agency. Moreover, some facilities gave us estimates of their revenues. Nevertheless, these data suggest two conclusions:

- Licensure under Rule 36 may significantly affect the kinds of funding for which a facility may qualify, particularly limiting its access to Medicaid funds.

- Nevertheless, licensure--in and of itself--apparently has not resulted in a crippling cut-off of all potential sources of facility funding.

Whether all those facilities, particularly those now dependent on Medicaid monies, could qualify for Title XX funds should they become licensed under Rule 36 is a question beyond the scope of this study.

Moreover, the need for additional state monies for residential facilities serving the mentally ill is a question which will have to be addressed by the Legislature. It is clear, however, that the present system of providing funding for mentally ill persons in residential facilities lacks cohesiveness and thoughtful organization. Moreover, as we have suggested elsewhere, it currently provides disincentives for facilities to develop treatment programs which can pass muster under DPW Rule 36 since to develop such programs and to seek licensure jeopardizes an important source of funds.

B. OTHER CARE FACILITIES

In addition to those residential facilities specifically identified by county welfare agencies, there are many other health care facilities which provide short-term or long-term care for persons with mental disabilities. Many of the state's general hospitals, for example, have psychiatric units which provide a variety of mental health services. The average length of stay in such a unit may range from one to two weeks. In addition, most nursing homes or hospital nursing units provide services to persons with mental as well as physical disabilities. The majority of residents in such facilities are elderly and many suffer from organic brain disorders. The average stay in nursing units is several years.

In order to determine the number of persons with mental disabilities in these additional facilities--as well as the degree to which they are provided with services commensurate with those required by Rule 36--we sent our questionnaire to all nursing homes, nursing and convalescent units, and hospital psychiatric units which are licensed by the Department of Health in the state. In addition, we sent our questionnaire to all state hospitals which provide services to the mentally ill. Out of a total of 454 questionnaires, 411 (90.5 percent) were returned.

Among those facilities responding, 323 claimed to be licensed as nursing homes, 30 as hospitals, 39 as both nursing homes and hospitals, and 12 as other health facilities. The seven state hospitals, excluded from the analysis below, held various health licenses.

Table 16 shows that the total number of persons in these additional facilities judged to be mentally ill (based on the definition which we supplied) is substantial. The number of persons in nursing homes alone is 6,671. Most of these persons, according to comments made to us by many nursing home directors, are elderly people with organic brain disorders who receive psychotropic or tranquilizing medications. Many facility directors expressed reluctance to categorize these persons as "mentally ill," in part, perhaps, because Department of Health rules specifically state that "disturbed mental patients shall not be received or retained in a nursing home or boarding care home."[1] Although the meaning of "disturbed mental patient"

[1]Minn. Reg. MDH 51(c).

is somewhat unclear, the intent of the provision may be solely to ensure the protection of other residents and not to exclude all mentally ill persons. In any case, the table shows that approximately one-half of all those categorized as "mentally ill" have been in a state hospital. These are, therefore, persons with mental disorders who have been "deinstitutionalized."

TABLE 16
MENTALLY ILL PERSONS IN SECONDARY CARE FACILITIES[a]

Type of Facility	No. of Beds	Total Residents	Mentally Ill Residents	Mentally Ill Residents with St. Hosp. Exper.
Nursing Home (N=323)	30,747	30,254	6,671	3,371
Nursing Home/ Hospital (N=39)	2,951	1,834	259	48
Hospital (N=30)	3,200	2,713	610	52
Other (N=12)	2,021	1,111	150	55
TOTAL	38,919	35,912	7,690	3,526

[a]Using the definition of mental illness on page 65 of this report. Excluding state hospitals.

While persons suffering from organic brain disorders may be medically distinct from those with other mental diseases, such as psychosis, most definitions of "mental illness" used for identifying facilities subject to regulation seem broadly inclusive. As we noted above, Rule 36 explicitly states that facilities serving persons who demonstrate "an inability to interpret [their] surroundings in a realistic way" may be subject to licensure by DPW.[1]

Certain nursing homes and hospitals are excluded from licensure by the Public Welfare Licensing Act. However, the act is unclear in defining which facilities may be exempted. It specifies that a hospital whose psychiatric program is located within the hospital is exempt, but it goes on to declare that nursing homes and hospitals are not exempt if they serve six or more persons in an "identifiable unit" in the facility. According to our survey, 251 facilities of the 404 which responded to our questionnaire claimed to have six or more mentally ill residents. However, since the exclusions are unclear, we could not establish exactly how many of these facilities might be exempted from licensure under Rule 36. Therefore, in the analysis that follows we have included all 251 facilities.[2]

[1]12 MCAR §2.036.

[2]Early in the licensing program, a decision was made at DPW to exempt all nursing homes and hospitals from Rule 36. Although early drafts to revise Rule 36 had a specific licensing category for nursing homes, the most recent draft excludes it.

In examining the 251 facilities with six or more mentally ill persons, we find that the services offered to mentally ill residents generally reflect the medical orientation of the facilities in this group. Table 17 shows that nearly all facilities provide help with dressing, bathing, and administration of medications. A comparison with the data in Table 11 suggests that these care facilities are more likely than those in the primary residential care system to offer most specific services to the mentally ill. Not surprisingly, perhaps, facilities in the primary group are more likely to provide help in finding a job and in providing instruction in independent living skills. But the facilities in the secondary group are more likely to offer every other service to their mentally ill residents--even including psychotherapy by a licensed professional.

TABLE 17

SERVICES AVAILABLE TO THE MENTALLY ILL IN SECONDARY CARE FACILITIES SERVING SIX OR MORE MENTALLY ILL PERSONS[a]

Service	Facilities claiming to have the service: Number	Percent
Help with Dressing or Bathing	245	97.6%
Help with Medications	244	97.2
Recreation Programs	229	91.2
Help with Personal or Financial Affairs	218	86.9
Help in Using Community Resources	170	67.7
Private Counseling Sessions	120	47.8
Group Counseling or Therapy Sessions	67	26.7
Instruction in Independent Living Skills (cooking, cleaning, etc.)	67	26.7
Psychotherapy by a Licensed Professional	60	23.9
Help in Finding or Keeping a Job	35	13.9

[a]N=251 (Mostly nursing homes and hospitals).

In addition, we looked at the types of client records kept by secondary care facilities with six or more mentally ill persons and found that there is a much greater likelihood that any given secondary care facility can meet the requirements of Rule 36 than any given primary care facility can. Table 18 shows that nearly all secondary care facilities regularly keep the kinds of records on each client which are required by the rule. As we noted earlier, fewer than one-half of the primary care facilities keep the kinds of records required.[1]

[1]See p. 20 for a list of the records required.

TABLE 18

TYPES OF CLIENT RECORDS KEPT BY SECONDARY CARE FACILITIES SERVING SIX OR MORE MENTALLY ILL PERSONS[a]

Type of Record	Facilities keeping records: Number	Percent
Information on Notification in Case of Emergency	249	99.2%
Social History	249	99.2
Progress Notes	248	98.8
Medication Record	248	98.8
Current Treatment Plan	247	98.4
General Medical Information	247	98.4
Discharge Summary	244	97.2
Information on Financial Eligibility	223	88.8
No Client Records Kept	0	0.0

[a]N=251

Finally, we examined the Medicaid certification rate among the 251 care facilities with six or more mentally ill persons and found that all but a handful were certified. Only 25 facilities (10 percent) were not certified. The other 226 facilities would find Medicaid funding for those under age 65 in jeopardy under current federal rules should they become licensed by DPW as facilities for the mentally ill.

In conclusion, our survey suggests that many mentally ill persons reside in this additional group of health care facilities--for long stays in nursing homes or shorter stays in hospitals--even though none of those facilities are licensed under DPW Rule 36. Despite the lack of licensure, however, many of these facilities may be able to meet the minimum standards required by Rule 36.

GLOSSARY

1. MINNESOTA DEPARTMENT OF PUBLIC WELFARE ADMINISTRATIVE RULES

   Rule 14. Rule to administer $2 million appropriated by the Legislature in 1979 for development of state-wide experimental programs for chronically mentally ill persons.

   Rule 21 - Community Based Residential Services for Mentally Ill Persons. Rule to administer the legislative appropriation for non-residential pilot programs in Ramsey, Dakota, and Washington counties.

   Rule 22 - Community Based Residential Services for Mentally Ill Persons. Rule governing "deinstitutionalization" funding originally appropriated by 1976 Legislature. ($1.8 million in FY 1980-81.)

2. MINNESOTA DEPARTMENT OF PUBLIC WELFARE LICENSING RULES

   Rule 34 - Standards for the Operation of Residential Facilities and Services for Persons who are Mentally Retarded.

   Rule 35 - Department of Public Welfare Rule for the Licensing Operation of all Residential Programs for Inebriate and Drug Dependent Persons.

   Rule 36 - Department of Public Welfare Rule for the Licensing and Operation of all Residential Programs for Adult Mentally Ill Persons.

   Rule 80 - Standards for Residential Facilities and Services for the Physically Handicapped.

3. MINNESOTA HEALTH DEPARTMENT (MHD) LICENSES

   Hospital (MHD Rule 76). "An institution . . . providing services, facilities, and beds for the reception and care for a continuous period longer than 12 hours for one or more non-related persons requiring diagnosis, treatment, or care for illness, injury, or pregnancy; and regularly making available clinical laboratory services, diagnostic x-ray services, and treatment facilities for (a) surgery, (b) obstetrical care, or (c) other definitive medical treatment of a similar extent."

   Mental Hospital (MHD Rule 85). "A hospital for the diagnosis, treatment, and custodial care of persons with nervous and mental illness."

Nursing Home (MHD Rule 44). "A facility or unit used to provide care for aged and infirm persons who require nursing care and related services."

Boarding Care Home (MHD Rule 44). "A facility or unit used to provide care for aged and infirm persons who require only personal or custodial care; nursing services are not required."

Supervised Living Facility (MHD Rule 391). "A facility to provide a residential home-like setting including supervision, lodging, and meals in accordance with provisions of Rules of the Department of Public Welfare, counseling and developmental habilitative or rehabilitative services to five or more persons who are mentally retarded, chemically dependent, adult mentally ill, or physically handicapped."

Board and Lodging (MHD Rule 151). Residential facilities which do not provide health care are licensed as "board and lodging" establishments. These regulations apply to "all lodging establishments such as hotels, motels, lodging houses and resorts [and] all food and beverage establishments such as restaurants, boarding houses, and places of refreshment."

4. FEDERAL SOCIAL SECURITY ACT

Title II - Old Age, Survivors and Disability Insurance (OASDI). Commonly referred to as "Social Security." A federal social insurance program funded through employer/employee contributions. Eligibility based on status as retired, disabled, or survivor and amount contributed during working years.

Title XVI - Supplemental Security Income (SSI). A federal cash assistance program for needy, aged, blind, and disabled persons.

Title XVIII - Medicare. A federal medical insurance program providing benefits to retired and disabled persons.

Title XIX - Medical Assistance (MA or Medicaid). A federal-state public assistance program providing payment for medical services for needy, aged, disabled persons, and dependent children.

Title XX - Social Services. Authorized federal support for certain state and county social services designed to help people maintain or achieve self-support and self-sufficiency, prevent the abuse or neglect of children and adults, prevent or reduce inappropriate institutional care, and secure institutional care when other forms of care are not appropriate.

5. STATE-COUNTY PROGRAMS

Minnesota Supplemental Aid (MSA). A state cash assistance program for needy aged, blind, and disabled persons. (Supplements the federal SSI program.)

General Assistance (GA). A state cash assistance program for needy persons who do not qualify for any of the programs authorized by the federal government.

General Assistance Medical Care (GAMC). A state program that provides payment for medical services to needy persons not eligible for other health care programs.

6. MEDICARE/MEDICAID CERTIFICATION CLASSIFICATIONS

Skilled Nursing Facility. A facility which provides nursing services which "require the skills of technical or professional personnel [and are] needed on a daily basis and required to be provided on an inpatient basis.

Intermediate Care Facility. A facility which "fully meets the requirements for a state license to provide, on a regular basis, health-related services to individuals who do not require hospital or skilled nursing facility care, but whose mental or physical condition requires services that: (i) are above the level of room and board; and (ii) can be made available only through institutional facilities."

Psychiatric Hospital. An institution which is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons."

APPENDIX A

PATIENT-TRACKING AND MANAGEMENT INFORMATION SYSTEMS

Since 1976 DPW has used four different management information systems regarding state hospital resident data. These systems have varied from computerized services purchased in 1976 from a private vendor to the current, largely manual, operation. Inadequacies of the department's management information systems compound DPW's task of tracking movement of patients between state hospitals and community facilities, describing those community facilities, and providing adequate information for decisionmakers. For these reasons DPW's recent experience with management information systems regarding mental health data is significant, and is summarized as follows:

- Prior to July 1976, state hospitals tabulated manually and submitted to DPW's central office information describing patient characteristics including diagnosis, sex, and age. The central office used the data to produce monthly and annual summaries. However, DPW's turnaround time reportedly was three to six months, an excessive delay which severely limited the usefulness of the reports for hospital managers and encouraged most institutions to maintain their own parallel system.

- In July 1976 DPW contracted with the Pennsylvania-based firm Shared Medical Services for a computerized billing and management information service known as the Patient Oriented Information System (POIS). POIS accommodated the collection, manipulation, and reporting of more data than the earlier system, providing some on-line capability for the state hospitals and reducing turnaround time for most items to days rather than months. However, POIS was designed for short-stay acute care hospitals rather than state hospital systems with multiple facilities serving longer-term patients, an orientation which caused significant difficulties when the state hospital system tried to adapt POIS. In October 1978 the department and Shared Medical Services chose not to renew the POIS contract because of the combination of DPW dissatisfaction with POIS, increased charges from the vendor totalling approximately $1.9 million for the new 32-month contract period, DPW belief that a better system costing less could be developed in-house, and Governor Perpich's cost-cutting budget directives.

- By July 1979, using uncommitted funds available from the terminated POIS contract, DPW had developed most of an automated in-house system known as the Welfare Institutions Information Management System (WIIMS). The department's request for funds to complete WIIMS was rejected by the senate and failed in the conference committee during the 1979-81 budget process.

- Lacking the requested appropriation, DPW scrapped most of WIIMS. The department presently uses a patient-tracking and billing system which is a patchwork of manual and automated steps. The system generally gives first priority to data necessary for billing and provides minimal management information, reporting only institutional populations by diagnosis and by admission/discharge totals. Several state hospitals continue to maintain separate manual systems for their own management purposes.

- DPW has requested $2 million in the 1981-83 budget for computerized data systems "to improve operations and information throughout the welfare system." These systems are requested to provide timely state hospital census, billing, inventory, and other types of management information, and to provide counties a common data base and information system to facilitate local compliance with state and federal reporting requirements.

During June 1976 public hearings of the House Committee on Deinstitutionalization, legislators criticized DPW for its inability to provide data on state hospital populations and the movement of patients between state hospitals and the community. Legislators found that DPW did not categorize its information in a fashion useful to decisionmakers and wondered how DPW was able to evaluate its own performance to determine areas of success and failure and make improvements.[1] We share these concerns. Two automated systems have been used and rejected since June 1976 and DPW's present capability continues to be inadequate.

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[1]House Committee on Deinstitutionalization, Public Hearing Tapes (June 1, 1976).

APPENDIX B

OFFICE OF THE LEGISLATIVE AUDITOR

RESIDENTIAL FACILITY QUESTIONNAIRE

This questionnaire should be answered by the person in charge of the above-named facility. Please answer and return to the Office of the Legislative Auditor, 122 Veterans Service Building, St. Paul, Minnesota, 55155, by SEPTEMBER 25, 1980.

1. Name of Director/Person in Charge _____

   Business Phone Number of Director _____

   Facility Name and Address, if different from above _____

   _____

2. Year of Facility Start-up _____

3. Type of Ownership *(check one):*

   - ☐ Governmental
   - ☐ Private, Non-Profit
   - ☐ Private, For Profit

4. Type of Licenses *(check all currently held, if any):*

MN DEPARTMENT OF HEALTH (MDH)
- ☐ Board & Lodging
- ☐ Boarding Care
- ☐ Supervised Living Facility (SLF) A
- ☐ Supervised Living Facility (SLF) B
- ☐ Nursing Home
- ☐ Hospital
- ☐ Other MDH License *(specify)* _____

COUNTY OR MUNICIPALITY
- ☐ Board & Lodging
- ☐ Other *(specify)* _____

☐ No License

MN DEPARTMENT OF PUBLIC WELFARE (DPW)
- ☐ Rule 34 (mentally retarded)
- ☐ Rule 35 (chemically dependent)
- ☐ Rule 36 (mentally ill)
- ☐ Rule 80 (physically handicapped)
- ☐ Other DPW License *(specify)* _____

MEDICARE OR MEDICAID CERTIFICATION
- ☐ Skilled Nursing Facility - Medicaid
- ☐ Skilled Nursing Facility - Medicare
- ☐ Intermediate Care Facility
- ☐ Intermediate Care Facility - MR
- ☐ Psychiatric Hospital

5. *For the purposes of this survey, a mentally ill resident is one who meets at least one of the following criteria:*

   a. *diagnosed as mentally ill or psychotic by a qualified professional, or*

   b. *has received treatment for mental illness at a State Hospital or private psychiatric hospital within the past five years, or*

   c. *is currently being treated with psychotropic medication (e.g., Thorazine, Prolixin, Mellaril), excluding common sedatives.*

Note that this definition distinguishes between mental illness on the one hand and mental retardation or chemical dependency on the other, although a mentally ill person may also be mentally retarded or chemically dependent. In addition, note that for nursing home and hospital settings, this definition is more inclusive than the term "disturbed mental patients" as referred to in MDH regulations.

Does your facility have *any* residents considered mentally ill under the above definition?

☐ Yes
☐ No

If yes, complete all the remaining questions.
If no, please sign on page 6 and return the questionnaire without answering the remaining questions.

---

6. Total number of beds in the facility (resident capacity) _____

7. Total number of sleeping rooms in the facility _____

8. The neighborhood around the facility is *(check one):*

☐ Mostly residential, majority of one-unit dwellings
☐ Mostly residential, majority of multi-unit dwellings
☐ Mostly commercial
☐ Other *(specify)* _____

9. Date of most recent fire inspection *(if any)* _____

By: ☐ State Fire Marshal
☐ Local Fire Authority
☐ Don't Know

☐ Check here if no fire inspection

10. Facilities on the premises that are available to *mentally ill* residents *(check all that apply):*

☐ Lounge
☐ Library
☐ Recreation room
☐ Meeting/therapy room
☐ Laundry facilities
☐ Private bathrooms
☐ Kitchen privileges for residents
☐ Private sleeping room (1 person per room)
☐ Semi-private sleeping rooms (2 persons per room)
☐ Sleeping rooms for 3 to 5 persons
☐ Sleeping rooms for more than 5 persons
☐ Dining room/full food service
☐ Snack bar/vending machines

11. Services available on the premises for *mentally ill* residents *(check all that apply):*

- ☐ Private counseling sessions
- ☐ Group counseling or therapy sessions
- ☐ Psychotherapy by licensed professional
- ☐ Help in finding/keeping a job
- ☐ Recreation Programs
- ☐ Help in using community resources
- ☐ Instruction in independent living skills (cooking, cleaning, etc.)
- ☐ Help with dressing/bathing
- ☐ Help with personal or financial affairs
- ☐ Help with medications
- ☐ Other *(specify)* _____
- ☐ No Special Services

12. Number of staff at the facility:

Primary Activity	ON PAYROLL		VOLUNTEERS*
	Full-time	Part-time	
Administration *(for example, bookkeeper, director, clerical staff)*			
Program Staff			
Nurses and nurses aids			
Physicians			
Counselors			
Other program staff *(e.g., Chaplain, social worker, occupational therapist)*			
Support staff *(people not directly involved in treatment program or administration)*			
Dietary, food service			
Laundry, housekeeping, maintenance			
Other support staff			
TOTAL			

* *not counting residents*

13. Nature of client records kept at this facility. *Please check each kind of record routinely kept for each mentally ill resident at the facility.*

- ☐ Social history
- ☐ Progress notes
- ☐ General medical information
- ☐ Funding sources/financial eligibility
- ☐ Discharge summary
- ☐ Current treatment plan
- ☐ Medication record
- ☐ Information on notification in case of emergency
- ☐ No client records kept

RESIDENT CENSUS

14. Total number of residents currently in the facility _____

15. Total number of *mentally ill* residents currently in the facility _____

16. Total number of *mentally ill* resident admissions during the past twelve months _____

RESIDENT CENSUS *(Continued)*

17. Total number of *mentally ill* resident discharges during the past twelve months _____

18. In the spaces provided please indicate for each category the number of *mentally ill* residents *currently* in the facility. Refer to client records when necessary, and answer in accord with the definition of mental illness supplied in Question 5.

18(a)

STATE HOSPITAL EXPERIENCE	Mentally ill, but other disability primary reason for stay at facility	Mentally ill, and other disability *not* primary reason for stay at facility
Has been in state hospital		
Has never been in state hospital		
Don't know		
TOTAL		

18(b)

AGE	Mentally ill, but other disability primary reason for stay at facility	Mentally ill, and other disability *not* primary reason for stay at facility
Under 22		
22 - 64		
65 and over		
Don't know		
TOTAL		

18(c)

LENGTH OF STAY IN THIS FACILITY	Mentally ill, but other disability primary reason for stay at facility	Mentally ill, and other disability *not* primary reason for stay at facility
Less than 6 months		
6 to 11 months		
1 to 2 years		
More than 2 years		
TOTAL		

18(d)

REFERRED TO THIS FACILITY BY	Mentally ill, but other disability primary reason for stay at facility	Mentally ill, and other disability *not* primary reason for stay at facility
Private Physician		
County Welfare		
Private Social Service Agency		
Community Mental Health Center		
State Hospital		
Private Hospital		
Family		
Self		
Other		
Don't know		
TOTAL		

18(e) *Some residents may receive funds from more than one source. Please indicate the total number of residents in each category receiving funds from each source. Estimate if necessary.*

RECEIVES SOME FUNDS FROM	Mentally ill, but other disability primary reason for stay at facility	Mentally ill, and other disability *not* primary reason for stay at facility
Suppl. Security Income (SSI)		
Minn. Suppl. Assistance (MSA)		
Medicare (Title XVIII)		
Medicaid (Title XIX)		
Social Services (Title XX)		
General Assistance (GA)		
General Ass't. Med. Care (GAMC)		
Self/Own Job		
Family		
Other		
TOTAL		

FACILITY REVENUES *Please estimate the amount of revenue acquired from each of the following sources during the last complete month, whether directly from the funding source or indirectly from residents.*

19.

TYPE OF REVENUE	Mentally ill, but other disability primary reason for stay at facility	Mentally ill, and other disability *not* primary reason for stay at facility
Suppl. Security Income (SSI)	$	$
Minn. Suppl. Assistance (MSA)	$	$
Medicare (Title XVIII)	$	$
Medicaid (Title XIX)	$	$
Social Services (Title XX)	$	$
General Assistance (GA)	$	$
General Ass't. Med. Care (GAMC)	$	$
Self/Own Job	$	$
Family	$	$
Other	$	$
TOTAL FACILITY REVENUE	$	$

20. Has this facility ever been audited by a certified public accounting firm or a government agency? If so, please supply name and most recent date below.

Accounting firm _____

Date _____

I HEREBY CONFIRM THAT, TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS ACCURATE AND CORRECT.

_____ _____

FULL NAME *DATE*

STUDIES OF THE PROGRAM EVALUATION DIVISION

Final reports and staff papers from the following studies can be obtained from the Program Evaluation Division, 122 Veterans Service Building, Saint Paul, Minnesota 55155, 612/296-8315.

1977

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

1978

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

1979

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

1980

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

1981

21. Department of Human Rights
22. Hospital Regulation
23. Department of Public Welfare Regulation of Residential Facilities for the Mentally Ill

In Progress

24. State Income Tax Return Processing
25. State Architect's Office
26. State Sponsored Chemical Dependency Programs, Follow-up Study
27. Real Estate Management Division