



Minnesota Department of **Human Services**

Olmstead Planning Meeting

May 3, 2012

9:00 a.m. to 12 Noon

Minnesota State Retirement System Boardroom

60 Empire Drive, St. Paul, MN

Members Present: Christopher Bell, Loren Colman, Milt Conrath, David Godfrey, John Hastings, Pamela Hoopes, Mickey Kyler, Maureen Marrin, Maridy Nordlum, Maureen O'Connell, Shamus O'Meara (represented by Annie Mullin), Roberta Opheim, Lori Schluttenhofer, Colleen Wieck.

Members Absent: Phil Claussen

Guest Presenters: Patricia Carlson, Jerry Stork, Jean Wood

Topic: Roll Call

Discussion:

Maureen O'Connell called the meeting to order at 9:05 and requested a roll-call of committee members and guests. Chris Bell and Maureen O'Connell shared that the order of the agenda would be changed slightly to accommodate time constraints of presenters.

Action/Decision: NA

Topic: Review and Approval of Meeting Minutes from Previous Meeting

Discussion:

Chris Bell made a motion to approve the minutes from the previous meeting. John Hastings requested an edit on page 2, last paragraph, to correct and clarify the definition of an Institution for Mental Disease (IMD).

Action/Decision:

A motion to approve the minutes, with correction, was made by Chris Bell. Seconded by John Hastings. Minutes were approved with correction.

Topic: State Operated Services Utilization

Discussion:

Patricia (Pat) Carlson, CEO of State Operated Services, was introduced. Pat referred to the handout that was added to the members' packets for today's meeting. She shared that the charts on the third page of the handout reflect FY11 admission/discharge data for SOS programs. She also noted that, as the Minnesota Specialty Health System (MSHS) programs in Brainerd and Cambridge opened in FY12, she included data for the first 6 months of operation for those programs. She clarified that as SOS' Minnesota State Operated Community Services (MSOCS) program are residential group homes, they are not included in this data. For today's presentation the focus would be on institutional services.

Pat shared that on any given day approximately 1,100 are served in SOS' Adult Mental Health, Chemical Addiction Recovery Enterprise (C.A.R.E.), Forensic Services and MSHS programs.

In response to a request for clarification about who is served in the C.A.R.E. program, Pat responded that these programs serve both individuals who voluntarily seek treatment and those who are committed to the Commissioner for treatment of their chemical addiction. In addition, many clients enter the program as an alternative to a jail sentence or other court action. In FY11, there were 4,175 patients admitted to SOS programs; of those admissions, 80% were admitted to either the community behavioral health hospitals (CBHHs) or C.A.R.E. programs. In FY11, SOS programs discharged 4,151 patients. Pat addressed the average 'length of stay' (LOS) within a C.A.R.E. program – 39 days; and the CBHHs – 17.5 days. Within the system, the average LOS varies from 1 day in an acute care program to 14 years in the Minnesota Security Hospital (MSH). Pat also shared that in FY11 there were over 14,000 bed days in which the patient did not meet “hospital level” of care criteria; noting that at an average of \$1,100 per bed day that equates to approximately \$15.4M spent on an inappropriate level of care.

Pat informed the committee that in opening the Minnesota Specialty Health System (MSHS) residential programs, SOS developed a medically monitored sub-acute level of care for individuals who struggle with return to the community because of lack of community integration skills and/or a history of community treatment failures. She provided further clarification regarding the specific populations to be served in the MSHS programs; noting:

- MSHS-Brainerd is for people with co-occurring traumatic brain injury and serious mental illness;
- MSHS-Cambridge is for people with intellectual disabilities and co-occurring serious mental illness causing public safety concerns;
- MSHS-Wadena is designed for people with serious mental illness and co-occurring substance abuse; and
- MSHS-Willmar is for people with serious mental illness and chronic medical problems.

Pat shared that currently the Minnesota Security Hospital has 50 people in the “Transition Readiness Program” and 82 people in “Transition Services;” noting that all of the individuals in Transition Services could be returned to the community with support from the county, a recommendation by the Special Review Board, and approval by the Commissioner. These 2 programs support 35% of the security hospital’s population.

Pamela Hoopes sought clarification between the Transition Readiness Program and Transition Services. Pat shared that the individuals in the “readiness” program are learning the necessary skills to return to the community and those in “transition services” are ready to move to the community as soon as appropriate living and support services are identified. Roberta Opheim commented that this gets to the heart of what her office sees when they look at the total bed capacity of the Minnesota Security Hospital – of the 380 individuals at the security hospital, 35% are at the transitional level. Her point being that whether it is a lack of funding or services, that number really speaks to a blockage for Olmstead consideration.

Chris Bell sought further clarification regarding:

- the population included in this number,
- a definition of the Special Review Board (SRB) and the Supreme Court Appeal Panel (SCAP).

- what percentage of the 35% actually have had their release approved by the SRB.

Pat shared that she didn't have that information today but would be happy to forward the information to Maureen O'Connell for the Committee. Chris further asked about the population she spoke about earlier who are "stuck" in the hospital, not necessarily just at MSH. Regardless of funding, are there state programs available to serve these individuals in the community? Pat spoke to the development of adult foster homes for individuals who because of their behaviors may not be successful in accessing community services. Chris also asked if with sufficient community supports could these individuals live in the community. John Hastings shared that he has some experience in this area; and noted that when it gets right now to the practical issue of moving this population into the community, the provider must obtain a conditional use permit (issued by the local municipality) which is virtually impossible to obtain because the first question asked is are you going to be serving anyone who is mentally ill and dangerous (MI&D). Roberta Opheim also noted that once an individual is committed as MI and D, that is an indefinite commitment until the court discharges it; and the court rarely issues a full discharge. Individuals are usually released under a provisional discharge (PD) with conditions of compliance defined in their discharge plan. A PD can be revoked if the individual does not remain in compliance with the conditions as outlined. Loren Colman asked what conditions may trigger a MI&D commitment. Roberta replied that an individual had to have committed an overt act of aggression or harm against another individual and; in some cases; many minor acts of aggression over time may result in a petition for commitment as MI&D. Pamela Hoopes also clarified that an MI&D commitment may be linked to a Rule 20 evaluation – e.g., if an individual is charged with a felony or a dangerous act, the court may require a Rule 20 evaluation to determine if the individual is competent to stand trial and able to assist their legal counsel with their defense. Chris Bell inquired if we have information about counties who are not responsive to returning these individuals back to the community. Pam Hoopes requested a breakdown of individuals currently at MSH who are not MI&D.

Pat then informed the Committee that SOS utilizes the "Level of Care Utilization System" (LOCUS) to monitor bed utilization within the Anoka-Metro RTC, the Community Behavioral Health Hospitals (CBBH), the Child and Adolescent Behavioral Health Services (CAHBS) and the Minnesota Specialty Health Services (MSHS). She explained the differences in the "6 levels" noting specifically LOCUS level 6 (medically managed or acute hospital); LOCUS level 5 (medically monitored or sub-acute); and LOCUS levels 4 or 3 (community level of care). The census at the Anoka-Metro RTC averages 33% of its patients at level 6; 52% at level 5 and 14% at level 4 or 3. The CABHS program averages 75% at level 6 and 25% at level 5, and the CBHHs slightly over 50% at level 6; 45% at level 5 and 4% at levels 4 and 3. Weekly LOCUS reviews are held to provide oversight of those who are "stuck" in an inappropriate level of care.

In response to David Godfrey's request for average length of stay at the Child and Adolescent Behavioral Health Hospital, Pat responded the average stay is about 6 months. Roberta Opheim inquired who, since the CABHS operates as a medical necessity model and draws down third-party insurance, covers the cost of care once the insurance company has deemed the child is no longer in need of hospital level care. Pat responded that the CABHS program is an appropriated program (funded through the State General Fund); however any recouped third-party insurance payments are also returned to the General Fund.

Chris Bell sought clarification regarding the status of the CBHHs, noting that it was his understanding that only 6 of the 7 hospitals are certified and that they are not eligible for federal funding. Pat clarified that 6 of the community based hospital are CMS certified and do draw down federal funds (16 beds or less). The one remaining hospital (CBHH-Rochester) is expecting another CMS on-site survey in the near future. It is her expectation that they will receive CMS certification.

Roberta Opheim noted that certainly one of the questions she has is about those individuals “stuck” due to lack of community services. She would like to see the waiting lists for both Anoka-Metro RTC and the Minnesota Security Hospital. Pat shared that waiting lists have been getting longer and noted that Anoka’s list is currently over 100. Milt Conrath requested recidivism data on those individuals “stuck” at Anoka and the Minnesota Security Hospital.

Maridy Nordlum asked, given the waiting lists, about the potential utilization of empty buildings in Cambridge. Pat Carlson shared that as much as possible we are trying to move individuals back into the community rather than to other institutional settings. She shared that the buildings at Cambridge might be effectively used for something else but she doesn’t believe it should be used for a large treatment facility. She noted that as a condition of the METO settlement, SOS has to be very careful about admissions to the Cambridge program; noting that individuals admitted to that program must pose a serious risk to public safety. We want to do it right; and we don’t want to create a knee jerk reaction to the current situation. John Hastings also reacted to Maridy’s comments about filling up empty buildings, sharing that the objective is to get people out of SOS programs and back into the community receiving needed services in community settings, not in large institutional settings. As a part of the discussion on waiting lists, Pamela Hoopes requested additional information regarding individuals who have been approved by the Special Review Board for a lower level of security but because of the back-up can’t move to a less secure setting on the campus in St. Peter. Chris Bell asked for the percentage of individuals who have been provisionally discharged who have reoffended; noting that he wants to make the distinction between “reoffending” vs. violating their conditions of release.

In concluding this discussion, and in light of the amount of interest expressed, Maureen O’Connell asked if the committee would be interested in a presentation from a county, as they are a vital partner in moving people through the system. She suggested that hearing from a metro county that is heavily involved with clients who petition for a review before the SRB could identify some of the barriers faced by the counties in reintegrating clients back into the community. Roberta Opheim noted that because the variables are so multifactorial, and because Hennepin County is conceived as a resource rich county, it might be interesting to hear from them. David Godfrey shared that it might also be helpful to hear from some rural counties who are less ‘resource rich’ and who may face different challenges but in some cases, seem to do it better. Maureen O’Connell also suggested that Judge Quam, a District Court Judge in Hennepin County’s Mental Health Division, might be a good resource. Roberta noted that as he is more progressive than other judges throughout the state, he might be a good resource for engaging with other court systems. Maureen noted that Region 3 might also be a good resource.

Loren Colman thanked Pat Carlson for her informative presentation; noting the complexity of the issues involved. He noted this is about the treatment system, the court system, funding, work force, etc. In concluding, Pat shared her early work experience at the Faribault State Hospital and thanked the committee for the work they are doing to help make our system a quality system.

Action/Decision:

Request for Forensic Program Definitions:

- Transition Readiness program
- Transition Services
- Definition of Special Review Board
- Definition of Supreme Court Appeal Panel

Data Requests:

- Data on disposition of SRB Hearings
- Identification of unresponsive counties
- Breakdown of MSH patients who are not MI&D
- Number of individuals at MSH approved for transfer to lower level of security at MSH who are unable to move due to bed shortage.
- Percentage of individuals on PD who have reoffended.

Request for AMRTC & MSH Data:

- Waiting lists
- Recidivism data on individuals who are “stuck”
- Disposition of SRB hearings.

Topic: Long Term Care

Discussion:

Maureen O’Connell opened this discussion by sharing that some participants come to the table with the “big picture” of where their system is, the upcoming presentation is meant to provide foundational information of where the system is now and where it is going.

Loren Colman announced that Alex Bartolic was not available for today’s meeting; however, he welcomed Jean Wood, Director of the Department’s Aging and Adult Services Division. Loren reviewed the presentation outline and shared he would defer to Jean to present the “State Profile” document. Jean shared that the entire document was available on the Department’s website; however she was here to present background regarding the development of the 2009 State’s Profile – a comprehensive, high-level assessment of the state’s progress toward a balanced long-term support system. She noted that Minnesota’s State Profile Tool includes seven major population groups (i.e., Older Adults, Adults with Physical Disabilities, Adults with Intellectual/Developmental Disabilities, Children and Adults with Mental Illness, Adults Living with HIV/AIDS Infections, Adult with Traumatic Brain Injuries, and Children with Special Needs).

Chris Bell commented that when we categorize individuals by a “primary” disability we miss the individuals who have multi-disabilities or impairments and believes that skews the data. Jean concurred; however noted that the existing waivers are not as isolating to a specific diagnosis as

may be suggested by their title. She went on to share that the State Profile presents background information that applies to all population groups; a section for each system component that describes in more detail the long-term care system across all populations and extensive feedback and input which was provided by the Home and Community-Based Services expert panel. Jean further shared that the profile tool is intended to address information gaps and identify coordination opportunities, service gaps, and assist in comparing Minnesota's system to other states.

Loren Colman informed the Committee that 10 states were funded by CMS to develop this profile and a final chapter on quality is yet to be developed but will address a description of Minnesota's quality management strategy related to the Medicaid Waiver programs for older adults and people with disabilities. This includes a description of relevant measures and how they are used as a part of the quality management strategy and discussion of the development of future data sources to inform quality management strategy. The final product will be completed by August 2012. Jean Wood then addressed the data on demographics and funding for older adults noting that 34.7% of the older adult population in Minnesota have a disability; 40% of public long-term care spending for older adults is spent on home and community-based services serving 63% of seniors; and 60% of public funding is on nursing home care which serves 27% of the older population. She then moved onto demographics and funding for people with disabilities sharing that 6% of persons age 5-20; and 10.3% of persons age 21-64 have a disability. Of people with disabilities receiving Medical Assistance, 95% received home and community based services; and 89% of public long-term care spending for people with disabilities was spent on home and community-based services. Institutional care for people with disabilities accounted for 11% of public long-term care spending.

In response to Roberta Opheim's question if the data only reflected people receiving services; or did it include people not yet receiving services Jean Wood responded that the data was collected from census data and included only those "self-reporting" a disability.

Jean went on to report that a gaps analysis has been conducted on aging services since 2001 and is conducted every two years. In 2009 a gaps analysis was conducted for both aging and disability services but the level of information was not fine enough. Starting in 2013, as a result of new legislation, the gaps analysis will be conducted jointly. The role of this analysis is to inform Eldercare Development Partnerships and Area Agencies on Aging about service development needs in local communities. Roberta provided clarification that long term care data is for individuals 65 and over. Now the Department will be doing a better job to track under 65 but that data is not as refined or available in way that is useful. Loren Colman shared that in 2001, the "crisis" prompting action was the amount of money being paid for nursing home services and the realization that, to prevent the need for nursing home level of care, services needed to be developed in the community. In 2009, DHS realized information was missing and in 2012, current legislation calls for the counties to assess what services are needed to serve individuals of all ages. Jean then spoke to the gaps analysis changes between 2001 and 2009; noting that in 2001 the top five service gaps were identified as transportation, in-home respite and caregiver support, chore services, non-county information, referral and assistance and long-term care consultation relocation. In 2009, the top five changed slightly but still included

transportation (both non-medical and medical transportation) and chore services. In addition, companion service and out-of-home respite were in the top five.

David Godfrey asked about 2013 and if provider rates will have an impact on services. He noted that he thought there was specific legislation that called for a review of provider rates. Jean shared that a contract has just been awarded to Thomsen Reuter to do such a review; and Loren Colman noted that this came out of the concern about the need to reduce rates and the potential impact of that on the availability of services. He shared the Department is doing an analysis to look at access to services. Roberta commented that services may be available; but you couldn't get a provider to provide the service at the rate being offered – which means Minnesota may look good because the service is offered but individuals may not be able to access them. For federal financial participation (FFP), we have to assure the federal government that not only do we offer the service but that services are actually being provided to the individuals who are trying to access them. The financial health of the community provider has to be taken into consideration and needs to be addressed at the Legislature. Good data will help us advocate for those resources when we identify problems.

Loren Colman presented information regarding needs determination noting that it will be more targeted and that, using existing funds, funding is being redirected to allow counties to look at their communities and individuals in need of corporate foster care to craft a plan to help determine where beds can be removed from the system. There is still a moratorium on new development; however, it has been delayed to allow for this needs determination. Roberta again addressed her concerns about the ability of counties to sway data and the necessity for the assessor to challenge counties to determine if considerations have been given to services other than the know tool of corporate foster care. Loren clarified that the Department will give clear instruction to the counties and will provide additional education and understanding; but we have to start with the basis of trust that counties want what is in the best interest of their consumers. The needs determination is due in February 2014. Roberta inquired if the needs determination will include the “consumers voice” to which Loren responded it has not yet been designed. John Hastings shared that the original forum included other resources but that got dropped from the legislation – another case of good intentions going bad.

Jean Wood concluded her presentation by addressing next steps for Medical Assistance waiver reform sharing that the desired system dynamic is that people get the right service at the right time; that the system be flexible and fluid so that people get a higher level of service when needed but stay or return to lower levels when those are sufficient. She noted that the focus areas will include bolstering community and family supports, providing supports to maintain and increase independency, as well as intensive services and supports.

Chris Bell inquired about the roll-out of MNChoices. Loren Colman shared that training will be held in June/July of 2013 with the first phase implementation scheduled for January 2013. Currently 20+ counties are serving as “testers.” Pamela Hoopes sought clarification about the reference to MNChoices and this long term care profile, gaps analysis and Medical Assistance waiver reform. Maureen O'Connell suggested the development of a timeline to share with the Committee to help clarify the cross-overs.

Action/Decision: NA

Topic: Public Participation Plan

Discussion:

Maureen Marrin reported on the Outreach Subcommittee meeting held on April 30, 2012 sharing that the general discussion of the meeting concerned using the website currently under construction to reach stakeholders to help inform this Committee. It was determined that there is not sufficient time to hold statewide focus group; however the subcommittee proposes the development of a survey to gather information from stakeholders. Maureen Marrin shared that she would like to see the survey developed in time for the upcoming Consumer Survivor Network Annual Conference to be held in mid-May in Bloomington and was seeking guidance from the larger Committee regarding questions to appear on the survey. John Hastings added that the subcommittee met for 2 hours and identified several things to be brought back to the Committee as a whole; one of which was a determination of the “purpose” of the survey – noting that the first priority in his mind, is the need to be transparent and to let people know what the Committee is up to; and second to provide people with an opportunity to provide feedback.

Maureen O’Connell sought clarification regarding the purpose of the survey – is it intended to help determine what services are needed to assist individuals to be more integrated into the community? Should we use a survey “monkey tool” that would be tabulated with one or two open questions that would allow people to share comments? As a part of this discussion, the following survey components were identified:

- Brief and concise summary of the goal of an Olmstead Plan
- Seek information about personal choice
- Identification of what is missing that would allow an individuals to live according to their personal choice
- User friendly and developed at a level that can be understood by users of services
- More consumer than provider directed
- Open ended questions that don’t lead the response

Loren Colman shared that he would like to see the survey focus on the consumer and to make the sure the questions are phrased to determine their interests and what they see as barriers, not what providers have identified for them.

Milt Conrath shared that anytime he’s talked to any consumer group, he finds that there are millions of things they don’t know about and questioned how we determine what they know. He would like to see something on awareness utilization; that is, “are you aware,” “did you use it,” and “were you satisfied” type of questions. Roberta noted that we are interested in determining if individuals are able to live in the environment of their choice. Colleen Wieck inquired if the subcommittee looked at the information set and shared that a lot of the questions have been asked. The Committee as a whole may want to review the survey questions because many of them have already been developed. Chris Bell concurred that it is important to look at data that is already available; and noted that questions directed at different multi-disability population may be very useful as an engagement tool. John Hastings again reiterated that it is important not to miss the point of transparency and that it is very important for people to feel that they are able to provide input to the process. There was discussion regarding the provider community as stakeholders and how their feedback is useful for statistical information. Maridy Nordlum noted

the importance of including input from guardians, family members, and support systems. Pamela Hoopes reiterated her support for developing a survey at a literacy level that ensures accessibility and offered her office as a resource that could assist. She also asked if people accessing the website would be able to “self-identify” on the website. It was noted that even the term “consumer” is jargon.

Before concluding this discussion Wendy Weden was asked to give an update on the status of the website. Wendy referred to the handout that was included in the packet for today’s meeting noting that the website is approximately 95% complete. The Department is currently reviewing documents for posting on the website (i.e., meeting agendas, minutes of meetings, handouts from the meetings) as well as creating the participant page to collect demographic information as identified by the Outreach Subcommittee. She is recommending that Co-Chairs Chris Bell and Maureen O’Connell review the final site content before it is posted. Wendy shared that for now she has labeled the website “Choices for all Minnesotans – Minnesota’s Olmstead Plan” however was open to other suggestions. After discussion, it was the consensus of the full Committee that, for now, the website would be named “Minnesota’s Olmstead Planning Committee.”

Action/Decision:

Maureen Marrin will convene another meeting of the Outreach Subcommittee and a report will be presented to the 5/17 Committee meeting. A link to the “draft” website will be sent to all members of the Olmstead Planning Committee.

Topic: Community Inpatient and Residential Treatment

Discussion:

Jerry Stork, from the Department’s Adult Mental Health Division’s Information and Data System unit, was invited to the table and introduced. As there were only 10 minutes left on the docket for today’s meeting, Maureen extended an apology to Jerry, noting that he may need to be invited back to more adequately address this agenda item.

Jerry distributed the following handouts:

- Calendar Year 2010 Mental Health Management Report
- Community-Based Extended Psychiatric Inpatient Hospital Contracts – Description and Map (2/1/12)
- Intensive Residential Treatment Services (IRTS) – Definition and Map (2/1/12)
- Adult Mental Health Minnesota Health Care Program Community Inpatient Stays During CY 2010
- Adult Minnesota Health Care Program IRTS Stays During CY 2010
- List of Licensed Rule 36 Facilities (by county, city, and capacity).

Jerry called attention to the handout on inpatient hospital contract beds and pointed out that there are two types of community contract beds – those funded under the Medical Assistance (MA) contract which covers MA fee for service recipients; and the subsidy grant contract which covers uninsured and underinsured individuals who do not qualify under the MA contract. The map shows the location and funding source of the type of beds.

Jerry then referenced the chart reflecting inpatient community hospital stays noting that for CY 2010 the average length of stay for adult mental health inpatient treatment in regular community Olmstead Planning Committee – May 3, 2012

hospital mental health beds was 8.8 days; and in the community contract mental health beds it was 21.2 days.

In the brief time available, Jerry attempted to address the following questions and comments:

- Roberta Opheim -- sought clarification about the subsidy grant contracts and asked if the money was paid to the hospital or the individual. Jerry responded it goes to the hospital.
- Chris Bell asked if the hospital could reject an admission to a contract bed due to another disability; however Jerry responded that he would have to check with someone more familiar with the policy side of the contracts.
- Pam Hoopes inquired if, when the Civil Commitment Defense Panel determines that an individual should be committed and they are placed in one of the contract beds, what happens to the individual if the 45 days runs out and the patient is not ready for release?
- John Hastings shared that another issue is after 45 days in a contract bed, the individual may be ready for discharge to the community but is there an appropriate community placement available.

At this point Jerry suggested that if the Committee had “programmatic” questions, it might be more appropriate to have a representative from the Adult Mental Health Division who was more familiar with the policy side of the contracts as his specialty is “statistics.”

In concluding the agenda item, Loren Colman wondered if there is data on non-public health utilization of mental health services and what is happening in the public sector. Jerry shared that the Department of Health collects information about “hospital use” but rate information might not be available from their information.

Maureen O’Connell thanked Jerry and again apologized for the shortage of time; sharing that Jerry may be invited back.

Action/Decision: NA

Next Meeting

Date: May 17, 2012
Time: 9:00 a.m. to 12 Noon
Location: Black Bear Crossings on the Lake
1360 N. Lexington Parkway, St. Paul

Adjournment:

Meeting adjourned at 12:05 p.m.