

POLICY ANALYSIS SERIES

ISSUES RELATED TO WELSCH v. NOOT / NO. 1

TAXONOMY OF ISSUES SURROUNDING IMPLEMENTATION OF THE WELSCH V. NOOT CONSENT DECREE

Braddock (1980) has observed that the implementation of a court decree is an "expensive, complex, and slow process" because court mandates do not necessarily mesh with an existing system. Usually the human services system has an extremely large number of actors, several different decision points, and an inherent inertia to avoid change. The complex task of "intermeshing" the Welsch v. Noot decree with the existing Minnesota system will require an understanding of the issues involved in deinstitutionalization and the process by which needed system changes can be effectively accomplished.

The purpose of this paper is to outline the planning issues and problems related to decree implementation, and to clarify where responsibility lies for specific mandated activities. Four major areas of activity in the implementation process will be discussed: (1) deinstitutionalization planning on federal, state and county governmental levels, (2) finalizing deinstitutionalization, (3) administration, licensing, monitoring, and regulation, and (4) planning on the individual level.

Within each of these areas, several important issues are raised that merit extensive discussion and action. For example, deinstitutionalization planning on various governmental levels raises questions regarding the need for inter-agency coordination on each level and between levels of government as well as with non-governmental agencies. In financing there are many facets to the questions of how to match fiscal incentives with the policy goals and intent of the Decree, and how to overcome the institutional bias of governmental funding. Ensuring adequate funding bases for a range of alternative residential, support services, and day programs requires a coordinated effort by a range of policymakers and service providers. In establishing and enforcing guidelines for controlling the quantity and quality of care, such issues as duplication of regulation and monitoring activities, the location and array of services, and future growth of the system must be addressed. Finally, on the individual level, issues to be dealt with include assessment, program planning, treatment, and discharge planning.

I. PLANNING FOR DEINSTITUTIONALIZATION BY GOVERNMENT LEVEL

A. FEDERAL Directives and Responsibilities

1. Recent executive, congressional, and judicial messages about deinstitutionalization:
 - a. Executive: Executive Order 11776, issued by Richard Nixon in 1974, reaffirmed the 1971 national goal of returning one-third of 200,000 institutionalized mentally retarded residents to community settings.

- b. Congressional: P.L. 94-103, the Developmental Disabilities Assistance and Bill of Rights Act, was passed by Congress in 1975 and amended in 1978 (P.L. 95-602).
 - c. Judicial: The April, 1981 Supreme Court decision in the Halderman v. Pennhurst State Hospital case held that the 1975 D. D. Act did not secure a constitutional right to appropriate habilitation for mentally retarded people or require the states to provide such habilitation as a condition to receiving federal funds. This decision was narrowly based on statutory interpretation. The Third Circuit Court of Appeals is considering remaining statutory and constitutional issues in the case, and the Supreme Court is scheduled to hear the Romeo v. Youngberg case, which will be a constitutional test of the right to habilitation in the least restrictive environment in Fall 1981.
2. Fiscal incentives and mechanisms for implementing deinstitutionalization currently favor institutional care over community care alternatives.
- a. Will increased money from the federal government for community alternatives provide an incentive for out of home placement thus working at cross purposes to depopulating institutions?
 - b. What is the effect on deinstitutionalization of substantial changes in federal social policy, including block grant funding, reductions in spending, and changes in eligibility in federal programs such as Medicaid and Title XX?
 - (1) Developmental Disabilities and Vocational Rehabilitation have been reauthorized as categorical programs without cuts in authorization levels.
 - (2) The federal share of Medicaid funding will be reduced by 3-4.5% in 1982-84. A special waiver provision in the current bill will allow states to place non-medical services (except room and board costs) under Medicaid for high risk persons to prevent institutionalization.
 - (3) Title XX current funding will be reduced by 17.2% to \$2.4 billion in 1982, \$2.45 billion in 1983, and \$2.5 billion in 1984. This reduction will particularly affect day programs in Minnesota.
3. There is a lack of interagency coordination at the federal level resulting in piecemeal approaches to community-based programs. The GAO reported in 1977 that there were "135 programs administered by 11 major departments at the federal level" concerned with deinstitutionalization. Will this fragmented approach continue?

B. STATE Agency Responsibilities

1. Department of Public Welfare current responsibilities include planning, coordinating, setting policies and standards, licensing, monitoring, funding, development of administrative rules, providing technical assistance, and providing direct services through nine institutions and two state-operated nursing homes. The consent decree further specifies the following responsibilities in order to implement the decree:

- a. Training of state hospital staff with specific topics mentioned in the decree;
 - b. Consultation services to community providers;
 - c. Monitoring of assessment and discharge planning;
 - d. Technical assistance to counties and facility developers;
 - e. Licensure of DACs and community residential facilities;
 - f. Planning, development, and support of necessary legislation;
 - g. Determination of the future role of state hospitals including a phase out schedule for use of buildings as well as an employee protection plan including retraining. The continued roles of state hospitals should focus on outreach work, respite care, crisis intervention, and other activities.
2. Department of Education is currently charged with providing a free, appropriate education for handicapped children in the least restrictive environment consistent with state and federal regulations. The Welsh decree implies:
- a. Maintain and provide accurate counts of handicapped children and youth by disability and by age. This data will be used for planning purposes in determining demand for adult services.
 - b. Provide technical assistance to local districts on how to serve severely/profoundly retarded, multiply handicapped children.
 - c. Preventing admissions of children to state institutions implies school districts should assume prevention/intervention strategies.
3. Department of Economic Security - Division of Vocational Rehabilitation--responsibilities include employment/independent living training, sheltered workshop training, and client evaluation/case planning.
- a. The court decree specifically mentions 300 additional sheltered workshop slots, but there is some concern for the allocation of those slots given the current waiting lists.
 - b. There is a need for an unduplicated count of people who need sheltered workshop placements.
4. Department of Health - handles several functions including facility licensure, quality assurance reviews, complaint handling, medicaid certification, and certificate of need.
- a. There is no mention of the Health Department in the consent decree, although there is an implication of increased workload for each of these areas.
5. State Planning Agency has two units that are directly concerned with deinstitutionalization activities.
- a. The Health Planning Unit provides direction and technical assistance to the Health Systems Agencies which perform 1122 reviews. The Health Planning Unit is currently drafting IFC-MR guidelines for facilities serving developmentally disabled people.
 - b. The Developmental Disabilities Unit is responsible for planning, coordination and evaluation of services for developmentally disabled people through intergovernmental and interagency activities. The regional coordinators assist counties and HSAs with planning activities related to community program development. Finally, there is a need for ongoing assessment of individual needs and services in cooperation with several existing data banks.
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- c. Neither unit is specifically mentioned in the consent decree, but will be working together with the Human Resources Unit to staff the Governor's Task Force on Implementation of the decree.

C. STATE INTERAGENCY Cooperation and Collaboration.

1. Never before has there been a need for written interagency agreements which clarify responsibilities during a period of declining resources. In particular, there must be greater clarity of roles and responsibilities when children and youth are moved through the system of services (e.g., placement of individuals in residential treatment facilities) which cuts across responsibilities of the State Department of Education, the State Department of Public Welfare, the Department of Corrections, as well as in the areas of assessment and diagnosis (Department of Public Welfare, Department of Health, and State Department of Education).
2. In addition to interagency agreements, there is a need for "policy linkages" that combine the statutory and regulatory functions with policy intent. For example, there are several conflicting statutes and regulations related to the size of community residential facilities and little effort to coordinate these guidelines with the policy of deinstitutionalization and concomitant principles of normalization, least restrictive environments, and developmental models.

D. COUNTY Responsibilities are defined in DPW Rule 185, Request Bulletin 81-53, Minnesota Statutes, and the Consent Decree:

1. Securing appropriate residential placements for the residents who will be moving from state hospitals. (Consent Decree)
2. Case management services including case finding, diagnosis, assessment of need, development of individual service plans, arrangement and provision of services needed, evaluation of individual service plans, and submission of annual report on wards. (DPW Rule 185, Consent Decree)
3. Planning, including development and submission of CSSA plan biennially, that includes:
 - a. ensuring opportunity for involvement of local social service agency, developmental disabilities, state hospitals, service providers, and advocates;
 - b. taking initiative in planning and development of services not available;
 - c. identification of services available inside and outside geographic area for its mentally retarded population;
 - d. identification of priority need of services not available currently;
 - e. provision and arrangement for services within CSSA grant;
 - f. submission of a letter of recommendation regarding new or changing services. (DPW Rule 185)

4. Evaluation of the county social services program on the basis of measurable program objectives. Submit annual report on effectiveness of CSSA program. (MS 256 E.11)
 5. Payment for services and audit trail regarding program costs and administrative costs. (DPW Rule 185, MS 252.21, MS 245.61, and MS 256 E.09)
 6. Resource development and provision of services including community residential facilities, developmental achievement, transportation, mental health, and other services. (DPW Rule 185)
 7. County planning requirements as related to Request Bulletin 81-53. (Request Bulletin 81-53)
 8. Crossover patterns of utilization from one county to another for services:
 - a. possibility or need to charge for case management fees;
 - b. concentration of services in metropolitan area;
 - c. possible opportunities for two or more counties to plan inter-county arrangements for serving special populations. (DPW Rule 185)
- E. Interplay of OTHER GOVERNMENT AGENCIES including the Governor's Office leadership efforts and the legislative appropriations committee. There is a need for a state plan to address and coordinate executive activities.
- F. Interplay of ADVOCACY GROUPS, PLAINTIFFS, AND PROVIDER ORGANIZATIONS in the legislative process.

II. FINANCING DEINSTITUTIONALIZATION

- A. Funding base for state hospitals.
- B. Funding base for community based residential facilities.
- C. Funding base for day program services--education, developmental achievement, work activity, and sheltered workshops.
- D. Funding base for support services.
- E. Fiscal incentives must match the policy goals and intent of the *Welsch v. Noot* consent decree.
- F. Cost models and projections including:
 1. Calculating the impact of Reagan's budget proposals on state and counties;
 2. Calculating the double funding bulge of two service systems (community and institutions) during the period of implementation (1981-87);
 3. Calculating cost function analysis to determine the multiple factors affecting variations in per diems.

- G. Can the current system of funding be refashioned to allow money to follow the individual? If an individualized assessment-prescription-voucher method is used, what preparatory steps must be taken to effectively implement this approach?

III. ADMINISTRATION, LICENSING, REGULATING, AND MONITORING ISSUES

- A. Duplication of regulations and monitoring activities regarding ICF/MR facilities from several different agencies including DPW, Department of Health, etc.
 - 1. There is a need for some effort to eliminate duplication and monitoring of the number of reviews performed by separate agencies.
 - 2. Licensors and monitors must be adequate in numbers, training, and have sufficient supervision to assure that quality exists in both state hospitals and community services.
- B. A full and adequate array of services must be available in the community including: transportation, health, leisure/recreation, education, prevention/intervention, day programs, vocational training, employment, respite care, advocacy and others.
- C. Guidelines should focus on size, location, and concentration of residential facilities to prevent tendency toward either isolation or over-concentration of services.
- D. What is the future of system growth in Minnesota, and is there a danger in a small number of residential facility operators monopolizing services?
- E. Strategies for minimizing community resistance including changes in public attitudes, special covenants, property value studies, and Supreme Court testing of the current zoning law.
- F. Will minimum standards or certification of training of direct care staff in community based programs be required in the future? If so, what impact will these standards have on per diems, beginning salary levels, and turnover?
- G. There is a need to examine both rate setting and "pass through" methods currently used by the Department of Public Welfare to assure equity and cost containment.
- H. There appears to be a need for a formal evaluation system (meta-evaluation) to monitor effectiveness of the existing evaluation reports completed by the State Department of Education, the State Department of Public Welfare, the Office of Health Facility Complaints (Department of Health). In addition, some determination should be made regarding the consequences of deficiencies.
- I. Defining inputs by regulatory measures does not insure appropriate outputs/outcomes. There should be more attention paid to outcome measures at the individual level and systems level.

- J. With movement of multiply-handicapped residents from state hospitals to community services, attention must be paid to converting existing buildings into barrier free environments.

IV. PLANNING AT THE INDIVIDUAL LEVEL

A. Individual Assessment Issues

- 1. Adequacy of screening, diagnosis, and assessment of individuals in state hospitals, community residential facilities, developmental achievement centers, and public schools.
- 2. Limitations of state tracking systems for individuals (e.g., response rate, reliability, and validity measures).

B. Individual Program Plans (IPPs)

- 1. Face validity of IPPs in terms of items included and completeness of forms.
- 2. Content validity of IPPs in terms of assuring that the program matches individual needs and assessment of needs.

C. Discharge Planning

- 1. Adequacy of discharge planning process and involvement of resident and family.
- 2. Do discharge plans specify appropriate residential day programs, and support services needed by client rather than reflect only the available services?
- 3. Is the 60-day follow-up or post placement assessment a benchmark of appropriateness of placement?

D. There is constant concern for active treatment in all types of residential and day programs.

- 1. How can the gaps in information dissemination about curriculum materials and behavioral technologies be closed?

E. Planning for special populations.

- 1. Medically fragile people.
- 2. People with behavior problems.
- 3. Severely/profoundly retarded people with multiple handicaps.

F. Placements.

- 1. Reduction of inappropriate placements to nursing homes, etc.
- 2. Post institutional placements--will mortality rates increase for residents who have lived most of their lives in institutions?

- G. The role of the court appointed monitor.
 - 1. Monitoring psychotropic drug use in state hospitals.
 - 2. Monitoring the use of mechanical restraints, separation, and seclusion.
 - 3. The lack of monitoring for these practices in community settings.
- H. Reduction of admission and readmission rates.
 - 1. Examine appropriateness of court commitments and provide information to county judges about the Welsch v. Noot Consent terms.
 - 2. Intervention methods for preventing admissions/readmissions due to behavior problems.

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The purpose of this series is to enhance communication among state and local agencies, service providers, advocates, and consumers on timely issues. We encourage reader participation by giving us feedback on your ideas and perceptions of this problem. This paper may be cited:

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