POLICY ANALYSIS SERIES

ISSUES RELATED TO STATE HOSPITALS / NO. 8

OPTIONS AND RECOMMENDATIONS FOR THE MINNESOTA STATE HOSPITAL SYSTEM

I. INTRODUCTION

This is the last in a series of reports in response to a legislative mandate to study and plan for the state hospital system.

The Legislature directed that:

> The Institutional Care and Economic Impact Planning Board shall develop a plan. The plan shall include proposals which protect the general interests of employees and communities affected by the deinstitutionalization of state hospitals, including proposals that attempt to preserve employment rights and benefits, provide training and retraining of these employees. In addition, the plan shall propose specific methods for assuring minimal impact on the economic life of communities affected by the deinstitutionalization of state hospitals (Chapter 654, Section 19, Subdivision 4).

The purpose of this paper is to discuss several options and present a final set of recommendations approved by the Institutional Care and Economic Impact Planning Board at its January 18, 1985, meeting.

II. METHODOLOGY

Experiences in other states were gathered from a review of national literature. Within Minnesota, numerous reports have been produced on the future of the state hospital system by the Department of Public Welfare (now the Department of Human Services).

Based on this review and information gathered from the research studies and public input, a set of options was prepared and presented to the Institutional Care and Economic Impact Planning Board. Each option is described briefly followed by implications in terms of residents/patients, employees, economic impact, and alternative uses of the facility.

The remainder of this report will present each option in the following order: (1) Maintain all state hospitals but reduce staff complement in the mental retardation units and increase staff complement in the mental illness units, (2) Decentralize the state hospitals, (3) Increase efficiency and introduce elements of competition, and (4) Closure of one or more state hospitals. The preferences and final recommendations of the Institutional Care and Economic Impact Planning Board are presented in the final section.

The state has multiple interests in the state hospital issue. At times these interests are conflicting:

a. The state has primary responsibility for providing services through state hospitals and overall supervision for community services.

b. The state monitors and licenses both state and community services.

c. The state serves as guardian and protector of vulnerable people.

d. The state is a defendant in court action and must adhere to court rulings.

e. The state is the employer of all workers at state hospitals and has a responsibility to deal with them equitably.

f. The state has contractual agreements with unions that represent employees. Contracts must be adhered to and relationships maintained.

g. In case of closure, the state would provide services to unemployed state hospital workers through these agencies:

   (1) Department of Economic Security
   (2) Department of Human Services

h. The state is concerned with cost containment and prudent purchasing of services.

i. The state also tries to maximize federal financial participation through reimbursement of eligible services.

III. OPTION 1: CONTINUE OPERATION OF EIGHT STATE HOSPITALS WITH STAFF REDUCTION IN THE MENTAL RETARDATION UNITS AND STAFF ADDITIONS IN THE MENTAL ILLNESS UNITS.

Serve people with mental illness and chemical dependency at approximately the 1984 levels of service.

Serve people with mental retardation in declining numbers according to Welsch v. Levine Consent Decree and Title XIX Home and Community Based Waiver. At this time the number of people served by the waiver compared to the projected numbers to be served show that the waiver's impact will probably be smaller than expected in its first year of operation.

Maintain specialized treatment programs as appropriate.

Continue reliance on private providers for community services.

IMPLICATIONS

A. Residents/Patients

1. Three hundred (300) mentally retarded residents will be transferred to community settings under the Welsch v. Levine Consent Decree by July 1, 1987 (population will be 1850 according to the Consent Decree).

2. Two hundred and eighty-two (282) mentally retarded residents will be transferred to community settings under the Title XIX Waiver.

3. The projected reduction according to the Welsch Decree and the waiver, by state hospital is as follows:

TABLE 1

MENTAL RETARDATION POPULATION PROJECTIONS 1984 - 1987

State Hospital	MR Pop. 6-30-84	Projected MR Pop. 6-30-85	Projected MR Pop. 6-30-86	Projected MR Pop. 6-30-87	Population Reduction 1984 - 87
Brainerd	273	254	228	200	73
Cambridge	487	444	382	318	169
Faribault	706	669	618	562	144
Fergus Falls	232	217	196	174	58
Moose Lake	108	97	80	62	46
St. Peter	171	159	142	124	47
Willmar	152	141	125	107	45
TOTAL	2,129	1,981	1,771	1,547	582

Source: Department of Human Services: Biennium Budget 1985 - 87.

5. During the fall of 1984, each mentally retarded resident at the state hospitals was screened by staff at each state hospital. The Waivered Services Screening Document was used to determine the recommended placement of the residents. The results are as follows:

TABLE 2

RECOMMENDED PLACEMENT OF STATE HOSPITAL MENTALLY RETARDED RESIDENTS

Recommended Residential Placement	Number	Percentage
Natural or Adoptive Family	10	0.5%
Foster Care	15	0.7%
Relatives (not immediate family)	7	0.3%
Own Home - Supervision < 24 hours	1	-
Own Home - 24 hours	5	0.2%
Out of Home - Supervision < 24 hours	1	-
Out of Home - 24 hour Supervision	48	2.4%
Skilled Nursing	6	0.3%
State Hospital	1,313	66.0%
ICF	21	1.0%
ICF/MR	560	28.0%
Other	14	0.6%
TOTAL	2,001	100.0%

Source: Department of Human Services, Waiver Screening Survey, 1984

5. The anticipated average daily population for mental illness, chemical dependency, security, adolescents, and geriatrics is as follows:

TABLE 3

PROJECTIONS FOR OTHER POPULATIONS - FY '86

State Hospital	MI	CD	Geriatrics	Adol.	Security	Total
Anoka	240	80				320
Brainerd	72	66				138
Fergus Falls	96	143				239
Moose Lake	65	165	115			345
St. Peter	165	54			213	432
Willmar	240	104		45		389

TABLE 4

PROJECTIONS FOR OTHER POPULATIONS FY '87

State Hospital	MI	CD	Geriatrics	Adol.	Security	Total
Anoka	245	80				325
Brainerd	78	68				146
Fergus Falls	96	145				241
Moose Lake	65	165	120			350
St. Peter	165	54			213	432
Willmar	235	104		48		387

B. Employees

1. As a baseline, if the number of employees were to remain the same, the staffing levels (full time equivalents) would be as follows:

TABLE 5

PROJECTED FULL-TIME EQUIVALENT POSITIONS AT MINNESOTA STATE HOSPITALS FROM 1984 - 1987

	Staffing Levels for Each Year
Anoka	378
Brainerd	686
Cambridge	796
Faribault	1,093
Fergus Falls	622
Moose Lake	512
St. Peter[1]	712
Willmar	643

[1]Includes Security Hospital

2. The Department of Human Services submitted its 1985-1987 budget request with an anticipated reduction in force of 644 positions in the mental retardation units. The budget request also included an additional 125 positions for the mental illness units.

TABLE 6

PROJECTED REDUCTIONS AND ADDITIONS FOR FY '86 - FY '87

State Hospital	1984 Staff Complement	Proposed Reduction in Positions	FY'86 & FY'87 Additional Staff for MI	Net Effect	Projected Separations FY'86-87 for All Employees[1]
Anoka	378	N/A	27	+27	126
Brainerd	694	110	13	-97	154
Cambridge	799	157	N/A	-157	216
Faribault	1,093	146	N/A	-146	420
Fergus Falls	622	72	7	-65	194
Moose Lake	512	45	23	-38	178
St. Peter	712	52	16	-36	140
Willmar	644	46	39	+7	212

[1]Includes retirement, death, and resignations for all employees.
Source: Department of Human Services Biennial Budget 1985-87.

3. The number of separations for all employees (including part-time) for FY '84 was as follows:

Anoka	63
Brainerd	77
Cambridge	108
Faribault	210
Fergus Falls	97
Moose Lake	89
St. Peter	70
Willmar	106

Downsizing can be accomplished through natural attrition with special effort made to fill positions necessary for health and safety standards and compliance with Welsch Decree standards.

4. Displacement of employees can also be lessened by extension of the Rule of 85 provision that allows early retirement if a person's age and years of state experience total 85.

5. Another way to lessen displacement of employees is to allow individuals currently eligible under Rule of 85 to receive medical insurance benefits until age 65. The estimated cost of this provision would be less than the cost associated with layoffs.

6. The projected staff reductions will be directly affected by the ability of the Department to meet the provisions of the Welsch Decree and the Title XIX Waiver. Failure to meet these goals would change the number of employees affected.

C. Buildings/Energy

1. Maintaining all eight state hospitals with the anticipated reduction in the mentally retarded population will reduce the demand for living space. Anoka State Hospital, which does not serve mentally retarded people, has experienced increased demand for living space.

2. The State will continue to incur capital costs for renovation and remodeling at all eight sites (Table 7).

3. If resident and patient populations are consolidated, selected buildings can be declared surplus and sold.

TABLE 7

REQUEST FOR CAPITAL IMPROVEMENTS
AT STATE HOSPITALS FY '86-87

Anoka	$ 80,000
Brainerd	$635,000
Cambridge	$240,000
Faribault	$560,000
Fergus Falls	$595,000
Moose Lake	$140,000
St. Peter	$855,000
Willmar	$535,000
TOTAL	$3,640,000

Source: Department of Human Services Biennial Budget 1985 - 87

D. Community Impact

1. There would be no change in community impact if all eight state hospitals remain open.

E. Economic Impact

1. The reduction in force proposed by the Department of Human Services will have a negative economic impact depending upon the number of employees affected and the total salaries.

2. The addition of staff in the mental illness units proposed by the Department of Human Services will have a positive economic impact depending upon the number of employees affected and the total salaries.

IV. OPTION 2: DECENTRALIZE STATE HOSPITALS

All eight state hospitals could begin to decentralize services with the state operating community based services.

The transition process would take several years and the change would reflect regional needs.

All three groups, mentally ill, mentally retarded and chemically dependent people would be affected.

APPROACHES

There are at least three different approaches to decentralizing state hospital services:

AFSCME November 19, 1984 proposal with background from Rhode Island

Department of Human Services proposal on state operated community services

Massachusetts model (mental health)

AFSCME November 19, 1984 Proposal

AFSCME proposes that Minnesota institute a project for state-owned and operated group homes and other community facilities. This project will begin in 1985 and be evaluated after two years. Recommendations will be made at that time on further expansion of the system. This project will have eight parts:

1. Residents of state hospitals who are slated for placement in the community will be chosen for the project. Clients could also come from the population of those to be diverted from placement in state hospitals, and those to be placed under the Welsch Consent Decree and the Medicaid Waiver. Residents will be screened and evaluated for program needs and the level of care they require. The families of residents will be consulted when that is possible, and efforts made to see that community facilities will be conveniently located. It is imperative that "adequate professional judgments" be the determining factor in any placements decided upon. Only residents for whom a community placement is beneficial should receive community placement.

2. Staff in the hospital will have the project explained to them, and positions in the project will be posted for bid, following union contractual procedures. Staff must be aware that interim residence and training are part of the project, and that relocation may be required. Staff will maintain all collective bargaining rights. Some modifications of the contract and work rules to address working conditions in the community would be anticipated and negotiated through normal collective bargaining procedures.

3. Successful bidders for positions and targeted residents will have a transition/training process, to get to know each other prior to a move, and to develop the skills needed for residential life in a smaller setting. For staff, this could include half-time hands-on training, and half-time working, as in Rhode Island. This interim period should be at least six weeks long. The State University system could serve as primary organizer for staff training using experts and advocates from the public and private sector to teach employees these skills.

4. Community residences will be built or leased by the state following Class B certification standards. Any adaptation of the residences will be completed during the interim period based on the needs of residents to be transferred. Such modifications as are needed may use the state bidding system and/or service, maintenance, and technical staff from the hospitals. It is anticipated that bonding will be required for purchase or building of new residential facilities.

5. Wherever possible, hospital facilities such as day programs and specialized services and equipment will be coordinated so that the project community facilities do not duplicate hospital facilities. Weekly meetings of hospital and community staff would be held through the duration of the project.

6. Community Involvement Boards, consisting of local residents, will be established to explain and publicize the project, and ensure that community life is a reality for both residents and staff. Staff training would include skill development in community outreach and organizing to help integrate the home and its residents into the community. Community integration is crucial. Not every private sector program has failed to develop community linkages, but few have done so to the extent necessary. Business leaders, churches, volunteer groups, and other local organizations and individuals would be actively solicited. A monthly Board meeting, incorporated with the staff meeting, would maintain these local contacts.

7. Monitoring must be an integral part of the pilot project, so that any problems or successful aspects of the project can be avoided or duplicated in the future. This should include weekly meetings among community staff and hospital staff, monthly meetings with the local board, and careful documentation of the progress of residents. We do not know, for example, if residents benefit from a smaller setting. Data from Rhode Island indicate that staff prefer smaller settings. We need to know how much time residents spend being transported and how normal the lives of residents really are. We also need to know what stresses residents find in smaller settings, particularly when residents are severely disabled. What is the effect on clients of living in close proximity to a randomly selected family? We need to know medication levels, both in and out of hospitals. We also need to know what construction and facility adjustments really work, for both residents and staff.

8. Evaluation procedures must be in place early. Costs are obviously crucial to evaluate, but evaluations must also be made of progammatic and developmental aspects of the project. Every six months the meeting of staff and local board will be an evaluation session. At one and two year intervals, more extensive evaluations can be carried out, resulting in recommendations concerning enhancement of the system.

Rhode Island Background

1. In Rhode Island, the Governor, state agencies, and AFSCME signed a memorandum of agreement that assured no AFSCME member would be laid off because of deinstitutionalization. Although Rhode Island is similar in geographic size to Ramsey County, and has a population of 1,000,000, there are lessons to be learned from their experiences.

2. The Ladd Center is the only state institution for mentally retarded persons. The Ladd Center is under a Consent Decree to reduce its population. Some state officials predict Ladd Center will eventually be closed.

3. After the Governor directed that deinstitutionalization continue and that no AFSCME employee would lose his or her job, the Department of Mental Health and Mental Retardation began developing group homes, apartments, and day programs using state employees.

4. The State of Rhode Island has a mix of privately and publicly operated community based services.

5. In Rhode Island case management is carried out by state employees; day programs receive Commission on Accreditation of Rehabilitation Facilities accreditation; there are unannounced visits every two months required by law for every group home; and a 5-member program audit unit reviews programs.

6. The cost of state-operated community services is 15% higher than nonprofit community services. Rate setting for nonprofit providers is negotiated with state officials.

7. All funding for the state institution, community based services (public and private), and the waiver, is centralized in one person (state mental retardation director) who has the authority to transfer funds from the institution to the community as residents and staff leave Ladd Center for community settings.

8. There are 300 state employees working in the community (150 in day programs and 150 in residential settings). All state employees are retrained prior to working in the community.

9. All state and community facilities (land and buildings) are owned by the state of Rhode Island. The capital funds come from bond referenda. An Office of Community and Residential Development is responsible for siting and real estate development.

10. The state uses performance contracts and contracts have been revoked for failure to perform.

11. A complete set of policy and operation manuals is available in the State Planning Agency.

IMPLICATIONS

A. Residents/Patients

1. The AFSCME proposal affects mentally retarded persons who will be discharged from the state hospitals for community placement because of the Welsch Decree and the Title XIX Waiver.

2. The number of mentally retarded people affected would be the same as the numbers given in Option 1.

B. Employees

1. Employees currently working at the state hospitals would be allowed to bid by class and seniority for positions in community settings.

2. Employees would continue to be covered under collective bargaining agreements and the pension plan.

3. A training program would be necessary to allow the transition.

4. The number of employees affected needs further analysis.

C. Buildings/Energy

1. Maintaining all eight state hospitals with the anticipated reduction in the mental retardation units will reduce the demand for living space. Anoka State Hospital, which does not serve mentally retarded people, has experienced increased demand for living space.

2. The State will continue to incur capital costs for renovation and remodeling at all eight sites (Table 7).

3. If resident and patient populations are consolidated, selected buildings can be declared surplus and sold.

4. The construction of ICF-MR, Class B facilities for mentally retarded persons will require state funds. Further analysis is necessary to determine these costs.

D. Community/Economic Impact

1. The economic impact for each state hospital area would vary depending upon several factors:

   a. The number of employees who relocate to work in community services.

   b. The relative dependence of the community on state hospital economic activity.

   c. The alternative uses of vacant buildings.

   d. Depending upon the location of new community services, there would be a positive redistribution of economic impact.

Department of Human Services Proposed Pilot Program for State Operated Community Services, January 18, 1985.

The Institutional Care and Economic Impact Planning Board requested the Department of Human Services to prepare a plan for the provision of state operated community services. The following is an outline of the plan submitted by the Department of Human Services at the January 18, 1985, meeting of the Institutional Care and Economic Impact Planning Board. The information presented by the department is intended to outline the basic parameters for the establishment of a pilot program for state operated community based services.

1. The Department of Human Services proposed creation of a three-year, one state hospital catchment area pilot project to test the viability of a design for development of state-operated community services for mentally retarded people.

2. The Department proposes pilot project development in four major areas:

   a. Residential (long-term). Group homes of up to six adults or three children staffed 24 hours a day. The homes would primarily care for medically fragile or behaviorally impaired residents.

   b. Residential (short-term). The same setting as above but program emphasis would be on immediate temporary care.

   c. Day Habilitation (non-facility based). This approach would provide staff support to adults on job sites with non-handicapped persons.

   d. Support Services. Supportive services for clients and direct care staff for the following:

      1) Diagnosis and evaluation
      2) In-home respite care
      3) Family support
      4) Provide training and technical assistance
      5) Crisis intervention.

      The services listed above would be provided by state employees to current state hospital residents targeted for placement, as well as to persons who are at risk of being admitted to state hospitals.

3. The services outlined above would be developed and managed by a regional management entity. The project director would be responsible for administration, quality assurance and supervision of service staff.

4. The project manager would report directly to the Commissioner of the Department of Human Services through an Assistant Commissioner. The central office of the Department of Human Services will select the project director and oversee all administrative and programmatic policies and procedures.

5. The selection of pilot project site(s) will take into account the following:

   County cooperation,
   The capability of a state hospital to support the effort,
   The programming needs of the area,
   Compatibility with the Department's priorities.

6. The operation of the pilot projects will be phased in over time with the establishment of the management entity by January, 1986.

7. Two sets of performance indicators will be established:

   Program or service indicators,
   Management performance indicators.

8. At the close of the project, December 1987, a report on the pilot project will be submitted to the Legislature. The report will include an evaluation of the effort and recommendations for the future operation of state operated community based services.

9. The following are currently unresolved issues which will need to be addressed to ensure long term success of state operated community based services:

   Case management, county and state relationships in the pilot project area(s),
   Relationship to the Welsch Consent Decree,
   Relationship of state hospital and counties,
   Funding methodology and flow of dollars, i.e., rate setting, source of funds, etc.,
   Relationship to Title XIX Waiver,
   Capital assets during the pilot period.

IMPLICATIONS

A. Residents/Patients

1. A pilot project would have limited size.

2. Residents affected would be those scheduled for community placement under the Welsch Decree. The projected number of residents/patients at the state hospitals would not be changed.

B. Employees

1. The number of employees required to conduct the pilot project has not, at this writing, been determined.

2. Employees may have to perform multiple job functions in community setting.

3. Job descriptions may have to be modified to reflect the changes in work tasks.

4. The selection of staff to work in the pilot project may be subject to the provisions of collective bargaining agreements.

C. Buildings/Energy

1. The pilot projects will not directly affect the buildings currently on the grounds of state hospitals.

2. The issue of ownership of buildings (purchase, leasing) in the community will need to be resolved.

3. The effects as presented in Option 1 will remain the same.

D. Economic Impact

1. The community services as outlined will have a limited positive economic impact on the community in which the services are located.

2. The pilot project will not change the economic impact as outlined in Option 1.

E. Cost

1. The cost of the pilot program has not been determined.

Massachusetts Mental Health Approach (Gudeman and Shore, 1984)

1. In 1959, Massachusetts served 23,000 mentally ill patients in state hospitals. In 1984, the number was 2,700 (1,900 in state hospitals and 800 in state-operated community mental health centers).

2. The Massachusetts Mental Health Center is a state-owned and state-operated community mental health center. It is affiliated with the Harvard Medical School.

3. The Massachusetts Mental Health Center is responsible for 200,000 people in its catchment area and has had no backup state hospital except for security purposes (6 people per year go to security).

4. The Massachusetts Mental Health Center includes two day hospitals (40 - 50 patients each), a 30 bed intensive care unit for acute episodes, and an "inn" (30 - 35 patients) to house temporary residents as a transition to community living, a full range of community residences and day treatment programs (170 patients), and a specialized psychiatric-geriatric nursing home (20 patients). Other nursing homes serve an additional 200 patients.

5. The basic tenet is that chronically mentally ill patients require a system that allows easy movement between community and hospital setting. The average length of stay in intensive care is 10 days, 28 days in the day hospitals, and 21 days at the inn.

6. The Massachusetts Mental Health Center estimates there are at least 15 persons per 100,000 population who need specialized services as presented in Table 8.

TABLE 8

ESTIMATES OF MENTALLY ILL PATIENTS IN MASSACHUSETTS
WHO NEED SPECIALIZED SERVICES
(Gudeman and Shore, 1984)

Type	Per 100,000
1. Elderly, demented, behaviorally disturbed	3.0
2. Mentally retarded and psychotic	3.0
3. Brain damaged and assaultive	1.5
4. Psychotic and assaultive	2.5
5. Chronically schizophrenic, disruptive and endangered	5.0
TOTAL	15.0

7. In order to make this approach work, the following conditions must be met:

   a. Stringent preadmission screening must be established to ensure alternatives have been exhausted.

   b. Units should be developed to address needs of five special groups. These units are described in greater detail in the New England Journal of Medicine (September, 1984).

   c. A multidisciplinary staff must be assembled that includes affiliation with a department of psychiatry.

   d. Units for no more than 25 - 30 patients can be housed on the grounds of a state hospital or in general hospitals.

   e. Backup by an acute care psychiatric hospital or unit in general hospital must be available.

   f. Political and advocate support must be in place.

   g. Operation can be public or contractual between the state and private providers.

8. Jonathan Balk, CEO of Anoka State Hospital, sent over 130 questionnaires to county social services, consumers, professionals, police departments, courts, and medical centers. The questionnaire assessed agreement with the five categories presented in Table 8 and assessed agreement with the Massachusetts Mental Health Center approach. Based on preliminary results (December 20, 1984 personal communication), 40 people who responded agreed with the five categories as presented but respondents offered two additional categories (mentally ill and chemically dependent; character disorders and chemically dependent). Those who responded agreed that the five categories of people should be treated at the regional level, although some elderly, assaultive clients can be treated at the local level.

V. OPTION 3: IMPROVE EFFICIENCY AND EFFECTIVENESS OF STATE HOSPITALS. INTRODUCE ELEMENTS OF COMPETITION DEPENDING UPON THE SUBGROUPS SERVED.

Prior to the installation of competitive elements the following management systems will have to be in place:

Uniform Chart of Accounts
Cost Accounting System
Resident/Patient Outcome Measures
Quality Assurance
Organizational Performance Measures

State hospitals would generate revenue as a direct function of services rendered.

The management of the state hospitals would be decentralized and each state hospital would be responsible for:

Program mix,
Budgeting and accounting,
Marketing, and
Rate setting.

Performance measures would be established to determine the economic and programmatic viability of each hospital.

Catchment areas would be eliminated and counties would have a choice of providers of treatment.

The funding mechanism would change to allow counties to be responsible for payment of service.

Benefits of Management Systems:

1. Uniform accounting system allows detailed operational comparisons between each hospital without further accounting analyses.

2. Cost accounting system provides hospital management with a clear understanding of the cost of providing various products and services. It also assists the planning process.

3. Resident/patient outcome measurement system provides an efficient and cost-effective way for hospitals to track the resident/patient population and the services provided to those residents/patients. This system should also improve the quality of care provided.

4. A quality assurance system provides a mechanism for more objective assessment of the quality of care provided. Such a system would also improve the opportunity for outside agencies to audit the quality of care being provided.

5. An operations performance measurement system allows for significant improvement in all areas measured - patient/resident data, staff records, expenditures, etc.

IMPLICATIONS

A. Residents/Patients

1. The counties would choose among the state hospitals providing treatment. Referrals would occur through the existing mechanisms such as case management, court commitments, etc. Individuals affected would have a choice or "proxy" choice through family or case manager to select service site.

   The counties would choose the state hospital which would provide the best treatment for the particular needs of the clients at a pre-negotiated cost.

2. Under the Department of Human Services proposal, the choice of chemical dependency treatment would be among all types of providers.

3. Mentally retarded residents would continue to be placed from the state hospitals per Welsch v. Levine Consent Decree and the Title XIX Waiver. The number of mentally retarded residents affected would be the same as outlined in Option 1.

4. Services developed by each state hospital would be subject to the same state policies as all other providers (moratorium, rate setting caps, etc.).

B. Employees

1. Employees working at the state hospitals may be trained and transferred internally to work in program areas as the state hospitals change to meet the needs of the residents/patients.

2. Job descriptions have to be redefined to accommodate the flexibility required for a competitive environment.

3. The number of employees affected would be a function of the program direction taken by each state hospital.

C. Buildings/Energy

1. The utilization of the building space will be a function of the programming mix, which is a decision of the chief executive officer at each state hospital. The remodeling, construction or demolition of buildings will be the responsibility of each state hospital.

2. Per diem costs will include the capital cost for improvements, remodeling and new construction.

3. The proceeds of the sale of state hospital property would revert to the budget of the respective state hospital.

4. Energy cost is an operational expense. The decision to manage those costs will be at the discretion of each chief executive officer.

D. Community/Economic Impact

1. The economic impact for each hospital would vary depending on the skills of the local management team. The size of the state hospital will be dependent upon the successful operation of the hospital.

E. Cost

1. Each state hospital would be a profit center. Revenue must equal cost, and revenue would be generated as a direct function of services and treatment rendered.

2. A cost accounting system will be established at each state hospital in order to determine the actual cost of services and treatment at the hospital and its different departments and services.

3. Per diems will be determined at each state hospital based upon the actual average fixed and variable costs.

4. Specialized services and treatment cost will be calculated in order to determine the cost of providing the service and treatment to each resident/patient.

5. Enterprises, e.g., laundry, will function as profit centers, in that the charge for the service must equal the actual cost of providing the service.

6. Any rental or leasing of state hospital space would require the space be rented or leased at fair market value and separate metering for the utilities.

F. Experiences and Cautions about Competitive Approach

1. The individuals who receive services from state hospitals are highly vulnerable people with few resources. Caution must be exercised to avoid "dumping the most difficult cases," "creaming the easiest clients," or simply not providing services. The state has always been there as a back-up resource and cannot reject individuals because of the type of problems presented or because of the person's lack of resources.

2. True competition does not exist in human services given the state's overall control of the number of beds (moratorium), the overall funding levels and rate setting mechanisms, as well as the licensing and certification responsibilities.

3. In Michigan, community mental health centers have overall responsibility for development of community services. The state of Michigan recognizes differences in county capabilities. In some cases the state runs all services. In the majority of cases responsibility is shared. In a few cases the community mental health boards have total control including state institution allocations. However, in the latter case, some counties avoid financial risk by extending the negotiation process for funding to the end of the fiscal year thus avoiding loss on the county's behalf.

4. If individual state hospitals are responsible for streamlining budgets, then central office indirect costs will have to be shifted away from the state hospital per diems to other sources.

5. Counties may not want the responsibility or risk of additional block grants to purchase state hospital services. If the amount is based on a historical figure or capitation approach, then the county may run out of funds before a fiscal year ends. In that case, individuals who need services would not be served.

6. Depending on the type of funding approach there are several unintended consequences that may occur. These same problems occur under the current system:

   a. Length of stay - If funding is linked to length of stay, individuals usually stay the maximum and then are discharged. Length of stay may not be related to treatment need or outcome.

   b. Admission/readmission - Individuals can be treated and released several times in the same year.

   c. "Creaming" - If providers have a choice, the clients who are easier to work with will be chosen first.

7. Quality assurance must become a reality in terms of onsite inspections, regular reviews of records, and monitoring for program outcomes.

8. The role of the central office of the Department of Human Services must be clarified. The Department of Human Services should develop overall state goals for the system and work with the state hospitals to ensure adequate and appropriate program mix, geographic access, and measurable outcomes.

VI. OPTION 4: CLOSE ONE OR MORE STATE HOSPITALS BY JULY 1, 1987 OR LATER.

Consolidate services for people with mental illness, chemical dependency, and mental retardation in the remaining state hospitals.

The mental retardation population will continue to decline according to Welsch v. Levine Consent Decree and the Title XIX Home and Community Based Waiver. At this time, the number of people served by the waiver compared to the projected number to be served show that the waiver's impact will probably be smaller than expected in its first year of operation.

Maintain or move specialized treatment programs to remaining state hospitals.

Continue reliance on private providers for community services.

IMPLICATIONS

A. Residents/Patients

1. Transfer of residents/patients would be required. Depending on the transition timeline, residents/patients could move to community services. Based on the Rochester closure, however, most residents/patients were transferred to other state hospitals.

2. In order to estimate where the residents/patients would transfer, several factors must be considered:

   a. What is the home county or county of financial responsibility for each person? Services should be offered as close to home as possible.

   b. What beds are available at other state hospitals? There are licensed beds (largest number), certified beds (compliance with ICF-MR regulations, for example) and staffed beds (smallest number).

c. Determine or match the person's needs with the availability of beds (for example, a mentally retarded person should be moved to an ICF-MR bed). Consideration should be given to client characteristics (sex and physical handicaps), and the type of accommodations available at the receiving facility (male/female units and physically accessible space).

d. If there aren't sufficient number of beds to meet licensing and certification regulations, then how much money is needed to bring the receiving facility into compliance?

3. The first determination must be the licensed capacity and availability of beds.

TABLE 9

POPULATION, BED CAPACITY, AND AVAILABLE BEDS
IN MINNESOTA STATE HOSPITALS FY '84

State Hospital	Average Daily Population FY '84	Licensed Bed Capacity	Licensed Beds by Type	Average Population by Type FY '84	Average Available Beds by Type FY '84
Anoka	316	347	257 (MI)	237 (MI)	20
			90 (CD)	79 (CD)	11
Brainerd	450	531	80 (MI)	65 (MI)	15
			71 (CD)	60 (CD)	9
			363 (MR)	325 (MR)	38
			17 (Hosp.)		
Cambridge	483	556	556 (MR)	483 (MR)	73
Faribault	712	845	775 (MR)	712 (MR)	133
			35 (NH)		
			35 (Med.)		
Fergus Falls	469	561	115 (MI)	99 (MI)	16
			198 (CD)	139 (CD)	59
			248 (MR)	231 (MR)	17
Moose Lake	435	645	090 (MI)	62 (MI)	28
			267 (CD)	159 (CD)	108
			143 (MR)	107 (MR)	36
			145 (Ger.)	107 (Ger.)	38
St. Peter	602	674	176 (MI)	155 (MI)	21
			58 (CD)	54 (CD)	4
			204 (MR)	170 (MR)	34
			236 (Sec.)		
Willmar	552	644	276 (MI)	253 (MI)	20
			118 (CD)	103 (CD)	15
			170 (MR)	154 (MR)	16
			66 (Adol.)	42 (Adol.)	24

Sources: Department of Human Services 1985-87 Biennial Budget for each state hospital; and phone interviews with each CEO or designated respondent, November, 1984.

4. The second consideration would be the proximity of beds. The following are possible transfer plans if any state hospital were to close. (Based on approximate average daily population figures and proximity of nearest beds.) These figures do not include consideration for MR, MI, CD designation, the person's home county, compliance with licensing or certification, and no regard for personal characteristics such as physical handicap.

TABLE 10

POSSIBLE TRANSFER PLANS IF ANY STATE HOSPITAL WERE TO CLOSE

If Anoka closes:	200	transferred	to Willmar
	75		to St. Peter
	30		to Brainerd
If Brainerd closes:	240	transferred	to Moose Lake
	115		to Fergus Falls
	86		to Cambridge
If Cambridge closes:	240	transferred	to Moose Lake
	92		to Brainerd
	173		to Faribault
If Faribault closes:	78	transferred	to St. Peter
	86		to Cambridge
	205		to Willmar
	240		to Moose Lake
	92		to Brainerd
If Fergus Falls closes:	92	transferred	to Brainerd
	205		to Willmar
	240		to Moose Lake
If Moose Lake closes:	92	transferred	to Brainerd
	86		to Cambridge
	115		to Fergus Falls
	240		to Willmar
If St. Peter closes: (Not Security)	173	transferred	to Faribault
	205		to Willmar
If Willmar closes:	115	transferred	to Fergus Falls
	78		to St. Peter
	173		to Faribault
	92		to Brainerd
	240		to Moose Lake

4. Institutional closure does affect individual patients/residents. Based on the Rochester experience as presented in public testimony, closure has resulted in at least three suicides of former patients, longer lengths of stay in other state hospitals, an increased number of street people, increased use of emergency rooms of Rochester hospitals, and an increased number of people incarcerated in jails.

5. Existing research on the effects of closure on residents/patients and families has been summarized as follows:

   a. General effects on residents/patients

      1) Increases in mortality rates (Heller, 1984; Marlowe, 1973; Kasl, 1972; Miller & Lieberman, 1965)

      2) Increases in health problems (Heller 1982a; Rago, 1976)

      3) No increase in mortality of mentally ill people (Markson & Cumming, 1974)

      4) Problems in emotional, behavioral, and mental health changes with biggest impact on those who are in poorest physical health (Goldfarb, Shahinian & Burr, 1972; Heller 1982b; Killian, 1970; Marlowe, 1973)

      5) Contradictory results on changes in intelligence

   b. Dixon closure effects on mentally retarded residents (Braddock, Heller, & Zashin, 1984):

      1) Residents showed little transfer trauma, but did have some adjustment problems

      2) No increase in mortality

      3) Activity level of residents increased at new facilities

      4) Families initially opposed and then accepted closure

      5) Employees were most severely affected

      6) Diminished quality of care for new residents at receiving facilities. Staff-resident ratios were lowered.

   c. Families

      1) Families report high degree of stress and strong resistance (Conroy & Latib, 1982)

2) Surveys in Washington, Pennsylvania, and New Jersey indicate 2/3 of families of institutionalized mentally retarded people oppose community placements (Conroy & Latib, 1982; Landesman-Dwyer et al 1980; Vitello & Atthowa, 1982)

3) Opposition to relocation comes from several sources:

   a) Institution provides better care, more experienced staff, greater security

   b) Reservations about normalization

   c) Process used to close state hospitals

   d) Family stress because of initial difficulty in placing the family member.

4) After placement in community, the majority of families are satisfied with community services and deinstitutionalization (Conroy & Bradley, 1983).

IMPLICATIONS

A. Employees

1. There are nine possible options for state employees in the event their particular hospital should reduce its staff.

   a. Transfer to another state hospital in the same position. This option is currently possible under Minnesota Statute if an employee would consider relocation. The state can provide some moving expenses.

   b. Transfer to another state hospital in a different position. Although it is more difficult than Point A, it is possible.

   c. Transfer to another state agency in a different position. Also legally possible but difficult.

   d. Human service work outside of the state system. Both public and private sector employment options are possible. Continued work in public service will permit retirement plan portability; however, other benefits derived from state seniority would be lost. Employment in the private sector would result in the loss of all rights and benefits which were acquired while in state service.

e. Nonhuman service work in the public or private sector. This option includes the full range of nonhuman service employment opportunities. Employment with another government entity including school systems would permit the portability of retirement and pension benefits. This option is a function of the labor market and the choice of each individual.

f. Education and training. Employees could choose to go back to school or seek additional skill development and training which would result in a possible career change.

g. Unemployment compensation. This is a temporary option for the employees. The amount and length of benefits are determined on an individual basis.

h. Public assistance. Some employees will have limited, if any employment possibilities, particularly if they are unable or unwilling to relocate for another job or if their age makes reemployment difficult.

i. Retirement. Some employees may be close enough to retirement to consider it to be their best option. The current Rule of 85, which permits certain employees who meet specified criteria to retire early, expires December 31, 1986.

2. If a facility is closed, staff reductions occur separately within each state hospital. Each hospital is a separate "seniority unit" for purposes of bumping and layoff. In the event of a closure, the following actions might be taken:

a. A system wide hiring freeze would go into effect except for positions necessary to meet health and safety standards and the Welsch Consent Decree.

b. Staff at the affected state hospital would be offered transfers to the remaining state hospitals as openings occur.

c. The state would pay moving expenses per the respective collective bargaining agreements.

d. Employees refusing to transfer would be terminated per arbitrator's decision.

3. Table 11 presents the number of full time employees, the projected number of separations or turnover for FY '84, and the number of employees eligible for retirement. Based on the employee survey conducted by the State Planning Agency, the number of employees willing to accept a transfer to any location is presented followed by the net number of positions available in state service according to the Department of Employee Relations.

4. Research has been conducted on the effects of closure on employees. The following summary highlights the findings:

   a. Closure affects morale and performance of staff. Staff behavior affects residents/patients (Schinke & Landesman - Dwyer, 1981).

   b. 79% of the staff lost interest in their work after closure was announced at Cleveland State Hospital and 29% of the staff reported decreased concern about quality of care. (Schultz, Nothnagel & Lyons, 1975).

   c. There is a personal toll felt by employees facing unemployment, underemployment, and downward mobility that includes increased stress, suicide, homicide, physical problems and mental health problems.

   d. During closure the emotional stages are (1) shock, (2) denial, (3) relief, (4) anger (5) bargaining, (6) depression, and (7) acceptance (Arvey & Jones, 1982; Greenblatt & Glazier, 1976).

B. <u>Buildings</u>

1. The state has the option to sell or convert an entire facility. Up to three years may be required to develop alternative uses.

2. Based on a national survey of other states, the most likely alternative use of a state hospital is for other institutional settings (correctional facility, veteran's, etc.).

3. The state has the opportunity to dedicate revenue from the sale of property for special use or general revenue.

4. If the residents/patients are transferred to other state hospitals, the receiving facilities may have to upgraded.

TABLE 11

HYPOTHETICAL CHOICES OF EMPLOYEES IN CASE OF CLOSURE
Based on Employee Survey Conducted in 1984 (N = 3,154)

		State Hospital								
		Anoka	Brainerd	Cambridge	Faribault	Fergus Falls	Moose Lake	St. Peter	Willmar	Total
1.	Full Time Employees November 15, 1984	354	609	699	850	526	438	711	563	4,750
2.	Projected employee separations	53	47	94	161	40	52	33	67	547
3.	Employees eligible for retirement	33	61	31	30	49	38	68	59	369
4.	Employee willing to accept transfer to any location	33	110	80	81	132	109	89	131	765
5.	Net number of positions available	190	26	67	34	4	4	29	6	360
6.	Employees willing to take local transfer	126	92	159	162	74	97	100	86	896
7.	Tranferred	97	26	67	34	4	4	29	6	267

Sources: Lines 1, 2, 3, and 5 provided by Department of Employee Relations;
Lindes 4, 6, and 7 provided by State Hospital Employee Survey, 1984.

C. Community/Economic Impact

1. All areas surrounding state hospitals would be severely affected, with the exception of the area surrounding Anoka State Hospital. The economic impact of each area is presented in a separate detailed report.

2. In the event of a closure, if residents, patients, and staff are moved to another state hospital, there would be a positive economic impact in the area of the receiving facility. The impact depends on the number of residents/patients and employees at the receiving facilities.

3. Throughout the public process, comments were made about the effect closure has on distances traveled for family members, county case managers, sheriffs, judges, and others. Table 12 provides a guide pertaining to the miles between state hospitals.

TABLE 12

IMPACT OF CLOSURE ON ADDITIONAL DISTANCES TRAVELED TO OTHER STATE HOSPITALS

Anoka	Brainerd	Cambridge	Faribault	Fergus Falls	Moose Lake	St. Peter	Willmar	
	104	36	68	161	125	89	88	Anoka
		100	173	96	98	171	116	Brainerd
			90	160	75	106	106	Cambridge
				224	182	40	138	Faribault
					194	203	109	Fergus Falls
						201	187	Moose Lake
							103	St. Peter
								Willmar

D. Cost

1. The closing of one or more hospitals does not immediately result in cost savings. The state, through its collective bargaining agreements and state law, has specific obligations to its employees regarding involuntary separations, except for firings and terminations of employees. The obligations are: severance pay, health benefits, and unemployment insurance. Severance pay and the payment of health benefits are part of the negotiated collective bargaining agreements with the unions representing the employees. The payment of unemployment insurance is required by federal and state law. The following is an explanation of the terms and stipulations regarding the payment of the benefits.

Severance Pay:
All employees, except for certain seasonal and intermittent employees, are eligible to receive severance pay if they are terminated from employment involuntarily (laid off). Employees receive severance pay at a rate of 40% up to 900 hours, and 25% of the hours above 900, of their unused sick leave at their last hourly wage. Employees who elect to retire are also eligible for severance pay.

Health Benefits
Employees with three or more years of consecutive state service receive 6 months of health insurance benefits paid by the state of Minnesota upon involuntary termination, with the one exception of employees terminated with good cause. The cost of health insurance varies for each employee depending upon the particular coverage; however, the system wide average is $923 per employee for six months.

Unemployment Compensation
Unemployment insurance benefits are paid to employees who meet specific eligibility requirements. The maximum benefits are currently $198.00 per week for 26 weeks. The amount of weekly benefits a person receives is a function of the hourly wage and other factors. Receiving the maximum weekly benefits requires a person to work 37 consecutive weeks prior to application for unemployment benefits. The first year cost of closing a hospital will vary depending upon a number of factors:

1. The number of employees to be terminated
2. The reemployment possibilities for affected employees
3. The number of employees eligible for retirement
4. The willingness of employees to transfer to another job
5. The willingness of employees to move to accept another job

Table 13 is a projection of the first year cost of closing a hospital. The analysis assumes:

1. A one year notification until complete closure
2. A hiring freeze
3. Employees eligible to retire would do so
4. The state would provide jobs (as they become available) to employees who desire them

Unemployment costs are calculated for the maximum time of eligibility, 26 weeks of $185 per week. Health benefits are based upon systemwide average at $923 for six months. Severance is determined from the average obligation at each hospital. Moving costs were calculated, based upon the professional judgment of staff at DOER and the average moving cost for Rochester employees ($2,500 per move).

E. Other Costs

In addition to personnel costs due to closure, there are other costs that result from closure:

1. Maintenance, heating and security of buildings for one full year after closure occurs.
2. The extra expense of transferring residents/patients to other state hospitals (including all pre-visits and actual transfer trips).
3. Additional staff for the personnel office to handle employee issues.
4. The cost to the affected counties of providing social services after employee benefits have been terminated.

Additional analyses are necessary to estimate these costs.

TABLE 13

ESTIMATED PERSONNEL COSTS OF CLOSURE BY STATE HOSPITAL DURING THE FIRST YEAR

Type of Cost	State Hospital								Total
	Anoka	Brainerd	Cambridge	Faribault	Fergus Falls	Moose Lake	St. Peter	Willmar	
Unemployment Costs	$ 442,520	$1,755,650	$2,053,870	$2,616,640	$1,447,810	$1,130,350	$2,366,520	$1,443,000	$13,256,360
Health Benefit Costs	84,916	336,895	394,121	502,112	277,823	216,905	454,116	276,900	2,543,788
Severance Costs	145,000	497,994	347,164	637,140	497,000	303,030	785,120	515,165	3,727,613
Moving Costs	82,500	275,000	200,000	202,500	330,000	222,500	327,500	327,500	1,912,500
TOTAL COST OF HOSPITAL CLOSURE	$ 754,936	$2,865,539	$2,995,155	$3,958,392	$2,552,633	$1,922,785	$3,828,256	$2,562,565	$21,440,261

Source: Department of Employee Relations, 1984.

VII. IMPACT OF CLOSING STATE HOSPITALS

In 1982, each state hospital projected what the impact of closure would be. For the purposes of this study, each state hospital was asked to update that report. A summary of those documents has been prepared for each state hospital. The complete report provided each state hospital is available for review at the State Planning Agency.

ANOKA STATE HOSPITAL

1. Capacity Lost
   CD- 90 beds, averages 79 patients
   MI- 248 beds, averages 237 patients (operates at 96% capacity)

2. Impact on Client
   Anoka State Hospital provides services without restriction with regard to ability to pay. Approximately 90% of the patients at Anoka State Hospital are no longer covered by hospitalization or health services insurance. A high percent (90%) of the mentally ill patients are committed, many have never been institutionalized before.

3. Impact on Counties
   Patients from Anoka would be transferred to other state hospitals, filling most available beds. As a result, beds for voluntary (informal) patients would not be available; the likely result is greater use of the commitment process by counties. Transportation costs for the counties would increase. Ramsey County, currently assigned to Moose Lake, has an annual transportation cost of $10,000 to $12,000. In addition, communication between county staff and state hospital staff would be more difficult.

4. Impact on Staff
   It is unlikely that many Anoka staff would choose to relocate to another state hospital. However, most should be able to find new employment without relocating.

5. Impact on Community
   Tertiary level psychiatric and chemical dependency treatment services would no longer be available at Anoka. Approximately $5.8 million of state hospital payroll would be lost to the communities of Anoka, Coon Rapids and Andover. An additional $5 million would be lost to the remainder of the metropolitan area. Approximately $600,000 of direct hospital expenditures would be lost to the local community.

Source: Anoka State Hospital.

BRAINERD STATE HOSPITAL

1. Capacity Lost
   CD- 71 beds, 54 patients on July 1, 1984
   MI- 80 beds, 59 " " " " "
   MLC- population 37 on July 1, 1984
   DD Prog. Div.- 270 beds, 270 population on July 1, 1984

2. Impact on Client
   Clients would have to be transferred to other hospitals in the state system or to private facilities. At the moment the capacity of private facilities in the immediate area is not sufficient to accommodate more than a small percent of the present population of Brainerd. Of particular concern would be the loss of a 16 bed adult Native American Program providing chemical dependency services to three Indian Reservations.

3. Impact on Counties
   Transportation costs would increase for counties for all clients who would be transferred to another state hospital. County Social Service officials have stated that although day rates are generally less in community facilities, the all-inclusive costs are substantially more.

4. Impact on Staff
   Not discussed.

5. Impact on Community
   Brainerd was listed with an unemployment figure of 8.4% which would accelerate to 13.9% with the closure of the state hospital. The total dollar loss is estimated to be over $11.5 million.

Source: Brainerd State Hospital.

CAMBRIDGE STATE HOSPITAL

1. Capacity Lost
   Cambridge State Hospital currently serves a population of 474 mentally retarded residents from 43 of the 87 counties in Minnesota. If it were necessary to transfer the 474 residents from Cambridge into other state hospitals, the largest number of transfers that could take place would be 346 (based on vacant beds in other state hospitals).

2. Impact on Client
One-third of the population at Cambridge is non-ambulatory. The treatment programs at Cambridge are highly respected for their DAC services, behavior modification programs, program evaluations and research. Cambridge State Hospital has a number of physically handicapped/medically involved children and adults who require the services of St. Paul Ramsey Hospital, Gillette Children's Hospital, University Hospitals, Mercy Hospitals and Unity Hospital. Approximately 100 trips are scheduled to these hospitals each year. If residents were transferred to more distant hospitals, it is doubtful whether the families would be able to continue regular contacts.

3. Impact on Counties
Transportation costs would be greater at all steps in the process - pre-placement tours, followup contacts, county staff visits for reviews and meetings, pre-hearings and hearings.

4. Impact on Staff
A Department of Human Services Personnel Officer estimates that the maximum percentage of employees who would transfer to other state facilities as a result of a hospital closing would be no more that 20% of the staff. The current job market for service work and work in general is extremely poor in this area. Even those few employees who may be assimilated (locally) would suffer a reduction in their standard of living.

5. Impact on Community
Services currently provided by Cambridge State Hospital would not be available: in-service training to counties, ICF-MRs, DACs; consultant services to many facilities and organizations; respite care service. Over $10 million would be lost to Isanti county per year. School District 911 employs 29 professionals, 44 para-professionals and 5 support service people to serve Cambridge State Hospital residents (a payroll of over $1 million). A foster grandparent program employing 32 grandparents, 2 support service staff and a director with a payroll of about $95,000 would be lost.

Source: Cambridge State Hospital.

FARIBAULT STATE HOSPITAL

1. Capacity Lost
The capacity is 810 residents. The population on Aug. 23, 1984 was 690. Vacancies available in ICF-MRs in catchment area and Regions 6, 8 & 9 range from 89 to 186. To accommodate remaining Faribault residents, all vacant state hospital beds would have to be used for all groups of people (MR, MI, CD).

2. Impact on Client
Over 90% of our residents are severely and profoundly retarded and require (a class "B") facility. For the most part community-developed group homes have not provided the services needed for this population. The client would have: reduced family and county contact because of increased distances; inappropriate placements; disruption of dependency reduction program; loss of stability and friends in their personal life.

3. Impact on Counties
Reduction in county caseworker involvement and added travel costs.

4. Impact on Staff
Among the 1,173 employees, 153 are over age 50 and might experience employability problems; 11 are mentally handicapped, with the same questionable employability. There are 40 Foster Grandparents with substantial income derived from their work with the hospital residents.

5. Impact on the Community
The possible social and economic cost of closure on the community of Faribault is even more dramatic, since the Faribault State Hospital is by far the largest employer (12%) in the city. The loss of 1,038 state jobs and $18 million in personal income could have the following effects:

- increase unemployment from 6.9% to 11.4%;
- cause a population decline of 3,633;
- reduce school population by 820;
- cause 9 or 10 retail businesses to close and an additional 173 jobs to be lost;
- put 465 homes on the real estate market.

Source: Faribault State Hospital

FERGUS FALLS STATE HOSPITAL

1. Capacity Lost
This hospital admitted 1,474 persons this past year for treatment for chemical dependency, 375 persons for treatment of a psychiatric condition, and 28 persons to the mental retardation program for training and care. The average population for the facility was 550 for that same year.

2. Impact on Client
There is no other state institution anywhere near this area with capacity to absorb this patient load. Private facilities are not sufficient to absorb the patient load. There is no available treatment services for a large proportion of the clients served by this facility within the region. We do have family participation in our family treatment program on the CD unit from all areas that we serve. Providing a regional facility encourages give and take between the staff and the county social services agency.

3. Impact on Counties
Legally the county is required to visit and review treatment plans at least quarterly for each client. To go further than Fergus Falls State Hospital for the counties in our region would be an unnecessary expense and would be decreasing services to each client. The cost of care in (Fergus Falls State Hospital) is more economical than in local areas.

4. Impact on Staff
This facility employs close to 700 people. There would, for all practical purposes, be no jobs available since there is a very high unemployment rate (10%) at this time in Otter Tail county. Nearly 600 persons would need to relocate to find work.

5. Impact on Community
The services provided by this facility would simply not be available to the extent they are now. The state hospital payroll is somewhere in the area of 16 million dollars and is expended entirely within Fergus Falls and the surrounding communities. There would be many businesses that would no longer be able to continue operation and the population would drop by 2,000 people from the families and dependents of persons in the labor force.

Source: Fergus Falls State Hospital.

MOOSE LAKE STATE HOSPITAL

1. Capacity Lost
We have four disability services (mental retardation, mental illness, chemical dependency and geriatrics) with a total average population of 450. Clearly it would seem that rural areas are best served by a concentration of programs and professional staff in order to offer needed services adequately. Other state hospitals could absorb the MR clients but not the CD or MI clients.

2. Impact on Client
Distances would increase for all concerned. A regional facility can feasibly provide follow along services which frequently result in the client being able to remain in a smaller community setting. Families are also able to participate more actively with their relatives.

3. Impact on Counties
Some counties may not have to travel as far assuming beds are available, others would have to travel further. Our figures demonstrate that the per diem cost of treating chemically dependent, mentally ill and mentally retarded clients would increase if individuals and community agencies were forced to rely on securing treatment services from a non-state hospital source.

4. Impact on Staff
The region currently has a 14% unemployment rate. Even a positive growth economy would have difficulty absorbing more than 500 employees of Moose Lake State Hospital. Since there is now one less state hospital (Rochester), there are that many fewer state positions into which eligible Moose Lake employees could transfer. Those who do transfer would probably incur higher relocation costs since the real estate market in this area is very weak.

5. Impact on Community
Community leaders, county officials, area legislators, state hospital staff, and other community members fully agree that the closure of the Moose Lake State Hospital would mean the economic ruin of Moose Lake and the surrounding smaller communities. The payroll of the Moose Lake State Hospital in fiscal 1985 ($13.3 million) represents 3.5% of the total gross income for Carlton County. Services no longer available: chemical dependency, mental illness and mental retardation programs; staff who serve as resources to schools, organizations, agencies,etc.; testing and counseling by DVR. A minimum of $9.3 million would be lost to the community.

Source: Moose Lake State Hospital.

ST. PETER STATE HOSPITAL

1. Capacity Lost
   Licensed bed capacity of 674, operating at over 90% occupancy during the last two years.

2. Impact on Client
   Most patients/residents could not be directly discharged into the community. Many of these persons lack the necessary skills to care for themselves even with some supervision and others present a clear danger to themselves and the community at large. In most cases, transfer to another state treatment facility would be the only logical alternative for them. If this were done, travel time and distance alone would decrease county involvement in treatment planning, disrupt support systems, reduce family contact, and increase the costs to counties and law enforcement agencies.

3. Impact on Counties
   The distance from county of referral would seriously hinder reintroducing the resident back into the community. County social workers would also be geographically removed from the serving hospital and consequently would have minimal contact with the resident and the treatment team. Distribution of patients from the Security Hospital to other state hospitals would result in severe problems especially for urban counties.

4. Impact on Staff
   As of Sept. 10, 1984, there were 793 employees working at St. Peter Regional Treatment Center in a full-time (607) or part-time (186) capacity. There are 62 married couples employed who would be particularly hard hit in the event of closure. A total of 731 households would be affected significantly by the loss of at least one income. A small number of clerical and skilled trades employees could eventually find work, but most others would have to relocate to continue their careers or seek employment in a new field.

5. Impact on Community
   The Center pays approximately 28% of all wages in St. Peter and approximately 7% of all wages in Nicollet County. Current figures indicate that the Regional Treatment Center employs 22% of the labor force in the City of St. Peter and 5.6% of the labor force in Nicollet County. During the last fiscal year (1983-84) the Center purchased $1,188,266 in goods and services in St. Peter. It is estimated that an additional 250 jobs within the community would be lost.

Source: St. Peter State Hospital.

WILLMAR STATE HOSPITAL

1. Capacity Lost
   The Willmar State hospital, with 637 beds, serves 23 counties.

2. Impact on Client
   The Willmar State Hospital operates the only publicly supported program for adolescents in MN. Eighty to ninety percent of all persons served by this hospital have already been deemed as not eligible or inappropriate for services in the private sector. The ability to place these patients (MI) in alternative mental illness programs is limited. The psycho-geriatric population needs special attention. There are two state nursing homes, usually filled to capacity. The majority of these patients would not be accepted in community nursing homes due to behaviors and level of care needed. Approximately 80% of our population would have to be hospitalized at other state hospitals which are already overtaxed with high occupancy rates. Impact on patients would be disruptive and unsettling. Certainly, closure would be a major environmental change affecting stability.

3. Impact on Counties
   Closure would mean county workers becoming less involved in patient treatment. Funding for transportation to distant hospitals would become formidable. The cost of private care is formidable compared to the cost of state hospital care. Patients on Hold Orders, Rule 20 evaluations, etc., would be placed in local hospitals or jails totally unequipped, both staff and space-wise, to deal with this type of admission. The burden on law enforcement agencies would increase.

4. Impact on Staff
   A total of 643 full-time equivalent jobs (involves over 700 persons) would be lost. Fifty five (55) couples are employed at Willmar State Hospital which would result in a loss of total family income for 18% of the staff, many of whose skills are nontransferable in the community. One hundred and fifty (150) or 23% are between the ages of 50 and 65.

5. Impact on Community
   Constitutes 5.0% of total covered employment in the county and 6.75% of total covered employment in the city. The hospital is the third largest employer in the Willmar area. Its $16 million payroll provides 27.4% of total wages paid to government employees in Kandiyohi County. The unemployment rate in Kandiyohi County, which is currently at a seasonally unadjusted 5.3%, could rise to as high as 9.3%.

Source: Willmar State Hospital

ACTUAL IMPACT OF CLOSURE AT HASTINGS AND ROCHESTER STATE HOSPITALS

Two state hospitals have closed within the past eight years, Hastings and Rochester. Although there were considerable similarities between the two state hospitals, there were differences in the number of employees, the processes used to close the respective operations and release staff, the geographic locations, and the general economic conditions of the surrounding communities.

1. Number of employees:

   a. Hastings State Hospital had 199 employees on the payroll at the time the Legislature ordered the closure.

   b. Rochester State Hospital had 540 employees at the time of closure.

2. Process employed to close the state hospitals:

   a. Hastings State Hospital employees were given an absolute choice of a transfer to another state job even if no vacancies existed. Hiring above complement was permitted to facilitate the transfers.

   b. Rochester State Hospital employees were not give a choice as to new positions and they were only transferred if a position was vacant. The decision not to transfer Rochester State Hospital employees to positions above complement was due to the economic recession.

3. Geographic location of the state hospitals:

   a. Hastings State Hospital is 25 miles from St. Paul making commuting to the central office of the Department of Human Services possible.

   b. Rochester State Hospital is 85 miles from St. Paul and 50 miles from the nearest state hospital, Faribault. Many employees transferred to Faribault State Hospital and most were required to sell their homes and move.

4. Impact on employees: (data as of 6-22-82)

   a. <u>Hastings State Hospital</u> (199 employees affected):

      112 found employment in the following places:
      48 Veterans Home
      42 Other state agencies including the Department of Human Services
      22 Private sector employment

8 unemployed
23 left the work force
19 retired
3 deceased
1 in school
44 lost contact
(Note: The number totals 210 and not 199.)

b. Rochester State Hospital (540 employees affected):

338 employees were laid off
63 resigned
3 dismissed with cause
2 deceased
13 retired
87 accepted employment with Dept. of Human Services (includes transfers to other state hospitals)
7 accepted employment in other state agencies
13 remained on skeleton crew at Rochester State Hospital

5. Cost of closure:

Through federal and state statute and collective bargaining agreements the state had specific obligations to meet during these closures. Costs (as of 6-22-82) associated with the closing of Rochester State Hospital are given below. There is no similar information available on the closing of Hasting State Hospital.

$1,154,518	special severance benefits
324,137	sick leave severance
58,584	projected additional severance to be paid
283,583	vacation
288,492	unemployment insurance
288,492	projected additional unemployment to be paid
49,934	health insurance payment
31,764	moving expenses
26,684	realtor fees
5,115	travel
13,350	miscellaneous
$2,524,653	Total

Source: Julie Chamberlin, Department of Human Services, 6-22-84

VIII. OTHER IDEAS SUBMITTED FOR CONSIDERATION

UTILIZATION OF STATE HOSPITALS

Walter A. Baldus, Woodvale Management Corporation

Proposes placing the existing units of the state hospitals under an open bid process.

Mr. Baldus is not proposing the mentally retarded residents be removed from the state hospitals, but that separate units or entities would be created within each state hospital and that the units be operated by the successful bidders.

The objective of this approach is to remove the state from direct provision of care.

One of the significant aspects of this approach is that state employees could also bid to provide the service. Assuming that state employees are successful in obtaining the contract this approach would:

- Provide continued employment for state employees.
- Assurance of wage and benefit equity with the state system for three years; [the brief paper presented by the author did not explain how this would happen].
- Demonstrate that the quality of life would be enriched by an improvement of the physical plant at the state hospitals.
- During initial development, providers with past experience would aid the state employees in their work.

SPECIAL PLANNING REPORT GUIDELINES FOR STATE-OPERATED HOSPITALS AND NURSING HOMES

Jonathan A. Balk, CEO, Anoka State Hospital

The Minnesota Hospital Commitment Act and the Community Social Services Act establishes Minnesota policy. Mental health services are to be provided at the local level, if possible. State hospitals are to provide regional-level services for people who cannot be provided care and treatment at the local level and are to return patients to the local level as soon as possible.

There are two sets of constituents of the services of state hospitals:

> The general public who want personal and community safety and the patients who need personal safety, care, treatment, habilitation/rehabilitation, aftercare planning and community placement, and follow-along services.

Counties would be the appropriate gatekeepers and payors for state-operated services for non-committed patients.

This concept could be extended to committed patients as well. Both approaches assure that services meet economic as well as clinical tests.

State hospital resident/patient needs for the next ten years:

Mentally Ill:
The projected number of beds for mentally ill patients is 670 to 682, based upon Gudeman and Shore. This estimate is in addition to the number of security beds (213). This estimate assumes the average length of stay is 6 months.

Mentally Retarded:
Assumes all mentally retarded residents are residing in community facilities by 1994 except for 130 mentally ill/mentally retarded persons and assaultive people who will need to receive services in a mental illness hospital facility. No state hospital beds will be maintained for mentally retarded people.

Chemically Dependent:
The current utilization of state hospital chemically dependent beds statewide per 10,000 is 1.989. Applying this rate evenly through 1994 an estimated 822 chemically dependent beds are needed.

Nursing Homes:
Should be a direct function of a county's willingness to contract for services from them.

Two major unresolved policy questions:

1. What level of state-delivered chemical dependency services should be made available at state hospitals?
2. What level of nursing-home services should be provided by the state at state hospitals and nursing homes?

DEMONSTRATION MENTAL HEALTH AND CHEMICAL DEPENDENCY BLOCK GRANT
Sheila Kiscaden, Olmsted County Human Services, and
Tom Bounds, Northland Mental Health Center

Plan calls for the development of a block grant program for mental health and chemical dependency program for six counties.

Appropriation would be based upon county utilization of state hospitals in 1982 multiplied by the 1985 per diem rate.

Providers would be identified who would be responsible for the full cost of treatment services regardless of the choice of vendor, including the full cost of care at state hospitals.

In the northern counties, the mental health center would be the primary provider, but would use multiple treatment vendors.

Participating counties would agree to provide eight basic services.

The demonstration period would be for three years.

Underlying Hypotheses:

1. There is and will continue to be a real need for the treatment services that state hospitals provide, but this treatment resource is often used inappropriately because of the financial incentives to do so.

2. Although counties have responsibility for case management and service availability, one of the biggest obstacles to development of community-based care is the lack of flexible, client-centered, public financing at the local level.

3. A lack of local community-based treatment resources results in patients being referred inappropriately to state hospitals for in-patient services. State hospitals are thus receiving patients that do not need the intensity of care that the state hospitals are designed to provide.

4. Many communities do not have the human resources available to develop treatment programs. This approach would permit the state or its employees to contract for community-based services.

MINNESOTA PSYCHIATRIC SOCIETY
Lee Beecher M.D., Legislative Representative

1. State hospitals, in order to intelligently plan for the future, must be told which patients they will be treating, how many patients, and how these patients will be funded, and what is expected by way of treatment provided in state hospitals.

2. State hospitals should be used only when community based acute care facilities, residential treatment facilities, county based and supported partial hospitalization and safehouses are not able to treat a given population effectively.

3. Funding for state hospitals should emanate from county authority, as much as is possible. Modifying the CSSA block grant mechanism, counties should contract for state hospital services in competition with other services.

4. Case management for a subset of mentally disordered patients should be provided by county resources (social workers and nurses). Linkage of "payee status" to case managment is necessary for certain indigent mentally disordered clients in the community.

5. There should be a move toward a service network system entailing the development of "bridging" strategies, patient-tracking systems, and interagency linkages, using new technological advances and information processing while protecting clients' rights to confidentiality.

6. The State of Minnesota should be discouraged from organizing and managing hospital systems and providing direct patient treatment.

7. The State, however, must develop effective ways to evaluate the competency, appropriateness, and performance of hospitals and organized care settings providing treatment to mentally ill people. Some of these functions could be delegated to organizations such as the Joint Commission on Accreditation of Hospitals, but the Department should have the expertise and capacity to do its own evaluations. If this is not to be, the Department of Health should take on these functions.

8. The State of Minnesota is the provider of last resort for the indigent mentally ill. Therefore, the State should not delegate this responsibility to entrepreneurial systems such as HMOs unless there is a verifiable mechanism to determine the appro-priateness, quality, and outcome of clinical and social ser-vices provided in such systems.

9. The undeniable fact is that Minnesota has a need for an expert, clinically competent, administratively sound, cohesive mental health authority.

IX. INSTITUTIONAL CARE AND ECONOMIC IMPACT PLANNING BOARD RECOMMENDATIONS:

A. Buildings/Energy:

1. Release of Capital Improvement Funds:

   Minnesota Laws 1984, Chapter 597, Sec. 18, Subd. 11, placed a freeze on some funds for capital improvements and/ or new construction for state hospitals and state nursing homes until the completion of the State Planning Agency study of the future of state hospitals.

   The Institutional Care and Economic Impact Planning Board has not recommended the closure of a state hospital; therefore, it recommends the funds be released.

2. Declaration of Surplus Property:

   There are currently buildings on the state hospital grounds which are either unused or in such disrepair that the continued maintenance and heating of them serves no beneficial purpose to the state hospital system.

   The Institutional Care and Economic Impact Planning Board recommends that such buildings be immediately declared surplus property by the Department of Human Services and that the Department of Administration dispose of the property in accordance with state law.

3. System wide Capital Improvement Plan:

   The Institutional Care and Economic Impact Planning Board recognizes the projected decline of mentally retarded residents will reduce the current need for building space. The Board recommends a system wide capital improvement planning process that incorporates long term space requirements and the condition of the buildings.

   The Board further recognizes that energy cost can be managed and recommends the Department of Human Services in conjunction with the Department of Administration continue to control and reduce the cost of energy at the state hospitals by:

   a. Demolition of unneeded buildings;
   b. Utilization of shared savings contracts;
   c. Use of alternative fuels;
   d. Purchase electricity from wholesalers; and,
   e. Separate metering of leased or rented buildings to tenants of state hospital buildings.

B. Employees:

4. Staff Reductions:

The Institutional Care and Economic Impact Planning Board recommends that any staff reductions emanating from declining state hospital resident/patient populations should occur through natural attrition and retirement whenever possible.

5. Staff Transfer and Retraining:

The findings of the Employee Study indicate there are job opportunities for state hospital employees in other state agencies.

The Institutional Care and Economic Impact Planning Board recommends the development of a plan by the Department of Employee Relations to facilitate the voluntary transfer of state hospital employees affected by the downsizing. The plan should address the retraining needs of the affected employees.

6. Intradepartmental Transfer and Retraining:

The Department of Human Service's biennial budget proposes a reduction of staff serving mentally retarded residents. The budget also proposes an increase in staffing for units serving mentally ill patients.

The Instititutional Care and Economic Impact Planning Board recommends that persons affected by the staff reductions be retrained as necessary and appropriate to work with mentally ill patients.

C. Economic Impact:

7. Economic Development Strategy:

The findings of the economic impact analyses show that state hospitals are major employers. The analyses also indicate that seven of the eight state hospital communities are highly dependent upon the state hospitals.

The Institutional Care and Economic Impact Planning Board recommends that if the Governor's proposed new economic impact zone program is enacted, the Department of Energy and Economic Development should give consideration to state hospital sites in determining zones.

8. Alternative Use of Buildings

The findings of the study of the alternative use of state hospital facilities show little precedent for private redevelopment of state hospital facilities. The study further shows that one reason for the lack of private sector use of the facilities is the lengthy process governing the disposition of state property.

The Institutional Care and Economic Impact Planning Board supports the Department of Administration's proposed changes in state law easing constraints on the sale of state property to the private sector. The Board further recommends that the Department of Administration, in conjunction with the Department of Energy and Economic Development and local officials, aggressively market the surplus properties at the state hospitals. However, any potential use should not conflict with established state policy and should be compatible with the purposes of the state hospital.

D. Public Process

9. A large part of the state hospital study was devoted to gathering public opinions through town meetings, phone calls, and letters. The Institutional Care and Economic Impact Planning Board recommends that the public process associated with this study continue.

E. Residents/Patients

10. The study of "Patients and Residents in Minnesota State Hospitals" provides only preliminary information about demographic characteristics. Additional information has been collected and will be analyzed after January 31, 1985. The Institutional Care and Economic Impact Planning Board recommends that additional reports be prepared and recommendations regarding the relationship between state and county responsibilities be submitted to the Legislature. The Board also recommends increased emphasis be placed on supporting quality of care and quality of life in the current service system.

F. OPTIONS:

The Institutional Care and Economic Planning Board recommends the following positions on the options.

11. Option 1: Downsizing of the mental retardation units should occur in the 1986-1987 biennium with emphasis on natural attrition. Staff ratios should remain in compliance with the Welsch v. Levine Consent Decree.

    The staffing levels of the mental illness units should be increased.

12. Option 2: State operated community services should be developed and tested during the 1986-1987 biennium.

13. Option 3: The efficiency of the current state hospital system should improve by adding management systems outlined in the section on competition. After these management systems have been implemented, then elements of competition should be introduced.

    The chemical dependency block grant proposal prepared by the Department of Human Services received tentative approval.

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The 1984 Legislature mandated that a study and plan for Minnesota State Hospitals be prepared (Chapter 654, Section 19).

An Institutional Care and Economic Impact Planning Board was created composed of the following state agency heads: Sister Mary Madonna Ashton, Dept. of Health; Barbara Beerhalter, Dept. of Economic Security; Gus Donhowe, Dept. of Finance; Bill Gregg, Dept. of Veterans Affairs; Sandra Hale, Dept. of Administration; Leonard Levine, Dept. of Human Services; Orville Pung, Dept. of Corrections; David Reed, Dept. of Energy & Economic Development; Nina Rothchild, Dept. of Employee Relations; James Solem, Housing Finance Agency; and Tom Triplett, Chair, State Planning Agency.

Responsibility for the studies was given to the Developmental Disabilities Program/Council of the State Planning Agency.

Eight technical papers have been prepared to respond to the legislative requirements. This paper may be cited:

State Planning Agency. (1985, January). Policy Analysis Series Paper No. 8: Options and recommendations for the Minnesota State Hospital system. St. Paul, MN: Developmental Disabilities Program, State Planning Agency.

"Residents" refer to people with mental retardation who live in state hospitals.

"Patients" refer to people with mental illness and people with chemical dependency who receive services at the state hospitals.

Additional free copies of reports or information about this project can be received from:

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