Statist. Gen + FHS

71-MHC-DJV

Harold Gillespie
cc: Dr. Bruhl

Public Welfare

Copies to: Gillespie
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Senator William Dosland, Chairman
Senate Finance Sub-Committee on Welfare

March 5, 1971

David J. Vail, M.D., Director
Medical Services Division

Mental Hospital Corporation(s)

Mr. Chapado recently referred to me a list of questions you had asked him relating to the possibility of converting the state hospital system into a public corporation or group of corporations. As I told you in a previous note, this subject is very close to my heart and I am glad to have this chance to respond.

According to Mr. Chapado's notes your questions are as follows:

1. What effective controls on the quality of patient care could be developed under the corporation approach?

2. What effective cost controls could be developed?

3. What impact might federal construction and other federal funds have on the mental hospital corporation and what would be the requirements in qualifying for federal funds?

4. What have other states done along these lines?

Before taking up the questions specifically there are general comments I would like to make, to provide a context or conceptual framework to the questions and their answers.

I have been impressed in this legislative session especially with the futility of solving the problems before us so long as we try to operate within the present management model. We have on the one hand a set of local programs operating independently from one another in response to community needs. We have on the other a large and expensive establishment in the form of a dozen institutions run by a state agency in St. Paul. The legislature is being asked to invest in both systems and is faced with the real prospect of building up one at the expense of the other. This is unavoidable in the present framework, in which two parties are funded separately in a way which tends to prevent them from being partners with one another and makes them rivals instead.

The present system of direct funding of the state hospital system is bound to lead to self-perpetuation efforts, attempts to keep up case loads, and various other false outcomes. The present system of funding and management of the state hospital system tends to keep down the responsiveness of the hospitals to the real needs of its service community and there is insufficient power of influence and control given to service consumers.

Maybe now is the time to change over entirely to a new funding and management system. The idea is simply this: turn the state hospitals loose to make their own way in the world. The best way to do this, I believe, would be:

1. Make each hospital an independent public corporation.

2. Reduce direct state subsidy of each hospital to amortization and/or property maintenance costs, plus a subsidy adequate to maintain a decent domiciliary level of care, based on a formula related to the general population of the region served and not to the in-patient population of the hospital.

3. Pool the balance of money that now goes to the state hospitals and redistribute it on the basis of general population to county welfare departments, existing area boards, or special new regional mental health and hospital boards created for the purpose. The bodies which would receive the money under the new plan would buy the service they need from the vendor who gives them the best deal. Said deal would have to be subject to advocacy-type monitoring on behalf of individual service recipients or patients -- especially those who are indigent or unable to protect themselves -- to make sure that case plans are made truly in the best interests of the patients.

   Such an arrangement would strengthen the hand of community groups who now complain about inadequacies of the hospitals. Under this plan the hospitals would be impelled to provide a service which the community views as necessary and of the proper quality.

   A single public corporation might accomplish the same ends, but it might lend itself to the centralism, self-perpetuation and bureaucracy in a way that would not be an advantage over the existing system.

To answer your questions:

1. Quality of Patient Care.

   To approach this question properly I suppose one would have to ask, What control do we have at the present time over the quality of patient care? I think it would be fair to say that the mechanisms that exist are very imperfect. They consist chiefly of peer review processes at the hospital level, such supervision as we are able to provide from the central office, and special advocacy activities like Review Boards and the Humane Practices Committees. The advent of federal Titles XVIII and XIX have promoted the establishment of Utilization Review Committees and has exerted other pressures to up-grade service and this has been helpful. Let me put in a plug here for our Right to Treatment bill, which would work to bring about a better quality of case planning and care generally.

   The corporation approach would immeasurably improve the quality of care and strengthen the control mechanisms. It would bring consumer and community pressure directly to bear on the hospital. More importantly, if the money would be in the hands of a community agency to purchase care from the corporation as a vendor, the local agency would then demand a high quality of service as being in the direct interest of the community and its citizens, including those citizens who are now residing and receiving care in the hospital.

2. Cost Control.

   All that I have said about quality of care applies in principle to cost control. A new element added under the corporation idea, if coupled with rearranging the

finance mechanisms, would be the market principle, by which prices and costs would be controlled by the competitions existing in the free enterprise system.

3. Federal Requirements.

I am not sure I can address this question too well, for there are many complexities in the federal finance area which I do not understand. But again, I think the corporation approach would lend itself far more readily to federal financial assistance than the present system, especially if we would go to the model of individual corporations. The federal requirements keep a very important pressure on us in the direction of program improvement, as for example in their insistence on Utilization Review Committees, adequate medical records, etc. I think that independent corporations operating much more in accordance with the free enterprise system than is now the case would be motivated to "maximize the federal buck", especially in qualifying as being eligible to receive reimbursement through insurance programs. Under the corporation model I believe that the hospital would be able to deal more directly and effectively with the federal agencies than is now the case. The corporation model would change the hospitals into community facilities in the true sense, and this would increase their eligibility for such federal staffing, construction, and project grants as may be available as compared to the present situation; for in my experience historically the federal agencies do not like to deal with the monolithic state institutional systems, and see them as being outside of the mainstream of "community-based services" and "community care".

4. Other States.

I know of no other state that has gone into the corporation idea. Iowa for many years has made the counties responsible to provide and pay for mental health care. I believe that the state appropriates directly to the hospitals only about 20% of the total cost of operation, and the rest goes to the counties, which provide or purchase care. One result of this arrangement has been a very drastic reduction in the number of patients in state hospitals in Iowa, a reduction even more dramatic than Minnesota's. One unfortunate effect, I believe, is that the counties, handling the money with which to buy services, tend to go on the cheap and may place large numbers of persons in county-run institutions at a lower cost than that of the state hospitals. Critics of this system have pointed out that while the state hospitals have become smaller and possibly better, this is little aid and comfort to the patients who may now be residing in a sub-standard county homes. It would be important to build in safeguards to see that this would not happen. California has rearranged its financing plan to provide 90% of the cost of mental health care on a capitation basis to counties, which then negotiate with state hospitals or other vendors, or provide the care themselves. The state hospitals there are still run directly by the state Department of Mental Hygiene. The California plan is relatively recent and I believe the results are not in yet. I have heard that there was a great deal of confusion about converting to the new plan. But at the same time I believe that at least one of their state hospitals has been closed down after having literally gone out of business.

I am not aware of the corporation model as such in other countries. Britain has regional hospital boards which distribute money on a regional basis to all the hospitals -- general, mental, tuberculosis, etc. -- within the region in accordance

with a regional plan; but there all hospitals are owned and operated by the government. Sweden recently turned over their state (i.e., national) mental hospitals to local governments to operate, with the national state continuing to subsidize the bulk of the cost. The Netherlands for decades has had a system somewhat like the multiple corporation approach. There the care is basically the responsibility of the local health departments. They arrange for care where they can find it from among a fairly large number of mental hospitals, which may be run by churches, non-profit corporations, or sometimes local governments. One of the very desirable effects of this arrangement is that the local health department keeps a very close watch on all their patients even while they are in hospital, and as we would say do not lose control of the case.

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This is a very complex issue. I have tried to cover some of the points in this memorandum. I am sure there are many other questions to discuss. I would be very pleased to meet with you at any time to go over this matter.

If there is any further information which you need, please let me know.

DJV:mhv

CC: DPW Cabinet

Mental Health Medical Policy Committee

Medical Services Division Staff

MSD Institutions
ATTN: Medical Director
ATTN: Administrator

In the past 3 months there have been 8 admissions to Sunny Side Unit, all 8 are readmissions. They are higher functioning ~~than~~ than those we are now trying to place. Readmitted for 2 reasons.
1. Inadequate supervision at point of placement.
2. No jobs.
Conclusion: We provide better supervision than given at County level. Co. is not functioning as they should.
So if they have the money they will seek lowest cost placements despite programming. Quality control is of vital importance if not properly followed we will backslide to pure custodial care. (statewide)

Typed version of the unsigned and undated handwritten comments on Page 4 of this memorandum as found in Box 127.H.6.2 (F) at the Minnesota Historical Society, the subject matter files of the Superintendent of Faribault State Hospital.

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