

A Plan for Ceasing Department of Public
Welfare Operations at Hastings State
Hospital and Further Developing
Community Services

REPORT TO THE 1976 MINNESOTA LEGISLATURE

DEPARTMENT OF PUBLIC WELFARE

January 5, 1976

"The commissioner of public welfare shall present a comprehensive report to the legislature by January 5, 1976, setting forth in detail a plan to phase down or cease operations at one or more state hospitals. The plan shall be submitted to and acted upon by the 1976 legislature."

Minnesota Laws, Chapter 434, 1975

TABLE OF CONTENTS

| | <u>Page</u> |
|---|-------------|
| I. BACKGROUND AND PROPOSAL | 1 |
| A. Legislative Mandate | |
| B. Options for Ceasing Operations at Hastings | |
| C. Summary Proposal | |
| D. Legislative Issues | |
| E. DPW 1975 Comprehensive Plan | |
| F. Hastings Planning Committee Plan (March, 1975) | |
| G. Selection of Hastings State Hospital | |
| H. Barriers to Phasing-Out A State Hospital | |
| II. LEGISLATIVE PROPOSALS | 7 |
| III. FINANCIAL RESOURCES | 9 |
| IV. A PLAN AND BUDGET FOR CEASING DPW OPERATIONS AT HASTINGS AND THE DEVELOPMENT OF NECESSARY COMMUNITY CARE | 11 |
| A. Individual Treatment Planning | |
| B. Example Timetable for Patient Placement or Transfer | |
| C. Community Program Development | |
| D. Staff Relocation and Training | |
| E. General Allocation Formula | |
| F. Formula Calculations | |

I. BACKGROUND AND PROPOSAL

A. Legislative Mandate:

The 1975 Minnesota Legislature required that the Commissioner of the Department of Public Welfare (DPW) submit a plan to the 1976 Legislature to phase down or cease operations at one or more state hospitals. This document represents that plan and calls for DPW to cease operations at Hastings State Hospital on such date as specified by the 1976 Legislature.

Pending legislative action on this report, funds provided for the 1975-77 biennium for the development of residential community services to the mentally retarded (MR), mentally ill (MI), and chemically dependent (CD) (Minnesota Laws, Chapter 434, Section 2, Subd. 3, 4 and 5) can be utilized in the Hastings area. The statute does indicate that the funds should "primarily" be utilized within one hospital district. Available funds, with the exception of special monies for MR facility construction, are not being distributed until the 1976 Legislature clarifies policy on the state hospital issue.

The terms "phasing-out" or "closing" in the case of Hastings State Hospital or other state hospitals do not necessarily imply abandonment of a state facility. The terms are used in the limited sense of the Department of Public Welfare ceasing direct administration of such facilities and their programs.

It may be that the facilities (and in some instances their programs) will be transferred to local administration or to some new organizational arrangement -- e.g., a local private nonprofit corporation or a regional body. In addition, as with Hastings State Hospital where the Department of Veterans Affairs has expressed an interest, state hospital facilities could be utilized for other state programs when appropriate.

Although this report deals with Hastings State Hospital, the issues are applicable to the entire hospital system. This plan, in developing a "model" for Hastings, has obvious implications for other state hospitals.

B. Options for Ceasing Operations at Hastings:

There are three methods to cease DPW operations at Hastings State Hospital. There may be combinations of the options.

1. Simply close intake at the Hospital and transfer remaining residents to other state facilities where space is now available. This option would not be concerned with accelerated development of community care programs.

2. Place Hastings' residents in the community through direct action by the Department of Public Welfare in sponsoring and/or providing new community services. This would provide a "streamlined" method for developing new community care slots but would directly violate the Department's objective of divesting itself of direct service responsibilities.
3. Undertake the development of a cooperative model wherein the three county welfare departments, the three area boards, DPW, service providers and related advisory groups jointly work on problems related to individual patient planning, service development and funding. Although the third option is the most difficult because of fragmented authority, responsibility and resources, it provides the best method of insuring responsible development of services and facilities to replace services at Hastings State Hospital. If successful, the cooperative model could provide sufficient information to clarify state hospital/deinstitutionalization/community-based services issues state-wide.

The fragmentation problem is a result of historical growth of MR/MI/CD programs at state and local levels -- whether the concern is with licensing, funding, program development, direct services, or standard setting. The Department of Public Welfare is committed to overriding the implicit fragmentation if the legislative decision is to move on option three.

The challenge is to bring together sufficient available resources to ensure that the current Hastings population base (December, 1975) of approximately 172, plus 15 on provisional discharge, can receive care as good or better than in the Hospital, while at the same time beginning to establish a continuum of community services -- not only to account for the population at Hastings, but also for other residents in the three-county area who need, but are not now receiving, services.

C. Summary Proposal:

1. Cease DPW operations at Hastings State Hospital on a date specified by the 1976 Legislature and develop necessary alternative community services in Dakota, Ramsey and Washington Counties.
2. Provide ongoing community services funding to the three east metro counties to replace hospital services available to the counties before DPW phase-out.

Total: \$2,417,559 annual county subsidy.

This appropriation is based on these assumptions:

- An average hospital population of 209 for the three counties (based on actual population figures during the past five years).
- Replacement services for these 209 hospital slots with equivalent community care slots at "going" cost of care rates.

--A county obligation to pay full per diem for any county resident who uses any state hospital (with the exception of those county residents now receiving MR services at Cambridge and Faribault State Hospitals). County liability will cease, except for the standard \$10 per month charge, if a person remains at a state hospital beyond five years.

--The total amount will be adjusted each year for inflation, based upon average yearly DPW rate adjustments for community services.

3. Draw the above funding primarily from already existing resources identified on pages 9 and 10.
4. Provide an additional non-recurring appropriation to cover start-up/transitional costs necessary to develop the increased capacity for community care in the three counties.
5. Provide sufficient funds for employee relocation. There are 217 employees (will drop to 200 around January 15) at the hospital and relocation costs are estimated at \$2100 per employee (and family) - \$600 for average moving expense and \$1500 for average realtor fee. About 75% of the employees own their own homes.

The number of employees to be relocated is contingent upon such factors as:

- a. The number of employees who would not seek re-employment with the state or the enactment of an early retirement provision.
- b. The possible alternative use of facilities and staff (Veterans Home, locally administered/financed programs, etc.).

Staff retraining could be achieved using departmental training resources already available for those employees remaining in the Public Welfare System.

6. Establish the Hastings State Hospital phase-down as a "pilot project" for a period of up to four years.
 - a. Assure ongoing funding of community services within the agreed upon formula.
 - b. Charge back to the counties full per diem rate for cost of state hospital care to discourage inappropriate use of state facilities and to encourage the development of cost effective community alternatives.
 - c. Provide for follow-up evaluation of the Hastings population during DPW phase-out.

D. Legislative Issues:

If the 1976 Legislature agrees with the recommendation to cease DPW operations at Hastings State Hospital, the following issues must be addressed:

1. What plan should be employed to achieve the objective and by what date?
2. For 1976-77, what funding should be made available to the east metro counties (Dakota, Ramsey and Washington) to provide alternative programs to hospital services which would no longer be available?
3. What should be the source of such funding?
4. What "strings" should be attached to the funding (e.g., facility development, service provision, joint three-county utilization, etc.)?
5. On what basis should ongoing funding for community services be provided and in what amount?
6. What should be the plan for the employees working at the Hastings facility?

The resolution of one issue will influence the resolution of the others. This report discusses the options, overriding problems, and cost implications.

There are many paths the state can follow in ceasing operations at Hastings State Hospital, but the final plan is contingent upon legislative policy decisions on the funding of community-based services, staff relocation and timing. Detailed planning and costing out work awaits legislative discussion and direction. Worksheets detailing and costing out various options will be made available to the Legislature as specific policy objectives are identified.

E. Department of Public Welfare 1975 Comprehensive Plan:

In response to the 1973 Legislature, DPW submitted a Comprehensive Plan (December, 1974) to the 1975 Legislature calling for the closing of Hastings State Hospital and the possible ceasing of DPW operations at three other state hospitals by 1980. The Comprehensive Plan as such was not acted upon by the Legislature in 1975, although some of its proposals were enacted.

This document is a further refinement of the 1975 Comprehensive Plan, providing a detailed report on how Hastings State Hospital could be phased out if the Legislature in 1976 sees this as an appropriate course of action.

In addition, as recommended in the 1975 Comprehensive Plan, task forces in Regions I and IV are studying the future use of Fergus Falls State Hospital and will report back to the Legislature in 1977 (with an interim report in February of 1976). The 1975 Legislature appropriated \$100,000 for this purpose.

As this report covers only Hastings State Hospital, reference to the 1975 Comprehensive Plan is necessary for a complete discussion of long-term goals and objectives of the Department as well as detailed arguments on the hospital issue.

Since the late 1960's, a Department objective has been the phasing-down of state hospital facilities as a result of drastically declining hospital populations, major increases in expenses of operating state facilities, and the growing recognition that noninstitutional care should be significantly expanded. By 1971, there was a legislative mandate for a comprehensive plan on state hospitals and this resulted in the Department recommending that DPW cease operations at unnecessary facilities beginning within three to five years.

F. Hastings Planning Committee Plan:

In 1975, through the auspices of the three county welfare departments and three area boards in Dakota/Ramsey/Washington Counties, the Hastings Planning Committee was established in the east metro area to develop a community-based services plan for area residents in need of services for mental retardation, mental illness, and chemical dependency if the Hospital were closed. This report was submitted to several individual legislators and the Department of Public Welfare in March of 1975, but was not examined fully in relation to the 1975 DPW Comprehensive Plan.

The Hastings Planning Committee report called for \$10.7 million per year in expenditures for community-based services. The Plan took into account all potential service recipients, not just those residing at the Hospital. Of the \$10.7 million, approximately \$3.9 million was in "new costs" to support the three-county plan. The Hastings Planning Committee also requested that the current Hospital budget and reimbursements, totalling \$3.3 million, be turned over to the three counties in addition to the "new costs" specified above. The remaining \$3.5 million was accounted for in funds already under the control of the three counties.

G. Selection of Hastings State Hospital:

When the hospital issue surfaces, Hastings State Hospital has usually been identified as the one which should be phased out first. The specific reasons are detailed in the 1975 Comprehensive Plan. In summary, the relatively high per capita costs at Hastings, combined with the potential for developing community services in the metro area and the location of other nearby state hospitals, makes Hastings State Hospital the most likely candidate.

In May, 1974, intake was closed for the Mental Retardation Unit at Hastings and by early 1976, all mentally retarded residents at Hastings will have been placed in the community or transferred to other state facilities.

H. Barriers to Phasing-Out A State Hospital:

1. Initially, the Legislature must make a policy decision to phase out the Hospital. Without such a decision it is difficult, if not impossible, to bring together all of the resources necessary to provide alternative care in the community.
2. There has to be general agreement, especially at the county level, that funds in the 1975-77 biennium are sufficient to provide the necessary community services as alternatives to institutionalization.
3. The counties want legislative assurance of ongoing funding if they are to be responsible for individuals who would otherwise have used the Hospital. The counties feel they have become increasingly liable for costs related to new services and that they will have difficulty in the future in supporting such community services without state aid.
4. There is considerable fragmentation of authority and responsibility at state and local levels making it very difficult for a deinstitutionalization/community services strategy to work smoothly. A temporary ad hoc structure will be necessary to centralize authority and resources to get the job done. (Human Services Boards and/or the Office of Human Services may provide a solution to this pressing dilemma, but not in this biennium.)
5. There has to be an agreed upon plan for the current hospital staff which protects employee rights while at the same time permits an orderly cessation of programs at the facility.

There is agreement that state facilities should not be phased-down unless there has been adequate individual case planning to ensure that each resident will receive as good or better care following program changes. In the Hastings situation, this means the development of more community care slots as well as adequate patient transfer plans to other state institutions when necessary.

II. LEGISLATIVE PROPOSALS

The following proposals are made on the basis of the Department's recommendation to cease operating Hastings State Hospital. DPW supports the work completed by the Hastings Planning Committee to ensure systematic development of community care.

There is a preference on the part of DPW and the three counties to work under option three -- the cooperative model -- to develop an ad hoc organization between the three counties, DPW and other interested parties in order to facilitate a continuum of care between the hospital and the community.

The following proposals are offered for consideration:

- a. Cease DPW operation of Hastings State Hospital on such date as specified by the 1976 Legislature, if agreement is reached on a 1976-77 plan and budget. If DPW ceases operations, there will have to be some decision on covering costs for maintenance of the institution or sale, transfer, rental or demolition of the facility.
- b. Establish a formula beyond the 1975-77 biennium where counties would be assured of new funds in assuming client care responsibilities that were previously held by the Hospital.
- c. Transfer a portion of the Hastings State Hospital budget to the three counties during this biennium. Without this or newly-appropriated money, start-up costs cannot be covered and new facilities and services will not be developed.
- d. Grant legislative authority to carry over the unspent appropriations for community residential services in Chapter 434, Section 2, Subd. 3, 4 and 5. The 1975-76 appropriation may not be spent by June 30, 1976 as it is the intention of the Department to withhold distribution of this money until the Legislature makes a decision on Hastings State Hospital.
- e. It is recommended that the Legislature consider providing a guaranteed loan program for facility development. This would be particularly important for the care of chemically dependent and mentally ill.
- f. Enact new legislation to handle the staff relocation issue (H.F. 636 and S.F. 1642 were introduced for this purpose during the 1975 session).

There are any number of ways to proceed in phasing-out DPW operations at Hastings State Hospital. This becomes apparent when funding alternatives are considered for the community services which are necessary to replace hospital programs.

Decisions must be made on the sources of these funds. Worksheets on funding alternatives for the Hastings situation can be developed upon instruction from the Legislature. This information can be generated quickly once the legislative committees provide direction as to which funding alternatives are considered most appropriate.

III. FINANCIAL RESOURCES

A number of resources are applicable to the three-county situation. Some of these resources have special problems for use in implementing the proposal.

1. 1975 legislative appropriation for community residential services for the mentally retarded, mentally ill, and chemically dependent (Chapter 434, Section 2, Subd. 3, 4 and 5).

Approximately \$2.2 million is available. No new money is available for services to the chemically dependent and only \$659,800 is available for community-based residential services for the mentally ill. \$450,000 is for state-wide development of facilities for the mentally retarded and the remaining \$1,126,000 is available for community residential services for the mentally retarded. Although there is some confusion over how this money is to be distributed, the statute does state that it is to be used "primarily" in one hospital district and there is a general impression that this refers to the Hastings State Hospital situation. There is not sufficient money to develop the necessary community programs for the chemically dependent and mentally ill currently using the Hastings facility.

2. Housing Finance Agency Funds.

There is a potential \$10 million available through the Housing Finance Agency to support the development of facilities for the mentally retarded. This program is just getting underway and it is anticipated that the first funds will soon be available for facility developers. This money is not available for facilities for the mentally ill or the chemically dependent.

3. National Institute of Mental Health Grants for Facilities for the Mentally Ill.

Minnesota has been notified of a \$242,324 allocation for the development of facilities for the mentally ill. There remains question as to whether the three counties in the Hastings receiving district qualify for these funds because of certain federal stipulations. DPW is attempting to resolve these problems.

4. Hastings State Hospital Funds.

In 1975-76, the projected Hastings State Hospital budget is \$3,477,125. Over \$2,700,000 of this amount is for staff salaries. In 1975, the Hastings Planning Committee suggested

transferring such funds to the three-county area to provide care for those residents of the Hospital who would fall under county responsibility. Because of Judge Larson's decision in Cambridge State Hospital (Welsch vs. Likins) and the general assumption that staffing patterns should be equated at all state hospitals, there is question as to whether the money available for staff salaries should be transferred to the three-county area. Some argue that support staff funds should be transferred directly and that direct service staff should be relocated in other state facilities. Whether the money is transferred or not, present statute requires that all staff shall be retained in state employment at no loss in salary (they could be absorbed into vacancies elsewhere in the system).

5. DPW Evaluation Funds.

The Department of Public Welfare has identified evaluation funds in its 1975-77 appropriation which can be used to follow-up residents of Hastings State Hospital who are placed in the community during phase-down operations. This will provide short-term overall assessment of the placement situation of individuals who previously received services within the institution. Although there is not sufficient money available to undertake in-depth research, funds are available to conduct a "pilot". The Legislative Advisory Committee has approved an expenditure of \$30,000 to develop a state hospital patient follow-up evaluation design.

6. Grant-in-Aid, Cost of Care Funds, and Federal/State Reimbursement.

For fiscal years 1976 and 1977, \$4.5 million and \$4.8 million grant-in-aid/cost of care funds, respectively, are available for services through the area boards in the three counties. Given the growing financial stresses on community services, it will be difficult to carve out major new service programs from this appropriation. Reimbursement from Titles XVIII and XIX is available to pick up a portion of program costs.

7. MR Demonstration Funds - Family Subsidy Program.

The 1975 Legislature allocated \$300,000 to fund not more than 50 families for providing in-home residential care for mentally retarded children eligible for state hospital services. This money is available state-wide.

IV. A PLAN AND BUDGET FOR CEASING DPW OPERATIONS AT
HASTINGS STATE HOSPITAL AND THE DEVELOPMENT OF
NECESSARY COMMUNITY CARE

The confusing mixture of programs and responsibilities has constantly aggravated efforts to develop a continuum of care between the state hospital system and the community. Fragmented funding and disjointed relationships between agencies have severely limited the development of a fully coordinated care system in the community.

There is not now a structure to effectively deinstitutionalize Hastings residents and to develop the community care system in the three-county area. An ad hoc organization will have to be established if the Legislature moves ahead utilizing option three, the cooperative model. In addition to the patients and their families, the following also must be involved:

1. The three county boards.
2. Hospital staff.
3. The Department of Public Welfare Central Office.
4. The three area boards and their advisory committees.
5. The three county welfare departments.
6. Interested associations (Association for Retarded Citizens, Mental Health Association, Association of Minnesota Counties, etc.).
7. Service and facility developers.
8. Other state departments and agencies such as Health, Education, Administration, State Planning, and Housing Finance Agency.
9. Local units of government in which new community facilities will be located.

If the above operate independently, there is no way to develop a coordinated care system that can provide a responsible alternative to Hastings services, nor can there be adequate individual case planning.

Considerable activity has been undertaken to plan for the Hastings State Hospital population. The Hastings Planning Committee provided detailed statistics on the community care system in relation to the population in need of service. If the Legislature decides to phase out DPW operations at the Hospital, there are six interrelated activities which must be accomplished.

1. Need assessment and individual patient planning for community placement or transfer to another state hospital. This requires cooperation between the Hospital staff and county agencies.
2. A resource survey on the availability of specialized community care slots for placement of Hospital residents.
3. A concerted effort at local and state levels to develop community care which will provide placements for the population at Hastings as well as those individuals who would have entered Hastings had it continued to operate under DPW. This concern relates to funding of new facilities, locating potential developers, and facilitating the licensing, reimbursement, and funding processes.
4. An agreement as to which agencies will be responsible for after-care or replacement services in the absence of the State Hospital.
5. Provision for follow-up evaluation of patients placed in the community from the Hospital. DPW has developed a short-term, follow-up evaluation design which can be funded from the 1975-77 departmental budget.
6. A plan for State Hospital staff relocation and training.

A tentative agreement was arrived at on December 9, 1975, between the Mental Health Directors and Welfare Directors of Washington, Dakota, and Ramsey Counties regarding Hastings State Hospital. While the Directors of the Area Boards and County Welfare Departments were in basic agreement regarding the Hospital issue, each of the respective boards must also approve any local/state plan.

The three county representatives agreed that DPW could cease operating Hastings and that if the State Legislature would appropriate sufficient dollars to the Counties of Washington, Dakota, and Ramsey on a per capita population basis, the counties could develop community-based programs for current and potential residents of Hastings State Hospital.

A. Individual Treatment Planning:

When a date is specified for phasing-out Hastings State Hospital, the following is recommended for orderly and humane continued care of residents:

1. Cease all intake five months prior to phase-out date. Patients who would have been admitted to Hastings would be directed to community placement — if none is available, then to the appropriate State Hospital.

2. For those units at Hastings which might be continued under auspices other than the State (e.g., the chemical dependency unit), contractual agreements and arrangements should be secured as early as possible -- at least 30 days prior to phase-out.
3. Staff (state and local), patients, and families must begin to plan for treatment and care as soon as an agreement is reached.

For each resident:

- a. Inventory of current needs.
- b. Assessment of available community resources for individual resident.
- c. Placement of patient as soon as possible.
- d. Visits to community programs.
- e. Trial visits, to determine the appropriateness of placement.
- f. For those who cannot be placed in community facilities:
 - 1) Explanation of problem to patient and family.
 - 2) Transfer to state hospital which represents the least disruption in treatment and care.
 - 3) Interhospital (Hastings and receiving hospital) cooperative efforts (space, program, etc.).

B. Example Timetable for Patient Placement or Transfer:

Month 1 - Decision to phase out Hastings State Hospital

Month 2 - Close intake

Month 4 - Identification of all patients' care needs

Month 4 - Month 6 - Orderly movement of patients to community facilities or other state hospitals

Month 6 - Hastings State Hospital operations cease with skeletal staffing for protection of property (under Department of Administration)

C. Community Program Development (East Metro):

1. Identification of current service resources including:

a. Residential

By type of disability

By level of care

b. Supportive Services

Day Activity Centers, Work Training Centers,
Sheltered Workshops, etc.

Day Treatment

Medical-Dental

Recreational

Vocational-Educational

2. Identification of Hastings population need for Residential and Supportive Services. Profile of current population.
3. Identification of service gaps (#2 minus #1 = gaps).
4. Task force to develop needed services in the East Metro area. Representation on this task force: county welfare agencies, area boards, service providers, State Hospital representatives, DPW Central Office, consumers, Health Department, Housing Finance Agency, interest groups (Association for Retarded Citizens, Mental Health Association of Minnesota, Day Activity Centers, advisory committees), and others.

D. Staff Relocation and Training:

- Step 1) Assess the staffing patterns and projected vacancies of the Hospital and of potential hiring organizations.

As soon as possible, the staffing pattern of each affected institution or program should be reviewed and the filling of vacancies controlled. Only essential positions should be filled as operations are phased-down. Technical and/or professional positions in which employees are not easily placed can be covered by temporary assignment from other institutions.

A special reporting system should be instituted so that the Personnel Department or some central agency will have early notification of all anticipated vacancies.

Step 2) Inform employees of their rights and analyze their preferences and skills:

One of the most important phases of the plan is communication with employees about rights, options, and available services with as much lead time as possible. This information might be provided through descriptive handouts supplemented by meetings conducted by personnel from Minnesota State Retirement System, State Employment Services, State Personnel Department and other departments involved in the phase-out and placement of employees. Video tapes of the presentations could reduce costs and provide flexibility in instruction. The handout packet should include a questionnaire addressing the option (early retirement, severance pay, layoff, or other employment or retraining) desired by the employee, job preference and location and a skills inventory. Individual counseling to help the employee reach decisions should be available through the personnel office at the institution.

Step 3) Match employees to appropriate vacancies:

Questionnaires should be tallied and interests and skills of the current employees matched with vacancies or available retraining programs. Once the match is made, appropriate interviews should be arranged.

Step 4) Coordinate agencies involved in the administration of this plan:

Listed below are some of the agencies involved in the administration of the plan:

- a. Department of Personnel
- b. Minnesota State Retirement System and Public Employees Retirement Association
- c. The County Welfare Merit System and local civil service systems and the State Planning Agency's Offices of Local and Urban Affairs and Human Resources Planning
- d. Department of Administration
- e. Department of Finance
- f. Department of Employment Services

Step 5) Dev lop budget:

In addition t the direct costs (relocation expense, maintenance of benefits expenses, severance pay, unemployment compensation), administrative costs must be considered. Funds must be allocated to cover recordkeeping and reporting requirements including the use of the computer.

Step 6) Recordkeeping:

Because of the long-term effects of the plan, a complete recordkeeping system must be established.

E. General Allocation Formula for Three Counties:

Upon the phasing-out of DPW operations at Hastings, a local services gap would be created for the three counties currently relying on programs offered at the institution. To promote the development of alternative community care in the east metro area, the following plan is offered:

1. The three counties should receive ongoing funds to replace those services lost upon termination of operations at the Hospital.
2. The amount of funds allocated to the three counties should represent the "going" cost of care rates (currently in the community) for services which would have been provided at the Hospital. The counties will have to purchase such care from other vendors, develop the services themselves or, when necessary, refer individuals to other state hospitals.

The ongoing funding should be based on the average projected Hastings State Hospital population for each of the three counties if the Hospital were to remain open beyond 1976. The base average population (209) is calculated on actual figures for the past five years.

An inflationary factor, based upon yearly DPW rate adjustments, will be calculated into each annual allocation to account for cost of care increases in the community.

3. The counties will pay full per diem costs for any county resident who receives care at a state hospital, excepting MR residents currently placed at other state institutions, and for any current Hastings resident (from any of the three counties) who must be transferred to another state hospital. The counties will be responsible for such costs up to a period of five years (at which point the state assumes all costs but the standard \$10 charge-back per month from the counties). This will encourage community care -- residential or otherwise, except in situations where there is no alternative but long-term hospitalization.

4. To accelerate the development of community services as alternatives to hospital care and to cover start-up/transitional costs in moving to the community care system, special funds should be provided on a non-recurring basis to the three counties.
5. Counties may rent or purchase from the State available hospital facilities to provide local specialized care when State administered services are no longer available at the Hospital. For example, there will be a need for a primary chemical dependency facility and the counties might begin to operate such a program at the Hastings site. This would be a local decision based upon local need assessments and available financial resources.
6. Because of county concern for increased financial liability in assuming services previously state financed and administered, there will be a need to regularly assess the county funding formula and, as specified in the 1975 Comprehensive Plan, an eventual state-wide policy resolution of the entire MR/MI/CD funding mechanism. The Fergus Falls State Hospital report to be submitted in 1977 will also deal with this issue.

F. Formula Calculations:

The funding required by the three counties to replace services lost due to cessation of operations at Hastings State Hospital is displayed on the following tables.

Table I

It is assumed that funding should be based on a fair average usage rate of Hastings State Hospital over the past five fiscal years. The use of current population size understates the number of persons for which services would be required.

T A B L E I

HASTINGS STATE HOSPITAL - AVERAGE POPULATION BETWEEN FY 72-76

| | <u>MI</u> | <u>MR</u> | <u>CD</u> | <u>TOTAL</u> |
|---------|------------|-----------|-----------|--------------|
| FY 1972 | 168 | 53 | 61 | 282 |
| 1973 | 150 | 33 | 66 | 249 |
| 1974 | 144 | 51 | 62 | 257 |
| 1975 | 126 | 53 | 56 | 235 |
| * 1976 | <u>107</u> | <u>30</u> | <u>53</u> | <u>185</u> |
| TOTAL | 695 | 220 | 298 | 1,208 |
| AVERAGE | 139 | 44 | 60 | 243 |

* Projected from first quarter of FY 1976

AVERAGE PERCENTAGE OF RESIDENTS BY COUNTY

| | <u>MI</u> | <u>MR</u> | <u>CD</u> |
|------------|-----------|-----------|-----------|
| Ramsey | 55% | 55% | 55% |
| Washington | 8% | 2% | 10% |
| Dakota | 25% | 16% | 26% |
| Other | 12% | 27% | 9% |

** AVERAGE DAILY POPULATION FOR 5 YEARS BY COUNTY

| | <u>MI</u> | <u>MR</u> | <u>CD</u> | <u>TOTAL</u> |
|------------|-----------|-----------|-----------|--------------|
| Ramsey | 76 | 24 | 33 | 133 |
| Washington | 11 | 1 | 6 | 18 |
| Dakota | 35 | 7 | 16 | 58 |
| Other | <u>17</u> | <u>12</u> | <u>5</u> | <u>34</u> |
| | 139 | 44 | 60 | 243 |

** These figures are estimations based upon actual and projected average population counts and average usage rates by county.

Table II

In the event the Department of Public Welfare ceases operations at Hastings State Hospital, counties would be required either to provide directly or purchase services now provided by the hospital. Table II shows the current "types" of services being provided at Hastings State Hospital and the cost of providing those services in the community using fiscal year 1976 rates. Inflation and increased program costs are projected to run approximately 10% per year. The cost figures presented on Table II were developed by staff from Ramsey, Washington, and Dakota county welfare departments and area boards and the Department of Public Welfare. There were disagreements on some of the rates due to differential costs for services among the counties.

T A B L E I I

EAST METRO ONLY (209 RESIDENTS)

| | # OF RESIDENTS | COST FORMULA | GROSS COSTS | COUNTY SHARE | NET NEW COSTS TO COUNTIES |
|-----------------------------|-------------------|--------------------|---------------|---------------------------|---------------------------------|
| SNF | 24 | 24 x \$26.16 x 365 | \$ 229,162 | 4.32% | \$ 9,900 |
| ICF-MR | 32 | 32 x \$27.67 x 365 | 323,186 | 90% @ 4.32% 10% @ 100% | 12,565 32,319 |
| DAC | 32 | 32 x \$14.00 x 180 | 80,640 | @ 50% | 40,320 |
| Primary Care (CD) | 55 | 55 x \$50.00 x 365 | 1,003,750 | @ 100% | 1,003,750 |
| Residential/Controlled | 51 | 51 x \$40.00 x 365 | 744,600 | @ 100% | 744,600 |
| Residential/Semi-Controlled | 47 | 47 x \$31.00 x 365 | 531,805 | @ 100% | 531,805 |
| Sheltered Workshop | 47 | 47 x \$ 5.00 x 180 | <u>42,300</u> | @ 100% | <u>42,300</u> |
| T O T A L | | | \$2,955,443 | | \$2,417,559 |

FOOTNOTES TO TABLE II

1. The five year average daily population at Hastings State Hospital is 243. (See Table I). Cost projections on Table II are based on 209 patients leaving a residual of 34 patients from non-east Metro counties requiring treatment planning. Hastings State Hospital has a projected 1975-76 operating cost of \$3,477,125 for a projected patient population of 188 (plus indirect costs, depreciation and overhead expenditures estimated at approximately \$453,000). The average per diem cost was \$46.24 at the Hospital for November, 1975.
2. Skilled Nursing Facilities - Geriatric patients at Hastings State Hospital present particularly difficult problems. Public facilities such as the Ramsey County Home and Oak Terrace can and do work with this difficult type of patient with per diem rates between \$25.00 and \$28.00. Oak Terrace could absorb the 24 geriatric patients now at Hastings given sufficient lead time (approximately 4 months) to open an additional ward within the facility. The \$26.16 per diem used on Table II is the current maximum rate paid to a skilled nursing facility in the metropolitan area.
3. Intermediate Care Facility / Mentally Retarded - The \$27.67 per diem used on Table II is the maximum rate paid to a ICF/MR facility in the metropolitan area. It is estimated that 90% of ICF/MR residents will qualify for Title XIX reimbursement with the county being responsible for 4.32% of the total cost of care after January 1, 1976. The cost of care for the remaining 10% of ICF/MR residents will be borne by the counties.
4. The Day Activity Center per diem rate used on Table II is an average cost for this service in the metropolitan area. DAC costs are currently being funded between 50 and 60% by the state through the DAC grant-in-aid mechanism.
5. Primary Care for the Chemically Dependent - The \$50.00 per diem used on Table II is the current average cost for this service in the metropolitan area.
6. The mentally ill population at Hastings State Hospital receives care at two levels, termed residential controlled and residential semi-controlled. Residential controlled services include the short-term stabilization process (10-30 days) needed for effective treatment. The costs for this short-term care for acute MI has been built into the residential controlled per diem. It is difficult to determine a cost of care for this population since care similar to that at the hospital is not readily available in the community. The \$40.00 and \$31.00 per diem costs used on Table II are educated guesses that will need to be validated by experience.
7. Sheltered workshops costs are estimates based upon client fees (payments made to the facilities by DVR and Public Welfare) instead of a per diem rate computed by dividing the yearly budget by the number of clientele. Client fees for four facilities in the metro area (United Cerebral Palsey, Goodwill, Occupational Training Center, and St. Paul Rehabilitation) range from 15% to 37% of their total budget. The average annual cost per client in these four facilities is \$3,620. The average client fee is 25% of that cost or \$905.00. Using a work year of 180 days, the client fee per diem is \$5.03.
8. Additional costs for providing these services listed above cannot come from Title XX Social Service funds since counties are already claiming maximum reimbursement.

Table III

Table III identifies the present needs of the current Hastings State Hospital population. A category labeled "Hard to Place" has been included to show the number of residents for which community placement would be difficult to arrange due to the lack of appropriate community resources.

TOTAL HASTINGS POPULATION (AS OF 12-19-75)

| | <u>GERIATRIC</u> | <u>MI</u> | <u>MR</u> | <u>CD</u> | |
|-----------------------------|------------------|-----------|-----------|-----------|-----|
| Hard to Place | 19 | 4 | 15 | | |
| Provisional Discharge | 1 | 9 | 4 | | |
| Unauthorized Absence | | 2 | | | |
| ----- | | | | | |
| Skilled Nursing Facility | 14 | | | | |
| Primary - Extended Care | | | | | 29 |
| Domicilliary Care | | | | | |
| Crises Center | | | | | |
| Residential - High Support | | | 21 | | |
| Residential - Foster | | | | | 1 |
| Day Activity Center | | | 6 | | |
| Work Activity Center | | | | | |
| Residential/Controlled | | 19 | | | |
| Residential/Semi-Controlled | | 12 | | | |
| Group Supportive | | 20 | | | |
| Treatment Center | | 1 | | | |
| Half-Way | | 6 | | | 19 |
| Semi-Independent | 1 | 1 | | | |
| Day Activity Center (MI) | | 21 | | | |
| Day Treatment Center | | | | | |
| Sheltered Workshop | | 22 | 3 | | |
| Own Home | | 1 | | | 5 |
| Other State Hospital | (7) | (3) | (1) | | |
| TOTAL | 26 | 63 | 29 | 54 | 172 |

Not additive since some patients listed for more than one service.