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A Report to the 1983 Minnesota Legislature

Prepared by

The Task Force on Use of State Hospital Facilities

January, 1983

**Governor's Planning Council
on Developmental Disabilities**

Minnesota State Planning Agency

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USE OF STATE FACILITIES
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A long-term facility. Recommended by
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STATE FACILITIES—USE IN LIEU OF
PRIVATE FACILITIES

CHAPTER 532

Section 1. Study commission.

Subdivision 1. Members. There is established an advisory task force consisting of three members of the house appointed by the speaker, three members of the senate appointed by the subcommittee on committees of the rules committee, and the commissioners of health and public welfare or their designees.

The advisory task force shall include two representatives of private providers of long-term and short-term care, both non-profit and profit-making. It shall also include two representatives of state hospital employees, at least one of whom shall be an employee pursuant to Minnesota Statutes, Section 179.741, Subdivision 1, Clause (4); and one member, with one designated alternate member, who shall represent each of the following groups: mentally retarded, chemically dependent, and mentally ill. Public members shall be appointed by the legislative advisory commission.

Subd. 2. Purpose. The advisory task force shall report to the legislature by January 15, 1983, on the feasibility and cost implications of using existing state facilities for the care of persons who would otherwise be in private facilities either on a short-term or long-term basis with their cost of care reimbursed by the state.

The advisory task force shall consider life safety standards, geographic distribution of the facilities and populations affected, cost of care attributable to each category of patient, cost of physical plant construction, and alternative uses of the physical plants and buildings in making its report. Advisory task force meetings shall be open to the public and shall be announced in advance.

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EXECUTIVE SUMMARY

The Task Force on Use of State Hospital Facilities was established (Laws of Minnesota, 1982, Chapter 532) in response to concerns that inadequate planning was taking place to prepare for declining populations in the state hospital system. Because of improvements in drug therapy, court decisions, increasing availability of community residential and treatment programs, and other factors, the number of residents in the state hospitals has declined dramatically. Although the short-term trend in admissions for mental illness and chemical dependency treatment is up, it appears likely that overall hospital populations will continue to decline in the future if present circumstances continue. Because certain population groups may not be receiving appropriate care in existing community facilities or may be receiving no care because of a shortage of facilities, it was felt that consideration should be given to potential alternative uses that could be made of state hospital facilities to serve these inappropriately served or unserved populations.

The task force learned that the state's network of nursing homes serves more than 2,000 persons under age 65. While it could not determine whether these placements are inappropriate or not, it was felt that further study should be made to determine if a need for more appropriate treatment of these younger nursing home residents exists. Also, as the task force toured the state hospital campuses, much testimony was gathered about the need

for additional treatment programs on the campuses for the mentally ill and the chemically dependent.

As the task force proceeded with its work, it became apparent that along with considering alternative uses of state hospital facilities, it was also necessary to consider alternative administrative structures to make the system more effective in delivering necessary services. In particular, there was a great deal of support, both on the task force and in the testimony presented to it, for the concept of turning the state hospital system into a regional hospital system by expanding the authority of local officials over the campuses themselves and by encouraging better cooperation between the state hospitals and community programs in order to create one unified system of comprehensive mental health care.

The task force adopted as a set of guiding principles the following:

- X I. Persons living in all parts of Minnesota should have reasonable access to a full continuum of mental health services.
- II. Mental health services should be provided in the least restrictive and most normal environment which is consistent with the individual's treatment/rehabilitation needs.
- III. To the maximum extent possible, planning and delivering mental health services should be a local/regional function with appropriate state-level participation including financial support,

- IV. The planning and development of mental health services should stem directly from the identification of individual treatment/rehabilitation needs of persons living in the catchment area.
- V. For reasons of security, professional expertise, special physical plant requirements, and the low incidence of certain disorders, some mental health units such as the Minnesota Security Hospital should continue to serve the entire state as centralized programs.
- VI. State mental health resources should be equitably distributed to all regions of the state.
- VII. Any transition from the present state hospital system into any new configuration should be accomplished in a planned, orderly manner to minimize disruption to patients, staff, and communities.
- VIII. The goal of the state must be the creation of a single public mental health system in cooperation with private providers of mental health and developmental disabilities services ranging from prevention to long-term care compatible with the philosophy of the Human Services statute.

With these principles in mind, the task force makes the following recommendations:

1. Each state hospital facility shall have a Local/Regional Planning Committee in place by November 1, 1983.

2. Each committee shall meet at least two times per year with meeting minutes kept on file for Department of Public Welfare and public review.

3. Committee functions shall include a local/regional assessment of:

(a) individual treatment/rehabilitation needs for persons living in the region.

(b) services, programs and facilities currently involved in the regional continuum of care.

(c) additional or alternative services, programs and facilities that patients/clients could use if they were available to the regional continuum of care.

(d) all alternative uses possible for existing state hospital facility space, unused or underused, including a priority listing of these alternative uses in terms of the most beneficial use and maximum cost effectiveness.

4. Responsibility for assuring strict adherence to all laws, rules and regulations governing the operation of state hospital facilities shall remain as is.

5. The welfare commissioner shall give prime consideration to the recommendations of the Local/Regional Planning Committees.

6. The welfare commissioner shall include planning committee budget requests related to implementing committee recommendations within the department's biennial budget information submitted to the Governor.

*without requirement
to be no change*

7. The Legislature should revise and expand state law regarding state hospital planning committees to insure adequate local and regional representation.

8. The Commissioner of Health shall study the issue of the appropriateness of placements of individuals under the age of 65 in nursing homes and report his findings and recommendations to the 1984 Legislature.

9. The Commissioner of Administration shall study the difficulties presented to potential renters of vacant hospital space by the current policy of "as is" leases and report the findings and recommendations to the 1984 Legislature.

10. A legislative oversight committee should be formed to follow the progress of the regional planning committees. The Commissioner of the Department of Public Welfare will present quarterly reports to the legislative oversight committee.

BACKGROUND

Declining Populations/Hospital Closures. The task force conducted its work against a backdrop of declining state hospital populations and community fear about further hospital closings.

In January, 1965, the state hospital system housed 6,701 mentally ill persons, 6,080 mentally retarded, and 289 chemically dependent, for a total of 13,070 residents. On June 30, 1982, the system was caring for 4,252 residents: 1,303 mentally ill, 2,325 mentally retarded, and 581 chemically dependent. The Welsch V. Noot consent decree and the department's six-year plan for the mentally retarded both call for a reduction in the mentally retarded state hospital population to no more than 1,850 persons by July 1, 1987. According to the Department of Public Welfare the short-term trend in admissions for treatment of mental illness and chemical dependency is on the rise. The shrinkage in resources available to treat these persons in the community is given as the reason for this short-term trend. It appears likely, however, that barring significant changes in the programs the hospitals offer or the client groups they serve, their overall populations will continue to decline.

Given declining populations, and given the recent closure of the state hospitals at Hastings and Rochester, hospital administrators and interested community groups are understandably nervous about the continued viability of their hospitals. The task force sees increased regional authority over the hospitals

as one way to stabilize the role of the hospitals in their surrounding communities.

"Inappropriate" Care at Community Facilities. One of the initial thrusts behind the establishment of the task force was the concern that there might be an unknown number of persons placed inappropriately in facilities outside the state hospital system that might to more appropriately cared for on the hospital campuses. Because of the decline in state hospital populations, this may be the proper time to investigate this possibility. It was felt that one group that might be inappropriately placed at this time are non-elderly residents of nursing homes. The following summary from the Minnesota Department of Health's Quality Assurance and Review section indicates that in 1980 there were 2,049 Medicaid recipients residing in nursing homes who were under the age of 65. Of these, 555 were diagnosed as being mentally retarded and 1,494 were not.

QUALITY ASSURANCE AND REVIEW
MINNESOTA DEPARTMENT OF HEALTH

Medicaid Residents Reviewed in 1980 under Age 65 in Nursing Homes

Area of State*	Without Mental Retardation Diagnosis		With Mental Retardation Diagnosis	
	Residents	Facilities	Residents	Facilities
HSA #1	98	83	56	24
HSA #2	147	27	47	20
HSA #3	79	61	50	23
HSA #4	176	42**	103	32**
HSA #5	658	86***	139	50
HSA #6	197	38	100	51
HSA #7	139	73	60	31
TOTAL	1,494	410****	555	231****

* HSA is Health Service Area. The HSA's cover the following geographical areas: #1 - northwest Minnesota; #2 - northeast; #3 - west central; #4 - central; #5 - metro; #6 - southwest and south central; #7 - southeast.

** Includes Ah Gwah Ching Nursing Home, a state facility.

*** Includes Oak Terrace Nursing Home, a state facility.

**** Some facilities appear twice.

The task force was informed that no judgments are currently made on the appropriateness of these placements because no definition of appropriateness exists on which to base a judgment. The task force is concerned that the placement of non-elderly residents in nursing homes may deprive those residents of necessary peer group contacts, needed specialized care, etc. The task force believes that this issue should be explored further.

Additional Needs for Chemical Dependency and Mental Illness Treatment Programs at the State Hospitals. The task force received a great deal of testimony on the need for additional mental illness and chemical dependency treatment programs at the state hospitals. Of particular need are programs to serve persons with dual disabilities (mental illness and chemical dependency or mental retardation and chemical dependency) and to serve youths with mental illness or chemical dependency problems. For example, administrators at Anoka State Hospital feel the need for additional chemical dependency and mental illness beds because of the following factors (reported in "A General Report on the Anoka State Hospital", dated Aug. 10, 1982):

1. Unavailability of adequate beds to admit voluntary/informal patients who do meet criteria for admission. In FY82 approximately 75 people in this category did not gain admission when requested.
2. Complaints from Hennepin County, in particular, that the concomitant commitment process costs can not be avoided because this is the chief method of obtaining an Anoka State Hospital bed.

3. The frequent development of waiting lists for C.D. program admission.
4. The diversion of some CD. patients to other state hospitals (such as Fergus Falls State Hospital).
5. Increased tension applied by Anoka State Hospital staff pushing aggressively for patient discharge arrangements in the community.
6. Requests from Ramsey County to:
 - a. Establish an additional M.I. unit to provide transitional services.
 - b. To provide C.D. services (in lieu of Moose Lake State Hospital) to avoid transportation costs.
7. Requests from Tasks Unlimited to provide additional transitional units on campus to expand the capability of the Fairweather Lodge Programs to meet the needs of its waiting lists of patients.
8. Evidence that 51% of M.I. admissions have had previous Anoka State Hospital admissions. This fact is not indicative of anything clear at this point, but does indicate a need for a very careful research inquiry into the question of recidivism in the Metro area, and Anoka State Hospital/mental health system program implications.
9. Startlingly higher admission rates to Anoka State Hospital (17.7%) and the county psychiatric inpatient units during the past year.

10. Evidence of severe illness and disability: of the 508 M.I. admissions in FY82, 320 (63%) had documented evidence of threatening/assaultive behavior; 331 (65%) documented history of drug use/abuse; 177 (35%) documented history of suicidal ideation or behavior. This documentation was made available to the hospital at the time of admission by referral sources."

Fergus Falls State Hospital officials told the task force they have received a request from Region IV that an adolescent chemical dependency unit be established at Fergus Falls.

Cambridge State Hospital has proposed that it add beds to treat the chemically dependent and mentally retarded so that it can become a multi-purpose regional facility. At present Cambridge serves only the mentally retarded.

Brainerd State Hospital officials testified about the need for additional space for long-term chemical dependency treatment and for live-in spouses.

Testimony during several of the task force's site visits revealed a need for programs to treat individuals with dual disabilities, either mental illness combined with chemical dependency or marginal mental retardation (IQ of 70 to 90) combined with chemical dependency.

Alternative Administrative Structures. Early on during the task force's discussions of potential alternative uses for the physical resources at the state hospitals, it became clear that there was also a need to consider alternative ways of organizing the hospitals to enable them to accomplish their present goals and

the expanded goals the task force envisions for them. Of particular interest to the task force is the concept that the state hospitals become regional treatment centers; that regional, county and local control over each hospital be increased, and that each hospital become an integral part of a regional, comprehensive system of mental health care.

This idea is not new. In January, 1977, the Region IV State Hospital Task Force recommended that the responsibility for operating and managing Fergus Falls State Hospital be delegated from the state to the Region IV Area Mental Health Board through a management services contract. The study envisioned the establishment over a four-year period of a model comprehensive mental health delivery system in Region IV with the mental health board exercising authority over mental health planning, program development and funding, service delivery, and evaluation. One goal of this arrangement was to formally integrate the inpatient and residential services provided at Fergus Falls State Hospital with the outpatient and community services provided throughout Region IV.

More recently, in remarks prepared for a mental illness forum at Macalester College on June 30, 1982, Dr. Ronald Young, assistant commissioner for the Department of Public Welfare's mental health bureau, proposed a restructuring of Minnesota's public mental health system involving (1) the creation of governing boards for the state hospitals comprised of county representatives and members at large, and (2) the delegation to the boards of discretionary authority to allocate a portion of the state hospital budgets for other mental health treatment programs in each hospital's catchment area.

Dr. Young sees this restructuring as a way to fully integrate two existing treatment systems - the state hospital system and the county mental health system. "Unfortunately," according to Dr. Young, "we have now reached a point where patients and residents are beginning to be moved back and forth between the two systems, not because of treatment/rehabilitation needs but because there are strong fiscal incentives to shift financial responsibility on to the other system. We are seeing the first indications of a potential migration of people back into institutions because inadequate funding is available at the local level to pay for care outside of the state hospital." Dr. Young sees three key elements necessary to begin implementing his proposal. First, legislative authority is necessary to establish regional governing boards. Second, catchment areas with fixed boundaries and clear responsibilities will have to be formally established. Finally, state funding to each catchment area will have to be equalized, based on a per capita formula, to assure to all regions an equitable share of mental health resources, according to Dr. Young.

In a draft report on "The Future of Minnesota's State Hospital System" dated August, 1982, the Department of Public Welfare's Mental Health Bureau proposed the following policy statement intended to be used as a basis for restructuring the state's mental health system:

- I. All future decisions affecting the state hospital system will support the ultimate goal of phasing the state out of the direct operation of these institutions. Where continuing public control and direction is deemed advisable, state administration will be replaced by local/ regional governance.

- II. Although divesting itself of administrative control, the state will continue to provide funds to regional and local programs serving chronically and severely impaired mentally ill, mentally retarded and chemically dependent persons.
- III. Where special populations are too small to justify regional treatment programs, consideration will be given to maintaining single programs such as the Minnesota Security Hospital and the Minnesota Learning Center as state-operated facilities.

The welfare department has prepared draft legislation to transfer one or more state hospitals to local or regional control on a pilot project basis. The department has taken no position on the proposal until Governor Perpich has a chance to review the matter. The proposal would--

--Allow the commissioner of public welfare to establish one or more state hospital governing boards comprised of local citizens to each operate a state hospital. Members would be appointed by the commissioner with the advice and consent of local county boards.

--Give each governing board authority to operate a state hospital but subject to federal and state law, court orders, and state contracts, including those with employees. The board could hire and fire the chief executive officer and the chief medical officer, but could not reduce the established standard of patient care or ignore state regulations on quality of care and patient rights.

--Give the commissioner power to allocate a portion of a state hospital's budget for community services.. For the coining biennium the portion would be limited to 10 percent.

--Instruct the commissioner to assist county boards and state hospital boards as needed and to monitor the operation of the hospitals.

--Mandate that the commissioner report to the 1985 Legislature on the following:

1. the impact of the pilot projects on patient care;
2. the coordination of local efforts that occurs;
3. the feasibility of continuing state hospital boards as governing entities;
4. recommendations for creating additional governing boards for other state hospitals, and
5. recommendations for legal changes needed to implement a permanent system of local control, if that type of system is adopted.

Leases, Sales, Rentals. The task force spent some time examining the degree to which adequate use is made of surplus space on the state hospital campuses. The Real Estate Management Division is charged with the responsibility to lease space on state hospital campuses that is declared surplus by the Department of Public Welfare or that is unused or temporarily vacant. A variety of government agencies and private, non-profit organizations currently lease space on state hospital campuses. In addition, a large number of vacant, obsolescent structures have been demolished. Of specific concern to the task force is the requirement that all vacant properties be rented "as is", with the renter responsible for all remodeling necessary to bring the structure up to code or prepare it for its intended use. Many social service agencies lack the resources to pay for remodeling or secure a loan for this purpose. While recognizing the need for the state to protect itself from unnecessary financial responsibility for remodeling structures it no longer needs, the task

force believes the Department of Public welfare and the Administration Department should explore this issue further.

PRINCIPLES

The task force recommends the following principles as a framework for its recommendations and offers them as a clear direction to mental health planning efforts in Minnesota.

Principle I. Persons living in all parts of Minnesota should have reasonable access to a full continuum of mental health* services.

Discussion: Reasonable access must include having services available within a reasonable geographical distance at an affordable price.

Principle II. Mental health services should be provided in the least restrictive and most normal environment which is consistent with the individual's treatment/rehabilitation needs.

Discussion: This is a well-accepted principle of Minnesota's treatment philosophy and the task force endorses it.

Principle III. To the maximum extent possible, planning and delivering mental health services should be a local/ regional function with appropriate state-level participation, including financial support.

Discussion: It was the intent of the task force for the state to continue to provide appropriate levels of financial assistance to local governments,"

* The task force understands the term "mental health services" to refer to treatment of mental illness, mental retardation and chemical dependency.

Principle IV. The planning and development of mental health services should stem directly from the identification of individual treatment/rehabilitation needs of persons living in the catchment area.

Discussion: There is presently a lack of uniform data about the incidence and prevalence of mental disabilities upon which to base mental health programming efforts.

Principle V. For reasons of security, professional expertise, special plant requirements, and the low incidence of certain disorders, some mental health units such as the Minnesota Security Hospital should continue to serve the entire state as centralized programs.

Principle VI. State mental health resources should be equitably distributed to all regions of the state.

Discussion: The Department of Public Welfare has never analyzed the amount of mental health resources going to each region of the state. However, a formula could be developed to allocate these funds on a fair basis using population data and other appropriate indicators.

Principle VII. Any transition from the present state hospital system into any new configuration should be accomplished in a planned, orderly manner to

minimize disruption to patients, staff, and communities.

Principle VIII. The goal of the state must be the creation of a single public mental* health system in cooperation with private providers of mental health and developmental disabilities services ranging from prevention to long-term care compatible with the philosophy of the Human Services Statute.

RECOMMENDATIONS

The task force made the following recommendations:

Recommendation 1. Each state hospital facility shall have a local/regional Planning Committee in place by November 1, 1983.

Discussion: M.S. 246.022 should be amended to make the appointment of a planning committee mandatory at each state hospital. Ad hoc subcommittees of these committees can deal primarily with alternative physical facility uses.

Recommendation 2. Each committee shall meet at least two times per year with meeting minutes kept on file for Department of Public Welfare and public review.

Recommendation 3. Committee functions shall include a local/regional assessment of:

- (a) individual treatment/rehabilitation needs for persons living in the region.
- (b) services, programs and facilities currently involved in the regional continuum of care.
- (c) additional or alternative services, programs and facilities that patients/clients could use if they were available to the regional continuum of care.
- (d) all alternative uses possible for existing state hospital facility space, unused or

underused, including a priority listing of these alternative uses in terms of the most beneficial use and maximum cost effectiveness.

Discussion:

A suggested method of gathering data:

Groups to be considered:

1. Persons now in state hospitals
2. Persons discharged from state hospitals
3. Persons not in 1 or 2, but receiving public supported services.
4. Persons who have needs which are not being met by current system.

Goals:

1. Clear standards be developed defining the types of patients to be treated in state hospitals.
2. Only those patients for whom state hospital treatment is the most appropriate form of treatment be cared for in state hospitals, except no patient whose treatment, condition, or development would be impaired by transfer from a state hospital to a community based program should be so transferred.
3. Community-based programs be developed, if necessary, and utilized to provide treatment and service of equal or superior quality to those rendered by state hospitals for those individuals transferred or diverted from state hospitals.

The planning committee should review:

1. The Governor's Task Force Study and Recommendations on Use and Disposition of the Rochester State Hospital Site of December, 1982, and should also review the Department of Public Welfare Rochester State Hospital Final Closure Report.
2. the progress of programs at the Rochester facility.
3. the alternative uses of the physical facilities at the Rochester facility.

Recommendation 4. Responsibility for assuring strict adherence to all laws, rules and regulations governing the operation of state hospital facilities shall remain as is.

Recommendation 5. The welfare commissioner shall give prime consideration to the recommendations of the local/regional planning committees. Committee recommendations might include such items as:

- (a) the diversification of the facilities programs and services.
- (b) the priority listing of possible alternative uses of the facilities' unused or under used physical resources.
- (c) other items of concern.

Discussion: Any disagreement between the Department of Public Welfare and a planning committee's recommendations shall be documented by the Department of Public Welfare with a formal response

to the planning committee.

Recommendation 6. The welfare commissioner shall include planning committee budget requests related to implementing committee recommendations within the department's biennial budget information submitted to the Governor.

Recommendation 7. The Legislature should revise and expand state law regarding state hospital planning committees to insure adequate local and regional representation.

Discussion: It was the intent of the task force that all groups affected should be represented. The composition of the committee should include elected county officials or their designees, hospital staff, a state hospital employee pursuant to Minnesota Statutes, Sec. 179.741, subd. 1, clause (4), hospital patients, providers of mental health services, the public at large, and advocate groups, and should not exceed a total of 15 people.

Recommendation 8. The Commissioner of Health shall study the issue of the appropriateness of placements of individuals under the age of 65 in nursing homes and report his findings and recommendations to the 1984 Legislature.

Recommendation 9. The Commissioner of Administration shall study the difficulties presented to potential renters of vacant hospital space by the current policy of "as is" leases and report the findings and recommendations to the 1984 Legislature.

Recommendation 10. A legislative oversight committee should be formed to follow the progress of the regional planning committees. The Commissioner of the Department of Public Welfare will present quarterly reports to the legislative oversight committee. Completion of the plans will occur by November 1, 1985.

Discussion: The oversight committee could be the appropriate standing committee(s) of the Legislature or a separate mechanism.