MINNESOTA STATE PLANNING AGENCY

TOWN MEETING

CAMBRIDGE STATE HOSPITAL REGION

Cambridge Elementary School
Cambridge, Minnesota
August 22, 1984
7:00 p.m.

Miriam Karlins Town Meeting
Coordinator

Colleen Wieck
Project Director

DIANE M. PREECE
REGISTERED PROFESSIONAL REPORTER

Post Office Box 783
Nisswa, Minnesota 56468
(218) 568-8449
MR. CLAYTON PETERSON: My name is Clayton Peterson. I represent the Chamber of Commerce from Cambridge, and I want you to know that the Cambridge Chamber is very much interested in what happens with the State Hospital System and the Cambridge State Hospital in particular.

Obviously, there is a tremendous economic impact that derives itself to Cambridge and the surrounding area, and that's a concern to us.

The residents are a concern to us. Not everybody is appropriate for a group home setting, and I think that that has to be taken into consideration.

We are going to be the central area. We have a good location; we have easy access to the metro area; we share a common administration with Anoka State Hospital.

And we saw in the paper, I think it was last week, that Anoka State Hospital has a backlog, and I think there should be a way that we can strengthen Cambridge State Hospital by sharing in some of that backlog with Anoka.

Obviously, the employees are concerned and we have concern with them, either through relocation or other means. Thank you.

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MR. ROBERT FILSON; My name is Robert Pilson. I'm the city administrator from Mora. I represent the Mora Commercial Industrial Development Commission. I'm here because of jobs.

For the city of Mora, we have 29 employees at the Cambridge State Hospital; and Brook Park, which is in our trade area, there are 10; Ogilvie, 19; Dalbo 12; Braham 65, and I'm sure many people there trade in Mora; Grasston 9. That's a big impact.

We are definitely concerned about the economic impact, not only in Isanti County, but in Kanabec; and not only with this hospital but with Moose Lake. But we don't have the statistics on that.

Be fair.

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MR. WALT HIECKEL: My name is Walt Hieckel. I represent the Cambridge/Isanti Education Association, and I have a brief statement that I would like to read.

Members of the Cambridge/Isanti Education Association are concerned about the negative ramifications to our community if the Cambridge State Hospital is closed. Should this become a reality, many of the families in our community would be forced to move because of loss of employment.

As a result, a decline in school enrollment would mean
a reduction in state aids and possibly a reduction in teaching staff.

Most of us are aware of the value of the services provided by the Rum River Special Education Cooperative and the Cadbury Programs which have been administered from the hospital facilities for many years. These facilities have been provided without charge and have included East Central Custodial Services.

There have been many mentally and physically handicapped students from the schools in the Rum River District that have received valuable training from specialists through the educational programs at the hospital. It would be difficult to adequately assess the value of these services to the students and their families.

In addition, the loss of the educational services would result in the loss of foundation aids, which would directly affect the quality of education in our district. It would be difficult for our community to absorb the financial loss.

The Cambridge/Isanti Education Association strongly opposes any efforts to close the Cambridge State Hospital.

Thank you.

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MR. ROBERT BUCKINGHAM: My name is Bob Buckingham. I'm president of AFSCME at Cambridge State
Hospital. As a union, our main concern, of course, is jobs for our members.

We're also concerned about the residents. We believe we have developed a quality, we believe we have a quality service to the State of Minnesota through our work at the state hospital. We have quality care there, and we believe that the State of Minnesota should continue in its business of taking care of the mentally retarded. Thank you.

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MR. RAY HOHEISEL: My name is Ray Hoheisel, superintendent of schools, district 911. My remarks will reflect on the impact the state hospital will have on Independent School District 911.

The following listing is by no means all-inclusive, and we really don't have some of the data to be specific. For example, we don't know how many students have parents who are employees of the state hospital. But I would like to present the following for your consideration.

The school district has conducted an educational program for school-age residents of the Cambridge State Hospital. While the numbers of students has decreased substantially, we expect to have 40 to 50 students in the program during 1984-85.

To staff the program, we have six teachers, a
coordinator-behavior analyst, 14 teacher aides, developmental therapist, a secretary, part-time speech therapist, and part-time bus driver, which includes 25 people which would have an impact.

We have offices of the Rum River Special Education Cooperative located at the state hospital. This would include the districts of Braham, our district, Isle, Milaca, Mora, Ogilvie, Onamia and Princeton.

Like the state, school districts must plan in order to be in a position to provide services for students.

Our school district enrollment has grown substantially in the last 10 to 12 years. This community is under a considerable burden, bonded to provide facilities for its students.

Plans were based on predicted enrollment and existing conditions. Existing conditions ten years ago, as remains today, is a state hospital with residents to be served. School facilities were built to accommodate these conditions.

I mentioned earlier that I could not supply specific numbers, but I know that many children of state hospital employees attend our schools. This would include children of supportive, para-professional, professional and medical staff.

A dramatic change in the number of employees at the Cambridge State Hospital would have a negative impact on our school district and on proper utilization of our school
facilities.

One more note. The school district and the state hospital have worked together to provide an educational program for severely and profoundly handicapped young people. Twelve years ago no one thought this possible. Many thought no progress would be made, but students have learned, they have progressed.

While working with the state hospital students and staff these past 12 years, we've become friends and partners. We like our friends and partners, and we want them to remain a vital part of our city, school district, county and region.

In summary, let me say that the state hospital of district 911, to teach the residents we have 25 staff members which would be directly affected; we teach the children of employees; we have included the state hospital in our facilities planning; and we have become friends and partners over the years.

Thank you.

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REPRESENTATIVE RICHARD WELCH: Maybe as a legislator, let me make just a couple of comments regarding the town meeting and the legislation and a little bit of where it came from, as well.

In fact, even when I came in here tonight there were
people talking about this idea of closing the state hospital, and I guess the point other people have mentioned, why does the legislature want to close the state hospital?

I guess the point is that as far as the closing of the state hospital, the legislature isn't saying we've got to close the state hospitals no matter what.

I think the phenomenon is the numbers tell us that there is going to be considerably fewer people in state hospitals two, three years from now than there were two, three years ago.

And I know for the years I've been in the legislature, we've seen the people, well, Rochester was the most agonizing process, where there was action at one time. It was only afterwards where the planning occurred.

The point is that rather than have a decision being forced in two years or four years or whenever it comes about as far as should a hospital be closed or shouldn't it and which one and why, the purpose is, and was the intent when we talked about it, to do the planning now and have the action of that plan followed later for all the state hospitals and whatever that might mean.

In the past, most of the planning, legitimately, on the part of State government has been for the residents. That's their responsibility.

But we were saying, and I worked along with the AFSCME,
the American Federation of State, County and Municipal Employees, were saying that, "Let's do some of the planning now for not only residents but also for the employees, the thousands of employees across the state and the hundreds of employees here in the East Central Minnesota area, as well as for each of the respective communities, so when there is a plan or action that will have to be taken by the State or by the legislature within a year or two years or five years, there is information for making those judgments and those decisions.

And the fact is that the high legislative priority to pass that particular planning bill, which is now being carried out on the part of the legislature, on the part of the governor, on the part of the AFSCME employee organization, and I think that's a helpful process. It's also a painful process that we go through.

This is the first of what, eight, nine meetings across the state, but I'm personally very, very pleased to see the level of participation here because that's what it takes. So we've got people speaking and people participation as far as what about the future of this state hospital in general.

The point is made, what about the future as far as alternative uses of state hospitals. So as the next hour or so goes by, I hope we can also hear from individuals as well as these people for organizations for what the personal impact
might mean, what your suggestions and ideas are for the future.

But the purpose is to do the planning now. There are no immediate plans, imminent plans on the part of the legislature or anyone else to close the state hospital, but the numbers aren't—I don't know what we make a parallel to or analogue to.

If you're a family, if you've got a six-bedroom house with a family of ten people and you find a time when there is only Ma and Pa left, maybe you don't stay in a six-bedroom house.

The fact is there is going to be fewer people to be in state hospitals in five years, and does the state keep operating all those facilities?

I think that many people in the legislature in five years from now will say, or two years or whenever it comes about, will say, more than likely not, we have to cut back and reduce.

So that's why we're planning in advance of that. We, the State, can appreciate you folks coming out and sharing your thoughts, but that's the background. It's not necessarily assured that anything will happen. Most likely the numbers dictate that there is going to be less space required.

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UNIDENTIFIED SPEAKER: He just mentioned the fact that if hospital numbers are going to be smaller, that's fine, but talk about the family cutting down from ten people to two, most logical thing to do would probably be to move to a smaller house.

Why not — don't close one hospital. Keep them all open but make them smaller. Why make the rest of us move? That's really traumatic to residents. It's not just the staff. It's also the residents. So why not have, just have a smaller facility but have it in all of the towns.

MS. KARLINS: Let me see that I understand your commentary. Are you suggesting that the hospitals be retained but in a smaller size or that smaller facilities be in the community? I'm not sure I understand,

SAME UNIDENTIFIED SPEAKER: Either way to begin with. Just to keep them all open in smaller size. Don't close Cambridge or close Faribault. Just make each one of them a little bit smaller, but don't take all of them from Cambridge and move them to Faribault.

We have a lot of residents here that really suffered from coming from Rochester up here because they don't get the family visits like they got in Rochester.

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UNIDENTIFIED SPEAKER: Just seems to me
that there are an awful lot of dedicated people out there at
that state hospital, and it just seems totally unwise, for me
to look at it from my point of view, for the State of
Minnesota to waste their tax dollars building these group
homes when we already have the facilities already built.

So that's all I have to say. Thank you.

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UNIDENTIFIED SPEAKER: Along with what
Steve just said, I attended a meeting last winter, I believe,
for the Department of Public Welfare policy committee and
Council 6. Their statement at that time was—it was from
representatives from all the state hospitals--that our people
can do a better job than anyone else, we feel, under any type
circumstance, under any setting.

And if you want to close the hospital, you go ahead,
but you don't take the kids away, and you don't take us out of
the job that we're good at. And I know that's about the
general statement that we made at that time.

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UNIDENTIFIED SPEAKER: I agree with
Virginia that you don't take the residents, the clients away
from the hospital. This is their home, and you take them away
and it's a traumatic experience. It's a traumatic experience
for the direct care because they are attached to those residents.

We are their surrogate family. They have — the younger people, high school part-timers are like their brothers and sisters. They become attached to them.

We feel that when a resident is taken away and they say, "Well, they have a right to refuse," many of them do not have any ways of communicating. You are taking them away, placing them in a group home—not saying that the group home is bad—but placing them in a group home without their own consent because they really don't know.

And I myself feel that it is very, very traumatic experience for them. Thank you.

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MS. GLORIA MAE BECK: I'm Gloria Mae Beck. I'm a Mille Lacs County Commissioner. I'm also the chairman of the Mille Lacs County Welfare Board. I was sent here to represent Mille Lacs County.

I would like to share something with you tonight, an experience we have had. Mille Lacs County has people here, and people have been returned from Cambridge to the community, and some of this has been good, but I have one experience that has been very bad.

There was one gentleman, was at the top of the heap
he was happy; he was content. They took him out of this setting; they put him in, and he ended up in a nursing home in Foley.

The gentleman has, we have to drive from Milaca to Foley with the bus every day to bring him to the DAC and back again. Not only that, but he disrupts the whole DAC because he cannot control his physical body. Because of this, he is a very, very unhappy person.

He was happy in Cambridge. He is not happy out in the world, as we see it. And this is why — the gentlemen before me have expressed financial problems. I want you to think about the emotional trauma for these people that have to be taken away from where they are comfortable and put someplace where they are very unhappy. Please consider this.

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UNIDENTIFIED SPEAKER: As a former dietician at the state hospital, I'm well aware of the standards that we are expected to maintain in sanitation and nutrition and all these other things. I don't believe that group homes can be supervised and keep up the standards that we have kept up.

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MS. KARLINS: The comment was made by a person whom I assume has a group home in the community saying that there are no double standards for sanitation or for diet because they're under the same kind of licensing concerns that the state hospitals are.

I think you ended by saying that the only difference in the food process is that yours is family style in a smaller facility, if I'm quoting you correctly, for the record, and the atmosphere is more typical of a home atmosphere.

Okay. Thank you very much.

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UNIDENTIFIED SPEAKER: I would like to speak. I have a sister-in-law who is in a group home, and I won't say where because of the information that I would like to give.

She is in a, has been in a group home now for two years. She was at home for 41 years of her life, and in the group home that she is at we have found that the staff there, when it comes to suppertime—I know the woman who cooks, who is the cook there, personally—she has to go down to the grocery store to buy the groceries because the groceries that were available had disappeared. Also her clothing has disappeared, and the night staff bring in their laundry and do the washing.
Now, I realize that there is monitoring of group homes, but I feel personally, being an employee of the state hospital in the recreation department, that the monitoring of the State system that the State does in the State facilities is much better because by and large when you have a facility such as the State has here and the buildings, you have people in one building, say you have 60 employees and they're watching over on each one of their individual households.

Where if you have an establishment as my sister-in-law—is in, there are 14 residents and you have, oh, maybe 25 staff. Those staff, if one is going to get by with something, then the other one is.

Now, I'm not saying everyone is crooked, but this is just something that we know for sure has happened.

And another subject I would like to bring up on this is the fact that we have one bus at the state hospital that takes us where the residents want to go. We just have a new one up there. We have one wheelchair van, and we may have, I don't know what's the total on our vehicles. Five or six. And these vehicles are not new, and we make do with them, and we clean them up when we're done with them.

What will happen when we have to go into the group home, when these non-ambulatory residents are put into a group home? Each one of these group homes—if I'm not right, correct me—have to supply a wheelchair van for non-ambulatory
residents.

    You figure that out. Thank you.

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    UNIDENTIFIED SPEAKER: I've been an employee at Cambridge State Hospital for the last six years, and recently we went to a women's conference down in Chicago, and one of the counselors who were acting down there had a country singer, folk singer that wrote a song concerning her residents after her institution was closed, and she said:

    Mary was a woman who never had it very good. Perhaps she never got the loving care that she should. Maybe she was born that way. No one will really know because Mary's not around no more to tell us if it's so.

    It's lonely and it's cold out there when you have no place left to go. In and out of the hospital, as often was the case, she found certain comfort there. In and out. Excuse me. In and out of the hospital. I forgot the words.

    Now she found a certain comfort there, that there was no doubt. But when she couldn't handle things, as often was the case, the staff would take good care of her. They had come to know her ways.

    They put Mary on the street when the budget was attacked, and most of the time just half alive they had to bring her back. Then one day she found a terror. She would
have to leave once more. She preferred to die, and outside
they found her on the floor.

It's lonely and it's cold out there when you've got no
place left to go.

Well, they're closing down the places where folks like
Mary stayed. It seems you hear about a new one almost every
day. You that make such policies, I ask you tell me true, how
many other Marys will be lost because of you?

And as a state employee, I would just like to mention
that we are open to other suggestions, alternatives to the
care, but we would also like you to consider us as employees.

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UNIDENTIFIED SPEAKER: I have a few
questions. Where do they get the population numbers? What are
the alternatives for the workers there now? For example,
retrain the staff to be able to help with the drug-related
type problems or mentally ill or whatever. But I guess I
haven't heard any information.

Also, I don't see it being a group home versus a state
hospital situation because we both stand for the rights and
the improvement of lifestyle for the handicapped. I didn't see
it as us against them, you know, red versus white, black and
whatever.

I'm not seeing or hearing anything that's telling me,
giving me any information as to where we say why it's going to be less population. As far as I understand, the medical techniques are getting better all the time, saving premature children and having those people sometimes be handicapped and the person saying about, you know, them being put in a nursing home versus state hospitals.

Those things can be brought together, but I'm not hearing that being said. I think that is your job to tell us where you get your information, what you see as alternatives for us here so that we don't lose a job, because I think that's important, as well as maintaining the highest lifestyle for the handicapped people no matter where they go.

I guess that's, you know, you can address that Mr. Welch, whatever, but I have heard, you know, nothing, and that kind of goes along with what some of the other people said earlier.

Again, I just want to reiterate. I don't think it's us against them proposition. There is no reason for that because everybody here is concerned for the rights and the lifestyle of the handicapped as well as what the most economic way of bringing them, you know, to a conclusion.

Thank you.

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MR. JACK O'BRIEN: My name is Jack O'Brien, and I worked in the public school program for more than a decade now at the Cambridge State Hospital, 

I would like to just reinforce the point that Mr. Hanson was trying to make about pitting group homes against the state hospital. They all have their place in the service system of continuing services.

The state hospital people are very, very good. They work with some very, very tough people to work with, whether it be because they have acute medical conditions or behavior problems or a combination of mental retardation and mental illness. These people have withstood the test of providing service to a very difficult group of people. They're very good at it.

I've been impressed throughout the years with the continual increase in skills that these people have. They've got good staff training programs; they've got the experience; and they have the toughness to handle these; and we should not lose that resource in the State system of providing services.

The other point I want to make is I think many of you know that the state hospital sponsors a foster grandparent program. I haven't heard any senior citizens talk. I've watched the foster grandparents in operation for a decade, and that's a sight to behold. That's a real people-to-people kind
of interaction.

I know there are foster grandparents with the residents in the classrooms out at the state hospital, they're in our public schools and in all of our buildings. They work in the St. Frances public school system, at the Boys Ranches out there, and I'm wondering if, you know, we look at all of these other ancillary programs that are supported by the state hospital administration with their buildings and just with their philosophy of being cooperative.

We just have seen a nursery school take up space, open up operations down at the state hospital.

Taken together, taken collectively, you see that closing a state hospital involves an awful lot of things, residents and school districts and property values and programs and senior citizens. I think we have to look at that very, very carefully if that's the reason for this meeting, if that's what you're doing.

Thank you.

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UNIDENTIFIED SPEAKER: As a physician at the Cambridge State Hospital, I think it's important to point out that possibly 30 percent of the residents that we have severe convulsions, and again this is important because they can go into very sudden status convulsions, and we always
have physicians in attendance right away.

For example, last night I was on-call, and a patient went into a status convulsion. We had a physician right there. We had to give medication right away.

Some people say, "How important is that?" Well, it's important because I can remember three or four years ago there was a resident—not here but elsewhere—that was not seen right away; went into convulsions and in five or ten minutes died. So again, it can be fatal unless treated right away.

And again in group homes and other facilities, they do not have physicians constantly available to see the residents. As retarded residents, again they must be seen early.

We had another experience a couple of years ago, as you remember, of a child that got very sick very suddenly and again was seen right away. We realized that this child was very ill, and a physician was right with the child, accompanied the child over to the Memorial Hospital, and the child did have abdominal surgery.

And again for the fact that we must have a physician in attendance, particularly among the profoundly retarded, and as more and more of our residents are profoundly retarded, I think it's more important that we have medical services.

We also have a clinic open. There is a nurse on duty constantly and, again, a physician in attendance. These are not available in group homes.
DR. CARSTAH SEECAMP: I'm a member of the Cambridge City Council. I'm not sure that I'm the official spokesman for the council, but we are concerned about what happens to Cambridge State Hospital, which is a neighbor outside of the city limits.

We're concerned about jobs in our community. We actively seek industrial growth. We'd be concerned to have such a large loss of employment in our neighborhood, not just for the people involved but also for retail businesses and the other supporting businesses that have developed around our community.

I'm a neighbor of the Cambridge State Hospital. I don't live two blocks from the grounds. I've lived there for 13 years, and I remember at that time, when the population of the state hospital was about four times what it is now, and many of the residents were free to leave the grounds and to go downtown. Now most of these people who are capable are now in community homes. They're not there anymore.

For example, there were more profound handicaps, and I think I would just be concerned that these people, if moved from here, have an appropriate place for their care.

Oh, yes. The other thing I was going to comment on is that you raised several questions at the beginning of your presentation that you would like us to address, but this is really the first time that we've heard the questions you want
answered.

    I don't know. Maybe many others heard the questions that you would like answered, and in such a short period of time, I'm not sure that we can conjure up realistic answers to those questions, such as other uses for the facilities, et cetera. I don't think we can help you at this point. I think if we had time to think about it, we may be able to respond a little bit better. So we may not be able to give you the kind of feedback you're looking for.

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UNIDENTIFIED SPEAKER: One thing that I think we realize is that there is a reduction at the state hospital. That is something that is going to be encountered. But looking at Cambridge and having talked with our legislators, the largest amount of money from welfare funding is used to keep residents in nursing homes.

    And geriatrics is one place that – the hospital has set up a building with new remodeling. It would be perfectly suitable for this kind of thing; and I think this is one aspect of future use that the state should very definitely consider before they start building more buildings and everything like that.

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UNIDENTIFIED SPEAKER: For those of us who aren't familiar with the state hospital, I would like to know how many residents we have and what the degree of disabilities of the residents are. I would like to know how many residents are at the state hospital and what the gamut of disabilities is.

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UNIDENTIFIED SPEAKER: I understand the question. The number is 479 today, and virtually the total number are in the severe and profound level. There are some who are above that, and they possess some maladaptive behaviors and as yet are not acceptable in the community.

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UNIDENTIFIED SPEAKER: I have one more thing I would like to ask the Planning Agency. If—and I sincerely hope that that's an awful big "if"—if they do close the state hospitals, will the Planning Agency or commission or whatever it is, are they going to be willing to buy our homes so that we can find work elsewhere?

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UNIDENTIFIED SPEAKER: In response to that, I represent the Minnesota Board of Realtors, Century 21
Realty. I don't know how many people out of eight hundred forty or fifty people living in the Cambridge area, Isanti or Mora area, but if we took, suppose, 100 homes that have come on the market, we would deluge the market.

Not only would they lose their jobs, but they would lose equity that they have in their present homes. So you don't want to get in a situation like in Duluth or Hibbing where there is one employer that employs the majority of people. It has disastrous effects on the equity that the sellers have in their homes.

Not only do the employees get hurt, but if there is a John Doe that's retiring and moving to Arizona, he will get adversely affected too by deluging the market.

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UNIDENTIFIED SPEAKER: My biggest concern, I am a single parent, and I need a job to pay at least as well as the state hospital, and I wouldn't mind working in a group home with residents in a group home, provided I can have a full-time job with equal pay and benefits there.

You know, that's my main concern, and I know that a lot of group homes hire part-time help. They don't have the pay, they don't have the benefits. I would like to enjoy working with the residents, and I don't necessarily have to be at the State level, but I really need the money that they pay.
MRS. MARIE WELCH: I'm Marie Welch, and there has been a lot of talk about a community-based facility, and the point I would like to make is the Cambridge State Hospital is a community-based facility because we've made it part of us.

We have been a partner in the State of Minnesota for quite a few years. We took the hospital onto us. It's been part of our community, part of our schools, our people work there. It's been a partnership. And now the State of Minnesota is talking about abandoning us.

They abandoned, certainly abandoned Rochester, and I believe the State of Minnesota has a responsibility to us because if they needed us with 6,000 residents in the state hospitals, we were there for them. Now we need them, and we expect them to be there for us.

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MR. WARREN BOCK: I'm Warren Bock, and I'd like to respond to a gentleman's question regarding the numbers. There has been a lot of confusion about that.

The reduction of the state hospitals, at least in terms of the mentally retarded, started about 1960 when we had over 4,000 people. Today, system-wide, there are approximately 2,250 mentally retarded people in the hospitals.

We are required, and we have agreed to, under the Welch
versus, the consent decree, to reduce that number to no more than 1,850 by July 1, 1987. Beyond that number, we have projected, under Title 19, that an additional 135 could be placed, but that is only a projection. So I hope that answers your question.

While I have the mike, in addition, the woman that asked about children being placed in nursing homes, I am not aware of this. That is not a policy of the State. If that is occurring, I would like to know about that. It's not the State that places people, you have to remember. It's the counties.

But we have no policy that supports or encourages or even endorses that.

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MS. MAURINE MORT: I'm Caprine Hort. I'm a social services supervisor for Isanti County, and I would like to — Warren had just mentioned that there are plans for reduction of the population of the state hospitals.

I would like to recognize that not all state hospital residents are appropriate for community placement, and I think that's being said in that statement.

With that in mind, I would like to make some comments on what druthers might be, then.

One would be to keep all state hospitals open, perhaps on a smaller scale. Second would be to open an all-state
hospital to serve the various disability groups.

We currently have our services from Isanti County for the mentally retarded at Cambridge. The other disability groups have to go to Moose Lake, which is a 75-mile trip one way, and there is a lot of families that aren't able to get involved in the hospital process.

Third would be to open up cooperative service delivery between county and state hospitals to help the displaced employees remain in their home community. We recognize that the counties — we're serving retarded persons in the community, and there is a lot of expertise in the employees at the state hospital.

If there were programs available, they could provide consultation, specific specialized services that aren't available in some of the rural communities, direct care, and that way, through contracting between the counties and the state hospital, or perhaps some way of arranging part-time positions so that someone could find a part-time position at the state hospital and also a part-time in the community providing services to other people in the community.

I think this might be an opportunity for creativity and an opportunity to use the expertise of the state hospital employees that are being displaced by keeping them earning a living and contributing in our own community and not having them go out of the community.
The other issue that I want to address was the issue of severely handicapped infants who several years ago would probably not have lived and they are currently being saved through some of the new medical procedures.

Warren mentioned that there was no procedure or policy at the State level to place children in nursing homes, and yet, when we have a child like that and the hospital is saying they're ready to be discharged and the information we get from DPW and DHS is they need skilled nursing care.

So I guess I would like to add that the State needs to address that issue, and the skilled nursing care should be established at the state hospitals so it is available and children do not have to go into nursing homes.

That's the information we're being given now. So it isn't the county that makes that decision. It's based on the level of care that's needed, and they're saying skilled nursing care.

Thank you.

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UNIDENTIFIED SPEAKER: I'm a social worker at Anoka State Hospital. I would like to speak to the placement issue.

I've worked at Anoka for almost three years, and I continue to be appalled at the lack of community resources, as
well as concern about their, the placement facilities' commitment to take people back after they've been hospitalized.

I think that Anoka has always been a home for a lot of people because we can't turn people away, but once they have been treated by us, the facilities are not taking them back. Consequently, the mentally ill are pushed from pillar to post.  

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MR. FRANK PRZYBILLA: I'm Frank Przybilla, publisher of the Cambridge Star and the Braham Journal.

There has been lots and lots of good information brought out and shared tonight, but I think, I personally think we missed a couple of things.

No. 1, Miriam is not here to say we're going to have a hospital or not have a hospital. I think every employee out here is dedicated and worried about the care of the patient and worried about their livelihood. They should be.

I see shoe salesmen, I see mercantile, I see grocers. Where will your livelihood come from if it closes?

The effective thing is to write your elected people; contact your city council, your commissioners, your state representatives, your senators. Let them know.

But if the decision is to close the hospital, we have time now, we have brain power to match any community anywhere
in the state. Let's look for alternatives. We don't have to
die. We don't have to bare our houses. We don't have to say
the world is ending.

    We've got the intelligence to come up with something
else. That's why I think we better start looking at it right
now. Let's fight to save it, but let's not panic. There has
got to be other things we can do if we do lose the hospital to
keep all our people in the community, keep them working, keep
our community progressing.

    If we let this kill our community, it's going to die
anyhow, even if the hospital stays. So let's fight for it.
Let's let our elected officials know where we're coming from,
but let's look at Plan A, Plan B, Plan C if this is the case.
We can do it if we really want to.

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UNIDENTIFIED SPEAKER: I have a question.
Is the Planning Commission or agency or whatever it is that
will make the decision either to close, suggestion to be
closed or keep it open, are they going to follow some
scientific way of valuing things or factual way so we know the
right needs that have to be addressed, the needs of the people
that we're working with, these residents, the needs of the
people who are working there, the needs of the community, or
is the decision going to be ultimately a political one?
REPRESENTATIVE JOHN CLAWSON: I am John Clawson, state representative from a different district, but I am chairman of the, what we call the Legislative Commission on Long-Term Health Care, and it was out commission that was given, by the 1984 Legislature, the responsibility for receiving the report which Miriam and Colleen and a bunch of folks are working on.

The decision on what to do with state hospitals will be made by the legislature, not by bureaucracy someplace. It will be made by the elected officials.

As to the question of whether we make that scientifically or politically, I guess I have to tell you that out of my own sort of ethical sense of what politics is all about, that there are no nonpolitical decisions.

Where to build a bank or where to put in your driveway are never made scientifically; they're made politically, the decision.

I would guess you heard Colleen indicate about several studies that are being completed on a whole variety of questions about state hospitals and communities in which they're found.

I would guess that some legislature—and it will be a future legislature--will take a look at the information gathered in all of these and will say something like the state hospital in—I don't know. Pick a fictitious place so as not
to get in trouble—the state hospital in Cloquet is the oldest facility, the least energy efficient facility. It is the facility that would make less sense of any of the others to put money into in terms of energy efficiency or the rest of it.

The state hospital at Marshall is in a community that has no other economic resources except the state hospital. The closure of the state hospital would mean essentially the end of the town economically.

The state hospital at Mankato is a facility that could, because of its age and its condition and the other types of facilities in the community available for taking care of mentally retarded, chemically dependent or mentally ill individuals in the community, could be expanded to receive patients from South Central Minnesota or some such thing as that.

We kind of throw the whole thing up in the air and it's going to come down one way or the other. I can guarantee that the legislature is not going to take a 100-year-old facility, of which there are a number in this state, and put a ton of money into it to rehabilitate it and to fix it up so it can do what state hospitals always have.

There isn't anyone in this auditorium, I think, who could or would subscribe to the idea that we ought to put a ton of money into an old, leaky, run-down facility that isn't
appropriate anymore.

I guess some of the other options that people suggest, yes, would probably really be well considered. A hospital that's got, where the population is declining to such a point that it's maybe got no more than 100 or 150 people residing there, may well have most of the campus closed down, and retain a core residency, and kind of leave it at that.

Most of us remember a few years ago we bull-dozed a couple facilities in Cambridge because of declining population. I would guess that the oldest and the most decrepit facility is simply easier to bull-doze rather than fix them up or be used for some other kind of facility or some other kind of project.

That's a long way around of saying I think that a variety of things are going to happen.

The point I made last week when I spoke to the interagency board that's going to head up dealing with what's going to happen to buildings and so forth, is essentially this: In the past the legislatures have closed about three hospitals, one before I got there and two since I got there.

The Owatonna facility was closed because it was, at that time it really wasn't in excess of 100 years old. It really outlived its usefulness. Most folks agreed that it was pretty and it was nice but it was not worth fixing. Other things were done.
We closed Hastings. We found an alternative use for the facility by turning it into a veterans facility, and that's another whole long story.

We've got a lot of uses for geriatric facilities in the years to come.

Rochester was down and dirty, by which I mean to say it was done at three o'clock in the morning, and it was done simply because something needed to be done and no one had thought, scientifically, what kind of process to go through to do something.

And what I told the interagency board the other day is the day of down and dirty is done. We are unable to deal with that in that way any longer.

The legislature has grown, public awareness of the problem has grown to the point where the legislature, at least on the quasi-scientific basis, there is no way to do it scientifically. You cannot assign points to each facility and the rest of it, but the decision will be made in a much more community-conscious sort of way than it's been done in the past.

Thank you.

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MR. SHAWN STUEMPGES: I'm Shawn Stuempges, and I have a question. I can really appreciate Mr. Welch's
legislation that enabled the Planning Commission to look into
community impact and the impact on the residents, how things
are going to come down and to put a little planning behind
what's happening here.

I guess I viewed, though, the Title 19 waiver as just a
simple shutdown, and I view that as continued. It's continuing
right now, and I guess I'm a bit confused as to whether the
Department of Human Resources, DPW as we formerly knew it, is
going off on their own right now or if they're going to give
any credibility to the recommendations of the Planning
Commission.

And if I could, I know that the assistant commissioner
is here, address that to her, please.

MS. MARGARET SANDBERG: I'm Margaret
Sandberg. I work at the Human Services Department. We're in
a position here tonight of talking about two pieces of
legislation, policies and programs passed by the State
Legislature that the State agencies are in the process of
implementing.

We passed Chapter 312, or the waiver of services
legislation, a year and a half ago now and have been in the
process of implementing that since that time. It's not a
departmental policy. It's a state policy.

* * * *


UNIDENTIFIED SPEAKER: I would like to commend the Planning Commission for conducting this town meeting because I think it's an excellent idea and a better way to go about doing something, getting some ideas as to what should be done rather than what might have happened in the past, like Rochester.

My other concern is if indeed the decision is to close it, is it going to be political efficiency or is it going to be political convenience? I'm just concerned it might be the latter.

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UNIDENTIFIED LEGISLATOR: I didn't really intend to speak tonight because this was intended to be for input for the community and we in the legislature don't have an awful lot of opportunity to speak, but I do want to tell you:

There has been some questions about whether it's a political decision or a scientific decision, and I think the whole reason for this meeting and for the other meetings in this series of meetings is to try to get a better handle and better understanding of just what a decision, one way or the other, will likely mean.

If we just assume that everybody wanted, everybody in the whole state agreed that we should close the state hospital
and everybody agreed on which ones it was, it's still an awful lot that goes into doing something like that, and I doubt there is anyone in the state that could tell us all those things right now.

I know it's been said before tonight, but I want to stress again there is no plan in the legislature, I can say with almost 100 percent certainty—I know it's in the minds of all members of the legislature—but there has certainly been no expressed plan on the part of anyone to close down a state hospital.

I can tell you there is genuine effort to find out more about the whole situation, and we really do want to find out what the impact will be.

The Rochester State Hospital thing occurred, as John said, late in the session. It was a rush thing because everybody said we have to do something. Well, we did something, and there are some consequences from what was done that weren't anticipated just because of the haste.

If there is going to be another decision like that down the road, we don't want it to be a decision made in haste.

Now, John is absolutely correct. We're politicians, and that's what you people elected us to be. And if it's Cambridge-State Hospital somewhere down the line, somebody wants to close Cambridge State Hospital, I can guarantee everybody in this room or just about everybody in this room will ask me to
be very political in stopping it.

And I just want to say it because there are a lot of people in this area who think different than people in East Central Minnesota. That's when politics occur; when people don't agree what their self-interest is. So we can't treat politics as something that doesn't exist.

But I agree with the gist of your comment that this should be something that we sit down and figure out just what these decisions actually mean, what they mean in terms of dollars and cents, what they mean in quality of care for patients, what they mean in terms of human things that go on in the community.

That's what we're really trying to do here tonight, and hopefully we'll be able to avoid the kinds of problems that we've run across in the past.

* * * *

UNIDENTIFIED SPEAKER: I have a resident group home in town here. For the record, I'm as concerned as the rest of you. My husband is a teacher; my children go to school in this district. This is my home. It's not just I have a group home.

I think my heart is in getting the residents into smaller facilities. But realistically, I believe that there might be a case for the state hospital.
My question, though, right now for the legislators are
the two bits of legislation that they're talking about, one
decreasing by the Welsh vs. Levine decree and the other one
the complicated Rule 54 or three or whatever it is, putting a
cap on beds in group homes.

What exactly are we going to do in order to beef up the
group homes to take care of these residents coming out of the
state hospital? I understand that the waiver is supposed to
take care of this sort of thing. As I understand it, nobody
understands exactly what these services are and who is
available for them.

We understand now that only state hospital residents
can use waiver services. People that are in group-homes
already cannot be eligible for these waivers of services, but
that is just something that I've heard. I don't know.

I would like somebody to tell me what exactly they're
going to do about the caps on the beds that DPW is
promulgating and in relation to what they're doing with the
state hospitals.

I mean there has got to be a solution here. One is
saying we don't have beds for these people. We're not going to
encourage providers to provide these services in the
community. And at the same time, this other group of
legislators are saying you're going to do it no matter what.
We're going to decrease the population no matter what.
MR. WARREN POCK: This is going to be a long answer. We have, on the ICFMR, beds in the state to include not only group homes but state hospitals. According to federal definition, ICFMR is any group home certified as such in addition to the 2,200 beds in the state hospital.

The legislature put the cap on 7,500 because in its judgment it felt that that was enough for a population of this size. We currently have more people in long-term care per capita than any other state in the nation, and that was one of the reasons for the cap. Another reason was to help to implement the waiver.

Now we are talking about decreasing or closing a certain number of state hospital beds, as we have been doing under the consent decree. We are also talking about converting a number of existing community beds into waivered services.

In fact, overall the number of community beds that will be converted will equal the number of state hospital beds that will be closed, and that's how we would get under the cap.

The new construction which we do anticipate will be primary class facilities that will serve the non-ambulatory and physically handicapped, which is primarily population that resides in the state hospital. However, several of these people can also be served under the waiver.

(Discussion had out of the hearing of
She asked me if I said that the nonambulatory would be the first to leave the state hospital. No, that's not true. Actually we cannot (inaudible), under the consent decree, any population to go or to stay in the state hospital. We can't make that discrimination.

What I'm saying is that any new construction of beds in the community will be Class B beds because we already have enough Class A, and Class 3 beds are for the physically handicapped.

(Discussion had out of the hearing of the reporter.)

The question was: Does that mean there will be larger facilities in the community?

In the past, technically Class 3 facilities were larger. We have been looking at other facilities, and we have found that small six- and eight-bed Class B facilities are very cost efficient.

So, no, I do not anticipate any large Class 3 facilities.

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MR. BILL SAWYER: Bill Sawyer. I guess that in the event that the state hospital does close, I would like to know what the State feels its moral responsibility to not
only employees but to the community and to the surrounding area is.

In the sense of being the largest employer, the State has taken on the role of Godfather, and as such, a grave responsibility to the wide community. I do not think it can come into a community or an area for 10 years, 20 years or 15 and operate like a corporation in that it uses and abuses and then suddenly walks away. There has got to be some moral responsibility to fill the void.

If you have a beautiful shade tree in your yard that gets, and it's an elm tree and it gets Dutch elm disease, you cut it down. but the most wise person would probably replace it with a different tree.

So if the State does close the hospital, I suggest it have a plan to offer this community and to its employees something other than treating it as a bastard child.

* * * *

UNIDENTIFIED SPEAKER: I hate to do this again, but I don't feel my question was answered. This community and our employees have been in a state of confusion for a long time. We're not unaware that the Department of Public Welfare, DHS, can close Cambridge State Hospital at any time without legislative action. They can just simply transfer us out because they 're all going to be parted. We're not that
naive.

What I was asking the assistant commissioner is if their policy that they have made is still in action, are they still continuing on with that or are they waiting for the Planning Agency's recommendations? Could I get a clarification on that?

MS. MARGARET SANDBERG: We are proceeding to implement policy that the State Legislature passed with endorsement of Chapter 312. Waiver of service implementation is continuing.

Meanwhile, we are working very closely with the State Planning Agency and other agencies, looking forward to the information that's going to come as a result of this very in-depth study.

It's unique. We've never taken this comprehensive an approach before, and I think that it is very clear from Representative Clawson earlier that the Department of Human Services is not in the business--and I don't believe it ever has been--of closing state hospitals. That is a policy decision for the State Legislature, and we're all working very hard, and we're listening tonight to understand the issue.

* * * *

UNIDENTIFIED SPEAKER: I would like to make
a suggestion to the State Planning committee. Could you also
include in your study this New York and California, especially
California, deinstitutionalization program and then collect
some of the data?

They reopened some of their institutions out there
because the programs didn't seem to work, and New York is
coming out with statistics that close to 50 percent of the
street people population is made up of deinstitutionalized
people. And I would like that to be a part of your study.

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UNIDENTIFIED SPEAKER: This is a possible
suggestion for an alternative use of some of the buildings
here at Cambridge.

There are many physically handicapped. They are not
mentally handicapped in any way. But they need some type of
facility where they can use adaptive equipment.

Something that is a little similar to Courage Center
where the kitchen facilities are built in such a way that
someone in a wheelchair can do their own particular house care
and their own cooking and be able to use some of the adaptive
equipment.

If they are handicapped and have the use of one hand,
they have how to use a board for sliding the cake pans into
the oven, taking them out, using special handles to get the
cans out, having ranges set down at their level.

Possibly maybe some of the businesses could possibly come up with something in the way of vacuum cleaners set down a little lower so that they could get around and vacuum on their own.

It shouldn't be just Cambridge State Hospital we're looking at, I think a lot of the businesses in this area could get together and come up with some ideas for adaptive procedures so that the handicapped, physically handicapped, can be able to lead a more normal life in their own home.

Thank you.

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UNIDENTIFIED SPEAKER: I worked with retarded people for seven years in the Twin Cities in a day activity center before I came up to Cambridge and worked three years at the state hospital, and I notice like in the process of deinstitutionalization that there is a lot of people that don't work out, and some of the people that I used to work with in the Cities I see walking around on campus at Cambridge State Hospital.

So like when Mr. Bock talks about the number of people that are going to be deinstitutionalized or the number of people that have been deinstitutionalized by the State, I think the Planning Commission and the legislature should take
into consideration that there are a lot of people that just
don't work out under deinstitutionalization, and when those
people don't work out, there has got to be a place for them to
go. You've got to have someplace for the people that don't
work out.

* * * *

UNIDENTIFIED SPEAKER: Just a question. If
the State of Minnesota opened up from six- to eight-bed group
homes, State-run, utilizing State employees, this type of
thing, could they utilize also the waivered money or could
they utilize the money from the Title 19?

MR. WARREN BOCK: If the State of Minnesota
was to open up from six- to eight-bed State-run group homes
utilizing the State employees, would you also be able to use
waivered money? No.

Why? Because the State is an ICFMR provider, and the
employees in an ICFMR community cannot operate a waivered
service as a portion of that facility. The Waiver is an
alternative to long-term care, according to federal
regulations.

So you either are going to be a provider of waivered
services or a provider of alternative care services.

* * * *
UNIDENTIFIED SPEAKER:  I have a question that I would like answered. Something is going on around in my head. If the State is willing to spend money to open up homes, six or eight beds, to accommodate 300 people, it would take approximately how many homes? What would that cost to buy those homes, staff those homes?

Could that money not be note readily utilized in upgrading what we already have and keep that open and keep it going? Or instead of X-number of dollars, why don't we spend it where we are?

MR. WARREN BOCK: First of all, it will not cost any more money to do that as an alternative for what we're currently doing. Secondly, that's really not a question yet to be answered.

It is a policy. We agreed to it in 1980 under the consent decree and the legislature ratified that agreement and ratified the waiver by passage of the 312.

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UNIDENTIFIED SPEAKER:  I think it boils down to the fact that the State is back behind the eight-ball in the Welsh case, and the only way for them to get out from
behind there instead of going back into court is to close down
our hospitals and get away from it.

I think, to get back to the point, that it's dollars
and cents that the legislators are looking at, and with the
hospital being run with the requirements that are required now
and the cost per capita is too much, and that's why they're
going to close them regardless of what we're going to do in
the end and get them into smaller places, hide the taxes in
the counties where it won't show up in the State revenue.

I think this is all wrong because I have seen residents
that have gone into the community, done everything possible
they could so they could get back by misbehaving, doing all
the things that they've been untaught to be able to return.
This is their home. That's the way they want it to be.

And the point that I'm trying to get at is that the
dollars and cents they're going to take and give the group
homes, pay minimum wages, on-call people to work with these
residents, unqualified people to work with these residents,
and they won't have the sane qualifications, the same criteria
that the State does now.

* * * *

UNIDENTIFIED SPEAKER: I think it's US
against them. It's the State hospital against the group home
system. And I think that's the question here. But to dispel
the myth, we've had the same guidelines as you guys at the
state hospital, same system as yours. Everything you have to
do, I have to do in my home.

So as far as staff not being trained the same as you
guys, that's not true. We have to establish our own in-
services monthly. My staff goes down to the Cities for in-
servicing. We have to have many in-servicing.

We have to have licensed nurses on duty, things like
that. We are under the same guidelines as you. The people that
survey your books turn right around and survey my books,
probably in the same day. So as far as quality of services, it
can be both ways. It doesn't have to be one or the other.

UNIDENTIFIED SPEAKER: Just one question.

What do you pay your help?

UNIDENTIFIED SPEAKER: Right about minimum
wage. Starting five dollars an hour. Starting pay is five
dollars an hour for part-time, and I think most of my people
have been with me a lot longer than that to make more than
that.

* * * *

UNIDENTIFIED SPEAKER: I'm not sure which
program it was on the TV this past week, whether it was 20/2G
or 60 Minutes did a survey in one of our nation's big cities. They walked a four-block-square radius. Out of that radius, there was 700 people sleeping in hallways and in doorways. Out of those people, the majority were retarded from state institutions that had been closed.

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(Whereupon this Town Meeting was adjourned at 9:10 o'clock p.m.)
STATE OF MINNESOTA)  
) SS.  
COUNTY OF CASS  

I, Diane M. Preece, Notary Public and Registered Professional Reporter, do hereby certify that I reported the foregoing proceedings had at the Cambridge State Hospital Town Meeting to the best of my ability, and that the foregoing 52 typewritten pages were transcribed by me and are a true, full and correct transcript of my original machine shorthand notes taken at said Town Meeting,

WITNESS MY HAND AND SEAL this 6th day of September, 1984.

[Signature]

Diane M. Preece  
Notary Public  
Post Office Box 783  
Nisswa, Minnesota 56468  
(218) 568-8449