70-SHD-OJV
State Inst Gen + State Inst Fac. Gen

Mr. Gillespie
cc: RG

MEMORANDUM
STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA
55101

DATE: March 31, 1970

TO: DPW Cabinet

Medical Services Division Institutions
ATTENTION: Medical Director
ATTENTION: Administrator

Area Mental Health-Mental Retardation Programs
ATTENTION: Program Director
ATTENTION: Board Chairman

Daytime Activity Centers
ATTENTION: Program Director
ATTENTION: Board Chairman

Medical Services Division Staff

Mental Health Medical Policy Committee

Citizen Groups

Minnesota Association for Mental Health
Mr. Noel Busch

Minnesota Association for Retarded Children
Mr. Gerald Walsh

Minnesota Council for Alcohol Problems
Mr. Jack Sherrill

University of Minnesota
Dr. William Hausman

State Planning Agency
Dr. Fifer

Public Welfare Regional Facilities Survey Project Committee

Federal Regional Office (MH and MR)

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

SUBJECT: State Hospital Districts and Programs

State hospital administrations must begin very soon to develop budget requests that will go to the 1971 legislature, to be considered

for appropriations for the two-year period starting July 1, 1971.

It is obviously impossible for anyone to foresee all the changes that will take place, and there are many further studies to be made and discussions to be held before we can finalize plans for the 1971-1973 biennium. Still, we must try our best to make predictions.

In a series of discussions involving mainly state hospital staff we have developed tentative options for program development for the 1971-1973 period and beyond.

Rather than have the State Department of Public Welfare or Medical Services Division "declare a plan" I would prefer that we work from the opposite end and "build up" plans at county, area, and regional levels.

Assistance to the state hospital administrations in budget planning, which is their inescapable duty, will offer a useful forum for program planning for counties, areas, and regions in relation to their state facility or facilities.

I am establishing it as policy within the state hospital service system that there will be no changes in receiving districts or new program units established at state hospitals unless the following conditions are met:

1. The hospital plan, that is the hospital's statement that sets forth the proposed changes in the hospital districts and functions, must be submitted by the hospital administration to the Commissioner of Public Welfare via the Medical Services Division in writing, setting forth the explicit terms of the changes that are being proposed. The plan must be approved explicitly in writing by the commissioner before it goes into effect.

2. The plan must bear written endorsements by county welfare departments, area committees, and the regional mental health-mental retardation coordinating committee or committees if they exist in the region or regions affected by the plan, furnishing proof positive that the plan has been thoroughly discussed, understood, and approved at these levels, in particular at area committee meetings.

   We may very well follow through on hospital-county aspects of the plan by requiring hospital-county written agreements according to the model developed for inebriacy programs.

3. The plan must make a positive case that any proposed new unit can be feasibly established and put into operation in a way that will be an improvement over existing arrangements. Statements under the feasibility heading should include information on staff resources, especially training and

other prepatory measures, and facilities.

4. The plan must also show that establishing the new unit will not harm or downgrade existing operations.

5. In addition to area committees -- that is, groups representing county welfare departments, area programs, state hospitals, DPW Field Services and Medical Services Divisions -- the major citizen associations should be consulted and their understanding and approval obtained. These are the Minnesota Association for Mental Health, Minnesota Association for Retarded Children, and the Minnesota Council for Alcohol Problems.

With the foregoing in mind, I have asked the hospitals to bring their proposals and tentative plans to area committees for consideration, and concurrently to Medical Services Division program offices whenever possible. Where no area committee as such exists, then it would seem appropriate for the hospital to consult with the area program directors with a view to holding area-wide meetings of persons mentioned in #5 above, where the hospital plan could be discussed (as to protocol it seems to be proper for the area program director to "call" the area-wide meeting.) I think it would be highly desireable if out of such meetings permanent area committees would be formally established for purposes of planning and program development.

As I have suggested, this is timely in view of the imminence of budget planning. Another source of time pressure is the Governor's recent call for a long-range plan for state facilities, that is due to be completed by July 1, 1970. I think that county, area, and regional groups should participate in this planning process insofar as it is possible in the time that is available.

I would appreciate your comments on these matters.

Thank you.

DJV:mhv

70-SHD-DJV

Typed unsigned and undated handwritten comments attached to this memorandum in Box 127.H.6.2 (F) at the Minnesota Historical Society, the subject matter files of the Superintendent of Faribault State Hospital

This is especially confusing. Before we can "work from the opposite end and 'build up' plans at county, area, & regional levels", we have to have at least a general plan from Central Office. If not, we will be working at cross purposes. A group (county, or other) in Luverne might say to us, "Don't you people know what each other is doing? Willmar has plans for us, St. Peter has plans for us, & so do you, which one is in authority?"

Such an approach requires us to contact <u>everybody</u> so we can form some semblance of organization (tough enough) before we can even begin to plan.

Also, do we plan on the 37 counties in southern Minn., & for what programs, or do we plan to be the Metro resource? Each would require a different series of planning meetings.

I believe we are abdicating responsibility and the result will be that someone else will plan for us.

I suppose the best plan for us is to assume that our patients will number about 1600 & that they may come from southern Minn or from the metro area. In either case, the patient load would be the same & we would continue to provide the whole range of programs.

One fear & reservation. If Roch., St. Peter will begin to build MR programs, they will take the Phy. Disabled last-this means that we will end up with all of the basket cases in So. Minn., so either we take <u>all</u> MR from So. M. & they take none, or we take none & they take all, leaving us to take <u>all</u> from Metro area.