Minnesota Department of Public Welfare
March 12, 1973
Wes Restad, Assistant Commissioner

HOUSE APPROPRIATIONS SUBCOMMITTEE ON WELFARE
Representative Donald Samuelson, Chairman

At an earlier date the Committee requested that we develop certain criteria and indices and using the criteria and indices developed, rank the ten large state hospitals for purposes of considering which facility or facilities might be closed. We have responded to the Committee's request and in the pages which follow we will attempt to lay out for the Committee's consideration the various data and indices we have used in arriving at our judgments.

Before getting into the specifics of our report, we believe it important to present to you again our Department's view regarding the delivery of human services- Without going into a lot of repetitious detail which the Committee members have heard in other Committee settings, the Department's view can be summarized as follows:

As the result of direction given by the 1971 legislature, we have been studying the impact and effect we would have in Minnesota if our service delivery system would be reordered and focused more on what local communities want with the local communities having a more direct say in how services are to be delivered and by whom. Such an approach is highly consistent with the regionalization movement which has been becoming increasingly important in our state
said then, it follows that as a Department we could not look at only one facet of the human delivery system namely, the state hospitals. Rather, the state hospitals have to be considered as only one component of a continuum of service and service and agencies. With such a conclusion being reached on our part and recognizing the other state agencies

which. are involved in the delivery of human services are also looking forward to — and planning for — services to be delivered in a more comprehensive way but with a local community based focus. We concluded that state hospitals should not be closed until we were able to get the legislative support for mounting the planning process necessary which would eventually provide more direct answers as to **what** was or should happen to hospital based programs and services. Thus, as a Department, we have asked for the authorization to **proceed** in one or two regions of the state to carry out the intent **and** purpose of our Comprehensive Plan and along with such a request, **we** have asked, subject to appropriate legislative controls, for flexibility in the use of the hospital appropriation. The idea being that if as a result of appropriate study and planning, it was found that we were better able to provide those programs and services now provided at the hospital in community based facilities, we could then scale back hospital programs and services and use the dollar savings that would result to support the delivery of like programs **and** services in the community if such were desired and/or needed.

— With the assumption that the legislature would see value in and accept the Comprehensive Plan approach but recognizing that we do have a considerable number of vacant beds in the system, it was and is recognized that a "scaling back" of the physical plant at. one or more of the facilities with a redistribution of the patient population within the system — those who could not be accommodated in the community — would be in order.

In relation to either of the approaches we have mentioned so far or the comments which will follow regarding the closing of one or more facilities, we wish to underscore that persons with problems of mental illness, chemical dependency, and mental retardation will be with us and they will need to be served. Hence, the expenditures of public funds to serve persons with such problems will be required whether such expenditure is made at state facilities, existing community facilities, or facilities and programs yet to be designed. In this regard, with the "turn down" of federal dollars (cut back on social service funds, mental health expenditures, etc.) which we had been counting on in the past few years to underwrite community based programs, the problems of creating and establishing alternate programs and services within each community of the state will become more difficult and will probably require a greater investment of state dollars than we have counted on in recent years.

Recognizing the position of the Department as reflected in our remarks to this point but proceeding now to the specific request that the Committee made, we have proceeded to respond to the Committee's request in the following manner:

First, we have proceeded to develop an array of tables attempting to describe and provide the Committee with the data that the Committee might wish to have available for its study and review while they are considering the question of closing one or more of the facilities.

Second, from the data included in the array of tables, we have prepared a recommendation which includes the closing of one state facility, closing out the state operation of one additional small facility and the "scaling' back" and redistribution of state hospital population throughout the system.

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I. General State Wide Population Characteristics (Source — 1970 Census):

Table 1: Minnesota Population by Region.

Table 2: Minnesota Population by Counties.

Table 3: Minnesota Population by Age and Sex.

NOTE:

1) Census population projections that have been made indicate that by 1980, approximately 70 per cent of the state's population will be living in Regions 7, 10, and 11 (Southeast one-fourth of the geographical area of the state). Regions 7, 10, and 11 will have a projected population growth between 1970 and 1980 of l4.8 per cent, 2.7 per cent, and 20.6 per cent, respectively. All other regions of the state are projected to have a population decline.

2) Youth under age 25 represent 47.7 per cent of state's total population.

3) Youth in the age bracket of 15 - 24 represents 17.49 per cent of persons hospitalized within the state hospital system.

4) Persons 65 years of age and older represent 10.75 per cent of the state's population.

II. Median Family Income by Region:

Table 4: Median Family Income by Region (Taken from 1970 Census).

The State median family income during calendar year 1969 was $9,930.

III. Community Resources:

Table 5: Physicians and Surgeons in Rural Minnesota by Region.

Table 6: Skilled Nursing Home and Intermediate Care Facilities by Region.

VIII. Patient-Resident Population at the Ten State Hospitals:

Table 24 : State Retardation Facilities Receiving Area (Map).

Table 25: State Hospital Mentally Ill Receiving Districts (Map).

Table 26: State Hospital Inebriate Receiving Areas (Map).

Table 27: Population at the Ten State Hospitals as of February 1, 1973.

Table 28: Number of Resident-Patients at each State Hospital who are ' from Another Hospital Receiving Area (As of August 31, 1972).

Table 29: Retarded by Intellectual Level of Functioning at Each State Facility.

Table 30: Release Rates and Population Turnover for Fiscal Years 1962-63 Through 1971_72 by Disability Group.

Table 31: State Hospital Utilization by Region -- Admission Rates Per 1,000 Population, 1970.

Table 32: State Hospital Patient Movement Fiscal Years 1948-49 Through 1971-72 (Graphs).

Table 32(A) : All Patients.

Table 32(B): Mentally Ill Patients Only.

Table 32(C): Chemically Dependent Only.

Table 32(D) : Mentally Retarded.

Table 32(E) : "Bed" Turnover Rate.

Table 33: Performance of Minnesota State Hospitals — Fiscal Year 1971-72.

Table 33(A) : Recidivision Rate.

Table 33(B) : Average Length of Stay in Hospital.

Table 33(C): Patient Turnover Rate at Ten State Hospitals.

Table 33(D) : Net Patient Turnover Rate — Releases and Re-admission Considered.

Table 33(E): "Cure" Index at Each State Hospital by Disability.

Table 33(F) : Workload Index at Each State Hospital by Disability.

Table 33(G) : Average Cost Per Hospital.

Table 33(H): Overall Performance Ranking of State Hospitals Serving Mentally Ill and Chemically Dependent.

Table 33(I): Overall Performance Ranking of State Hospitals Serving the Mentally Retarded.

Table 33(J): Overall Hospital Performance Rating Considering Data Reflected in Tables 32(A) through 32 (E).

IX. Department Recommendation:

Tables 1 through 33(J) contain a wealth of information that can be used as a basis for considering the closing of one or more state hospitals. The key to any recommendation to be made relates to the premise one starts with and the data used to support the premise.

EXAMPLE: A) If the Department's premise were to be based on primarily the quality of services provided (recognizing "judgment" has entered into arriving at a performance ranking), it would follow that the Department would recommend that the first facility to be closed should be the one with the poorest overall performance ranking, next poorest, etc., see Table 33 (J).

B) If the Department's premise were to be based on primarily the per diem personnel costs, it would follow that the Department would recommend that the first facility to close would be the one with the highest personnel per diem cost — see.Table 23.

C) If the Department's premise were to be based on primarily the total dollar cost to the State to maintain and operate the facility, it would follow that the Department would recommend that the first facility to close would be the facility which per centage wise uses the greatest share of the appropriation made for the support of the hospital system — see Table 38.

D) If the Department premise were to be based primarily on the extent to which the community utilizes the services of the state hospital, it would follow that the Department would recommend that the facility (s) used the least by the community should be the first to be closed — see Table 30.

E) If the Department's premise were to be based primarily on considering the dollar impact the closing would have on the community in which the facility is located, it would follow that the Department would recommend that the first facility to be closed should be the one that effects the economy of the community the least — see Table 20.

F) Etc., etc.

It is the Department position, however, that no single premise can be used in arriving at recommendations to close one or more state facilities. Rather, a number of considerations as well as assumptions must be kept in mind. These considerations and assumptions include:

— We assume that the legislature will authorize a minimum of 300 additional line items for the system (to be assigned primarily in direct care classification).

— We assume that the legislature is identified with and accepting of the Regionalization concept consistant with the aforementioned would be the desire to have disabled persons (Mentally Ill, Chemically Dependent, Mentally Retarded) treated and/or programmed for as close to their home as possible.

— By increasing patient-resident load at a number of facilities the indirect staff ratio will not be substantially effected (additional staff not needed.

— That whether one or more of the state hospitals are closed, the persons being treated at one or all of the hospitals need care and treatment. Hence, it becomes important that community programs and care facilities be available. In this regard, also, it becomes important that community attitudes be conducive toward the development of alternative programs-services.

— If one or more state hospitals are to be closed, the State will assist local communities in paying for (purchasing) alternative forms of care, treatment, and service.

With assumptions and considerations such as the above in mind and recognizing that (l) the Department is dedicated to furthering the concept of comprehensive - community based programs with local communities have a direct say in what services are to be offered and by whom; and (2) the state hospital system has a considerable number of vacant beds, the Department is recommending that <u>one state hospital</u> be closed and program and population shifts be made throughout the system as per the following plan — all to be accomplished as soon as possible but no later than September 1, 1974•

1. <u>Close Hastings State Hospital</u>.

2. Close out the Mental Illness and Chemically Dependent programs at St, Peter State Hospital.

3. Reduce the Mental Retardation population at Faribault to 1,000.

4. Reduce the Mental Retardation population at Brainerd to 675.

5. Reduce the Mental Retardation at Cambridge to 775.

The above would be accomplished in the following manner:

1. Closing of Hastings:

2. Chemically Dependent: Make a diligent effort to develop and/or involve the chemically dependent population in alternative community based programs (i.e., Mineral Springs, Hazelden, St. Paul-Ramsey development of half-way houses). Those that need continued state hospital care would be transferred as follows:

- Residents of Ramsey-Washington County to Anoka.
- Residents of Dakota County to Rochester.

B. Mentally Ill: Make a diligent effort to develop and/or involve the mental illness population in alternative community based programs (i.e., area mental health center programs, St. Paul-Ramsey Hospital, day-night programs, etc.). Those that need continued state hospital care would be transferred as follows:

- Residents of Washington-Ramsey County to Anoka.
- Residents of Dakota County to Rochester.
- Mental Illness residents from other counties would be transferred to appropriate receiving hospital.

C. Mentally Retarded: Make a diligent effort to develop and/or involve mentally retarded in community based programs (residential facilities, DAC programs, foster care, etc.). Those who need

continued state hospital care would be transferred as follows:

- Residents of Washington-Ramsey County to Cambridge.
- Residents of Dakota County to Faribault.

RATIONALE FOR CLOSING HASTINGS INCLUDE:

- Small resident population.
- High per diem costs.
- Buildings are old – valuation of buildings and fixed assets low in relation to other state hospitals.
- East Metro Region has a number of treatment resources . available. Further, agencies in East Metro area have generally good rapport and are interested in developing community based alternatives.
- Residents who need to remain in state facilities would continue to be relatively close to their home county.

2. Close out the Mental Illness population and Chemically Dependent population at St. Peter:

A. Mentally Ill: Make a diligent effort to develop and/or involve the mental illness population in alternative community based programs. Those that need continued state hospitalization would be transferred as follows:

- Residents of Scott, LeSueur, Blue Earth, Martin and Faribault Counties to Rochester.
- Residents of Carver, Sibley, Nicollet, Brown and Watonwan Counties to Willmar.

- Mental illness residents from other counties throughout the state would be transferred to appropriate receiving hospital.

B. Chemically Dependent: Make a diligent effort to develop and/or involve the chemically dependent in community based programs. Those that need continued state hospitalization would be transferred as follows:

- Residents of Scott, LeSueur, Blue Earth, Martin, and Faribault Counties to Rochester.
- Residents of Carver, Sibley, Nicollet, Brown, and Watonwan Counties to Willmar.

RATIONALE FOR CLOSING OUT MENTALLY ILL AND CHEMICALLY DEPENDENT PROGRAM AT ST. PETER:

- Continuous decline in mental illness population.
- High percentage of mentally ill residents are not from present St. Peter catchment area (see Table 28).
- Chemically dependent per diem personnel costs is the highest in the system (see Table 23).

3. Reduce Mental Retardation population at Faribault to 1,000:

A. Make a diligent effort to develop and/or involve the community in establishing community based programs and/or care facilities.

B. For those that need continued state hospital care transfer:

- Up to 200 to St. Peter (Buildings at St. Peter vacated by Mental Illness and Chemically Dependent programs being moved out).
- Up to 150 to Willmar (those that are from the Willmar mental illness catchment area).

— Transfer the balance (approximately 100 given present population) back to appropriate receiving hospital area (Cambridge, Fergus Falls, Brainerd, Moose Lake, Rochester).

NOTE: Long Range plan would be to have Faribault care for the retarded from Hennepin, Scott, LeSueur, Dakota, Rice, and Goodhue County.

RATIONALE FOR REDUCING POPULATION AT FARIBAULT INCLUDES;

— A number of buildings are old and would be quite costly to bring up to Fire and Life Safety Standards.

— Buildings are scattered over a considerable amount of land area thus reducing efficiency of staff and appropriate use of buildings.

— By reducing the number of buildings used on the campus, savings would result in overhead and maintenance expense.

— Greater opportunity for program and service visability if population is reduced.

4.. Reduce Mental Retardation population at Brainerd to 675:

A. Make a diligent effort to develop and/or involve the community in establishing community based programs.

B. For those that need continued state hospital care, transfer as follows:

— Approximately 100 to Moose Lake (those that are from Moose Lake Mental Illness receiving district).

RATIONALE FOR REDUCING MENTALLY RETARDED POPULATION AT BRAINERD:

- Moose Lake has a very adequate physical plant to accommodate the additional retarded.
- County welfare boards in Region # 3 have, by resolution, advised the Department that they would like to relate primarily with one multi-purpose hospital.— namely, Moose Lake. The aforementioned is consistant with the stance of Region # 3 Planning Commission (Arrowhead Council).
- Would permit greater use of Brainerd for specialized programming for the retarded on a state-wide basis (Learning Center program, etc.).

5. Reduce Mental Retardation population at Cambridge to 775:

A. Make a diligent effort to develop and/or involve the community in establishing community based programs.

B. For those that need continued state hospital care transfer:

- Approximately 100 from Fergus Falls and Moose Lake mental illness receiving districts to their respective hospitals (Fergus Falls, Regions 1 and 4; and Moose Lake, Region 3).

NOTE: Terminate Lake Owasso as a State operating satellite facility to Cambridge. Do not renew lease with Ramsey County. Lease expires June 30, 1974

RATIONALE FOR REDUCING POPULATION AT CAMBRIDGE:

- Better care and programs.
- Interest in area of having Cambridge become a multi-purpose center.

NOTE: Assuming the legislature elects not to close a state facility, the Department would continue to recommend that the transfer of resident patients as reflected

in IX, 2 through 5, on page 6 and 7 of this report be affected. By so doing, we would generally have residents placed in their appropriate receiving district — hospital. The aforementioned would be considered an initial step in the process of having local comprehensive programs developed.

X. Overall what will the above plan accomplish:

1. Close Hastings.
2. Close Lake Owasso as a State operated facility for the retarded. Save on upkeep, repairs, maintenance expense of a facility not owned by the State.
3. By reducing population at Faribault we should be able to accommodate remaining population in good serviceable buildings.
4. The transfer of residents within the system as above outlined will be consistant with regionalization efforts.
5. The state would be making maximum use of buildings judged to be in fair or fair to good condition throughout the system.
6. By reducing the patient-resident load at a number of facilities, the staff to patient ratio will be considerably improved. Further, it would minimize the need for transferring of line items to other facilities.
7. Assuming additional staff is authorized (300) and assuming that a substantial percentage of the employees at Hastings will be authorized to stay on in the system, the greatest expansion of staff (over and above existing complements) would occur at Moose Lake, Willmar, Rochester, Anoka, St. Peter, with a lesser number at Fergus Falls. The reduction in patient load at Brainerd, Cambridge, Faribault should mean that present staff complement should bring each facility within staff to patient ratio limits (overall 1 to 1:23).
8. By transferring patient-residents currently in the system as outlined

in IX, the hospital population for the nine remaining facilities would be approximately as follows:

FACILITY	CURRENT POPULATION	PROPOSED POPULATION
Anoka	423	563
Fergus Falls	580	640
Moose Lake	431	610
Rochester	598	770
St. Peter	735*	700*
Willmar	538	763
Brainerd	885	785
Cambridge	892	775
Faribault	1,461	1,000
TOTALS	6,543	6,606

* Includes Security Hospital.