

A D D E N D U M  
TO TESTIMONY SUBMITTED  
TO THE SENATE FINANCE  
COMMITTEE

SUBMITTED BY  
THE NATIONAL ASSOCIATION OF  
DEVELOPMENTAL DISABILITIES COUNCILS

COLLEEN WIECK, PH.D.  
VICE PRESIDENT NADDC  
CHAIRPERSON NADDC PUBLIC POLICY COMMITTEE  
EXECUTIVE DIRECTOR, MINNESOTA GOVERNOR'S PLANNING  
COUNCIL ON DEVELOPMENTAL DISABILITIES

September 19, 1986

This addendum provides an executive summary of eight policy-papers prepared by the Minnesota Developmental Disabilities Council in response to a legislative request for a plan regarding the future of state institutions.

Let me emphasize that Minnesota has plenty of plans, and some would argue that our state hospital system is overstudied. The problems with planning is that when major stakeholders are not involved, the planning is meaningless. Second, the Legislature can act without planning or can require planning and then not act. The study that we conducted involved all stakeholders and did result in legislative action.

**PAPER NO. 1: MINNESOTA STATE HOSPITAL  
FACILITIES AND ALTERNATIVE USE (BUILDINGS)**

The major focus of this study was an analysis of the general condition of the buildings and potential alternative uses of those buildings.

We examined several variables including the years the buildings were built, property size, building square footage, physical condition, plumbing condition, and electrical condition of the buildings.

Generally speaking, 43 state agencies reported to us that they do not save money by using state hospitals for other government uses rather than renting or building other facilities. This is due in large part to the condition and age of the buildings, energy costs, and renovation costs.

Of the 31 institutions reported closed nationwide, none have been purchased by private industry. Over half have been converted to other types of institutions, e.g., corrections, Veteran's, geriatric apartments, college, and religious organization.

**PAPER NO. 2: MINNESOTA STATE  
HOSPITAL ENERGY USE AND COST**

Energy consumption in buildings is affected by many factors including original construction features, efficiency of heating plant, severity of weather and type of heating fuel used. Meaningful comparison of energy use at the eight state hospitals was difficult.

We recommended that states should undertake energy conservation measures including: utilization of shared savings contracts; use of alternative fuels; purchase of electricity from wholesalers; separate metering of leased or rented buildings to the tenants; identification of surplus buildings for demolition to eliminate heating costs; and installation of improvements such as summer boilers.

PAPER NO. 3: A PROFILE OF MINNESOTA  
STATE HOSPITAL EMPLOYEES

The legislation authorizing the study was very concerned about the effects on the employees should a state hospital close. The legislation sought specific information about the employees: What is the projected displacement of state hospital employees because of deinstitutionalization, and what is the extent to which displacement can be mitigated through attrition, retirement, retraining, and transfer?

There are over 5,900 people, including part-time and intermittent employees working at our eight state institutions. Direct care staff are often female. The average wage is \$4.00 to \$5.00 higher than minimum wage. The length of service averages over eight years, and the separation rate varies by location.

The State Planning Agency conducted a survey of state hospital employees to determine future career choices. There were 26 questions, and 3,154 employees responded to the questionnaire. Regardless of how the question was asked, most employees indicated preference for public sector employment.

States may have to be creative in making early retirement more attractive rather than incur layoff costs. The portability of pensions may also need to be investigated at the state level to encourage transfer of employees rather than layoffs.

PAPER NO. 4; THE ECONOMIC IMPACT  
OF MINNESOTA STATE HOSPITALS

A large industry such as a state hospital contribute significantly to a community's economy. The smaller the community and less diverse its commercial or industrial base, the greater the impact of any closure or downsizing. Economic impact is not only a function of where employees live and spend their money but also where they work in terms of commuting distance.

Salaries of employees are the most significant factor in estimating community economic impact. The impact changes depend upon the dispersion of employees in a geographic area. Economic impact should not be calculated by multiplying total revenue by a multiplier effect such as "10" because it over estimates true impact.

Since most states have centralized procurement systems, local purchases by the institution are a small percentage of local retail sales.

If institutions are located in rural areas with high unemployment, alternative employment strategies are difficult to develop. Retraining and voluntary transfers of employees should be considered as a preferred economic development approach.

Alternative economic development strategies should not imply "filling up buildings with a newly discovered devalued groups such as people with AIDS, Alzheimer's, or those who are homeless."

Institutions located on prime property may be the first to close since economic impact will be lessened. It may be a wrong reason, but it is often more feasible.

#### PAPER NO. 5: PUBLIC OPINIONS ABOUT STATE HOSPITALS

A significant part of the study of the state hospital system was the development of a public process which provided Minnesotans with an opportunity to express ideas and concerns regarding the future of state hospitals and the delivery of services to persons with mental illness, mental retardation, and chemical dependency.

This public process involved three major elements:

1. The convening of nine town meetings, one in each area of the state served by a state hospital and one in the Metro area. (Over 5,000 people attended. There were 362 witnesses, and 80 separate organizations were represented. )
2. Soliciting letters from the public and interested parties who would express their views. (Over 433 letters were received.)
3. Receiving calls during a "toll-free call-in" day. A total of 202 calls; 174 favored state hospitals.
4. We also sent a "Dear Colleague" mailing once a month to 1,500 people giving results and announcing meetings.

The overwhelming message of the town meetings and phone calls was to keep the state hospitals open. The letters were split on this issue.

Here are the most frequently heard themes emerging from the town meetings:

#### Concerns about Patients and Residents:

- ' The special needs of residents should be the primary concern in planning the future of state hospitals.
- ' Persons most "difficult to place" because of

severe behavioral, physical, medical, communication, or multiple handicap problems are often served by state hospitals.

#### Views on Community Programs;

- \* Individuals have moved out of institutions and into the community. They have improved.
- Community programs (community mental health centers, case management, and community support programs) need more financial support.

#### Quality of State Hospital Staff and Care:

- ' State hospital staff and the care provided were described as caring, helpful, dedicated, the best, concerned, enthusiastic, skilled, superior care, warm, professional, and nationally recognized.

#### **PAPER NO. 6: RESIDENTS/PATIENTS**

Minnesota's state hospitals exist to serve people with mental illness, developmental disabilities, and chemical dependency. While there are many factors which will influence the future of state hospitals, a very important factor must be the individuals for whom they exist.

The state hospital study also found:

1. In 1960, a peak of 16,355 residents/patients were served in the state hospital system.
2. In FY '84, the average daily population of the state hospitals was 4,006 people: 1,230 people who were mentally ill; 2,182 people who were developmentally disabled; and 594 people who were chemically dependent.

We recommend that states should undertake independent verification of individualized needs and treatments to address those needs.

#### **PAPER NO. 7: THE COST OF MINNESOTA STATE HOSPITAL**

There are four parts to the cost report. Here are some highlights from the cost study:

#### Costs of State Hospitals:

1. Fifteen (15) years ago, the care given in

state hospitals was custodial, and the cost per day was extremely low.

2. Court cases and federal standards resulted in better staffing. Costs increased.
3. In this same period, people with developmental disabilities were moving to the community. Costs continued to increase in the state hospitals because:
  - a. The fixed costs increased because of fewer residents;
  - b. Remodeling and construction occurred across the United States to meet federal ICF-MR standards;
  - c. Staffing increased or stayed level in order to reach ratios;
  - d. Unionization of public employees occurred which led to higher salaries;
  - e. Inflation had an impact;
  - f. The proportion of residents with severe/profound mental retardation increased as less handicapped people leave; and
  - g. Indirect costs were added such as overhead and other state administrative costs in order to maximize federal financial participation.

#### Costs of Community Residential Facilities;

1. The number of group homes in the community has increased dramatically.
2. The ownership patterns can range from family, non-profit, profit, chains, or systems. Family operations are the least expensive.
3. Community residential facilities need a standard chart of accounts and improved cost accounting.
4. Community residential facilities include capital items but not day programs or service costs.
5. Community residential facilities now serve all ages and all types of handicaps, but the proportion who are most dependent is slightly lower than state hospitals.

6. Why average per diems shouldn't be compared between state hospitals and community facilities:
  - a. Costs vary by type of resident (age, level of independence, services needed, and staffing needed). Children are always more expensive than adults. More severely handicapped people are more costly regard less of setting.
  - b. Per diems do not contain the same items.
  - c. No standard chart of accounts exists.
  - d. No cost accounting system exists.
  - e. There are several ways of determining costs which produce different outcomes in cost studies: reimbursable cost re porting; average per person costs; fixed and variable costs; units costs; and needs approach.
  - f. In Minnesota, costs vary by geographic location (urban, rural); size (6 or fewer, 17 or more); staff ratios, and special certification.

#### **PAPER NO. 8: OPTIONS/RECOMMENDATIONS**

The four options presented in this last report include: 1.

Keep all state hospitals open but downsize.

- ' 2. Decentralize the state hospitals and begin state-operated, community-based services.
3. Increase efficiency and introduce elements of competition in all state hospitals.
4. Closure of one or more state hospitals.

On page 2 of this final report, we begin with a list of all the conflicting roles. Whenever interest groups discuss what is the state's role, there is a tendency to say, "the state ought to," forgetting that we do not have a blank sheet but rather a complex set of roles including: provide services; supervise services; monitor and license; guardian; defendant in court; employer; negotiator; provider of services to employees in case of closure; cost containment; and maximize federal financial participation.

**OPTION 1;** Continue operation of all eight state hospitals

with staff reductions or downsizing in the mental retardation units.

- \* The mental retardation population will continue to decline because of the Welsch Consent Decree and the waiver.

#### Effects on Employees:

- \* Because all types of staff levels are stipulated in the Welsch Consent Decree, the number of staff who could be reduced could be projected.
- \* The number of staff to be reduced totaled 644 positions.
- \* Based on historical experience, there are 1,640 separations because of turnover, retirements, deaths, and resignations. This number includes all employees including part time.
- \* It is our opinion that natural attrition can be used for downsizing as a first option compared to layoffs. Special exception is made to fill positions for health/safety and for Welsch compliance reasons.
- \* The next option is to make early retirement attractive through extension of early retirement.
- \* The final option is to extend the early retirement option and to add medical insurance benefits for people until they reach age 65 years. This option is also less expensive than layoffs.

#### OPTION 2: Decentralize the state hospitals.

We looked at Rhode Island's approach in beginning state-operated, community-based services. Our state AFSCME group prepared a proposal. The Department of Human Services also created a proposal included in this report.

#### Effects on Residents and Employees:

- ' Individuals would continue to move to the community.
- \* Employees would be allowed to bid on positions in community settings.
- \* Employees would be covered under collective bargaining and pension plan.
- ' Retraining would be necessary.



- Space needs would be reduced. Property could be declared surplus.
- The state might incur new capital costs in the community or existing housing could be used.
- Economic impact would be dispersed depending on relocation of residents.

OPTION 3; Improve efficiency and effectiveness of state hospitals and introduce elements of competition.

- Management information systems would have to be in place—chart of accounts, resident tracking, etc.
- State hospitals would generate revenue as a function of services rendered.
- Each state hospital would be responsible for program mix, budgeting, marketing, and rate setting.
- ' No catchment areas would exist.
- Counties and case managers would be responsible for payment of service.

#### Effects:

Individuals and counties would have choice of using state hospitals at a prenegotiated cost of service.

State hospitals would still be under the same policies.

There would be more need for flexibility than civil service currently allows. Employees would be trained and transferred based on need.

Each state hospital would have control over buildings. There would be an incentive to conserve. (This is a real problem area because the state bonds and every facility is not equal in terms of buildings.)

Proceeds of sale of property would revert to state hospitals.

Economic impact depends on skills of state hospitals:

- rental value would approach fair market value;

- laundry could be a profit center; and
- per diems would reflect true costs.

#### OPTION 4: Closure of the state hospitals.

- It is extremely difficult to terminate governmental organizations. There is little political incentive to do so.
- Terminations are usually accompanied by a budget crisis, and/or an ideological struggle.
- There is a lack of systematic evaluation studies to determine impact of closure.
- Why closure doesn't occur:
  - guarantees instant, galvanized opposition to the idea;
  - benefit is minimal and means "fractionally lower taxes"; and
  - incrementalism forces most programs to grow rather than be terminated.

Each state hospital was hypothetically closed for purposes of this study, and the impacts were assessed.

#### Effects:

Based on past experience, if the state does not have time and money to develop community alternatives, the residents are sent to another state hospital. Consideration must be given to:

- what is the home county of each resident?
- where are beds available?
- do they match what the individual needs?
- if not licensed or certified, how much money is needed for bringing into compliance?

There are several research studies of effects on residents, patients, and families. Results are mixed—changes in mortality, health problems, emotional changes, and adjustment issues.

In the event of closure, we listed nine separate options for employees (pages 28-29). We also estimated the number of people who would take each option, including listing bargaining issues such as layoffs.

We summarized the research on closure and effects on employees (lowered morale, stress, physical problems, emotional problems).

We summarized the alternative uses of buildings, the cost of closure and calculated by hospital, the amount for severance, health benefits, unemployment compensation, and other costs such as heating, security, etc.