

TESTIMONY OF:

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TO:

Senator John Chafee
and the
Community and Family Living
Amendments Forum
Chicago, Illinois

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Senator Chafee and Forum participants.

The Minnesota Governor's Planning Council on Developmental Disabilities supports the Community and Family Living Amendments and has, supported the bill since 1984. We provided written testimony to your Senate hearing which was held on August 13, 1984, in Minneapolis that outlined the values, issues, and philosophical reasons for our support. We stated at that time:

1. CFLA supported a consumer driven system rather than a provider driven system.
2. CFLA would help meet demands for service through a range of alternative living arrangements .
3. CFLA would emphasize meeting the needs of individual residents in small, homelike residential programs.
4. CFLA would provide less costly alternatives to out-of-home placements.
5. CFLA would emphasize and strengthen support services such as day programs and case management.
6. CFLA defines the target population in comparable terms with our state statutes, but more attention is needed for emotionally disturbed children and people with mental illness.

Rather than repeating our original testimony, the Council directed me to testify about the results of a nine-month study of our state hospital system. We are interested in discussing the broad range of issues that each state must face in downsizing residential facilities.

During the 1984 Legislative Session, the D.D. Council of the State Planning Agency was given lead responsibility to conduct a study and propose a plan for state hospitals. There were four events that prompted the legislation: (1) the sudden closure of Rochester State Hospital, (2) the Title XIX Home and Community Based Waiver which called for additional reductions in the mental retardation units, (3) the Welsch v. Levine Consent Decree, and (4) the December 1983 proposed reorganization of the state hospital system by the Department of Human Services.

We completed eight separate reports which you have in front of you. Each of these reports answers specific questions

posed by the legislation. In addition to these reports, we published this 40-page graphically illustrated report giving "highlights" of the reports.

An interagency board was established and consisted of 11 state agency commissioners. The interagency board entitled, the Institutional Care and Economic Impact Planning Board, met six times to carry out its mission. This board approved all reports and recommendations that were presented to the Legislature.

Let me emphasize that Minnesota has plenty of plans, and some would argue that our state hospital system is over-studied. 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.

The first priority in planning must be the individuals who are served; however, other issues need attention such as economic impact, employee displacement, and alternative use of buildings. My testimony will describe how we organized these studies and the conclusions we reached.

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.

There are many buildings in the state hospital system which are unused and in poor repair. Many of these buildings continue to be heated because they have not been declared surplus property. There are tables on the disposition of surplus property from 1983-1984 in this report, and our analysis shows that the state does not excel at disposing surplus property.

Even though the projection for services for mentally ill people and chemically dependent people remains constant for the next biennium, the projected decline of people who are developmentally disabled will reduce the current need for building space.

There has been considerable experience across the United States concerning the conversion and disposal of state

hospital properties. We conducted a national survey of states with 43 of 50 states replying.

Generally speaking, state agencies report 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.

Recommendations:

1. We recommended a systemwide capital improvement planning process that recognizes long-term space requirements and the condition of the buildings.
2. We recommended that unused buildings in poor condition should be declared surplus and demolished if necessary.
3. We recommended an aggressive, coordinated marketing strategy should be undertaken for all potential alternative uses of state hospitals. Specific use decisions will require the active involvement of state, county, and local agencies, and affected communities. The uses should not conflict with established state policy and should be compatible with the purpose of state hospitals.
4. We supported proposed changes in state law easing constraints on the sale of state property to the private sector.

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 is difficult.

The Legislature directed us to analyze the energy efficiency of all state hospital buildings. The analysis was accomplished in five different ways:

1. Energy use by resident/patient;

2. Energy cost per resident/patient (FY '83 in 1982 dollars);
3. Energy use by square foot/degree day/MMBTU;
4. Energy use and cost by square foot of building space (FY '83); and
5. Energy cost as a percentage of operating cost •

Recommendations;

We recommended that energy conservation measures continue to be taken:

1. Utilization of shared savings contracts;
2. Use of alternative fuels;
3. Purchase of electricity from wholesalers;
4. Separate metering of leased or rented buildings to the tenants;
5. Surplus buildings to be identified for demolition to eliminate heating costs; and
6. Energy improvements such as a summer boiler.

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 hospitals.

1. 64 percent of all employees are female; the majority are covered by the Non-Professional Health Care Unit, which is the largest bargaining unit, and this group of employees earn an average wage of \$8.51 per hour.
2. The average length of service for all employees is 8.15 years.
3. The separation rate for all employees (all forms of termination: death, voluntary, and involuntary retirements) varied greatly in the state hospital system. The total number of separations for FY '84 was 820.
4. Under the Rule of 85 (if a person's age and years of experience equals 85), 369 employees are currently eligible for retirement. If

the Rule of 85 were extended, 742 additional employees would be eligible within five years.

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.

Here are some results:

Question: "If this state hospital were to close within the next five (5) years, or if patient/resident reductions were to result in staff reductions, and if I were offered a transfer to another state hospital for a similar position, I would most likely" The hypothetical question was followed by a set of four (4) choices:

1. Maintain my current residence, refuse the transfer, and seek other employment elsewhere. 34%
2. Refuse the transfer, seek other employment outside the area, and change my address accordingly. 12%
3. Accept the transfer and move to the area offered. 24%
4. Accept the transfer but would attempt to maintain my current residence and commute if at all possible. 27%
5. Unknown. 2%

Question: "If this state hospital were to close within the next five (5) years, or if patient/resident reductions were to result in staff reductions, and if I chose not to accept a transfer to another state hospital, my next career preference would be"

1. Work for a state agency in the field of human services. 31%
2. Work for a state agency outside the field of human services.
3. Work in another public sector (city, county, federal) in the field of human services. 20%
4. Work in another public sector (city, county, federal) outside the field of human services.

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| 5. Work in private industry in the field of human services. | 12% |
| 6. Work in private industry outside the field of human services. | |
| 7. Retire, if possible. | 7% |
| 8. Self-employment. | 14% |
| 9. Return to school. | 5% |
| 10. Unknown. | 11% |

Question; "Should you wish to continue in the human services field, what would be your most preferred work setting?" The choices on the questionnaire were:

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| 1. State hospital. | 54% |
| 2. Privately operated community program (day or residential). | 11% |
| 3. State-operated community program (day or residential). | 22% |
| 4. County-operated community program (day or residential). | 7% |
| 5. Unknown. | 6% |

We also examined the question of portability of pensions. Pensions are portable in some cases but cannot be transferred when leaving public service.

Recommendations:

1. We recommended that any staff reductions resulting from declining state hospital populations should occur through natural attrition and retirement whenever possible.
2. The Department of Human Services and the Department of Employee Relations should develop a plan to facilitate the voluntary transfer and retraining (i.e., retraining of workers transferring to mental illness units).

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

A large industry such as a state hospital contributes 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.

For purposes of the report, there are three economic impact areas. We used zip codes to define the areas:

1. Primary impact zone is where 50 percent of the employees live. (Zip codes closest to state hospital.)
2. The secondary impact zone is where 75% of the employees live (includes the primary impact zone).
3. The regional impact area is where at least 90 percent of the employees live and includes both primary and secondary zones.
4. This report has several sections:
 - a. Direct Effect of Hospital Employment:
 - employment as a percentage of total area employment;
 - hospital payroll as a percentage of total area wage and salary income; and
 - estimates of unemployment by county.
 - b. Indirect Employment Loss.
 - c. State Hospital Purchases.
 - d. Effect of Resident/Patient Spending.
 - e. Effect of Visitor Spending.
5. Counties where most state hospital employees reside are:

a. Rice	1,017	
b. Crow Wing	.	647
c. Otter Tail	637	
d. Kandiyohi	605.	
6. Alternative employment would be more difficult in an area of high unemployment. State hospital counties' unemployment rates as of July 1984 showed a high in Carlton County (Moose Lake) of 10.1 percent, 8.0 percent

in Crow Wing (Brainerd), and 7.9 percent in Otter Tail (Fergus Falls).

7. Salaries of state hospital employees may be the most significant factor in community economic impact. Of the total operating expenditures, \$128,433,135, or 85.9 percent, are for personnel costs. The amounts ranged from \$9,809,295 at Anoka State Hospital to \$24,993,232 at Faribault.
8. Since the state of Minnesota has a centralized procurement system based in St. Paul, the local state hospital purchases as a percentage of local retail sales are small as shown by the tables on pages 20-26.

Recommendations:

We recommended that alternative economic development strategies can be developed but require a cooperative effort between state and local officials. Economic impact zones may be one way to handle this issue in the future.

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.)
 - a. Pro state hospital 117
 - b. Neutral 15
 - c. Pro community-based facilities 121
 - d. Opposed the waiver 49
 - e. Against state-operated community facilities 131.

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 major themes that we heard at 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 served by state hospitals.
- Residents and patients need quality care and a base of support—state hospitals are the only home they have, they should not be made "homeless" nor "shuffled about."
- The improvement of residents and patients has been documented. Individuals described the progress they have made. Some families prefer the state hospital placement.
- The fact that state hospitals are geographically dispersed makes it easier for families to visit. Closure is viewed as forcing families to travel longer distances.
- During the call-in day, several callers cited incidents and criticized both state hospitals and community services because of inadequate or inappropriate treatment.
- Family members requested greater involvement and respect from staff.

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.
- Community placement will occur, but it must be orderly.
- Community-based services are client-centered and provide integration.
- Residents have a right to live in the community. The state hospital is not the least restrictive environment.
- The state should phase out of operating any program. The state should use a "request for proposal" approach. The state cannot provide services and at the same time monitor itself.
- We need a state policy on deinstitutionalization.
- Do not stop community-based facility development because of employees and economic impact issues.
- Community services are not available in all parts of the state.
- Some community services experience high staff turnover. Staff aren't well trained. Community services are underfunded. Community programs do not provide a full range of therapy and health care services. Class action suits may be necessary to address inappropriate placements in the community.
- Community-based facilities do not accept all types of people.
- Community programs do not provide the same level of care as state hospitals.
- There is abuse in the community programs and overmedication in some.
- Community facilities are not prepared for the clients who are leaving state hospitals.
- County case management is understaffed.
- Some state hospital programs are smaller than-larger group homes.

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, excellent care, warm, professional, and nationally recognized.
- Staff care about residents and provide a surrogate family relationship 24 hours per day.
- Staff are concerned about quality of care, continuity of care, standards, and a multidisciplinary approach.
- State hospital staff salaries are justified because the residents are the most difficult to serve. The salary levels in the community are low by comparison.
- Staff turnover rates are lower in state hospitals compared to community services.

Community Economic Impact on Hospital Closure

- The effect will be an economic chain reaction characterized by direct loss of hospital jobs, indirect loss of jobs because of slowed industrial growth, lowered gross community income, reduced retail sales, closed stores, fewer families, underutilized schools, increased taxes, higher utility costs, depressed housing market, and rising unemployment.
- Several attempts to estimate the magnitude of the economic impact were presented.

A summary of every town meeting is provided in this policy paper. A file of letters is also available and copies of transcripts from the meetings.

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.

All eight state hospitals do not provide the same services. Cambridge and Faribault state hospital serve only persons with developmental disabilities; Anoka serves only persons with mental illness and/or chemical dependency.

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.
3. Patients who were mentally ill range from the severest forms of illness (9 percent) to the least severe symptoms (12 percent). Patients who experienced psychotic episodes, attempted suicide, and abused drugs comprised 26 percent of the state hospital population; and patients with poor social skills, little initiative, and difficulty controlling emotional control comprised 39 percent of the population. The remaining 13 percent have limited social interaction and self-care skills.
4. 90 percent of the residents in state hospitals were severely or profoundly mentally retarded.
5. Residents who were developmentally disabled were highly dependent in areas such as self-preservation (ability to egress a building on their own in case of an emergency), behavior problems, bathing, grooming, and dressing.
6. Patients with chemical dependency were typically young white males who were single, unemployed, had a high school degree or less, were alcohol dependent, and were indigent.

Recommendations:

The study of "Patients and Residents in Minnesota State Hospitals" provides only preliminary information about demographic characteristics. The Institutional Care and Economic Impact Planning Board recommended that additional reports be prepared and recommendations regarding the relationship between state and county responsibilities be submitted to the Legislature. The board also recommended increased emphasis be placed on supporting quality of care and quality of life in the current service system.

PAPER NO. 7: THE COST OF MINNESOTA
STATE HOSPITALS

The legislation mandating the state hospital study and plan required the Long Term Health Care Commission to "evaluate the comparative costs to the state institutional and noninstitutional care for developmentally disabled persons." There are four parts to the cost report: (1) review of literature, (2) revenue and expenditures of state hospitals, (3) comparisons of money spent on institutional and community facilities, and (4) a needs approach to cost. 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, nonprofit, 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 regardless 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 produces different outcomes in cost studies:
 - reimbursable cost reporting;
 - average per person costs;
 - fixed and variable costs;
 - unit 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.

Conclusions from Past Cost Studies:

1. Costs don't differ if both types of clients are provided full array of service. (Mayeda)
2. Community costs are fragmented across several accounts. (O'Connor)
3. By adding in day programs and medical services, the difference narrows. (Mayeda)
4. As a treatment site, the state hospital is not as desirable as a community setting. (Jones & Jones)
5. Impossible to compare because no standard chart of accounts and no standard cost accounting exists. (O'Connor)
6. We need to add in the issue of the "family" that provides care. The family may be the most cost-beneficial approach.
7. Reallocation of funds must be considered if numbers of people keep moving out of state hospitals.
8. The Pennhurst study concluded:
 - a. State salaries and fringes are higher than community salaries and fringes.
 - b. Community staff spend more hours of direct staff time per client than Pennhurst staff.
 - c. There is a greater division of labor in state hospitals—more management, more specialists, and more medically oriented staff. Community staff do more jobs.
 - d. Savings in community are due to use of generic services.
 - e. How soon before community staff unionizes?
 - f. How long will we expect a low paid, transient work force to serve more severely handicapped people in the community?

- g. Rather than say community services are cheaper, we should say that we get more staff time for the money.
 - h. Some institution programs are less expensive than community; most institutions are more expensive; average per diem reflects a wide range of people.
- 11. The gross cost of Minnesota state hospitals for FY '84 was \$159,045,479; 85.9 percent was for personnel.
 - 12. Reimbursements totaled \$120,594,420 from all sources with the largest amount coming from federal Medical Assistance (\$52,656,694).
 - 13. In 1980, expenditures for community services reached the same level as expenditures for institutional services for mentally retarded people. Since 1980, expenditures for community services have exceeded institutional services.

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.
- There could be as many as 582 fewer mentally retarded people by July 1, 1987, or it could be a minimum of 3 00 fewer people under the Welsch Consent Decree.

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 Rule of 85.
- The next option is to extend the Rule of 85 and to add medical insurance benefits for people until they reach age 65 years. This

option is also less expensive than layoffs.

Effects on Buildings/Energy;

- The demand for living space is going down and yet capital costs will continue for remodeling/renovation.
- If the population can use consolidated living space, then selected buildings can be declared surplus and sold, rented, or demolished.

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.

Cautions about this approach:

- Concern about "dumping" most difficult clients or "creaming" or not providing service. The state has up to this point not rejected clients.
- True competition does not exist since the State Legislature has imposed moratoriums, sets funding levels, and has rate setting mechanisms.
- Counties have differing capacities to handle these new responsibilities.

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:
 - * 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.

Finally, each state hospital gave their own views about closure.