A REPORT

TO THE

MINNESOTA STATE LEGISLATURE
State Capitol
St. Paul, Minnesota

February - 1973

Department of Public Welfare

Residential Facilities

for

Mentally Ill -- Mentally Retarded Chemically Dependent

FACILITY	ADMINISTRATOR
Anoka State Hospital	Jerry E. Poole
Brainerd State Hospital	Harold Peterson
Cambridge State Hospital	John Stocking
Faribault State Hospital	Harold Gillespie
Fergus Falls State Hospital	Robert F. Hoffmann
Hastings State Hospital	James E. Brunsgaard
Moose Lake State Hospital	Harvey G. Caldwell
Rochester State Hospital	Robert Rosenthal
St. Peter State Hospital	William C. Lightburn
Willmar State Hospital	Lester Johnson

Presented on Behalf of the
Administrators
by
Robert F. Hoffmann, Administrator
Fergus Falls State Hospital

REPORT TO THE LEGISLATURE

DEPARTMENT OF PUBLIC WELFARE

Ten facilities for the mentally ill, mentally retarded, and chemically dependent

February, 1973

This report deals with the ten facilities under the jurisdiction of the Department of Public Welfare that serve 16,000 mentally ill, mentally retarded and chemically dependent citizens of the State of Minnesota in need of residential care. The population of each of the state facilities has been steadily decreasing oyer the past decade due to a number of factors. One of the major influences has been the development of community services and facilities to serve those in need of mental health services closer to their homes. Earlier recognition of problems and greater community acceptance increased the admissions to state facilities, but populations of the facilities decreased because residents returned to their homes more rapidly. Continued community support made their re-integration into society more successful and reduced the length of stay in a residential facility. One of the stated goals of the Department of Public Welfare is to organize institutional programs in order to facilitate their incorporation into local community based programs and thus eventually reduce the role of the Department in providing direct services. Until a decade ago, seven of the ten state facilities served the mentally ill (one of them serving inebriates as well for the entire state) and three served the mentally retarded. Subsequently the Department instituted a policy of establishing multi-purpose programs in various of these state facilities to bring residential services for each of the disability groups closer to the home locale of each citizen. A further purpose of this move was to encourage the development of coordinated planning, policies and programs among the wide range of agencies and programs including county welfare departments, state facilities, mental health centers, Day Activity Centers. for the mentally retarded, Alcoholics Anonymous groups, etc.

POPULATION DATA - February 1, 1973

Average daily population

Institution	M.I.'s	M.R.'s	Chem. Depend.	Total
Anoka	286		137	423
Fergus Falls	174	325	81	580
Hastings	162	28	66	256
Moose Lake	270	92	69	431
Rochester	463	135		598
St. Peter	227	359	41	627
St. Peter Security	105			105
Willmar	378		160	538
Brainerd	65	778	42	885
Cambridge		814		814
Faribault		1461		1461
Total	2130	3992	596	6718

I fear that the tremendous changes in the field of mental health of the past decade too often pressure us to forget historical perspective. Over the past century, a philosophy has prevailed in this country that the misfits of society should be removed for the protection of society. Massive institutions were established throughout the country to care for those individuals society defined as unacceptable. While heroic efforts were made by hundreds of thousands of caretakers, the impact was negligible because of the public attitude of protecting itself from those who are different and the economics of a massive institution being the cheapest way to care for the most people with the fewest custodians. This trend, slowly over the past century, led to the gradual establishment of the ten Minnesota state hospitals which, at their peak, were custodians of close to 17,000 residents.

Recent changes, particularly brought into focus over the past decade, have resulted in the re-alignment of society's attitude toward recognition of the individual's right to life, liberty and the pursuit of happiness. The swing toward the rights of the individual broadened the definition of behavior society could accept. Individuals who faltered under stress or who, because of birth, were unable to cope with society's demands were recognized as being in need of help so they could return to a more tolerant society. The concept of segregation from society was being changed to re-integration into society. The initial successes, although conservative, snowballed the creation of additional community resources. Residential facilities were recognized as a temporary expedient to meet a crisis and facilitate return to society. Individuals provided with insufficient resources to compete at the same pace as their fellow-man were given opportunities for training and education according to their capabilities so that they might function at their optimal level. The moral issue of "sinful" and "bad" associated with the mentally ill and chemically dependent is rapidly changing to recognition of the need for help and an awareness of "there but for the grace of God go I". As a result of this change in public attitude, together with great progress in treatment and training skills, the number of admissions has greatly increased while the residential population of the state facilities has been reduced to less than half.

As a consequence, there has been some pressure to close certain state facilities to gain economies. While a re-alignment is certainly indicated, I feel I must vigorously resist moves based purely on economics which lose sight of human needs and the benefits of regionally based facilities and coordinated programs. The matrix formed by a century of repetition is not readily re-shaped in a biennium. Re-shaping is needed, and re-shaping has been occurring. But the next biennium is a most crucial one in re-alignment of the forces promoting mental health for the citizens of Minnesota. The Department has presented a progressive plan that,

vigorously pursued and supported by the communities and the Legislature, will provide for its citizens improved human services for the dollar expended.

We want more businesslike practices in our governmental operations; and we certainly support the concept of getting the most for our tax dollar. But in my twenty-one years of administrative experience in the state service, I have never fully understood the rationale of line item budgeting that held us to predictions made two and a half years in advance of needs and expenditures in specific accounts. Historically, each hospital has appeared individually before you to justify any increase from the previous biennium in each 2-digit breakdown in current expense ; increases in staff compelemnt; and justification for each item in the special equipment account. This tends to support expenditures based only upon experience and therefore supports mediocrity rather than innovations and adjustment to change. For example, restrictions discourage: effective utilization of salary appropriations due to complement restrictions; utilization of contractual services where more feasible than full-time employees; and purchase of supplies or equipment that results in reduced manpower. Despite all the restraints, controls and roadblocks, it is my experience that agencies tend to expend the total amount of dollars appropriated to them for items currently needed by costly manipulation of the system. But at what price efficiency and progress?

I believe, for the first time in the history of the state hospitals, we have requested - and your committee has granted - permission for a single presentation to be made on behalf of the ten state hospitals. The budget I am presenting does not represent the stated individual needs of the ten hospitals, but rather what we have agreed - in concert - we can get along with in view of constraints of limited increases. We recognize our obligation to serve your constituents in need of residential services in the best way possible with the funds provided us.

We, therefore, fervently urge you to consider the goals of the Department of Public Welfare as presented to you previously by Commissioner Likins, particularly as it relates to the residential facilities. If you support these goals, give the Commissioner the authority and responsibility to obtain these goals by providing greater budgetary flexibility and then hold her accountable for the results. Specifically, we strongly urge a single appropriation to the Department of Public Welfare for Current Expense, Salaries, Special Equipment, and Repairs and Replacement, and the authority to use these resources among the state facilities or community programs as will most effectively attain the stated objectives.

The administrators of the state facilities have for some time been working on methodology that would provide for more equitable distribution of economic resources. The past system of appropriations has resulted in such inequities that the per diem cost of one state facility was half again as much as that of another. In other words, the citizens served by State Hospital A were provided with considerably fewer resources than those citizens served by Hospital B. We have examined each of the accounts separately for each of the facilities to take into account individual differences due to size, location, age of facility, and differences in physical plant. The compilation of the results of these studies, which represents thousands of man hours of soul searching, is before you in the revised request on behalf of the ten facilities for care of the mentally ill, mentally retarded, and chemically dependent.

CURRENT EXPENSE:	71-73	Governor's Recommendation	Formula Request
	$13,577,900	$13,271,036	$13,942,220
Add. for 25¢ increase for provisions			1,168,000
			$15,110,220

As near as I can determine, the Governor's recommendation was based on the present biennium anticipated expenditures less a sum representing decreased food costs due to declining population. The formula figure above represents the results of a study by the administrators to take into account price increases, comparability among institutions, past experience, and projected population decreases. The combined current expense figure of $13,942,220 for the biennium is basically based on $2.20 per patient per day at each of the facilities, exclusive of utilities and fuel. The latter two items were excluded because we have absolutely no control over prices charged for these items and because there are such great differences among the facilities in costs, depending upon the type of fuel, shipping distances, and source of utilities. Of the $2.20, .90 was used as a base for feeding each patient each day. This leaves $1.30 for each patient each day to cover all other costs of operation, including all drugs and medications, clothing, linens, housekeeping supplies, maintenance items, telephone, postage, indigent patient accounts, and a host of other items necessary to keep the facility functioning. The $2.20 is an average figure of basic needs of the ten hospitals. The Department would allocate to each hospital funds based on variables such as size because the larger the hospital the lower the per diem should be because of spreading some fairly fixed costs among a larger base. We know the $.90/pt./da. provides less raw food than it did two years ago. The Department of Public Welfare presently has a request to the Department of Administration to increase the 900 to $1.03 due to increase in food costs according to Wholesale Price Index. Projecting this rate of increase through the next biennium will require an increase of 120 for a total of $1.15/pt./da. This is provided for above by the addition of $1,168,000 to the formula request. The formula then represents $2.45/pt./da. exclusive of fuel and utilities. Our most recent information indicates that surplus commodities are being withdrawn. The value of surplus represents approximately 70/pt/da. We have adjusted all budget items to reflect the revised projection of population of 6500 the first year of the biennium and 6300 the second year.

	71-73	Governor's Recommendation	Agency Request
SALARIES:	$90,820,00	$92,617,594	$97,641,151

The present approved staffing complement is 5110 positions. The Governor's recommendation provides for an increase of 300 on July 1, 1973 for a total of 5410 with a gradual decrease of staff throughout the year due to projected population decreases to a complement of 5208 on July 1, 1974 and 5044 on July 1, 1975. There are two points I wish to bring to your attention in connection with this request that indicate to me that the stated goal of increased programming for patients will not be attained:

1. Studies by the hospital administrators thoroughly examined the number of staff required at each facility to merely open the doors. In other words, taking into consideration the size and individual differences, how many staff are required to run the power plant, provide minimum maintenance, operate the kitchen, laundry, housekeeping, switchboard, medical records, and administrative services. The conclusion of this examination indicated that a minimum of 1673 staff were required to perform the described functions. This is 32.74% of the total complement of 5110. This leaves 3437 direct care employees, or 1.93 patients per employee. However, the reductions on staff that have been imposed due to projected decrease in populations are at the overall ratio of 1:1.23. We have stated that the indirect staff cannot be reduced below the 1673 level, so all attrition must come from the direct care group., Putting it another way, the overall ratio of 1:1.23 represents 81 employees per 100 patients. Of these 81, there are 25 providing indirect services basically unrelated to the number of patients; i.e., it takes five engineers to run the power plant 24 hours a day seven days a week whether there are 100 or 1000 patients. This leaves 56 employees providing direct care for 100 patients 24 hours a day, seven days a week. If the population decreases by 10, we could reduce the direct care staff by 5.6, leaving.50.4 for 90 patients, which is still a ratio of 56 per 100. However, the Governor's request assumes the 25 indirect staff can be reduced as population declines and, therefore, 8.1 employees are reduced for

the reduction of ten patients and these must all come from direct care. This leaves a ratio of 53 direct care staff per 100 patients. To look at it yet another way - the present population means that there are approximately 132 wards of 50 patients each in the ten state facilities. If each ward decreased its average population by 2.5 patients, this would result approximately in the projected population decrease for the year. And yet, the forced decrease in staff complement based upon the 1.23 ratio would result in a decrease of 163 staff for the projected decrease of 250 patients. Therefore, we lose 1.212 employees for each decrease on a ward of 50 of 2.5 patients. To over-simplify, ward populations are based upon individual behavioral and program differences and needs. It is, therefore, impossible if one hospital decreases two patients on each of 25 wards to close one ward and mix the remaining patients together - this is like mixing goldfish and sharks. There is a limit.

2. We cannot start with 300 new employees July 1 because attrition also occurs among indirect services. If we attain the minimum level for indirect staff we will have to replace people as they leave; therefore, if we add 300 direct care staff on July 1 and attrition is 300 per year, we will be unable to follow the projection because one-third of the turnover would be in indirect staff that must be replaced. In addition, hospitals with a low turnover rate of staff would not be able to attain their rate of attrition and, therefore, would have to lay off staff they had just hired. Therefore, we cannot hire 300 staff.

When one takes into account that staff must provide coverage 24 hours a day, 7 days a week; that employees work 40 hours a week and have vacations sick time, and holidays off; this actually translates into between four and five staff members on duty per shift to care for 50 residents - many of whom are unable to care for themselves. Very little time is left for staff to spend on training and therapy.

Demands of accreditation, utilization review with resultant Federal financing, and licensure place more and more demands on the staff for record keeping and administrative duties as well as increased demands for increasing growth experiences on those in our care. As has been indicated to you, the larger proportion of those remaining in our care are the most severely disabled and require greater attention. Therefore, increasingly more is demanded of us and we have less to do it with.

The Alabama Court decision, presently before the United States Supreme Court, established a staffing pattern for its state facilities which would, according to one study, if converted to our state facilities, require an additional 2446 staff. There is presently a Class Action Suit against the administrators of six of the Minnesota State facilities relating to many of the same questions raised in the Alabama suit.

We urge acceptance of the Governor's proposal for 300 new positions funded within agency request of $97,641,151 for the full biennium. With the projected decrease in population, this will bring our direct care staff closer to Minnesota State Licensure Standards.

SPECIAL EQUIPMENT:	Actual 71-73	Dept. 73-75	Gov. Request
	$380,081	$691,420	$451,420

Institution:	Population 1-10-73	Department Request	Governor's Recommend.	Formula Request
Hastings	242	45,000		$24,200
Moose Lake	433	36,820		37,810
Anoka	437	41,450		38,090
Willmar	539	46.000		44,060
Fergus Falls	564	45,380		45,060
Rochester	597	213,210		46,380
St. Peter	612	47,640		46,980
St. Peter Security	110	10,500		11,000
Brainerd	868	71,100		57,220
Cambridge	892	58,260		58,180
Faribault	1462	76,060		90,980
		$691,420	$451,420	$499,960
Rochester Surgical Unit				76,420
				$576,380

A third study that the hospital administrators conducted dealt with special equipment appropriations. Again in the past, appropriations for this purpose have resulted in great inequities. For the past several bienniums appropriations have been made primarily based upon what was granted the previous biennium. The account is for the replacement of major items of equipment or for the purchase of new, more efficient equipment. We established a sliding scale on the premise that each hospital has certain basic replacement needs, regardless of size, and that the need is greater the larger the facility but at a decreasing rate. Therefore, we established a formula

of $100 per patient for the first 250 patients; $70 per patient for the next 250 patients; and $40 per patient for the balance. This results in a total special equipment request of $499,960 plus the special needs of the Rochester Surgical Unit of $76,420 for a total of $576,380.

	73-75 Dept. Request	Governor's Recommend.
REPAIRS & REPLACEMENT:	$766,682	$766,682

This request is based upon $.07 per square foot plus 25% for special projects as it was in the past biennium, and our experience supports that we will adequately maintain the State's investment in its buildings with this appropriation.

SUMMARY:	Available Funds 71-73	Department request 73-75	Governor's Recommend.	Presentation Request 73-75
CURRENT EXPENSE (combined)	$ 13,577,900	$ 14,622,566	$ 13,271,036	$ 13,942,220
		Plus 25¢ increase - food		
SALARIES (combined)	90,820,000	97,641,151	92,617,594	97,641,151
SPECIAL EQUIPMENT	375,000	691,420	451,420	576,380
REPAIRS & REPLACEMENTS	1,185,353	1,157,257	1,157,257	1,157,257
TOTAL	$105,958,253	$114,112,354	$107,497,307	$113,317,008
Add 25¢ increased food		1,168,000		1,168,000
GRAND TOTAL	$105,958,253	$115,280,394	$107,497,307	$114,485,008

In summary, we are requesting an appropriation of $114,485,008 to the Department of Public Welfare with authority to utilize these funds for the stated objectives for the ten facilities for care of the mentally ill, mentally retarded, and chemically dependent persons. This represents an increase of 8% over the present biennium. Projected revenue from the Federal Government, insurance and patient payments for the next biennium, 1973-75 for care of the residents in these ten facilities total $69,830,000 for the biennium. Therefore, the net cost to the State is $44,655,008 for the biennium, or $22,327,504 expenditure of State funds per year. Considering admissions, a total of 17,000 citizens are provided residential services per year for this sum. With a projection of 2,336,000 patient days for 1973-74, the requested appropriation translates into $9.56 per patient per day from State tax monies.