EXECUTIVE SUMMARY

RESIDENTIAL CARE STUDY

Department of Public Welfare

OFFICE OF POLICY ANALYSIS AND PLANNING

ST. PAUL, MINNESOTA

MARCH, 1979

Residential Care Study

I. INTRODUCTION

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

OFFICE OF THE
COMMISSIONER
6!2/294-2701

GENERAL
INFORMATION
612/2964117

August 10, 1979

TO: The Honorable Albert H. Quie
Governor

FROM: Arthur E. Noot
Commissioner

SUBJECT; Residential Care Study

Please find enclosed the draft summary of the Residential Care Study. This study has been conducted by the Office of Policy Analysis and Planning and represents a two-year effort to assess the future role of the state-operated facilities in the system of care for mentally retarded, mentally ill and chemically dependent persons in Minnesota.

The study recommendations have been reviewed by the Department's Cabinet and program staff, the staff in the state-operated facilities, mental health centers, county welfare departments, and affected groups in the private sector. On the basis of a careful review of the recommendations, available information on the subject, and the comments submitted by the different groups, I recommend that:

— The study's recommendations become the accepted state policy concerning state-operated facilities provided that;

- Enough funds are appropriated to allow the initial development of the community-based residential and support services needed.

- The proposed policy changes are reviewed and acted upon by the legislative policy committees during 1980 Legislative Session for the purposes of making appropriations during the 1981 Session.

Funds are necessary to implement the recommendations because certain community services must be developed prior to effecting a change in the admission and discharge policy of the state-operated facilities.

The recent appropriation of $2,000,000 for local programs for the mentally ill is an example of a needed funding base. However, once the system stabilizes and we begin to achieve savings in the state-operated facilities, the total cost of the proposed system would not be higher than the projected cost of the current system. Furthermore, by promoting the development of alternatives the proposed system would encourage care programs that meet the individualized needs of the participants.

It is my opinion that clear policy guidelines based on long-term objectives are critical if we are to operate our state facilities effectively. I hope this study will be a good starting point as we examine our residential care policy.

Arthur E. Nelson

AEN:MG:mtc
Enclosure
cc: Darcy Winer

In June, 1977, the Governor requested the Department of Public Welfare to assess the role of the state-operated hospitals and nursing homes in the residential care system and to produce recommendations concerning these roles as well as their implications for the future operation of these facilities.

Recognition of the fact that the population of the state hospitals had substantially decreased in the past 15 years and concern over the placement of individuals in appropriate treatment settings prompted this request.

This study examines the total residential care system for mentally ill, mentally retarded and chemically dependent individuals in Minnesota. The residential care needs of the state for the next five years are projected, and the roles which state facilities can play in meeting certain identified needs are recommended.

In order to obtain diverse perspectives and expertise from outside the Department, the Commissioner appointed a fifteen-member Residential Care Study Advisory Council* which served from August to October, 1978. This council provided recommendations concerning the type of residents to be served by State facilities and the role of the State in programming for each disability group.

This study consists of seven sections which present:

1. General purpose of the study.

2. A descriptive history of the residential care system in Minnesota.

3. The current status of the residential care system in Minnesota.

4. A comparative analysis of the different geographical areas served by the state hospitals and the state-operated nursing homes. Population and economic factors and their relationships to the incidence of disabilities and to available resources are included in this analysis.

5. Problems and issues.

6. Presentation and analysis of policy options.

7. Recommended policy options and suggestions for their implementation.

*A list of Advisory Council members is provided in Appendix A.

II. HISTORICAL PERSPECTIVE

This section examines the history of state-operated and community-operated residential care facilities in Minnesota. It demonstrates the dynamic nature of the residential care system and its sensitivity to changes in public attitudes, funding sources and technological developments.

The greatest changes in the system have occurred in the last 15 years with the introduction of psychotropic drugs and other improved treatment methods and with the enactment of state and federal laws pertaining to quality of care and protection of patients' rights. These laws, together with their corresponding regulations and funding sources, have significantly influenced the nature of residential care in Minnesota.

STATE OPERATED FACILITIES - HOSPITALS

Population

.The total state hospital average daily population has declined by 64 percent in the last 15 years from 14,520 residents in fiscal year 1962 to 5,181 residents in fiscal year 1977.

.The average daily population of mentally retarded residents in fiscal year 1977 was 3,035 residents, a 45 percent decline from 5,532 residents in 1962.

.By fiscal year 1977, the average daily mentally ill resident population in the state hospitals had declined to less than 20 percent of what it was in fiscal year 1962, from 8,709 residents to 1,542 residents.

.Unlike the mentally retarded and mentally ill populations, the average daily population of chemically dependent residents in state hospitals has increased to just over twice its size, from 279 residents in fiscal year 1962 to 571 residents in fiscal year 1977.

.In fiscal year 1977 the younger age groups {under 35 years) represented the largest portion of the average daily populations for the mentally ill and chemically dependent and remained the majority of the average daily population for the mentally retarded.

.In particular, the 18 to 34 age group increased as a proportion of the average population for all three disability groups.

.The proportion of groups above 35 years of age in the average daily population for all disability groups either decreased or had little change.

.The proportion of mentally ill residents under age 18 has decreased from 5 percent in fiscal year 1971 to 4 percent in fiscal year 1977.

.The proportion of chemically dependent residents under age 18 has increased from 1 percent to 4 percent since fiscal year 1971.

.The over 65 age group represented 1 percent of the mentally retarded population, 25 percent of the mentally ill population, and 4 percent of the chemically dependent population at state hospitals during fiscal year 1977. These percentages have shown little variation since fiscal year 1971.

Physical Plants

.Since January 1, 1972, the Department of Public Welfare with legislative concurrence and approval of the Department of Administration has declared surplus 717,330 square feet of building space and three vacant lots, plus 79.9 acres of land. Of this surplus property, 330,026 square feet of primarily farm structures and some cottages were demolished; 156,077 square feet of primarily staff residences were sold to private parties for a total of $535,596; 231,227 square feet are pending sale, some of which is being leased; 10.5 acres of land were transferred to the Department of Natural Resources and the disposition of 6 9.4 acres of the old Hastings State Hospital campus is awaiting a decision by the Department of Administration.

.In the last 20 years, state hospitals and portions of state hospitals have been closed or transferred out of the Department of Public Welfare:

-Sandstone State Hospital - closed 1959.
-Minnesota Residential Treatment Center, Lino Lakes, transferred to Anoka State Hospital in 1970. The Lino Lakes facility was transferred to the Department of Corrections the same year.
-Owatonna State School - closed 1970.
-The Surgical Unit at Anoka State Hospital - closed 1971.
-Gillette Childrens Hospital - became a public corporation in 197 3.
-Tuberculosis Unit at Anoka - closed in 1971
-Minnesota Residential Treatment Center at Anoka State Hospital - closed 1972.
-Glen Lake Sanatorium - last provided services for tubercular patients in 1976.
-Lake Owasso became county operated in 1976.
-Hastings State Hospital - closed 1978.

Cost

.The chargeable per diem at state hospitals has increased from $6.58 for mentally ill and chemically dependent residents and $4.6 8 for mentally retarded residents in fiscal year 1965 to $52.20 for all disability groups in fiscal year 1977. In the last 3 years, per diems have been increasing at approximately 12 percent per year.

.Total expenditures in state hospitals have increased from $29 million in fiscal year 1965 to over $77 million in fiscal year 1977. The net state funding of the state hospital system has not increased as dramatically as total expenditures 'due primarily to federal financial participation in the Medicare and Medicaid programs. Net state cost has increased from $25 million in fiscal year 1965 to $40 million in fiscal year 1977.

NURSING HOMES

Population

.Ah-Gwah-Ching and Oak Terrace Nursing Homes were created by the Minnesota State Legislature in 1962. Ah-Gwah-Ching Nursing Home is located on the campus formerly occupied by the Minnesota State Tuberculosis Sanatorium in Walker. Oak Terrace Nursing Home once shared a portion of the Glen Lake State Sanatorium in Hennepin County (leased by the state from Hennepin County) until the last tubercular patient was discharged in 1976.

.The average daily population at Oak Terrace has steadily increased from 253 residents in fiscal year 1962 to 335 residents in fiscal year 1977. The average daily population at Ah-Gwah-Ching peaked at 479 residents in fiscal year 1969, and then declined gradually to 363 residents in fiscal year 1977. The largest single factor producing this decline at Ah-Gwah-Ching has been changes in physical plant space necessary to meet National Life and Safety Code Standards.

.Originally, both of these facilities were created for the purpose of providing nursing home care for geriatric patients discharged from state hospitals. In the last five years, as more admissions have come directly from the community, the proportion of residents under 60 years of age has increased. In fiscal years 1976 and 1977, approximately 30 percent of the Ah-Gwah-Ching residents and 35 percent of the Oak Terrace residents were under 60 years of age. The primary reason for admission is need of nursing care which cannot be effectively given in community-operated nursing homes.

Cost

.The average annual expenditure per resident has increased from $8,631 in fiscal year 1972 ($23.64 average per diem) to $13,586 in fiscal year 1977 ($37.22 average per diem) at Oak Terrace. During the same time period, the average annual expenditure per resident increased from $4,704 ($12.88 average per diem) to $11,883 ($32.56 average per diem) at Ah-Gwah-Ching.

Physical Plants

.Since 1973, 9,408 and 49,850 square feet of building space have been declared surplus at Ah-Gwah-Ching and Oak Terrace, respectively.

.Capital improvement funds allocated to the two facilities in the last two biennia (1976-77, 1978-79) have been used primarily to meet National Life and Safety Code requirements and Medicaid regulations for intermediate and skilled nursing facilities.

COMMUNITY-OPERATED FACILITIES

Population

.Community residential facilities for the mentally retarded have increased from 5 facilities with a bed capacity of 100 in fiscal year 1962 to 170 facilities with a bed capacity of 3,500 in fiscal year 1977.

.The most important events affecting the development of community residential care for the mentally retarded occurred between 1972 and 1974: court affirmations of the constitutional right to treatment; the promulgation of the Department of Public Welfare Rule 34 prescribing program standards for the mentally retarded; the monitoring of the National Life and Safety Code; and the federal funding of community facilities for the mentally retarded under Medicaid.

.Community residential facilities for the mentally ill have developed very little since the Department of Public Welfare Rule 36 prescribing program standards for facilities for the mentally ill went into effect in 1974. As of fiscal year 1977, there were 15 Department of Public Welfare Rule 36 facilities with a capacity of 384 beds.

.While the state hospital mentally ill population decreased by 77 percent between 1964 and 1976, approximately 500 beds were added to psychiatric units of private and community hospitals.

.Out-patient care of mentally ill persons rose from 25 percent of all episodes of care in 1955 to more than 50 percent of all episodes of care in 1973, according to a national study. It is reasonable to believe that this trend has also occurred in Minnesota.

.Over 12,000 persons with some form of mental illness reside in nursing homes and boarding care homes. Most of these persons in nursing homes are elderly and in need of nursing care.

.Non-hospital based community residential facilities for the chemically dependent have increased from no facilities in 1971 to 70 facilities in 1977, with a capacity of 2,171 beds for primary or extended care. Additionally, over 600 beds in community hospitals are used to provide primary care for chemical dependency.

.The Department of Public Welfare Rule 35 which prescribes program standards for facilities for the chemically dependent became effective in 1974. State law exempts chemical dependency programs offered in private and community hospitals from licensure under this rule.

Funding

.Residential programs in intermediate care facilities for the mentally retarded have a stable federal funding base through Medicaid.

.Residential programs specifically designed for the mentally ill (Rule 36) depend almost entirely on limited funds available through federal social services funds (Title XX). Boarding care homes provide food, shelter and some supervision to approximately 2,000 mentally ill clients. Some of the costs incurred in these homes are paid through a combination of Supplemental Security Income and Minnesota Supplemental Aid to cover room and board costs and Medicaid to cover outpatient medical services to eligible clients. Clients not eligible for Supplemental Security Income and Medicaid and unable to pay for the service are usually eligible for General Assistance and General Assistance Medical Care to cover maintenance costs and outpatient medical services.

.Residential programs for the chemically dependent are funded through a mix of state and local funds, client fees, private insurance, federal social services funds (Title XX) and Medicaid funds (Title XIX). Medicaid funds are only available for acute care in hospitals accredited by the Joint Commission on Accreditation Of Hospitals.

.Through its funding of community mental health programs, the state has participated in the residential cost for chemical dependency programs since 1972, particularly in the cost of halfway houses and detoxification services.

III. CURRENT STATUS

RESIDENTS IN STATE-OPERATED FACILITIES, FISCAL YEAR 1977

Description of Mentally Retarded State Hospital Residents

.Cambridge and Faribault State Hospitals are single purpose hospitals serving only mentally retarded persons. These two hospitals serve primarily the Twin Cities metropolitan area.

.With the exception of Anoka State Hospital, the seven multipurpose state hospitals have mental retardation programs which serve specific receiving districts.

.In general, the mentally retarded population served by state hospitals at the present time is a lower functioning, more disabled population than the population generally served by community-based programs.

.All state hospitals had more discharges of mentally retarded residents than admissions in fiscal year 1977. This indicates a declining mentally retarded resident population in the state hospitals. There were 307 admissions and 571 discharges. The Minnesota Learning Center at Brainerd State Hospital receives 29 percent of the admissions and is responsible for 18 percent of the discharges.

.Ninety-two percent of the people admitted to the state hospitals' mental retardation programs in fiscal year 1977 were admitted only once during fiscal year 1977. Overall,59 percent of the admissions were first admissions to the state hospital system and 41 percent were readmissions.

.Eighty-seven percent of the persons admitted to mental retardation programs in the state hospitals were 34 years or younger; 57 percent were under 18 years of age.

.There was a fairly even percentage of discharges of mentally retarded residents across the age groupings. Thus, more of the older residents were being discharged than admitted to mental retardation programs, and the overall mentally retarded resident population in the state hospitals became younger.

.The largest percentage of year-end mentally retarded residents in each of the state hospitals was between 18 and 34 years old. The smallest group was 65 years or older.

.Sixty-seven percent of the 3,015 year-end mentally retarded residents were fully mobile/fully ambulant, while 17 percent were non-mobile/non-ambulant.

.Brainerd State Hospital's Minnesota Learning Center (MLC) admits primarily persons who are mildly or borderline retarded. The MLC accounted for 29 percent of all the people admitted to the state hospitals' mental retardation programs. With the exception of the MLC, mentally retarded admissions to the state hospitals were generally comprised of those individuals with lower levels of functioning, i.e. profoundly and severely retarded.

.Eighty-three percent of the year-end mentally retarded residents were severely or profoundly retarded.

.Twenty-one percent of the year-end mentally retarded residents had been in a state hospital between 7 and 12 years; 25 percent between 13 and 24 years; 27 percent between one and six years; and 2 0 percent less than one year. The remaining seven percent had been in the hospital more than 24 years.

.The average length-of-stay of year-end mentally retarded residents in 1977 was eight years.

.Fifty-seven percent of the mentally retarded admissions in 1977 came directly from the resident's own home, while group homes were the next largest admission source at 18 percent of all admissions.

.Fifty-five percent of the discharged residents went to group homes, primarily to intermediate care facilities for the mentally retarded (ICF/MR), while 25 percent returned to their homes.

Mentally Ill State Hospital Residents

.Seven of the nine state hospitals have programs for the mentally ill. In general, the state hospitals' mental illness programs serve all kinds of mentally ill persons in need of inpatient care, whether it is acute or long-term care.

.In fiscal year 1977, there were more discharges than admissions to mental illness programs in the state hospitals. Each of the state hospitals' mentally ill resident populations declined slightly. There were 3,008 admissions and 3,262 discharges.

.Approximately 87 percent of the individuals admitted to the state hospitals' mental illness programs were admitted only once during fiscal year 1977. Overall, 44 percent of the admissions were first admissions to the state hospital system and 56 percent had been admitted at least once before.

.Children under the age of 18 accounted for only five percent of total admissions, while the age group 18 to 34 years accounted for 50 percent of total admissions.

.The largest age grouping of year-end residents was 55 years and older, comprising 41 percent of the total year-end residents. The age groupings of 18 to 34 and 35 to 55 years old each had approximately 28 per cent of all year-end residents.

.Forty percent of the admissions and discharges and S3 percent of year-end residents were diagnosed as schizophrenic.

.Of the year-end residents in 1977, 32 percent had been in residence three months or less, 26 percent had been in residence 4 to 21 months, and 42 percent were classified as long-term residents, in residence 13 months or longer.

.The average length-of-stay at discharge in fiscal year 1977 was just under five months for mentally ill residents.

.Fifty-eight percent of the mentally ill admissions to state hospitals in fiscal year 1977 came from their own homes, while 27 percent were admitted from medical or psychiatric hospitals.

.Fifty-six percent of the discharges returned to their own homes while almost 15 percent went to group care facilties, such as halfway houses, group homes, nursing homes and veterans facilities.

Chemically Dependent State Hospital Residents

.Seven of the nine state hospitals have chemical dependency programs. Most state hospital residents in chemical dependency programs receive primary care (30 to 60 days). Moose Lake, Fergus Falls and Willmar State Hospitals also offer extended care (over 90 days).

.In fiscal year 1977, the number of admissions to state hospital chemical dependency programs was close to the number of discharges. There were 5,565 admissions and 5,627 discharges.

.Eighty-six percent of the persons admitted to state hospital chemical dependency programs in fiscal year 1977 were admitted once during the year, while 11 percent were admitted twice, and only one percent was admitted four to seven times. Overall, 53 percent of the admissions were first admissions to the state hospital system and 47 percent had been admitted at least once before.

.Forty-five percent of admissions and discharges were in the 18 to 34 year old age group, with 13 percent of admissions and discharges in the 35 to 54 year old age group. Persons under 18 accounted for three percent of admissions and discharges .

.Approximately 75 percent of the year-end chemically dependent residents were between the ages of 18 and 54.

.Eighty percent of fiscal year 1977 year-end residents had a primary diagnosis of alcoholism, while ten percent were diagnosed as having a drug dependency. Other categories accounting for ten percent of total year-end residents were various types of mental illness or mental retardation with a secondary diagnosis of chemical dependency.

.Sixty-three percent of the 1977 year-end residents had been in residence less than four months.

.In 1977, 75 percent of the discharges were people in primary care with a length-of-stay of eight weeks or less.

.Approximately 50 percent of admissions and discharges in fiscal year 1977 came from and returned to their own homes; 30 percent of admissions came from detoxification facilities. The destination of 38 percent of the discharges was not recorded.

State-operated Nursing Home Residents

.Ah-Gwah-Ching Nursing Home's population has declined slightly with a few more discharges than admissions, while Oak Terrace Nursing Home's population has increased slowly. During fiscal year 1977, there were 71 admissions to and 76 discharges from Ah-Gwah-Ching. During the same year, there were 40 admissions to and 32 discharges from Oak Terrace.

.In fiscal year 1977, fifty-seven percent of the discharges from Ah-Gwah-Ching and 75 percent of the discharges from Oak Terrace were deaths. The remaining discharged residents went to a state hospital, to their own homes, or to a community-operated nursing home.

.During fiscal year 1977, 57 percent of the admissions to Ah-Gwah-Ching came from state hospitals, while only 33 percent of the admissions to Oak Terrace came from state hospitals.

.Sixty-eight percent of the residents at Oak Terrace and 30 percent of the residents at Ah-Gwah-Ching came from the Twin Cities Metropolitan area.

.Thirty-one percent of the residents at Ah-Gwah-Ching and 35 percent of the residents at Oak Terrace were under 65 years of age as of December 30, "1977.

.Ninety-four percent of the residents at Oak Terrace and 66 percent of the residents at Ah-Gwah-Ching during fiscal year 1977 were diagnosed as having some form of mental disability.

DESCRIPTION OF THE STAFF AT STATE-OPERATED FACILITIES

.In fiscal year 1977, the approved staff complement for the nine state hospitals was 5,316 (full-time equivalents). As of June, 1977 there were 5,511 employees in state hospitals and 659 employees in the state-operated nursing homes for a total of 6,170 in the entire system (5,435 full-time and 732 part-time employees).

.For fiscal year 1978, the overall staff-resident ratio at the state hospitals was 1.12 staff to one resident.

.Nearly one-half of the total employees worked in the service career cluster (food service worker, janitors, human service technicians and cooks).

.Fifty percent of all employees had worked 5 years or more in the state-operated facilities, while less than 8 percent had been employed more than 20 years. Eleven percent of all the employees had been employed less than a year.

.Almost 30 percent of the employees were between 20 and 29 years of age, and 30 percent were over the age of 50. Seventeen percent of the employees were 30 to 39 years old, 17 percent were 40 to 49 years old while 4 percent were under age 20. The eleven state-operated facilities had similar percentages of employees in each age group.

.Female constituted almost 64 percent of all employees.

DESCRIPTION OF SERVICES AVAILABLE TO RESIDENTS OF STATE-OPERATED FACILITIES

.Residents of state-operated facilities have a wide range of services available to them, both from within the facilities and from outside resources. The majority of services to residents of state hospitals are provided by hospital staff; the cost of the services provided by hospital staff is part of the overall state hospital per diem rate.

.Various special programs for subgroups within each disability are offered throughout the state hospital system. Some of the special programs such as the Minnesota Learning Center in Brainerd State Hospital provide statewide services.

.Services provided by other agencies or in combination with state hospital staff are primarily specialized services in work skills development or maintenance, education, or support groups to facilitate community adjustment upon discharge from state facilities. The bulk of these services are paid for by the Division of Vocational Rehabilitation in the Department of Economic Security and by local school districts, and the cost of these services is not part of the state hospital per diem.

.In relation to the number of services provided to residents of state hospitals, the infrequent use of community mental health centers and county welfare agencies should be noted. These resources may be underutilized.

.The state-operated nursing homes staff provide most of the services offered to residents. However, Ah-Gwah-Ching uses outside services more extensively than Oak Terrace.

DESCRIPTION OF THE STATE-OPERATED FACILITIES' PHYSICAL PLANTS

.The total square footage of building space in the nine state hospitals and the two nursing homes campuses was 7,141,683 square feet as of October, 1978.

.The total property value of the nine state hospitals and the two nursing homes as of September, 1977 was estimated at 549,562,075. This includes the value of buildings, land improvement, fixed equipment, and land.

.In fiscal year 1977, the total rental fee for leased state hospital property was $91,731. School districts were the largest single leasee with most of these leased spaces used for providing educational services to mentally retarded state hospital residents.

.The rental income from staff residences averaged $2,700 per month during fiscal year 1977. The total rental income during fiscal year 1977 was $32,400.

.An analysis of energy-related costs in the state hospital system indicates that Fergus Falls and Willmar State Hospitals have the most energy efficient physical plants.

COST OF PATIENT CARS IN A STATE HOSPITAL

.The cost of patient care in the state hospital system was determined by using information from the Department of Public Welfare's Patient Oriented Information System and the Statewide Accounting System. Four categories of cost were calculated. The first three categories are components of the fourth category - the gross per diem. The ranges of these costs for the entire system are:

HOSPITAL COST RANGES - PER DAY (FISCAL YEAR 1977)
(dollars)

COST CATEGORY		RANGE	AVERAGE
Program and Treatment Related	MR	24.86 to $31.95	26.61
	MI	19.85 to $26.47	22.22
	CD	16.60 to $32.90	21.71
Life Support and Maintenance	MR	2.84 to $ 6.92	5.72
	MI	3.10 to $ 6.96	5.55
	CD	2.89 to $ 7.27	5.65
General and Administration	MR	8.45 to $16.26	10.52
	MI	8.00 to $13.54	11.06
	CD	8.45 to $16.26	10.10
Gross Per Diem	MR	44.32 to $50.57	46.05
	MI	34.49 to $45.89	41.01
	CD	31.56 to $55.57	39.50

.Program and Treatment-Related costs are the costs of direct patient care and programming. Life Support and Maintenance costs include the costs of linen, housekeeping and food service. General and Administration includes general support, administration and building maintenance costs. The gross per diem includes the first three groupings plus depreciation and some miscellaneous costs.

.Without clear differentiation among types of programming, it is misleading to compare costs of individual hospitals.

.Approximately 80 percent of the per diem is saved as patient days in the state hospitals' decrease.

DESCRIPTION OF COMMUNITY-BASED RESIDENTIAL PROGRAMS

Facilities for the Mentally Retarded

.As of August, 1978 there were 206 community-based Rule 34 facilities with a bed capacity of 3,827. Department of Public Welfare Rule 34 licenses facilities for the mentally retarded.

.The facilities were almost equally divided into for profit and non-profit facilities.

.Seventy-three percent of the facilities were licensed for 15 or fewer residents. Facilities licensed for 16 or more residents were more likely to be for profit facilities.

.Facilities opened in the last three years tended to serve more of the lower functioning, physically disabled mentally retarded individuals than facilities operating more than 3 years.

.For similar populations, facilities opened in the last 3 years cost more than the older facilities.

.Facilities serving only children consistently cost more than facilities serving adults only or both adults and children.

.Community-based Rule 34 facilities in some areas - Moose Lake and Willmar State Hospitals' receiving districts -were consistently below the statewide average per diem. Others, such as Faribault and Cambridge State Hospitals' receiving districts tended to be above the statewide average cost.

.DPW Rule 34 facilities were surveyed in September, 1977 in order to collect more information on community programs for the mentally retarded. The majority of facilities surveyed (78 percent) reported occupancy rates between 91 and 100 percent in fiscal year 1977.

.Surveyed facilities with a licensed capacity of 15 or fewer residents were more likely to accept individuals with psychiatric and behavioral problems.

.Approximately 40 percent of the residents in all the surveyed facilities had their last formal treatment at a state hospital.

.Non-profit homes licensed for 16 or more residents had the smallest percentage (13 percent) of former state hospital residents.

.The majority of residents (65 percent) in the surveyed facilities were severely and moderately retarded.

.The large non-profit facilities with 16 or more residents had a much higher staff to resident ratio than other types of facilities, 86.4 staff per 100 residents compared to approximately 55 staff per 100 residents.

Facilities for the Mentally Ill

.The following types of community-based residential programs serve mentally ill individuals: DPW Rule 36 facilities, nursing homes, boarding care homes, board and lodging homes, local psychiatric units, and adult foster homes. Available information suggests that over 17,000 persons with some form of mental illness may be served by these facilities at any one time.

.Department of Public Welfare Rule 36 licenses residential programs for the mentally ill. As of August, 1978,15 community-based programs were licensed by the Department of Public Welfare under that rule.

.Approximately 10 percent (1,290) of the mentally ill persons in nursing homes were under 65 years of age. In total, approximately 23 percent (4,134) of all the mentally ill in community-based programs were under 65 years of age.

.As of August, 1978,the per diem cost of DPW Rule 36 facilities ranged from $10.45 to $21.34 with an average of $15.39. Per diem rates in boarding care and board and lodging homes ranged from $7.40 to $19.06, with an average of $14.84.

.The cost of non-residential services must be considered in order to assess the total cost of treating a mentally ill person in community-based programs. While there is little direct data available on service utilization, a desirable package of non-residential services would include: day programming, vocational services, transportation services, and social services. The unit cost for each of these services adjusted by client utilization in different levels of care is given in the body of the report.

.DPW Rule 36 facilities, boarding care homes, and board and lodging homes were surveyed in September, 1977 in order to collect more information on community-based programs. Sixty-eight percent of the surveyed facilities reported occupancy rates for fiscal year 1977 between 90 and 100 percent.

.Of the facilities surveyed, DPW Rule 36 facilities were more likely to admit individuals exhibiting psychosis, behavior problems, or multiple handicaps than boarding care and board and lodging facilities.

.Twenty-five percent of the residents in the Rule 36 facilities surveyed, and 35 percent of the residents in the boarding care and board and lodging homes surveyed had received their last formal care in a state hospital.

.Eighty seven percent of the residents in the Rule 36 facilities surveyed, and 9 8 percent of the residents in the boarding care and board and lodging homes surveyed were listed as "chronic."

.The surveyed boarding care and board and lodging facilities reported a higher staff to resident ratio than DPW Rule 36 facilities, 36.3 staff per 100 residents compared to 33.1 staff per 100 residents.

Facilities for Emotionally Disturbed Children

.The Department of Public Welfare, under Rule 5, licenses residential programs serving emotionally disturbed children. As of August, 1978, there were 31 facilities licensed under this rule, with a combined capacity of 1,183 beds.

.With the exception of four facilities in the state, all of the DPW Rule 5 facilities were non-profit facilities. The majority (77 percent) were licensed for 16 or more residents.

.Typically, these facilities served children from ages 6 to 17, though some facilities accepted younger children.

.As of August, 1978, the per diem cost in DPW Rule 5 facilities ranged from $39.98 to $64.50, with the exception of one facility which charged a per diem of $135.

.In a September, 1977 survey the majority of the facilities (73 percent) reported occupancy rates in excess of 80 percent,

.The surveyed facilities reported one percent of residents as having their last formal treatment in a state hospital.

.Adolescent adjustment problems were indicated in 56 percent of the population surveyed in September, 1977. Behavior problems leading to delinquency were indicated in 41 percent of the population, with the remaining 3 percent experiencing other psychiatric problems or learning disabilities.

.Ninety-five percent of the surveyed facilities would not admit persons with a psychosis.

.Of all the types of community facilities surveyed, DPW Rule 5 facilities had the highest staff to resident ratio. This high ratio is found primarily in the number of professional and direct care staff, 26.2 professional staff per 100 residents and 48.5 direct care staff per 100 residents .

Facilities for the Chemically Dependent

.Community programs for primary, halfway and extended residential care of chemical dependency are licensed under the Department of Public Welfare Rule 35. As of August, 197 8, there were 70 facilities licensed under this rule, with a combined total of 2,171 beds.

.Detoxification centers should be licensed under the Department of Public Welfare Rule 32, but due to needed rule revisions, that rule is not being enforced at the present time.

.Community-based hospital programs are exempted from li-censure under DPW Rule 35.

.Most DPW Rule 35 facilities (88 percent) were non-profit facilities.

.Most primary care facilities had capacity for 16 or more residents, with an average capacity of 66 beds. Halfway houses and extended care facilities had an average capacity of 25 beds.

.Per diem cost varied widely among the different facilities. As of August, 1978 the average per diem cost of all community non-hospital-based primary care facilities was ?50.73, while the average per diem cost in community hospital-based primary care programs was $100.

.The per diem cost for halfway houses and extended care programs averaged S20.39. The per diem cost in facilities serving only children was higher than that of facilities serving only adults, or both children and adults.

.In a September, 1977 survey most facilities reported occupancy rates for fiscal year 1977 in excess of 80 percent.

.Ten percent of the residents surveyed in September, 1977 were reported to be acute cases, that is, an episode with sudden onset and of short duration. Ninety percent were reported to be chronic abusers with lengthy histories and frequent recurrences.

.Most of the community-based DPW Rule 35 facilities surveyed appeared reticent to admit individuals where other problems, mental or physical, were present.

.Eleven percent of the residents in the primary care facilities surveyed and 23 percent of the residents in the halfway and extended care facilties surveyed had their last formal treatment in a state hospital.

.Halfway/extended care facilities had more than twice the number of administrative staff per 100 residents than primary care facilities. The latter, however, had almost seven times more professional staff.

DESCRIPTION OF FUNDING SOURCES FOR RESIDENTIAL CARE

.The cost of residential services for the mentally retarded, including state hospital services, are covered mostly through Medical Assistance (Title XIX). There is federal, state, and county participation in this program. However, the county share of Medical Assistance is paid by the state if the mentally retarded person resides in a state hospital.

.Mentally ill and chemically dependent persons over 65 years of age receiving residential care in a hospital or nursing facility certified by the Minnesota State Health Department for Medical Assistance (Title XIX) reimbursement may be eligible for medical assistance if they meet other eligibility criteria. Persons under 21 years of age are eligible only if they are receiving active treatment in a certified hospital which is also accredited by the Joint Commission on Accreditation of Hospitals.

.For those mentally ill and chemically dependent persons between the ages of 21 and 65 and for those who are under 21 but do not need care in a medical setting, most of the residential program cost is paid by state and county funds.

.Supplemental Security Income (SSI, federally funded), Minnesota Supplemental Aid (MSA, state and county funded) and General Assistance (GA, state and county funded) are used primarily to pay for the maintenance cost (room and board) of eligible individuals in group care facilities which cannot be certified for Medical Assistance (Title XIX) reimbursement. Outpatient medical services for residents in these facilities may be reimbursed through Medical Assistance or General Assistance Medical Care if the resident is eligible.

.Grant-in-Aid money from the state to community mental health centers are used in part to fund some residential services for chemical dependency, but only non-residential services for the mentally retarded and the mentally ill.

.Other funds such as Social Services-Title XX federal money matched by counties and Cost of Care of Children (state and county funded) are used at the counties' discretion to provide some non-medical residential care.

.State hospitals are funded by direct state appropriations. Any reimbursement collected by the hospitals from third party payors or fees goes into the general fund as undedicated receipts.

THE ECONOMIC IMPACT OF STATE FACILITIES ON LOCAL COMMUNITIES

The economic impact of state facilities on their immediate communities is both direct and indirect. State hospital payrolls account for the largest direct contribution to the local economies. The indirect contribution is expressed as additional jobs generated by the hospital's presence in the community. The economic impact of the hospital can be compared in several ways.

The Direct Economic Impact

Two factors affect the level of expenditures in the local state hospital community: (1) where the state hospital employees reside, and (2) the proportion of the state hospital employees' salaries spent in the local community. Using an economic model which accounts for both of these factors, the following range of probable contributions to local economies was developed:

	HOSPITAL	CONTRIBUTION (Millions of Dollars)
Most Dollars Contributed	Faribault	(5.29 to 10.623
	Willmar	(3.03 to 7.29)
	St. Peter	(2.87 to 6.67)
	Fergus Falls	(2.87 to 6.46)
Fewest Dollars Contributed	Rochester	(2.69 to 5.94)
	Brainerd	(3.19 to 5.14)
	Moose Lake	(2.16 to 4.67)
	Cambridge	(1.79 to 4.46)
	Anoka	(1.43 to 3.35)

While these ranges of expenditures are quite wide, this is as close an estimate as possible without collecting additional direct data.

The state hospital payroll comprises a certain portion of total county personal income. Since some studies indicate that personal income approximates 80 to 85 percent of a county's economic activity, the payroll of each hospital expressed as a proportion of total county personal income gives an indication of the relative importance to the overall economic picture of the county.

On this basis Cambridge State Hospital's payroll expenditures constitute the largest proportion of total county personal income among all facilities and the expenditures of Anoka State Hospital constitute the least.

The Indirect Economic Impact

Each state facility generates additional community jobs which provide support and services to the facilities and their employees. These additional jobs represent an indirect economic impact by the facility on the local community. The ranking (of each state hospital community) in terms of total jobs generated both in the facility and in the community is:

Faribault	1565
St. Peter	1178
Willmar	1003
Fergus Falls	975
Brainerd	965
Rochester	804
Moose Lake	755
Cambridge	640
Anoka	467
Oak Terrace	416
Ah-Gwah-Ching	356

The Local Employment Market and the Ability of the Community to Absorb Hospital Employment

Each community has an unemployment figure associated with the local labor market. These unemployment rates are:

1. Brainerd	7.5%	6.-10. Willmar	5.1%
2. Moose Lake	6.8%	8.-10. Anoka	3.3%
3. Ah-Gwah-Ching	6.7%	8.-10. Rochester	3.3%
4. Fergus Falls	6.3%	8.-10. Oak Terrace	3.3%
5. Cambridge	5.7%	11. St. Peter	3.1%
6.-7. Faribault	6.1%		

The northern areas of Minnesota have the highest unemployment rates, while the more urban and southern areas have the lowest.

An additional way of estimating the economic impact of state facilities on their local communities is to project changes in the unemployment level in the context of a hypothetical hospital closing. This calculation uses the jobs-generated figure and the local unemployment rate to give an indication of the ability of the local economy to absorb state hospital staff in a hypothetical lay-off situation. While a more accurate indication of ability to absorb employees would identify job type and the likelihood of individual placement, this general projection gives a good idea of the capacity of an area to absorb state hospital employees.

Column A in the following table indicates that the Brainerd, Moose Lake, and Cambridge areas would have the highest unemployment rate if all persons in directly and indirectly generated state hospital jobs were unemployed.

Column B shows the percentage increase in the unemployment rate from its current level to that projected in the hypothetical situation in Column A. The order of impact is different than in Column A — the Faribault, Willmar, and Cambridge areas show the highest increase in unemployment under the change.

	HOST COUNTY UNEMPLOYMENT RATE AFTER LAYOFF	PERCENT INCREASE IN HOST COUNTY UNEMPLOYMENT RATE
	Column A	Column B
Anoka	3.4	1.4
Brainerd	13.9	85.3
Cambridge	13.3	133.3
Faribault	12.8	151.1
Fergus Falls	10.6	68.6
Moose Lake	13.6	100.0
Rochester	4.9	48.4
St. Peter	6.0	93.5
Willmar	11.3	122.1
Ah-Gwah-Ching	11.0	64.2
Oak Terrace	3.4	1.4

IV. COMPARATIVE ANALYSIS

INCIDENCE ESTIMATES

Mental Retardation

.Although a statewide needs assessment of the three disability groups was not conducted, incidence estimates and social indicator analysis were used as a guide in assessing service needs. According to incidence estimates, approximately three percent of Minnesota's population is mentally retarded while one percent requires some type of service. Twenty percent of the one percent requiring services are estimated to require residential services. Incidence studies of mental retardation conclude that: (1) mental retardation is more prevalent among lower socio-economic groups as measured by income and occupation, and (2) environmental factors, such as prenatal care, can affect the rate of mental retardation.

.Mentally retarded people very frequently have major secondary handicaps such as speech or perceptual difficulties. It is estimated that 10 percent of the total mentally retarded population has hearing impairment problems.

.In each of the eight state hospital receiving districts for the mentally retarded, the total number of mental retardation residential beds currently available is very close to the mental retardation incidence estimate of the number of people who need residential services at any given time.

.A comparison of the rankings of demographic social indicators and population projections to the number of residential beds in the receiving district yields the following finding:

> The state hospital receiving districts for the mentally retarded with the lowest percentage of at-risk populations for mental retardation tend to be the receiving districts with the highest number (per 1000 population) of residential beds for the mentally retarded.

Mental Illness

.The National Institute of Mental Health estimates that two percent of the population has mental health problems severe enough to require a 24-hour residential program. Based on incidence studies, the following population groups can be characterized as having a potentially greater need for mental health services than the general population: low occupational status, the young, the elderly and urban residents (especially children).

.Moose Lake State Hospital's receiving district for the mentally ill has been the most effective in developing community residential facilities for the mentally ill. Fergus Falls State Hospital's receiving district has had the least community facility development for the mentally ill compared to the other six state hospital receiving districts for the mentally ill.

.A comparison of the rankings of demographic social indicators and population projections to the number of residential beds in the receiving district yields the following findings:

1. The receiving districts for the mentally ill with the highest percentage of at-risk populations needing residential services tend to be the receiving districts with the largest number of community residential beds for the mentally ill (excluding state hospital beds).

2. The more populated the receiving district for the mentally ill, the more likely it is to have a high ratio of community residential beds for the mentally ill per 1000 population.

Chemical Dependency

.The Minnesota State Alcohol and Drug Authority estimated that nine percent of the total 1975 state population (i.e., 359,500 Minnesotans) was chemically dependent.

.All of the receiving districts for the chemically dependent (except the Fergus Falls and Willmar State Hospitals districts) have more beds per 1,000 population in community facilities than in the state hospitals.

.Anoka and Moose Lake State Hospitals' chemical dependency receiving districts lead the receiving districts in the total number of residential beds developed for the chemically dependent.

.A comparison of the rankings of demographic social indicators and population projections to the number of residential beds in the receiving district yields the following finding:

> The receiving districts for the chemically dependent with the largest at-risk population needing chemical dependency residential services tend to have the highest number (per 1,000 population) of residential beds for the chemically dependent.

Composite Rankings

.At-risk populations for the three disabilities show moderate positive correlation with the number of community residential beds in Rule 5, Rule 8, Rule 34, Rule 35 and Rule 36 facilities. There is no correlation between at-risk populations and total community facilities.

.At-risk populations for the three disabilities have a fairly strong negative correlation with urbanization and overall population. Thus, those receiving districts with the highest percentage of at-risk populations tend to be the most rural ones.

USE OF STATE-OPERATED FACILITIES BY COUNTIES

Mentally Retarded

.The metropolitan area generally contains the counties with the lowest admission rate to state hospitals per 10,000 population while the Northeastern counties of the state generally rank second lowest in admission rates. This may be due to the high number of community residential facilities in both of these areas of the state.

.High admission rates occur in the Southwest, Northwest and extreme North Central areas of the state.

Mental Illness

.The metropolitan area, again, has the lowest mental ill admission rate per 10,000 population to the state hospitals compared to any other areas of the state. There is a high level of outpatient and residential services available in the metropolitan area as compared to other areas of the state.

.The North Central and Southeast areas of the state consistently have higher admission rates to state hospitals than other areas of the state. The North Central area of the state, in particular, has a high at-risk population for mental illness.

Chemical Dependency

.The metropolitan area has the lowest chemically dependent admission rate to state hospitals followed closely by Southeastern Minnesota. Both areas have a high development of community facilities for the chemically dependent as compared to other areas of the state.

.High admission rates predominate in the West Central, North Central and East Central counties of the state immediately surrounding Fergus Falls, Brainerd and Moose Lake State Hospitals. These areas tend to have large at-risk populations for chemical dependency services.

State-Operated Nursing Home

.Fifty-one percent of all 1976 admission to Oak Terrace were from Hennepin County while 68 percent were from the seven metropolitan counties. The remaining 30 percent of admission came from outstate counties.

.For Ah-Gwah-Ching, 63 percent of all admission came from outstate counties while 37 percent came from the seven metropolitan counties.

Use of State Hospitals by Counties Outside of Designated Receiving Districts

.Almost all of the admissions of mentally retarded person to state hospitals coming from counties outside of the state hospital's designated receiving district went to Brainerd State Hospital, largely because of the Minnesota Learning Center which serves higher functioning mentally retarded adolescents from across the state.

.Admissions to state hospitals of mentally ill persons coming from counties outside of the state hospital's designated receiving district generally were to Rochester or Willmar State Hospitals. Counties admitting people to Rochester tended to be from the South/South Central part of the state, while counties using Willmar State Hospital were from the Central area of the state.

.Chemically dependent persons admitted to state hospitals from counties outside of the state hospital's designated receiving district were to Moose Lake, Fergus Falls or Willmar State Hospitals, due to their extended care programs.

V. ISSUES

ISSUES CONCERNING THE RESIDENTIAL CARE SYSTEM IN MINNESOTA

The previous sections of this report have presented a historical and current description of the residential care system in the state. In the course of describing the system, a number of issues has been identified. Some of those issues are key factors which must be taken into consideration when examining policy options. This section lists the issues and discusses them generally. A more specific analysis of each issue is included in the context of the specific policy options presented in Section VI.

Funding

.Among the disability groups federal funds are not equally available for the payment of residential care. The flow of funds has a significant impact on the development of community residential care facilities for these disability groups. Facilities for the mentally retarded have developed at a faster rate than facilities for the other two groups primarily because of the existence of a stable federal funding base. Therefore, the commitment of the state to develop stable and adequate funding sources in the absence of federal funds for the residential care of the mentally ill and chemically dependent will be a major determinant of whether or not these groups will be served in community-based facilities.

.The residential care system for the three disability groups is very dependent on services provided by other components of the treatment system. Each component has its own funding source and each source has its own fiscal and programming requirements. In the absence of well-defined mechanisms to establish priorities, many times the objectives of the different funding sources are not supportive of each other nor are they supportive of the residential care needs of the local community.

.The cost to the county for a state hospital placement ranges from nothing to $10.00 per month or the county share in Medical Assistance (4.48 percent). This constitutes a fiscal incentive for counties to place persons with no resources and who are not eligible for Medical Assistance in state hospitals. Since a large proportion of mentally ill and chemically dependent persons are not eligible for Medical Assistance this fiscal incentive affects those groups more than it affects the mentally retarded. (In the case of mentally retarded residents eligible for Medical Assistance, the state absorbs all the non-federal share of the state hospital cost, but historically this has not been an incentive for counties to place mentally retarded persons in state hospitals).

.Federal and state funds tend to finance care provided in the more intensive and expensive settings of state and local hospitals and nursing homes. The result has been that there are few resources left to expand needed residential and non-residential services in other parts of the system.

.The state hospital rates are determined each year by following a formula set by state statute which takes into consideration anticipated expenditures, and the state legislature appropriates funds to cover these anticipated expenditures. All reimbursements to state hospitals by third party payors or by patient fees are returned to the general fund as undedicated receipts. Community residential facility rates are determined by the Department of Public Welfare Rule 49 for nursing homes, by the Department of Public Welfare Rule 52 for intermediate facilities for the mentally retarded, or by each county for residential facilities for the mentally ill and chemically dependent. The different rate setting and collection mechanisms have created some artificial differences in reimbursement rates among similar programs which make cost comparison very inaccurate.

.If it becomes state policy to transfer residents from the state hospitals to community facilities or to divert potential state hospital admissions to community programs, for a limited time it may be necessary to simultaneously fund state hospitals at the same level while increasing funding for community facilities. This double funding may be required since the community facilities and their support services must be in place before any change in admissions to or discharges from state hospitals occurs.

.The state has a large capital investment in the buildings and land of the nine state hospitals and the two state-operated nursing homes. The total value of the eleven campuses is estimated at $49,562,075 as of fiscal year 1977. This sizeable investment must be weighed in any decision to close a state facility or portions of it.

.The physical plants of the state-operated facilities are expensive to maintain and renovate, especially with the current emphasis on meeting National Life and Safety Code requirements and state program standards. In the biennium from January 1, 1975 to June 30, 1977, for example, $16,229,250 was appropriated for capital improvements at the state hospitals. These costs are in addition to the usual operating costs of these facilities. The age and soundness of the buildings and their efficiency in terms of upkeep and energy consumption are, therefore, important economic considerations in any strategy to change the size of a campus. This issues is similarly important when developing or maintaining community facilities.

Organization/Administration

.Need identification, program planning and resource development planning in the residential care system for the three disability groups are not being done cooperatively by county welfare department(s), mental health center(s), the area state hospital and the private sector. Furthermore, the definitions of the functions that each of these components should perform in the treatment system in some cases overlap and in others leave gaps. So when needs are identified in a particular area, there are sometimes few or no guidelines to determine which part of the delivery system should meet those needs.

.Process and outcome evaluation of residential programs are only sporadically performed. In the absence of this information, funding and placement decisions are often based on ideology, habit or pressures from special interest groups.

.The state's involvement in the provision of direct residential care services continues to be a controversial issue among those connected with the residential care system. Four different positions are usually taken by different people with respect to this issue: 1) the state should stop providing direct residential care services, and it should only concern itself with the regulatory function; 3) the state should provide residential services only as a backup until these services are developed in the community; and 4) the types and quantity of services provided by the state should be determined by the local community depending on the specific needs of the area.

Patients/Residents

.The criteria used to determine admission to the various types of residential care facilities are not well-defined, and some services are not available or accessible to individuals in certain geographic areas. Furthermore, adequate standards of care that can be applied to all areas of the state have not been fully developed and enforced by the Department of Public Welfare. These standards relate both to the types of- residential services required in each area and to the manner in which these services are delivered to the population.

.Infrequent monitoring of the individual treatment plan in order to assess compliance and to protect client's rights in community-based residential facilities is a cause for concern, especially in the context of policy options that call for increased community-based programs.'

Employees

.The state, the counties and the private sector are employers in different segments of the residential care system. The three segments have different personnel systems with different rules, classifications, and salary ranges. Therefore, transfers between systems are administratively very difficult.

For employees with seniority and accumulated benefits, such as retirement benefits, in one of the systems, the transfer to another personnel system is further complicated by a possible economic loss of the employee.

.As the state hospital populations are reduced, retraining of state hospital staff to fill manpower needs in the community programs may become a necessity.

.A flexible system which allows state hospital staff to participate more actively in outreach, outpatient and follow-up care has been suggested as a way of retraining staff while providing needed services to the local community.

.Besides providing direct employment to over 6,000 employees, the state facilities' payroll of $67,202,467 (fiscal year 1977) and local state hospital expenditures create between 0.9 and 1.4 community jobs for each state hospital job. Overall, the economic impact of the facilities on their immediate communities depends primarily on the size of the payroll and on the other sources of employment available to state employees.

Legal

.In the field of mental retardation there are many unresolved constitutional questions. For example, the Penhurst case in Pennsylvania, which is being appealed, held that placing mentally retarded persons in institutions exclusively because they are mentally retarded constitutes discrimination against a group. The Parham vs. J.L. and J.R. case in Georgia, now being heard by the U. S. Supreme Court, challenges the right of parents or guardians to place children in an institution without a commitment hearing. In Minnesota, the Welsh vs. Dirkswager case affirms a number of constitutional rights for the mentally retarded in state hospitals, including the right to treatment in the least restrictive alternative. The resolution on these cases and many others raising similar legal questions is still pending, creating a state of flux in which planning for the mentally retarded especially, but also for other mentally disabled groups, becomes very uncertain.

.The right to treatment versus mere custody has been debated locally and nationally. There is a Minnesota Supreme Court decision in which it was determined that custody alone may be a form of treatment in some instances. However, Welsh vs. Dirkswager stands for the proposition that the right to treatment in itself is not sufficient, but that patients have a right to treatment in the least restrictive environment.

.The right to refuse treatment is considered by some equally as important as the right to receive treatment. The trend in cases where involuntary treatment is necessary has been to increase the courts' role in the decision. Many states,

including Minnesota, have enacted laws protecting the rights of committed patients through due process and outside expert reviews. Still, only the state hospitals in Minnesota - not community facilities - are mandated by the Hospitalization and Commitment Act to provide special review boards to examine the cases of committed patients.

.Although voluntary admissions are becoming an increasingly larger proportion of admissions to state and community-operated facilities, the conditions under which many patients volunteer raise some concerns. Some "voluntary" admissions occur when the court advises the patient that either s/he "volunteers" for a particular treatment program in a given facility or the court will commit him/her to the facility. In some criminal cases, the choice is to volunteer for a* treatment program or to go to prison.

VI. POLICY OPTIONS

POLICY OPTIONS, COST AND POPULATION PROJECTION

Previous sections of this report have presented a historical and current description of the residential care sys-ten. This section analyzes policy options for the care of the mentally retarded, the mentally ill and the chemically dependent.

Theoretically, the number of changes that could be made to the residential care system is very large. By necessity the options for analysis had to be limited and certain criteria for option selection had to be set. The criteria employed for this selection are listed below.

.The state hospital system is the focus of all the policy options presented in this section.

Three factors support this criterion:

1. the state hospital system with an annual cost of over 5100 million is the single largest provider in the residential care system;

2. the state has direct control over the state hospitals, and, therefore, state policy has a greater impact on the functioning of the hospitals;

3. available information indicates that state-operated nursing homes are a cost effective alternative for serving primarily very disabled, older persons who have failed at other community placements and who because of their long-term nursing care needs cannot be properly served in state hospitals given present administrative structure.

.Community-based program needs are analyzed in terms of the options presented for state hospital services. In other words, the incremental increase or decrease in the demand for community-based services is identified and analyzed in the context of each policy option.

.A continuation of present state policy for the care of each disability group is always one of the options analyzed in order to provide a baseline for comparison.

SECTION SUMMARY - POLICY OPTIONS, POPULATION PROJECTIONS AND COST

MENTAL RETARDATION

Four policy options regarding the residential care of mentally retarded persons are examined in this section. One of the options is the status quo option, the other three propose to partially or totally shift the care of fully-mobile, fully-ambulant severely or profoundly mentally retarded person to community-based programs. The selection of Policy Options B through D was based on three factors:

1. the fully-mobile, fully ambulant-severely or profoundly mentally retarded residents with no major behavior problems can be served cost effectively in community-based facilities.

2. of the mentally retarded residents left in state institutions, this group has the highest potential for successful community adjustment and they constitute a large proportion of the mentally retarded resident population currently in state hospitals and of the admissions to state hospitals.

3. the options are in line with recommendations of the Residential Care Study Advisory Council.

Option A: Status Quo Option. Leave the present policies of the residential care system for mental retardation unchanged.

Option B: Admissions Policy Change. No longer admit fully-mobile, fully ambulant individuals who are severely or profoundly mentally retarded (FM,FA/SP) and with no major behavior problem to the state hospital system. These admissions will be diverted to the community. There are approximately sixty of these admissions into the state hospital system each year.

Option C: Admissions Policy Change and Limited Discharge Policy Change. Institute the admissions policy change outlined in Option B and discharge one-half of FM, FA/SP mentally retarded residents with no major behavior problems currently in the state hospital system into the community over a five-year period.

Option D: Admission Policy Change and Full Discharge Policy Change. Institute the Admission Policy Change discussed in Option B and discharge all FM, FA/SP residents with no major behavior problems currently in the state hospital system to community facilities.

Implications for Population

The projected average daily population in the state hospitals varies under each option. The projected populations under each option are summarized below:

TABLE VI-I

PROJECTED AVERAGE DAILY POPULATION OF MENTALLY RETARDED RESIDENTS IN STATE HOSPITALS
1980-1984

	1980	1981	1982	1983	1984
Option A (Status Quo)	2636	2552	2467	2435	2435
Option B	2629	2531	2414	2378	2356
Option C	2640	2455	2287	2199	2126
Option D	2579	2378	2159	2021	1897

Source: Developed by Project Staff.

Cost

The total state hospital cost for programs for the mentally retarded and the cost of serving fully-mobile, fully-ambulant, severely or profoundly mentally retarded persons in the community-based programs under each policy option are summarized in Table VI-2.

TABLE VI-2

TOTAL STATE HOSPITAL COST FOR PROGRAMS FOR THE MENTALLY RETARDED AND COMMUNITY COST FOR SERVING FULLY-MOBILE. FULLY AMBULANT SEVERELY OR PROFOUNDLY MENTALLY RETARDED PERSONS DISCHARGED UNDER EACH POLICY OPTION

1980-1984

		POLICY OPTION A STATUS QUO	POLICY OPTION B	POLICY OPTION C	POLICY OPTION D
YEAR 1	State Hospital	67,526,000	67,393,000	66,870,000	66,348,000
1980	Community	1,678,000	1,803,000	2,292,000	2,782,000
	TOTAL	69,204,000	69,196,000	69,162,000	69,130,000
YEAR 2	State Hospital	75,014,000	74,525,000	72,731,000	70,932,000
1981	Community	5,433,000	5,877,000	7,489,000	9,103,000
	TOTAL	30,447.000	80,402,000	80,220,000	80,035,000
YEAR 3	State Hospital	83,238,000	82,207,000	78,765,000	75,299,000
1982	Community	9,575,000	10,684,000	13,425,000	16,384,000
	TOTAL	92,813,000	92,684,000	92,190,000	91,683,000
YEAR 4	State Hospital	93,906,000	92,125,000	86,592,000	80,993,000
1983	Community	14,073,000	15,524,000	20,082,000	24,639,000
	TOTAL	107,979.000	107,649,000	106,674,000	105,632,000
YEAR 5	State Hospital	106,085,000	103,273,000	95,107,000	36,795,000
1984	Community	18,498,000	21,205,000	27,551,000	34,095,000
	TOTAL	124,583,000	124,478,000	122,758,000	120,890,000
TOTAL FOR	State Hospital	425,769,000	419,523,000	400,065,000	380,367,000
FIVE YEARS	Community	49,758,000	54,885,000	70,939,000	87,003,000
	TOTAL	475,527,000	474,408,000	471,004,000	467,370,000

Source: Developed by Project Staff.

MENTAL ILLNESS

Two policy options for the residential care of the mentally ill are examined in this section. The selection of Option B for analysis is based on four factors:

1. a large number of mentally ill persons are admitted each year into state hospitals (approximately 3,000 persons);

2. many of these persons (approximately 50 percent) are admitted into the state hospitals without a prior screening to determine if a less intensive form of care would meet their needs;

3. an undetermined number of persons stay in the state hospitals longer than they need to stay due to the lack of transitional community-based programs;

4. Option B is in line with the recommendations of the Residential Care Study Advisory Council.

Option A: Status Quo Option. Leave the present policies of the residential care system for mental illness unchanged.

Option B: Length-of-Stay Policy Change and Admission Policy Change. Accelerate discharges from state hospitals, and reduce the number of admissions to state hospitals by promoting:

1) community residential programs for mentally ill persons who require minimum supervision and whose primary problem is that they need to develop or redevelop the social skills necessary to function independently, and

2) community support services such as case management, crisis management, and day treatment programs.

Implications for Population

The projected average daily population in the state hospitals varies under each option. The projected populations under each option are summarized in Table VI-3.

TABLE VI-3

PROJECTED AVERAGE DAILY POPULATION OF
MENTALLY ILL RESIDENTS IN STATE HOSPITALS
1980-1984

	1980	1981	1982	1983	1984
Option A	1400	1402	1404	1403	1403
Option B	1176	1178	1179	1178	1178

Source: Developed by Project Staff.

Cost

The total state hospital cost for programs for the mentally ill under each policy option and the additional cost in community-based programs generated by Policy Option B are summarized below:

TABLE VI-4

TOTAL STATE HOSPITAL COST FOR PROGRAMS FOR THE
MENTALLY ILL UNDER EACH POLICY OPTION AND
ADDITIONAL COMMUNITY COST UNDER POLICY OPTION B
1980-1984

FISCAL YEAR	TOTAL STATE HOSPITAL COST OPTION A	TOTAL STATE HOSPITAL COST OPTION B	TOTAL ADDITIONAL COMMUNITY COST UNDER OPTION B	TOTAL COST OF OPTION B
1980	$37,692,191	$33,790,244	$2,683,620	$36,473,864
1981	43,012,074	38,565,398	3,059,235	41,624,633
1982	49,082,736	44,015,052	3,487,635	47,502,687
1983	55,922,395	50,144,166	3,975,705	54,119,871
1984	63,751,530	57,201,961	4,531,860	61,733,821

Source: Developed by Project Staff

CHEMICALLY DEPENDENT

Two policy options regarding the residential care of chemically dependent persons are examined in this section. The selection of Policy Option B for analysis was based on the following factors:

1. transitional (halfway house) services for chemically dependent persons can be offered at a lower cost in community-based programs;

2. persons participating in transitional programs benefit the most from participation in other community resources such as employment, educational and recreational activities.

Option A: Status Quo Option - Leave the present policies of the residential care system for chemical dependency unchanged.

Option B: Discharge Policy Change - Decrease the projected average daily population in the state hospitals chemical dependency programs by 11 percent by not allowing persons who have completed their participation in the state hospitals' primary care programs to reside in the state hospital while they are receiving transitional (halfway house) services.

Implications for Population

The chemically dependent projected average daily population under Options A and B is given below:

TABLE VI-5

PROTECTED AVERAGE DAILY POPULATION OF CHEMICALLY DEPENDENT RESIDENTS IN STATE H05PITALS 1980-1984

	1980	1981	1982	1983	1984
Option A	635	643	644	645	645
Option B	560	573	574	574	574

Source: Developed by Project Staff.

Cost

The total state hospital cost for chemical dependency programs under each policy option and the additional cost in community-based programs generated by Policy Option B are summarized below:

TABLE VI-6

TOTAL STATE HOSPITAL COST FOR PROGRAMS FOR THE CHEMICALLY DEPENDENT UNDER EACH POLICY OPTION AND ADDITIONAL COMMUNITY COST UNDER POLICY OPTION B. 1980-1984.

FISCAL YEAR	TOTAL STATE HOSPITAL COST OPTION A	TOTAL STATE HOSPITAL COST OPTION B	TOTAL ADDITIONAL COMMUNITY COST UNDER OPTION B	TOTAL COST OF POLICY OPTION B
1980	$16,763,653	$15,589,805	$ 818,462	$16,408,267
1981	19,279,097	18,118,169	933,046	19,051,215
1982	22,002,096	20,679,368	1,063,380	22,042,748
1983	25,108,649	23,602,573	1,212,610	24,815,183
1984	28,624,999	26,908,333	1,382,097	28,290,430

Source: Developed by Project Staff.

POLICY OPTIONS FOR THE CARE OF THE MENTALLY RETARDED, POPULATION AND COST PROJECTIONS

This section compares the cost of caring for mentally retarded persons in both state hospital facilities and in community-based facilities. It is organized in the following manner:

I. COST OF RESIDENTIAL CARE FOR THE MENTALLY RETARDED.

- .Cost of Residential Care in State Hospitals.
- .Cost of Residential Care in Community Facilities.
- .Cost of Non-Residential Services in Community Facilities.
- .Total Cost of Residential and Non-Residential Services.
- .Cost Sharing for Services to the Mentally Retarded

II. POLICY OPTIONS.

III. POPULATION PROJECTIONS UNDER EACH POLICY OPTION.

IV. COST PROJECTIONS UNDER EACH POLICY OPTION.

V. COST SHARING STRATEGIES.

VI. IMPLICATIONS OF OPTIONS AND STRATEGIES.

I. COST OF RESIDENTIAL CARE FOR THE MENTALLY RETARDED

Cost of Residential Care in State Hospitals.

In an earlier section of this report figures are developed for the cost of caring for a mentally retarded resident in a state hospital. The analysis uses 1977 figures. Preliminary data for fiscal year 1978 shows a 16.3 percent cost increase. State hospital per diems for the mentally retarded are:

STATE HOSPITAL PER DIEM	
$46.05	Fiscal Year 1977
$53.65	Fiscal Year 1978

The anticipated per diem in fiscal year 1979 is $58.25. Since the following sections make explicit comparisons between state hospital and community costs, it should be noted at this point that the hospital cost reflects several types of expenditures not found in community-based facilities. In particular the state hospital per diem includes about $1.60 attributable to:

.State-wide support - Personnel, Payroll, Accounting.

.Central Office Support - Department of Public Welfare Support Staff.

.P.O.I.S. - Information System.

.Collections and Miscellaneous.

Cost of Residential Care in Community Facilities

Chart A summarizes the per diem cost of community residential facilities licensed under the Department of Public Welfare Rule 34 as of August, 1978. The chart allows for differences in:

.Ambulation level

.Retardation level

.Acceptance of individuals with behavior problems.

The chart provides information on 185 of the 206 facilities which were licensed under DPW Rule 34 in August, 1978.

CHART A

Average Per Diem Residential Cost For Community-Based Facilities - Rule 34, As of August, 1978

XXX = Mean-All Facilities
(XXX) = Mean-Facilities Licensed 1976, 1977, 1978
[XX] = Number of Facilities
* = No Facilities Licensed before 1976

				M.R. POPULATION CHARACTERISTICS I. Not Specified, or Moderate to Borderline Residents	II. Severely Retarded to Mild or Borderline	III. Severely Retarded Only	IV. Profoundly Retarded to Mild or Borderline	V. Profoundly or Severely Retarded Only	Totals
Facility Characteristics	Accepts Ambulatory Residents Only	A	Not Specified, or No Behavior Problems Accepted	$25.31 [32] ($28.74) [13]	$27.89 [81] ($29.87) [29]	$20.13 [1] - [0]	$24.43 [8] [0]	$32.20 [2] [0]	$27.01 [124] ($29.52) [42]
		B	Facilities willing to Consider Behavior Problems	$27.09 [12] ($31.11) [4]	$25.01 [18] ($26.66) [7]	* ($31.23) [2]	$27.27 [3] ($31.15) [2]	$39.52 [2] $40.40 [1]	$26.99 [37] ($29.76) [16]
		C	Facilities Specializing in Behavior Problems	* ($54.22) [3]	* ($39.30) [1]				* ($50.49) [4]
	Will Accept Some Non-Ambulant Residents (Walker, wheelchair, etc.)	D	Not Specified or No Behavior Problems Accepted	$41.47 [2] [0]	$29.92 [5] $16.97 [1]		$40.10 [3] ($49.15) [2]	$33.41 [1] [0]	$35.11 [11] ($38.42) [3]
		E	Facilities willing to Consider Behavior Problems				$41.19 [4] ($44.45) [3]		$41.19 [4] ($44.45 [3]
		F	Facilities Specializing in Behavior Problems						
	Facilities with Predominant Non-Ambulant Population	G	Not Specified, or No Behavior Problems Accepted	$72.14 [1] [0]			$42.03 [1] [0]	* ($48.62) [3]	$52.01 [5] ($48.62) [3]
		H	Facilities willing to Consider Behavior Problems						
Unknown = 9		I	Facilities Specializing in Behavior Problems						
	TOTALS		1) All Facilities	$29.05 [50] ($33.04) [20]	$27.60 [105] ($29.19) [38]	$27.53 [3] ($31.23) [2]	$31.81 [19] ($41.99) [7]	$40.34 [8] ($46.57) [4]	$28.98 [185] $32.57 [71]

Source: Department of Public Welfare Rule 52 Records.

Chart A shows:

(1.)	*Average per diem all facilities*	*$28.98*
(2.)	*Average per diem all facilities opened in the last 3 years*	*$32.57*

Additionally, the following per diems are relevant to the policy options to be discussed later:

(3.)	*Average per diem all facilities serving fully-ambulant, severely or profoundly mentally retarded individuals (Columns II-V;A,D)*	*$28.14*
(4.)	*Average per diem facilities serving fully-ambulant severely or profoundly mentally retarded individuals -opened in the last 3 years.*	*$30.67*

The distinction between per diems for all facilities and facilities opened in 1976, 1977, or 1978 is important. It recognizes that future community placements will be primarily into new facilities. Costs for future placements will be associated with those facilities most recently opened. The cost difference reflects the higher cost of capitalization and of operating new facilities.

Cost of Non-Residential Services Provided to Residents of Community Facilities and not Included in the Facilities' Per Diem Charges.

There are certain non-residential services which are in addition to the in-house residential program. These services are usually rendered outside of the residential facility and their cost is not included in the residential per diem. Services provided by the developmental achievement centers (D.A.C.) are among the most important non-residential services provided to mentally retarded persons. The D.A.C.'s provide developmental activities to help mentally retarded persons achieve maximum self-sufficiency. Other services provided to mentally retarded residents of community facilities include transportation to and from other services, medical services covered under Medical Assistance, and different social services such as case management, information and referral, and family counseling.

A typical package of non-residential services would vary according to age and level of functioning. For severely or profoundly mentally retarded persons, the following non-residential services would be needed.

Age	Services
2-4	Preschool Developmental Achievement Center (D.A.C.), transportation services, medical services under Medical Assistance, and other social services.
Over five years	D.A.C., transportation services, medical services under Medical Assistance and other social services.

The cost of these services is outlined below. The figures have been prepared using fiscal year 1978 D.A.C. and transportation cost data from the Minnesota Department of Public Welfare. A three-county case record examination provided data on consumption of medical and social services. This examination provided information on over 10,000 patient-days.

THE PER DIEM COST OF NON-RESIDENTIAL SERVICES
FISCAL YEAR 1978

SERVICES	PER DIEM COST
D.A.C. Services	$15.69/day-adjusted for 90 percent utilization of the facility.
Pre-school D.A.C.	$28.52/day-adjusted for 90 percent utilization of the facility.
Transportation Services	$ 3.36/day-includes transportation of individuals to and from D.A.C.
Medical Services under Title XIX	$ 4.22/day
Other Social Services	$ 0.91/day

TOTAL PER DIEM COST OF NON-RESIDENTIAL SERVICES	2-4 Years of Age	Over 5 Years of Age
	$37.11	$24.18

Source: Community Programs Division, Department of Public Welfare and the Office of Policy Analysis and Planning, Department of Public Welfare.
Note: Each D.A.C. participant uses an average of 200 days of D.A.C. services and an equal number of days of transportation services.

Total Cost of Residential and Non-Residential Services

Total per diem costs are presented in Table VI-7 for residential services of fully-mobile, fully-ambulant severely or profoundly mentally retarded persons. The figures assume that 200 days of D.A.C. and transportation services are used annually.

TABLE VI-7

COST OF RESIDENTIAL AND NON-RESIDENTIAL SERVICES TO FULLY-MOBILE, FULLY-AMBULANT SEVERELY OR PROFOUNDLY MENTALLY RETARDED INDIVIDUALS IN COMMUNITY FACILITIES. FISCAL YEAR 1978.

		RESIDENTIAL COSTS			TOTALS	
	AGES	ALL FACILITIES	LICENSED IN '76,'77,'78	NON-RESIDENTIAL SERVICES"	ALL FACILITIES	FACILITIES 76.77.7S
COMMUNITY FACILITIES	0-4YRS	$28.14	$30.67	**S22.65**	$50.79	$53.32
	5+ YRS	$28.14	$30.67	**$15.57**	$43.71	$46.24
STATE HOSPITAL	ALL	$53.65*		Included in Residential Component	$53.65	

*Estimated **Adjusted for utilization rates among residents

In order to interpret correctly the cost information given in Table VI-7, it is important to note that:

.Since state facilities admit few residents under age 5, the cost for ages 5+ is the important one. Additionally, since most current placements are into new facilities, $46.24 is the best cost estimate.

.Placement of a mentally retarded person in the community appears less costly. Populations in the state hospitals and the community may not be comparable because the state hospital cost includes service to more difficult cases. The community, on the other hand, has more fully-mobile, fully-ambulant mild and borderline mentally retarded clients, Thus, the difference in costs may reflect the divergence of the two populations.

.There is a way to adjust for this difference and get a clearer picture. Referring to Chart A, the per diem given in Column I, Line A is for the ambulant individual who is not a behavior problem and is moderate or borderline mentally

retarded. This per diem, located in the upper left hand corner of the chart, is $28.74 for thirteen recently opened facilities. The state hospitals do not serve individuals associated with this per diem. If this per diem is segregated from the overall per diem of $32.57 in the lower right hand corner of the chart, a per diem associated with roughly equivalent populations is obtained. This per diem provides a basis for comparing state hospital and community facilities costs. The new residential per diem with this adjustment is $33.43. Adding the $15.57 per diem cost for non-residential services gives a total per diem of $49.00 for community facilities. This per diem is about eight and one-half percent less than the $53.65 state hospital per diem.

Cost Sharing for Services to Mentally Retarded in the Community

Cost sharing among the Federal, State and County governments is summarized below:

TABLE VI-8

RESIDENTIAL SERVICES
FISCAL YEAR 1978

	COST SHARING		
	FEDERAL	STATE	LOCAL
Residential Title XIX	55.26%	40.26%	4.48%

NON-RESIDENTIAL SERVICES
FISCAL YEAR 1978

	COST SHARING		
	FEDERAL	STATE	LOCAL
Medical Services	55.26%	40.26%	4.48%
D.A.C.	0.00%	42.00%	58.00%
D.A.C. Transportation	0.00%	100.00%	0.00%
Social* Services	37.00%	5.20%	57.80%

*Social service cost estimate is based on all social services costs, including administration.

Source: Office of Policy Analysis and Planning
Department of Public Welfare

II. POLICY OPTIONS

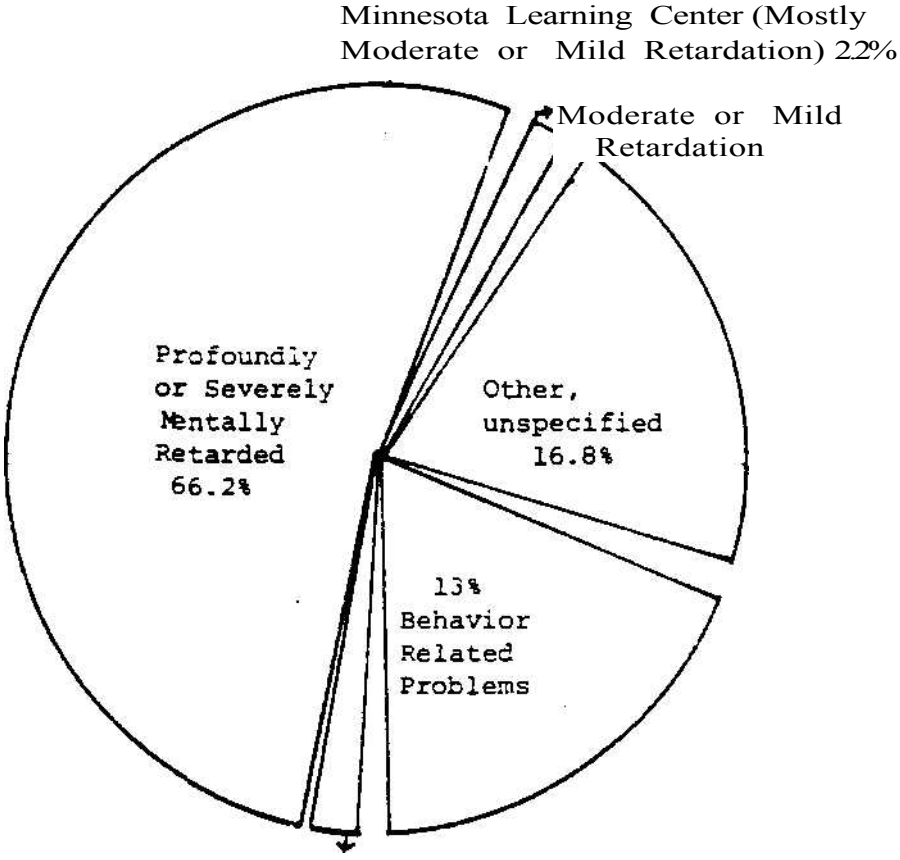
Before defining the policy options for the care of mentally retarded persons which will be analyzed in this section, it is necessary to discuss certain characteristics of current state hospital residents and admissions since those characteristics influence the selection of the policy options.

Characteristics of Current State Hospital Mentally Retarded Residents.

At the end of fiscal year 1977, there were 3,015 mentally retarded residents in state hospitals. By the end of fiscal year 1978, this figure had dropped to 2,769. From October 1977, to August 1978, the average daily population of mentally retarded residents was 2,801. Approximately 1,739 of these 2,801 residents were fully-mobile, fully-ambulant. This group can be divided into several subgroups:

CHART 8

FULLY-MOBILE, FULLY-AMBULANT RESIDENTS
CURRENTLY IN STATE HOSPITALS



Source: Patient Oriented Information System.
Department of Public Welfare

The group of 1,152 profoundly or severely mentally retarded residents can be further subdivided by years since admission:

Admitted 10 or fewer years ago - 568 individuals

Admitted over 10 years ago - 584 individuals

Since some individuals may be more difficult to place than others, this is an important distinction. The choice of ten years since admission, while arbitrary, gives an indication of this difficulty. In other words, individuals who have lived in the state hospital system over 10 years may be too "institutionalized" and their chances for successful community adjustment may be less than the chances of individuals who have not been institutionalized for a long period of time.

Characteristics of Mentally Retarded Persons Admitted to State Hospitals

Over the last six years state hospital admissions of mentally retarded individuals has varied widely:

Admissions of Mentally Retarded Persons to All State Hospitals

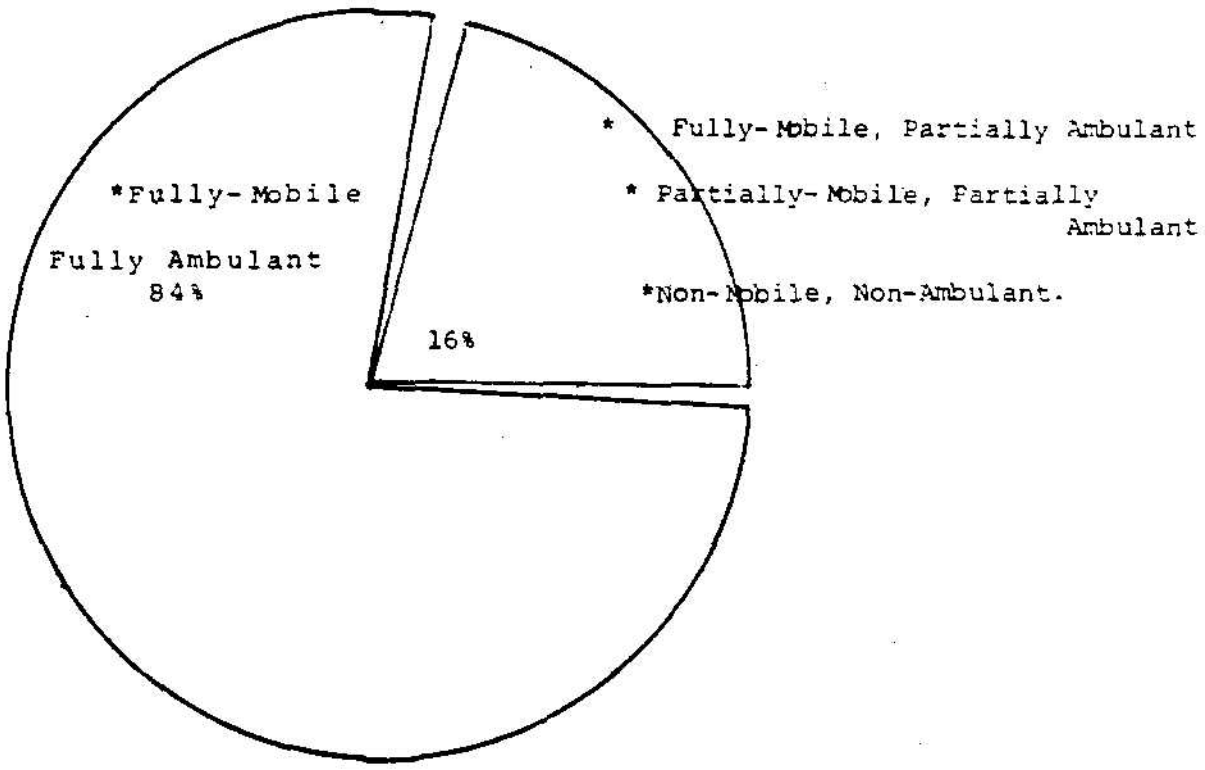
1973 - 307
1974 - 276
1975 - 317
1976 - 264
1977 - 307
1978 - 206

As shown in Chart C, of these admissions approximately 84 percent were fully-mobile and fully-ambulant. In fiscal year 1977 this group represented 259 out of 307 admissions; in fiscal year 1978 it represented 173 admissions.

CHART C

ALL ADMISSIONS OF MENTALLY RETARDED PERSONS TO STATE FACILITIES

Fiscal Years 1977 and 1978

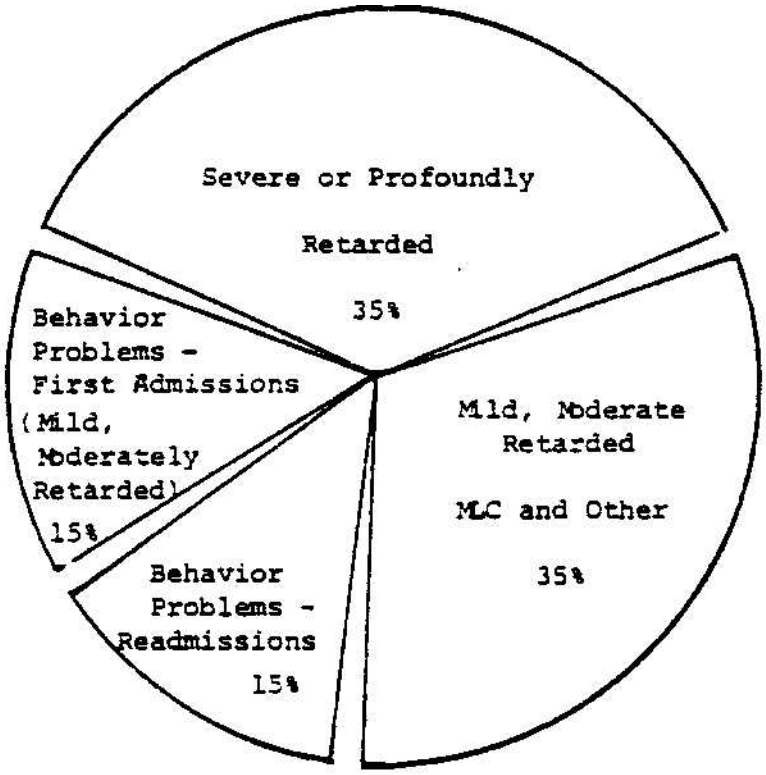


Source: Patient Oriented Information System.
Department of Public Welfare

The fully-mobile, fully-ambulant admissions can be further subdivided into levels of retardation.

FULLY MOBILE, FULLY AMBULANT ADMISSIONS BY LEVEL OF RETARDATION

Fiscal Years 1977 and 1978



Source: Patient Oriented Information System, Department of Public Welfare

In order to select policy options for the care of the mentally retarded state hospital population, the characteristics of current state hospital residents and admissions were examined in conjunction with the following factors:

.Of the mentally retarded groups still left in state hospitals, the fully-mobile, fully-ambulant severely or profoundly mentally retarded persons with no major behavior problem have the greatest potential for successful community adjustment.

.This group of mentally retarded persons can be served cost effectively in community-based programs.

.These determinations were in line with the recommendations of the Residential Care Study Advisory Council.

Four policy option are analyzed in this report. The first option is the status quo option. Policy Options B through D propose to shift, partially or totally the care of fully-mobile, fully ambulant severely or profoundly mentally retarded persons from state hospitals to community facilities.

Option A: Status Quo Option. Leave the present policies of the residential care system for mental retardation unchanged.

Option B: Admissions Policy Change. No longer admit fully-mobile, fully ambulant individuals who are severely or profoundly mentally retarded {FM,FA/SP) and with no major behavior problem to the state hospital system. These admissions will be diverted to the community. There are approximately sixty of these admissions into the state hospital system each year.

Option C: Admissions Policy Change and Limited Discharge Policy Change. Institute the admissions policy change outlined in Option B and discharge one-half of FM, FA/SP mentally retarded residents with no major behavior problems currently in the state hospital system into the community over a five-year period.

Option D: Admission Policy Change and Full Discharge Policy Change. Institute the Admission Policy Change discussed in Option B and discharge all FM, FA/SP residents with no major behavior problems currently in the state hospital system to community facilities.

III. POPULATION PROJECTIONS FOR EACH POLICY OPTION

State hospital populations were projected for each of the four policy options in the context of a five year implementation period.

Option A: Status Quo Population Projections. Leave the present policies of the state hospital system unchanged.

YEAR	Total S.H. Admissions all MR's	No Major Behavior Problem Hospital Admissions FM, FA Severely or Profoundly Retarded	No Major Behavior Problem Hospital Discharges To Community FM, FA Severely or Profoundly Retarded	No Major Behavior Problem Hospital Population FM, FA Severely or Profoundly Retarded At Year's End
1980	220	65	175	917
1981	220	65	165	817
1982	210	62	145	734
1983	200	59	130	663
1984	200	59	120	602

These projections indicate:

.There will be approximately 602 FM, FA severely or profoundly mentally retarded individuals with no major behavior problem in the state hospital system in 1984.

.The total number of discharges of this group will be 735. Of these discharges, 517 will be current residents who are FM, FA severely or profoundly mentally retarded.

.The remaining 602 individuals will represent approximately 25 percent of the total state hospital population in 1984, based on a projected average state hospital mentally retarded population of 2,435 residents by fiscal year 1984 under the status quo policy option.

.There will be a decrease in the number of discharges per year of FM, FA severely or profoundly mentally retarded individuals which will reach 120 1n 1984. This decrease reflects the expected decline in the total number of state hospital residents and an increase in the placement of this group in community-based facilities.

.In 1984 community-based facilities will be serving 735 FM, FA severely or profoundly mentally retarded individuals with no major behavior problem who were discharged from the state hospitals during the previous five years.

Option B: Admissions Policy Change Population Projections - No longer admit FM, FA severely or profoundly mentally retarded persons into state hospitals.

YEAR	Total S.H. Admissions All MR's	No Major Behavior Problem Hospital Admissions FM, FA Severely Or Profoundly Retarded	No Major Behavior Problem Hospital Discharges To Community FM, FA Severely Or Profoundly Retarded	No Major Behavior Problem Hospital Population FM,FA Severely Or Profoundly Retarded At Year's End
1980	155	0	123	904
1981	155	0	116	788
1S82	148	0	102	686
1983	141	0	91	595
1984	141	0	85	510

These projections indicate:

.There will be 510 FM, FA severely or profoundly mentally retarded individuals with no major behavior problems in the state hospital system by the end of 1984. This policy represents a net decrease of 105 persons or a 17 percent population reduction from the status quo.

.The community will serve these admissions. By the end of 1984 there will be 827 people who are being served in the community. Of these, 310 will be diverted state hospital admissions and 517 will be discharged from state hospitals.

.The state hospital system will be discharging few people under this policy option. This is because certain admissions will be diverted under this option and served in the community. In this context, it is estimated that the state hospital discharges of FM, FA severely or profoundly mentally retarded persons with no major behavior problems will drop from 175 to 123 in 1980. The estimate assumes that most of the admissions under the status quo would normally be discharged in a year.

Option C: Admissions Policy Change and Limited Discharge Policy Change Population Projections - Discharge approximately one half current FM, FA severely or profoundly mentally retarded state hospital residents with no major behavior problems and institute Policy Option B.

YEAR	Total S.H. Admissions All MR's	No Major Behavior Problems Hospital Admissions FM, FA Severely Or Profoundly Retarded	No Major Behavior Problem Hospital Discharges To Community FM, FA Severely Or Profoundly Retarded	No Major Behavior Problem Hospital Population FM, FA Severely Or Profoundly Retarded At Year's End
1980	155	0	174	853
1981	155	0	167	686
1982	148	0	153	533
1983	141	0	142	391
1984	141	0	136	255

These projections indicate:

.This option will reduce the number of FM, FA severely or profoundly mentally retarded residents in state hospitals to a level lower than Option B. It assumes that one-half of the 510 individuals remaining in the hospital under Option B can be discharged.

.Of the current 1,152 FM, FA severely or profoundly mentally retarded, approximately half have been residents of state hospitals 10 or fewer years. This policy uses this figure, fifty percent, as a proxy for the number of additional individuals who can be discharged.

.Under this option 1,082 individuals will be placed in community-based facilities. Of these, 735 would have had community placement under the status quo. This policy change represents an incremental change of 347 more community placements than the placements under Option A.

Option D; Admissions Change and Full Discharge Policy Change Population Projections - Discharge all current FM, FA severely or profoundly mentally retarded state hospital residents with no major behavior problems and institute Policy Option B.

YEAR	Total S.H. Admissions All MR's	No Major Behavior Problems Hospital Admissions FM, FA Severely Or Profoundly Retarded	No Major Behavior Problem Hospital Discharges To Community FM, FA Severely Or Profoundly Retarded	No Major Behavior Problem Hospital Population FM, FA Severely Or Profoundly Retarded At Year's End
1980	155	0	225	802
1981	155	0	218	684
1982	148	0	204	380
1983	141	0	193	187
1984	141	0	187	0

.This policy insures that by the end of 1984 there will be no residents of state hospitals who are fully-mobile, fully ambulant severely or profoundly mentally retarded. It also insures that all new admissions of these individuals will be diverted to the community.

.By the end of 1984 there will be 1,337 individuals in the community who are fully-mobile, fully-ambulant severely or profoundly mentally retarded with no major behavior problems. This group will be comprised of 310 persons diverted from admission to state hospitals and 1,027 persons who at the end of fiscal year 1979 are projected to be state hospital residents.

IV. COST PROJECTIONS FOR EACH POLICY OPTION

This section provides cost projections for each of the policy options for the care of the mentally retarded presented previously. Each of the four policy options presented a way to provide a given number of days of days of service to fully-mobile, fully-ambulant severely or profoundly mentally retarded persons (FM, FA/SP) with no major behavior problems. For example, at the end of fiscal year 1979, 1,027 of these individuals are projected to be residents in the state hospital system if current policies continue. Additionally, 65 new admissions to the state hospital system of FM, FA/SP mentally retarded persons can be anticipated to occur during fiscal year 1979 under current policies. Using anticipated annual admissions and number of residents currently in the state hospital system, the number of total patient days of service can be calculated.

TOTAL PATIENT DAYS = (Current Residents x 365 days) + (New Admissions x 182.5 days)

However, since during the course of the year some of the current state hospital residents may be discharged to community facilities, adjustments must be made to the formula. This adjustment entails assessing the community side of the service continuum. The adjusted formula becomes:

Total Patient Days Consumed By People Served By State Hospitals or Formerly Served By State Hospitals	=	Days Provided By State Hospitals	+	Days Provided By Community Facilities

Accounting for this discharge flow from the state hospitals to the community facilities and for diverted admissions under Options B, C and D allows the projection of total state hospital and community facility days of service to the fully-mobile, fully-ambulant severely or profoundly retarded persons affected by those options.

Total Patient Days of Service to FM, FA/SP MR Persons with No Major Behavior Problems - State Hospitals and Community Facilities

1980 - 386,718
1981 - 410,444
1982 - 433,620
1983 - 455,703
1984 - 477,238

Each policy option distributes these days differently between state hospitals and community facilities. In 1982, for example, the state and community systems will provide a combined total of 433,620 days. These days will be provided to the FM, FA/SP mentally retarded individuals who are current

* This projection assumes (i) people stay in either system, and (ii) the admissions are all new admissions.

state hospital residents, discharged state hospital residents, and projected new admissions to the state hospital system. In 1982 under Policy Option A, thirty-five percent of these 433,620 days would be provided in the community and sixty-five percent in the state hospital system. Under Policy Option D during the same year, these percentages would be 51 and 49 percent respectively. This example is graphed below:

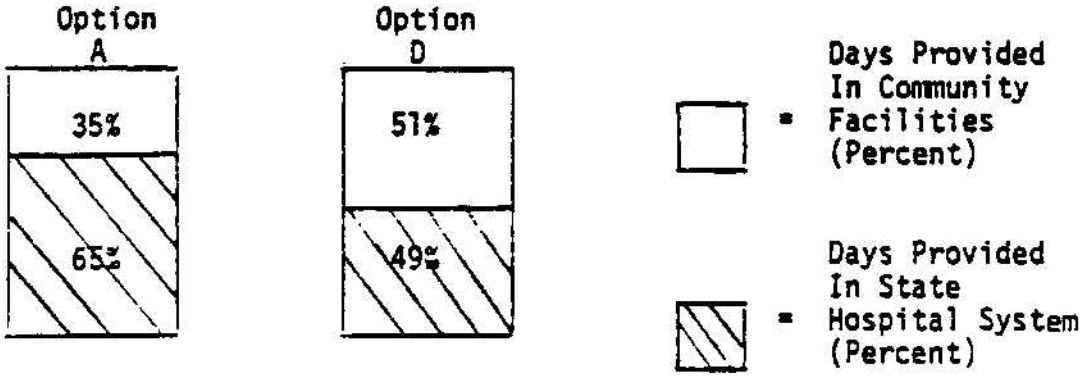
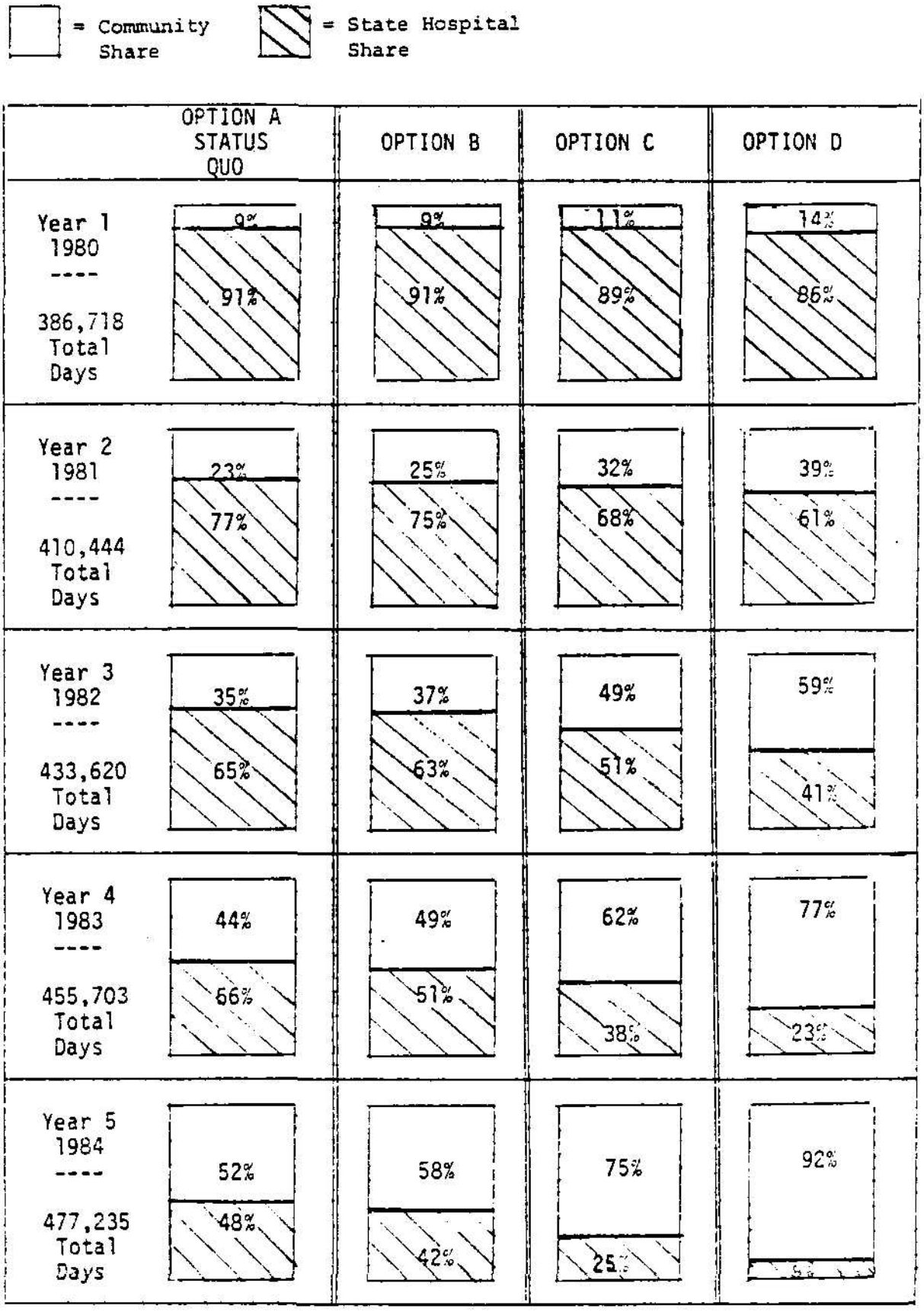


Chart E gives the distribution between state hospital and community facilities of the total patient days that would be consumed by the FM, FA/SP mentally retarded group under each policy option from fiscal years 1980 to 1984.

CHART E

PROPORTION OF PATIENT DAYS OF SERVICE TO FM, FA/SP MENTALLY RETARDED PERSONS GIVEN IN STATE HOSPITALS AND COMMUNITY FACILITIES. 1980-1984



Source: Developed by Project Staff

Once the number of patient days of service is estimated and distributed either to the state hospitals or to community facilities, the cost associated with each policy option can be estimated. These costs are for residential and non-residential services. Previous sections showed these costs to be:

I. Per Diem Cost for State Hospital Services (1978)	$53.65 Total
II. Cost for Community Services (1978)	
A. Residential Placement for FM, FA/SP Mentally Retarded Persons (recently opened facilities)	$30.67
B. Non-Residential Services	$15.57
	$46.25

Additionally, per diem costs can be projected under each of the policy options. These per diem projections assume:

.The annual inflation rate among all state hospital costs is 14 percent based on historical data.

.When a hospital resident is discharged or a day of service is shifted from the state hospital to the community, it is estimated that 80 percent of the hospital per diem is saved. The other 20 percent of the cost remains in the facility and is reflected in a higher cost of service to those remaining in the facility.

Since under each policy option, days of service will be shifted to the community, the state hospital per diem will increase. This increase will be in a proportion equal to the number of days of service shifted to the community. Table VI-14 shows the projected per diems for state hospital services to the mentally retarded population under each policy option.

TABLE VI-14

ESTIMATED PER DIEM FOR MR SERVICES
UNDER EACH POLICY OPTION

YEAR	OPTION A STATUS QUO	OPTION B	OPTION C	OPTION D
1980	70.18	70.22	70.36	70.50
1981	80.53	80.67	81.18	81.72
1982	92.44	92.74	93.78	94.92
1983	105.66	106.18	107.91	109.85
1984	120.72	121.56	124.19	127.26

Source: Developed by Project Staff

Under each policy option the per diem increases between 14 and 16 percent. The exact increase is determined by the inflation rate of state hospital cost and by the rate of population decline projected under the policy option.

The rate of decline under Option A, the Status Quo, is close to 14 percent annually; under Option D the annual rate is close to 16 percent. The difference between the two reflects the accelerated population decline under Option D.

These population projections and per diem estimates allow a total cost estimate to be generated. Table VI-15 provides estimates for:

1. the cost of state hospital service to *all* mentally retarded residents, and

2. the cost of servicing admissions diverted from state hospitals and state hospital discharges in community facilities for the FM, FA/SP mentally retarded persons with no major behavior problems affected by each policy option.

The cost estimates in Table VI-15 were made for *alt* the mentally retarded in the state facilities. This complete estimate was chosen because in accelerating the population decline, a certain portion of the cost formerly associated with the discharged residents stays with the state facility and is reflected in a higher per diem for the remaining mentally retarded residents (see Table VI-14). Therefore, since the per diem of the entire mentally retarded population rises, the cost of service to all mentally retarded residents must be considered.

On the community facility side, however, only the cost of service to the fully-mobile, fully-ambulant severely or profoundly mentally retarded persons with no major behavior problems who are currently in state hospitals or may seek admission to state hospitals are considered since these are the persons that would be added to the demand for community-based services as a result of the policy options analyzed here.

TABLE VI-15

TOTAL STATE HOSPITAL COST FOR MR SERVICE AND COMMUNITY COST FOR FULLY-MOBILE - FULLY AMBULANT SEVERELY OR PROFOUNDLY MENTALLY RETARDED PERSONS DISCHARGED UNDER EACH POLICY OPTION

		POLICY OPTION A STATUS QUO	POLICY OPTION B	POLICY OPTION C	POLICY OPTION D
YEAR 1 1980	State Hospital	67,526,000	67,393,000	66,870,000	66,348,000
	Community	1,678,000	1,803,000	2,292,000	2,782,000
	TOTAL	69.204.000	69,196,000	69,162,000	69,130,000
YEAR 2 1981	State Hospital	75,014,000	74,525,000	72,731,000	70,932,000
	Community	5,433,000	5,877,000	7,489,000	9,103,000
	TOTAL	80.447.000	80,402.000	80,220,000	80,035,000
YEAR 3 1982	State Hospital	83,238,000	82,207,000	78,765,000	75,299,000
	Community	9,575,000	10,684,000	13,425,000	16,384,000
	TOTAL	92,813,000	92.684.000	92,190,000	91,683,000
YEAR 4 1983	State Hospital	93,906,000	92,125,000	86,592,000	80,993,000
	Community	14,073,000	15,524,000	20,082,000	24,639,000
	TOTAL	107.979.000	107,649,000	106.674,000	105,632,000
YEAR 5 1984	State Hospital	106,085,000	103,273,000	95,107,000	86,795,000
	Community	18,498,000	21,205,000	27,651,000	34,095,000
	TOTAL	124.583.000	124,478,000	122,758,000	120,890,000
TOTAL FOR FIVE YEARS	State Hospital	425,769,000	419,523,000	400,065,000	380,367,000
	Community	49,758,000	54,885,000	70,939,000	87,003,000
	TOTAL	475.527.000	474.408.000	471,004,000	467,370,000

Source: Developed by Project Staff

V. COST SHARING STRATEGIES

Table VI-15 indicates that there is a *net* saving under each policy option from B to D when compared to Policy Option A (see Table VI-16). The savings are the greatest in Policy Option D which would save approximately eight million dollars over Policy A in the five year period from 1980 to 1984.

TABLE VI-16

FIVE-YEAR COST SAVINGS
(dollars)

	Total Cost	Cost Savings
Policy Option A	475,527,000	(None)
Policy Option B	474,408,000	1,119,000
Policy Option C	471,004,000	4,523,000
Policy Option D	467,370,000	8,157,000

Source: Developed by Project Staff

As programs and services shift from the state hospitals to community facilities, the responsibility for paying for these services also shifts from the state to the counties. Therefore, although a *net* savings is realized under each policy option from B to D over Policy Option A, the cost to the counties increases as more people are placed in community facilities. Recognizing the importance of the impact of these policies on the different governmental units especially on the counties, three cost sharing strategies are analyzed in detail. These strategies are:

Strategy One: No Change in Present Cost Sharing.

Strategy Two: Change D.A.C. Funding to Guarantee a 43 Percent State Financial Participation in Costs.

Strategy Three: Change D.A.C. Reimbursement Mechanism to Provide for the Inclusion of the Cost of D.A.C. Services to Medical Assistance Eligibles in the Residential Per Diem.

STRATEGY ONE: No Change in the Present Cost Sharing Ratios

This implementation strategy projects no change in current cost sharing rations. These ratios are presented earlier in this section under "Cost Sharing for Services to the Mentally Retarded in the Community" (page 46). In addition, this strategy assumes no new state dollars for D.A.C. services. This latter assumption in the context of increasing D.A.C. costs in all the policy options means that the projected state share of D.A.C. costs would decrease to approximately 33 percent by 1983 from the current 43 percent state share even if the status quo Option A is selected.

Under a strategy with no change in the cost sharing ratio the five-year cost share can be estimated for each policy option.

TABLE VI-17

STRATEGY ONE

FIVE-YEAR COST SHARING
(dollars)

Option A: Status Quo

TOTAL COST	475,527,000
Federal Share	257,795,000
State Share	210,871,000
County Share	6,861,000

Option B: Admissions Change

TOTAL COST	474,408,000
Federal Share	256,612,000
State Share	209,983,000
County Share	7,813,000

Option C: Admissions Change and Discharge Change I

TOTAL COST	471,004,000
Federal Share	252,996,000
State Share	237,254,000
County Share	10,744,000

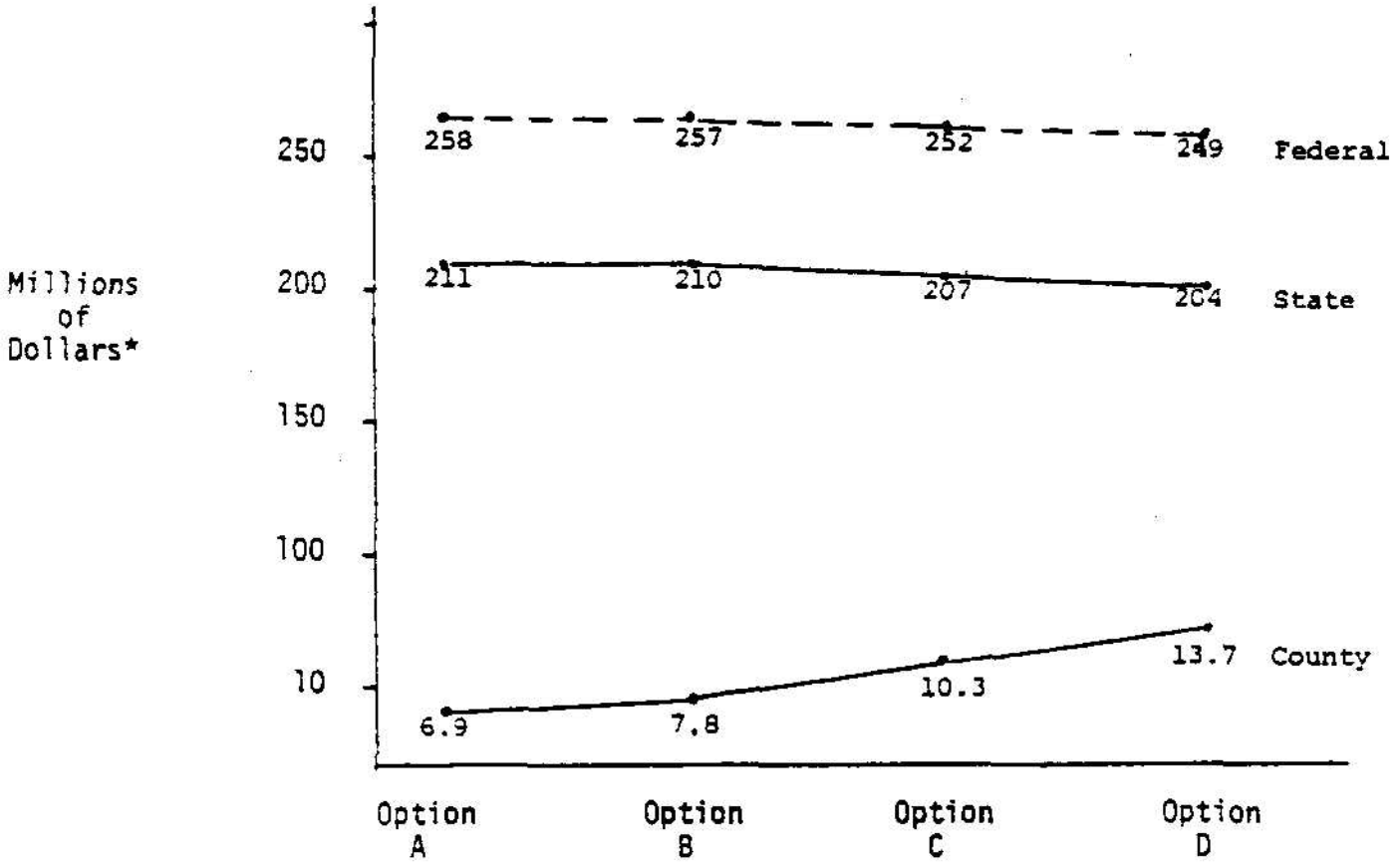
Option D: Admissions Change and Discharge Change II

TOTAL COST	467,370,000
Federal Share	249,489,000
State Share	204,187,000
County Share	13,694,000

These different cost shares under each policy option are shown in Chart F.

CHART F

FIVE-YEAR COST SHARING UNDER EACH POLICY OPTION. 1980-1984



*Not to scale

It is evident that the federal and state costs decrease while the county cost increases. Using the status quo projections as the baseline, the table below summarizes these increases and decreases.

TABLE VI-18

STRATEGY ONE

FIVE YEAR COST SAVINGS/INCREASES
UNDER EACH POLICY OPTION

(dollars)

	FEDERAL	STATE	COUNTY
Option A (Status Quo)	0	0	—
Option B	1,183,000 (savings)	888,000 (savings)	952,000 (increase)
Option C	4,798,000 (savings)	3,607,000 (savings)	3,833,000 (increase)
Option D	8,406,000 (savings)	6,684,000 (savings)	6,833,000 (increase)

Source: Developed by Project Staff

The sources of cost savings or increases for each level of government are:

Federal Cost

The federal cost saving comes primarily from the lower cost of community services. The federal share of hospital expenditures would decrease from $236 million in Option A to $210 million in Option D. This decrease would be offset, however, by an increase in the federal share of community costs from $22 to over $39 million. The offsetting community costs would leave the net savings to the federal government under Option D at $8.4 million.

State Cost

The five-year state share of hospital costs under the status quo policy option would be $190 million. Under Option D this share would decrease to S170 million. However, the increase in costs of state support of community programs would be from $20 to $34 million under the same two policy options. Thus, under Policy Option D there would be a net saving for the state of around 6.7 million dollars, and the savings under Option B and C would be $800,000 and $3.6 million dollars respectively.

County Cost

Under each policy option the cost to county governments would increase. The current state policy does not charge counties for MR services used by their residents in state hospital facilities. Consequently, added costs reflect the fact that under Policy Options B, C and D more service will be provided outside the hospital where the cost to the community is greater.

Since the cost increase to county governments is a critical issue, the nature of the county cost increase is given in Table VI-19. Since Option A is the status quo, only Options B, C and D are discussed.

TABLE VI-19

STRATEGY ONE

COUNTY FIVE-YEAR PROJECTIONS
(dollars)

Option B	Total County Increase	= 952,000
	Residential Services Increase	= 164,000
	D.A.C. Increase	= 704,000
	Medical Cost Increase	= 32,000
	Social Services Increase	= 62,000
Option C	Total County Increase	= 3,883,000
	Residential Services Increase	= 666,000
	D.A.C. Increase	= 2,870,000
	Medical Cost Increase	92,000
	Social Services Increase	255,000
Option D	Total County Increase	= 6,883,000
	Residential Services Increase	= 181,000
	D.A.C. Increase	= 5,038,000
	Medical Cost Increase	162,000
	Social Services Increase	452,000

According to this analysis the additional cost for D.A.C. funding is clearly the critical issue. The cost of D.A.C.'s accounts for almost 70 percent of the county cost increases generated by these policy options. The implications of this funding problem are outlined in the discussion of Strategies Two and Three.

STRATEGY TWO: Arrange D.A.C. Funding to Guarantee a 43 Percent State Financial Participation in D.A.C. Service Cost.

As discussed under Strategy One, the current state financial participation in D.A.C. service cost is approximately 43 percent. By 1983 with the inflationary increases in cost and with more people being served in community programs under Option A the state share of D.A.C. cost will decrease to approximately 33 percent if no new state funds are allocated to that program. The state share in D.A.C. funds would decrease even further if Policy Options B, C or D are implemented since more people would be served in community facilities under those options than under Option A.

Under Strategy Two, it is proposed that the state share in D.A.C. cost be maintained at 43 percent. Under this strategy there are two distinct impacts that must be considered:

A. The impact on Policy Options A, B, C and D, and
B. The impact on the overall funding of D.A.C.

A. The state and county cost for each policy option shifts under this strategy. The federal cost remains the same as under Strategy One. The cost sharing among the federal, state and county governments is shown in Table VI-20.

TABLE VI-20

STRATEGY TWO

FIVE-YEAR COST SHARING
(Dollars)

Option A: Status Quo

Total Cost	= 475,527,000
Federal Share	= 257,795,000
State Share	= 211,454,000
County Share	6,278,000

Option B: Admissions Change

Total Cost	= 474,408,000
Federal Share	= 256,612,000
State Share	= 210,860,000
County Share	6,936,000

Option C: Admissions Change and Discharge Change I

Total Cost	= 471,004,000
Federal Share	= 252,996,000
State Share	= 209,053,000
County Share	= 8,956,000

Option D: Admissions Change and Discharge Change II

Total Cost	= 467,370,000
Federal Share	= 249,489,000
State Share	= 206,886,000
County Share	= 10,995,000

TABLE VI-21

STRATEGY TWO

FIVE-YEAR COST SAVINGS/INCREASES
UNDER EACH POLICY OPTION
(FROM STRATEGY ONE-OPTION A, NO CHANGES IN CURRENT POLICIES)

	FEDERAL	STATE	COUNTY
Option A (Status Quo)	$ 0	$ 533,000 (increase)	$ 583,000 (savings)
Option B	1,183,000 (savings)	1,818,000 (savings)	2,095,000 (increase)
Option D	8,306,000 (savings)	3,985,000 (savings)	4,134,000 (increase)

Source: Developed by Project Staff

The most important impact of Strategy Two would be to shift some of the D.A.C. costs which were the county's responsibility under Strategy One to the state government. Thus, while federal savings stay the same under both strategies, the county cost increase would be smaller and under Strategy Two the state cost saving would decrease.

B. The impact of Strategy Two on the overall funding of D.A.C. services is presented below.

The total annual state support for D.A.C. services is currently $6,07 million. This funding is not expected to increase. Additionally, S6.2 million of federal Title XX funds support D.A.C. services. Anticipated cost sharing under the current policies is shown in Table VI-22.

TABLE VI-22

FUTURE D.A.C. COSTS
UNDER PRESENT POLICIES - TOTAL COST
(millions of dollars)

	PROJECTED COSTS	FEDERAL SHARE TITLE XX	STATE SHARE	COUNTY SHARE
1980	$15.57	$6.2	$6.07	$3.3
1981	16.67	6.2	6.07	4.4
1982	17.15	6.2	6.07	4.9
1983	17.64	6.2	6.07	5.4
1984	18.15	6.2	6.07	5.9
TOTAL	85.2	30.3	31.0	23.9

Source: Developed by Project Staff

Thus, without any policy change the total county share of D.A.C. costs will increase 80 percent between 1980 and 1984.

In context of the current status quo (Strategy One) with no change in the present cost sharing and no increase in state support, the following cost projections are shown under each policy option.

TABLE VI-23

FIVE-YEAR COST SHARING FOR ALL D.A.C. SERVICES
UNDER EACH POLICY OPTION
(WITH NO INCREASE IN STATE FUNDING)
(millions of dollars)

	OPTION A (STATUS QUO)	OPTION B	OPTION C	OPTION D
County Share	$23.9	$24.6	$26.8	$28.9
State Share	30.0	30.0	30.0	30.0
Federal Share (Title XX)	31.0	31.0	31.0	31.0
TOTAL	$85.2	$85.9	$88.1	$90.2

Source: Developed by Project Staff

In the context of the status quo option, the state share of the D.A.C. cost is expected to drop below the present 43 percent to 36 percent in 1981. With no additional state funding this percentage is expected to drop in subsequent years.

In the context of Strategy Two, the cost sharing shifts from the local to the state government.

TABLE VI-24

FIVE-YEAR COST SHARING FOR ALL D.A.C. SERVICES
UNDER EACH POLICY OPTION (WITH 43 PERCENT STATE FINANCIAL PARTICIPATION IN PROGRAM COSTS)
(millions of dollars)

	OPTION A (STATUS QUO)	OPTION B	OPTION C	OPTION D
County Share	$18.5	$18.8	$20.1	$21.3
State Share	35.8	36.1	37.0	37.9
Federal Share (Title XX)	31.0	31.0	31.0	31.0
TOTAL	$35.2	$85.9	$88.1	$90.2

Source: Developed by Project Staff

This cost shift to 43 percent state funding of D.A.C. cost means an increase in the state appropriation. The projected annual increase necessary for this shift is shown in Table VI-25.

TABLE VI-25

STRATEGY TWO

APPROXIMATE INCREASE IN STATE SUPPORT
NEEDED EACH YEAR TO INSURE A 43 PERCENT STATE COST SHARE
UNDER EACH POLICY OPTION
(dollars)

(Status Quo)	OPTION A	OPTION B	OPTION C	OPTION D
Additional	$530,000	$530,000	$530,000	$530,000
Funding.	0	60,000	250,000	420,000
TOTAL	$530,000	$590,000	$780,000	$950,000

Conclusions Strategy Two

The county government cost increases realized under each policy option will be offset by an increase in overall state support of D.A.C. costs. The net cost saving to county government is shown in Table VI-26.

TABLE VI-26

STRATEGY TWO

FIVE-YEAR COUNTY GOVERNMENT COST FOR EACH POLICY OPTION
UNDER A SHIFT IN D.A.C. COSTS TO 43 PERCENT STATE SUPPORT
(millions of dollars)

	OPTION A	OPTION B	OPTION C	OPTION D
Cost Increase Under State Hospital Policy Changes From Table VI-18 of Strategy One	$ 0	$0.95	$3.88	$6.83
Total D.A.C. Cost Savings With a 43 Percent State Share of Cost From Tables VI-23 and VI-24	$5.4	$5.8	$6.7	$7.6
NET COST TO COUNTY GOVERNMENT	$5.4 (Savings)	$4.85 (Savings)	$2.82 (Savings)	$0.77 (Savings)

A net cost saving to the county government is realized for each policy option although the saving decreases under each successive policy. The reason it decreases under each successive policy is that the initial savings realized as the state D.A.C. share increases are offset by other residential costs as more people are placed in the community.

Table VI-27 shows the state government costs for each policy option under Strategy Two. The table shows that there is a net increase in cost under each policy option. This cost increase is despite savings realized as persons leave the state hospitals.

TABLE VI-27

STRATEGY TWO

FIVE-YEAR STATE GOVERNMENT COST FOR EACH POLICY OPTION
UNDER A SHIFT IN D.A.C. COSTS TO 43 PERCENT STATE SUPPORT
(millions of dollars)

	OPTION A (Status Quo)	OPTION B	OPTION C	OPTION D
Cost Savings Under State Hospital Policy Change From Table VI-18 Of Strategy One	$0.0	$0.89	$3.51	$6.68
Total D.A.C. Cost Increase With a 43 Percent State Share From Tables VI-23 and VI-24	$5.4	$5.8	$6.7	$7.6
NET COST TO STATE GOVERNMENT	$5.4 (increase}	$4.91 (increase)	$3.09 (increase)	$0.92 (increase)

STRATEGY THREE: Change the D.A.C. Reimbursement Mechanism so that the Cost of D.A.C. Services to Medicaid Eligibles is Included in the Medicaid-Reimbursed Residential Per Diem.

Of the 3,335 mentally retarded individuals currently receiving adult D.A.C. services, about half reside in DPW Rule 34 facilities. Nearly all of these facilities are certified as intermediate care facilties for the mentally retarded (ICF-MR's) and are eligible for reimbursement under Medicaid. Additionally, the regulations governing residential services under Medical Assistance mandate active treatment programs which must include both day programming and residential services for each individual in the facility. Thus, day programming and residential services are part of the active treatment program for mentally retarded individuals residing in these facilties.

In Minnesota this day programming is provided outside the residential facility and is not an allowable expense under Medicaid. However, it is clear that such a service is required by the federal regulations, and as part of the active treatment program for a mentally retarded individual, it can be reimbursed as part of the residential per diem.

Accordingly, it is recommended that the Minnesota Department of Public Welfare's reimbursement mechanism be restructured to include as part of the reimbursable per diem to DPW Rule 34 facilities the cost of developmental achievement activities. It is expected that the DPW Rule 34 residences will contract with the developmental achievement centers on an individuals basis and that this cost will be included as part of the per diem cost of service reimbursed to these facilities under the Department of Public Welfare's reimbursement Rule 52. Appendix E in the full report more fully explains this proposed change.

The implication of this shift in D.A.C. funding is to increase the residential per diem by an amount equal to the cost of the D.A.C. services to eligible individuals. The calculations that follow assume that one half of the adult D.A.C. services provided will be eligible for inclusion under the Medicaid-reimbursed residential per diem.

The cost sharing among the federal, state, and county governments in Strategy Three is shown in Table VI-29.

TABLE VI-29

STRATEGY THREE

FIVE-YEAR COST SHARING
(dollars)

Option A: Status Quo

Total Cost	= $475,527,000
Federal Share	= 261,501,000
State Share	= 211,337,000
Local Share	2,689,000

Option B: Admissions Change

Total Cost	= $474,408,000
Federal Share	= 260,705,000
State Share	= 210,731,000
Local Share	2,972,000

Option C: Admission Change and Discharge Change I

Total Cost	= $471,004,000
Federal Share	= 258,287,000
State Share	208,885,000
Local Share	= 3,832,000

Option D: Admissions Change and Discharge Change II

Total Cost	= $467,270,000
Federal Share	= 255,879,000
State Share	= 206,661,000
Local Share	4,710,000

Under this policy the federal government would pay a greater share of the cost than under the other two strategies. The shift in D.A.C. funding to Medicaid results in a net increase in cost to the federal government under each option. The total cost savings from the status quo under Strategy One decreases under this strategy.

TABLE VI-30

STRATEGY THREE

FIVE-YEAR COST SAVINGS/INCREASES
UNDER EACH POLICY OPTION
(FROM STRATEGY ONE OPTION A - NO CHANGE)

	FEDERAL	STATE	COUNTY
Option A (Status Quo)	$3,706,000 (increase)	$ 466,000 (increase)	$4,172,000 (savings)
Option B	$2,910,000 (increase)	$ 140,000 (increase)	$3,889,000 (savings)
Option C	$ 492,000 (increase)	$1,986,000 (savings)	$3,029,000 (savings)
Option D	$1,916,000 (savings)	$4,196,000 (savings)	$2,151,000 (savings)

This analysis shows that the largest net savings result from Option D under this strategy. As the options progress from A to D the federal government realizes a successively larger saving as persons are more rapidly discharged from state hospitals. These estimates assume that most of those people being discharged from state hospitals under these policy options will go to ICF-MR facilities and will, thereby, be eligible for medical reimbursement under this strategy. These estimates also assume that about 73 percent of the discharged residents are adults and will participate in adult D.A.C. services. These assumptions are based on historical data.

TABLE VI-31

STRATEGY THREE

FIVE-YEAR COST SHARING FOR ALL D.A.C. SERVICES
UNDER EACH POLICY Option
(WITH FEDERAL COST SHARING FOR MEDICAID ELIGIBLES AND NO NEW STATE FUNDS)

(millions of dollars)

	OPTION A (STATUS QUO)	OPTION B	OPTION C	OPTION D
County Share	$ 7.42	$ 7.99	$ 9.74	$11.45
State Share	30.3	30.3	30.3	30.3
Federal Share (Title XX)	31.0	31.0	31.0	31.0
Federal Share (Medicaid)	16.48	16.61	17.03	17.45
TOTAL	$85.2	$85.9	$88.07	$90.2

Source: Developed by Project Staff

The net cost savings realized under this strategy for each option are shown in Table VI-32.

TABLE VI-32

STRATEGY THREE

FIVE-YEAR COUNTY GOVERNMENT COST FOR EACH POLICY OPTION UNDER A PARTIAL SHIFT OF D.A.C. COSTS TO MEDICAID, STATE SUPPORT REMAINING CONSTANT FROM TABLE VI-31 and TABLE VI-26

(millions of dollars)

	OPTION A	OPTION B	OPTION C	OPTION D
Cost Increase Under State Hospital Policy Changes From Table VI-18 of Strategy One	$ 0	$ 0.95 (increase)	$ 3.88 (increase)	$ 6.83 (increase)
Total D.A.C. Cost Savings With a Shift to Medicaid and State Dollars Constant	$16.48 (savings)	$16.61 (savings)	$17.03 (savings)	$17.45 (savings)
Five-Year Net Savings To County Government	$16.48 (savings)	$15.66 (savings)	$13.15 (savings)	$10.62 (savings)

TABLE VI-33

STRATEGY THREE

FIVE-YEAR STATE GOVERNMENT COST FOR EACH POLICY OPTION UNDER A PARTIAL SHIFT OF D.A.C. COSTS TO MEDICAID, STATE SUPPORT REMAINING CONSTANT

(millions of dollars)

	OPTION A	OPTION B	OPTION C	OPTION D
Cost Savings Under State Hospital Policy Change From Table VI-18 of Strategy One	$ 0.0	$ 0.89 (savings)	$ 3.61 (savings)	$ 6.68 (savings)
Total D.A.C. Cost Increase With No New Additional State Support	$ 0.0	$ 0.0	$ 0.0	$ 0.0
Net Cost To State Under Each Policy Option	$ 0.0	$ 0.89 (savings)	$ 3.61 (savings)	$ 6.68 (savings)

Under this strategy county costs would decrease with each policy option. Similarly, the state would realize a net savings under each of the policy options. The state savings is due to state hospital cost savings because of decreases in population. At the same time the federal government cost increases. The total savings/increases for each level of government is shown in Table VI-34.

TABLE VI-34

STRATEGY THREE

TOTAL FIVE-YEAR COST SAVINGS FOR EACH LEVEL OF GOVERNMENT UNDER A PARTIAL SHIFT OF D.A.C. COSTS TO MEDICAID STATE SUPPORT REMAINING CONSTANT (millions of dollars)

	OPTION A	OPTION B	OPTION C	OPTION D
County Costs	$16.48 (savings)	$15.66 (savings)	$13.15 (savings)	$10.62 (savings)
State Costs	$ 0.0	$ 0.89 (savings)	$ 3.61 (savings)	$ 6.68 (savings)
Federal Costs	$16.48 (increase)	$15.43 (increase)	$12.23 (increase)	$ 9.14 (increase)

The federal increase is a function of increased federal participation in D.A.C. costs. These increases are offset by a decrease in the federal share of state hospital costs.

Under each policy option in Strategy Three, the state participation in D.A.C. costs is expected to remain at a five-year total of $30.3 million or about $6.07 million per year. Under current policies this state support is administered under the Grant-in-Aid program by the Minnesota Department of Public Welfare and is distributed by the Department to the D.A.C's. However, with the stipulation under this strategy of no new state dollars, some of the Grant-in-Aid money would shift to Medicaid as state matching. Therefore, the Grant-in-Aid program would be affected by an annual decrease of about $2.5 million. The Grants-in-Aid portion of D.A.C. support would decline from $6.07 million to $3.57 million annually. This shift would maintain the current level of state support.

Table VI-35 presents a modification of Strategy Three. The modification retains the Medicaid funding shift of Stragegy Three and also allows for a 43 percent state cost share of D.A.C. costs for the non-Medicaid eligible population.

TABLE VI-35 STRATEGY THREE

- MODIFIED

FIVE-YEAR D.A.C. COST SHARING FOR EACH POLICY OPTION WITH FEDERAL COST SHARING FOR MEDICAID ELIGIBLES AND A 43 PERCENT STATE COST SHARING FOR NON-MEDICAID ELIGIBLES

(millions of dollars)

	OPTION A	OPTION B	OPTION C	OPTION D
County Share	$ 2.45	$ 2.74	$ 3.59	$ 4.40
State Share	35.27	35.55	26.45	37.35
Federal Title XX	31.00	31.00	31.00	31.00
Federal Medicaid	16.48	16.61	17.03	17.45
TOTAL	$85.20	$85.90	$88.07	$90.20

Shifting to 43 percent state funding for the non-dicaid eligible group would give additional fiscal relief to county governments. Accordingly, the five-year total county cost would sharply decrease. This drop would effectively allow the counties to switch some of their Title XX federal matching funds from D.A.C. services to other social services. The five-year cost to county and state governments is shown in Table VI-36.

TABLE VI-36 STRATEGY THREE

- MODIFIED

FIVE-YEAR COUNTY GOVERNMENT COST FOR EACH POLICY OPTION UNDER A PARTIAL SHIFT OF D.A.C. COSTS TO MEDICAID AND 43 PERCENT STATE SUPPORT OF D.A.C. COSTS NOT REIMBURSED UNDER MEDICAID (millions of dollars)

	OPTION A	OPTION B	OPTION C	OPTION D
Cost Increase Under State Hospital Policy Changes From Table VI-18 of Strategy One	$ 0	$ 0.95 (increase)	$ 3.88 (increase)	$ 6.83 (increase)
Total County D.A.C. Savings With a Shift to Medicaid and a 43 Percent State Cost Share	$21.15 (savings)	$21.86 (savings)	$22.92 (savings)	$24.50 (savings)
Five-Year Net Savings To County Government	$21.15 (savings)	$20.91 (savings)	$19.04 (savings)	$17.67 (savings)

Under this strategy county cost would decrease with each policy option, and state cost would increase with each policy option. A net increase of $320,000 under Policy Option D would be the smallest net state increase. The cost to the federal government would increase to the same degree as in the unmodified Strategy Three (see Table VI-34). The total cost savings or increases for each level of government are shown in Table VI-37.

TABLE VI-37

STRATEGY THREE - MODIFIED

TOTAL FIVE-YEAR COST SAVINGS FOR EACH LEVEL OF GOVERNMENT UNDER A PARTIAL SHIFT OF D.A.C. COSTS TO MEDICAID AND 43 PERCENT STATE SUPPORT OF D.A.C. COSTS NOT REIMBURSED UNDER MEDICAID

(millions of dollars)

	OPTION A	OPTION B	OPTION C	OPTION D
County Costs	$21.15 (savings)	$20.91 (savings)	$19.04 (savings)	$17.67 (savings)
State Costs	$ 4.97 (increase)	$ 4.36 (increase)	$ 2.49 (increase)	$ 0.32 (increase)
Federal Costs	$16.48 (increase)	$15.43 (increase)	$12.23 (increase)	$ 9.14 (increase)

Conclusions - Strategy Three

Strategy Three would provide increased federal participation in D.A.C. costs which would eliminate the cost savings realized by the federal government as residents are discharged from state hospitals. The savings would be eliminated by increased federal participation in D.A.C. costs to Medicaid-eligible individuals living in ICF-MR's.

The state and county costs would vary under this strategy. With no increase in state funds, the state government depending on the policy option chosen would realize a five-year cost savings between 0.89 and 6.68 million dollars. The county government five-year savings would be between 16.48 and 10.62 million dollars depending on the option chosen.

If Strategy Three is modified and the state assumes 4 3 percent of the non-Medicaid eligible costs, the state savings would be eliminated and the state would realize a net five-year cost increase of between 4.97 and 0.32 million dollars depending on the policy option chosen. On the other hand, this state cost increase would be reflected as an additional decrease in county cost. Under this modification of Strategy Three the county government would realize a net five-year cost savings of between 21.15 and 17.67 million dollars depending on the policy option chosen.

1. There are cost savings associated with each of the four policy options presented. This section has analyzed each of these options and has developed three distinct strategies which provide a context for the implementation of these policy options.

2. It should be noted that the federal government would save money under each of the first two strategies and also under Option D of Strategy Three (see Table VI-30). At the same time the net cost to the federal government for service to the entire MR population living in the community increases under Option D, Strategy Three.

   However, this net increase is a function of the federal government taking on a new role — Medicaid participation in the cost of D.A.C.'s. This cost was formerly the responsibility of the state and counties. Thus, in the strict context of Policy Option D the federal government would save money under each strategy for the FM, FA/SP state hospital residents affected by the policy.

3. Under Strategy Three each level of government would realize a net cost saving in the context of Policy Option D. With this option the hospital populations would also be substantially reduced.

4. New D.A.C. program slots would have to be created under each policy option. Approximate numbers are shown in Table VI-33.

TABLE VI-38

PROJECTED NEW D.A.C. SLOTS REQUIRED FOR INDIVIDUALS DESIGNATED UNDER

EACH POLICY OPTION

	OPTION B	OPTION C	OPTION D
1980	50	77	126
1981	50	77	126
1982	50	77	126
1983	50	77	126
1984	50	77	126
TOTAL	250	385	630

These projected new slots would be used by that 73 percent of discharged state hospital residents or diverted state hospital admissions who do not receive educational services from local school districts. While data on D.A.C. utilization patterns is scarce, these projections assume that the additional discharges beyond those that would be

absorbed under the status quo projections would go to new D.A.C. slots. Further, information on current underutilization is insufficient to adjust this estimate of need.

5. It is anticipated that transportation expenses would increase beyond the present $2.6 million. Under Strategy Three there would also be federal Medicaid participation in the cost of transportation services. This participation would mean a federal cost share of $900,000 of the $2.6 million currently spent.

6. A certain number of new or old community residential beds must become available under each policy option. The current residential rate of development is 375 new beds per year. Since the residential care system seems to be approaching its optimal size, a reduced development of 300 new beds per year would meet all needs under the options discussed in this section.

I. COST OF RESIDENTIAL CARE FOR THE MENTALLY ILL Cost of Residential Care in State Hospitals.

In an earlier section of this report figures are developed for the cost of caring for a mentally ill resident in a state hospital. The analysis is based on 1977 data. Preliminary data for fiscal year 1978 shows a 16.3 percent increase. State hospital per diems for the mentally ill are:

STATE HOSPITAL PER DIEMS
$41.01 Fiscal Year 1977
$47.57 Fiscal Year 1978

Cost of Residential and Non-Residential Services in Community Facilities.

There are seven types of community residential facilities serving mentally ill persons. These types of facilities and the approximate number of mentally ill persons served in them at any given time are listed below:

TYPE OF FACILITY	UNDER 65 YEARS OLD	65 YEARS AND OLDER
DPW Rule 36 Facilities	253	131
Nursing Homes	1,290	11,610
Boarding Care Homes	944	1,356
Board and Lodging	850	262
Psychiatric Hospital Units	300	141
Adult Foster Care	500	250
TOTAL MENTALLY ILL IN COMMUNITY FACILITIES	4,134	13,747

Source: Minnesota Department of Health-Quality Assurance Review and Minnesota Department of Public Welfare-Mental Health Division August, 1978 Telephone Interviews with staff in the facilities

There are certain types of facilities and certain mental health program needs associated with each one of the facilities listed in this table. Based on information furnished by the Department of Public Welfare, Mental Health Division, mentally ill residents have been grouped according to mental health service needs, including the type of facilities most likely to be needed in order to offer them residential care. Table VI-39 summarizes that information and also presents projected fiscal year 1979 per diem costs for both the residential care (care given within the facility) and the support services (usually provided outside of the facility) whose costs are usually in addition to the residential per diem.

The service packages presented in Column D of Table VI-39 represent the most probable utilization pattern if non-residential mental health services are available to the mentally ill residing in different types of community facilities. The cost for these additional non-residential services is usually outside of the residential per diem charged by the facilities. It is important to note that residents in community facilities may or may not be receiving those additional services at the present time, but the assumption in this discussion is that they should receive those services, and, therefore, their cost must be taken into account. The unit cost for the additional services given in Column D has been adjusted for differential program use among resident populations and for a seven-day week.

TABLE VI-39

COST OF RESIDENTIAL AND NON-RESIDENTIAL SERVICES IN COMMUNITY FACILITIES FOR THE MENTALLY ILL

TYPES OF MI RESIDENTS ACCORDING TO NEED	COMMUNITY RESIDENTIAL FACILITY	PROJECTED FISCAL YEAR 1979 AVERAGE RESIDENTIAL PER DIEM	ADDITIONAL COST (Unit Cost)	
I. Mentally ill person who requires both semi-skilled or skilled nursing services and psychiatric services due to acute or chronic medical and psychiatric problems.	Nursing Home (ICF, SNF)	$27.50	In-house Mental Health Program. $10.00	
II. Mentally ill person who needs an intensive, structured residential mental health program.	1. DPW Rule 36 and some boarding facilities. 2. Psychiatric Unit	$22.00 $110.00	1. DPW Rule 36 .Vocational Program $ 3.25 .Social Services/ Case Management $1.50 .Transportation $ 0.80 . Medical Care & Medication $ 3.00	2. Psychiatric Unit 0
III. Mentally ill person who requires minimum supervision, but who needs to develop skills for a successful reintegration into the community	1. Group home/ Boarding Care 2 .Group apartment Living	$16.59 $13.75	1. Group Home Boarding Care . Day Treatment Center $ 7.14 .Vocational $ 3.25 .Social Services/ Case Management $ 3.00 .Transportation $ 1.35 . Medicare Care & Medication $ 3.00	2. Group Apartment Living .Day Treatment Center $7.14 .Vocational $3.25 .Social Services/ Case Management $3.00 .Transportation $ 1.35 . Medical Care & Medication $3.00
IV. Mentally ill person who requires minimum supervision, but for whom group living or treatment in a large facility may be threatening	1. Foster Home 2.Safe House	$13.75 $22.00	1. Foster Home .Day Treatment Center $ 7.14 .Vocational $ 2.32 .Social Services/ Case Management $ 2.00 .Transportation $ 1.35 . Medical Care & Medication $ 3.00	2. Safe House .Social Services/ Case Management $2.00 .Transportation $0.80 . Medical Care & Medication $ 3.00

Source: Developed by Project Staff

Total Cost of Residential and Non-Residential Services in Community Facilities.

The total per diem cost for each one of the levels is given in Table VI-40.

TABLE VI-40

TOTAL PER DIEM COST IN DIFFERENT TYPES OF COMMUNITY FACILITIES FOR THE MENTALLY ILL, IF A MENTAL HEALTH PROGRAM IS AVAILABLE. FISCAL YEAR 1979 PROJECTED COST

TYPE OF RESIDENT	AVERAGE PER DIEM	ADDITIONAL COST PER DAY	TOTAL PER DIEM
I.	$27.50	$10.00	$37.50
II.	1) $22.00	$ 8.55	$30.55
	2) $110.00	0	$110.00
III.	1) $16.50	$17.74	$34.24
	2) $13.75	$17.74	$31.49
IV.	1) $13.75	$15.81	$29.56
	2) $22.00	$ 5.80	$27.80

Source: Developed by Project Staff

The total per diem includes both program and maintenance costs and an additional cost for non-residential services. The additional cost was adjusted for each level of service and was based on the probable use of each service within each group. Adjustments were made for vocational programs, social service and case management, transportation services, and medical care.

Cost sharing among the federal, state, and county governments varies and depends on the types of community facility used and the client group served. In general, nursing care facilities are certified for Medical Assistance reimbursement (Title XIX). In those facilities, the cost of care to eligible persons including the residential care is reimbursed by Medical Assistance in the following manner: 55.26 percent federals, 40.26 percent state, 4.48 percent county. In certified psychiatric units the cost of care for eligible persons may also be reimbursed by Medical Assistance.

In all other types of community facilities, Medical Assistance can never be used to reimburse the cost of residential care, but Medical Assistance may reimburse the cost of providing outpatient medical and psychiatric service to

eligible residents. In those facilities the residential maintenance cost may be funded by a combination of Supplemental Security Income (all federal funds) and Minnesota Supplemental Aid (state and county funds), or by General Assistance (state and county funds). General Assistance Medical Care (state and county) may be used to provide outpatient medical and psychiatric services to General Assistance recipients. The residential program cost in these facilities may be paid for by social service monies (federal and county funds) or special state and county appropriations.

Mentally ill persons between the ages of 21 and 65 are not eligible for Medical Assistance to cover their residential care. Medical Assistance will cover the cost of residential care for Medical Assistance - eligible mentally ill persons over 65 years of age. Mentally ill persons under 21 are eligible for Medical Assistance for residential care only if they are receiving active treatment in a hospital unit accredited by the Joint Commission on Accreditation of Hospitals.

II. POLICY OPTIONS

Two policy options are analyzed in this report:

Option A: Status Quo - Leave the present policies of the residential care system for mental illness unchanged.

Option B: Length of Stay Policy Change and Admission Policy Change - Accelerate discharges from state hospitals, and reduce the number of admissions to state hospitals by promoting:

- Community residential programs for mentally ill persons who require minimum supervision and whose primary problem is that they need to develop or redevelop the social skills necessary to function more independently in the community, and

- Community support services such as case management, crisis management, and day treatment programs.

III. POPULATION PROJECTIONS UNDER EACH POLICY OPTION

Option. A: Status Quo Population Projections

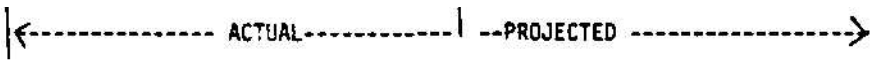
Table VI-41 gives the projected annual average population in state hospitals under this policy option. The table indicates that until fiscal year 1980, the average daily population will increase steadily in all the state hospitals to approximately one hundred more residents than in 1973. After fiscal year 1980, the mentally ill average daily population in state hospitals is projected to stabilize and remain stable through fiscal year 1984. In these projections, the current and future availability of community resources under the present system has been taken into consideration.

TABLE VI-41

POPULATION PROJECTIONS

AVERAGE DAILY HI POPULATION IN STATE HOSPITALS -
STATUS QUO POLICY OPTION A

	1977		1978		1979	1980	1981	1982	1983	1984
FACILITY	A.D.P.	Admission/ Discharge	A. D. P.	Admission Discharge	A.D.P.	A.D.P.	A.D.P.	A.D.P.	A.D.P.	A.D.P.
ANOKA	238	487/521	248	497/500	257	265	265	265	265	265
BRAINERD	57	307/315	67	282/257	71	75	75	75	75	75
FERGUS FALLS	130	313/320	131	417/371	133	135	137	139	139	140
MOOSE LAKE	174	349/341	155	303/297	158	160	160	160	160	160
ROCHESTER	241	796/823	226	882/710	258	290	290	290	290	290
5T. PETER	154	290/268	150	191/135	148	145	145	145	145	145
WILLMAR	324	395/439	316	356/360	323	330	330	330	330	330
TOTALS	1318	2937/3027	1293	292/2130	1348	1400	1402	1404	1403	1403



ADP = Average Daily Population

Source: Developed by Project Staff

Option B: Admission Policy Change and Length-of-Stay Policy Change Population Projections

This policy option proposes to reduce the number of admissions to the state hospitals' programs for the mentally ill. Underlying this policy option, there are two generally accepted tenets among mental health professionals:

- Admission into a mental health program should adhere to the concept of treatment in the least restrictive alternative which meets the patient's needs.

- The length-of-stay in inpatient settings should be minimal in order to avoid the development of unnecessary dependencies in the patient.

Two assumptions are implied in this policy option:

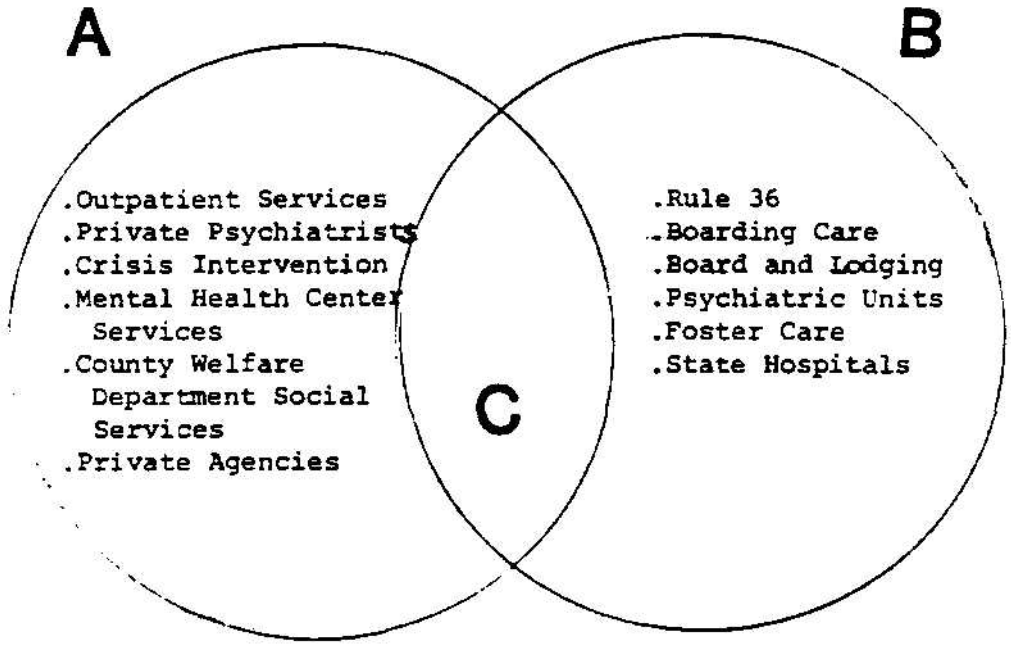
- Some mentally ill state hospital residents would not have been admitted to a state hospital had there been a less restrictive alternative and/or community support system to serve them.

- Some mentally ill state hospital residents stay in the state hospital longer than they need to stay because of the lack of transitional community programs.

Any policy option that attempts to change the current distribution of services in the mental health system confronts the problems of insufficient information and the absence of a model through which the present system can be conceptually understood.

The evidence now available suggests that in the State of Minnesota there are approximately 19,000 mentally ill persons who at any given time are placed in some type of out of home facility. If one subtracts from this number the mentally ill persons in nursing homes and the long-term residents (over 4 years) in state hospitals who are a stable population, there are approximately 6,000 mentally ill persons in state and community operated facilities who are moving through the residential care system at any given time. How these persons move in, through, and out of the system is not known with certainty, but limited information suggests there are really two mental health service systems which function independently of each other most of the time, but which may overlap at certain points in the treatment of some persons. The overlapping systems are graphically represented below.

APPENDIX A



The most critical characteristic of these two systems is the nature and size of the overlap. Ideally, System B should be a subsystem within System A. In other words, persons in System B would be integrated into the support services offered in System A. However, at the present time, it seems that many persons in System B have only sporadic contact or no contact at all with the services provided in System A. The way of moving out of System B, for most people, would be to move first into the overlapping area C and later into the non-overlapping part of System A.

The policy implications of this reasoning are:

1. Programs, not necessarily beds, should be concentrated in the overlapping area C.

2. The goal of those programs should be 1) to prevent admission into the residential system, and 2) to help persons in the interim period as they move from residential care into independent living.

3. The results of such actions should be a reduction in the length of stay in the residential system, and a reduction in the number of first admissions and readmissions into the system.

4. The following community programs are essential for a policy option aiming at reducing admissions to and accelerating discharges from the residential care system:

a. Community Support Services: Case Management, Crisis Management, and day treatment programs.

b. Community residential programs for mentally ill persons that require minimum supervision and whose primary problem is that they need to develop or redevelop the social skills necessary to function independently in the community.

The effect of this policy approach on the population of the state hospital programs for the mentally ill is analyzed below.

This policy option would affect both the number of admissions to the state hospital programs for the mentally ill and the average length of stay of all the state hospital mentally ill residents. The number of admissions would probably be reduced because the community support services would act as a buffer and persons that would be admitted to a hospital would go instead to other forms of care. The length-of-stay at state hospitals would also be reduced as the number of transitional community residential programs increases.

In projecting the average daily mentally ill population in state hospitals under this policy option, only the change in the number of admissions has been quantified. It was not possible, with the available information, to estimate the change in length-of-stay and, therefore, its effect on average daily population.

The admission groups most likely to be affected by the availability of the critical services previously listed are state hospital admissions coming directly into the hospital from their own homes and readmissions. These two groups are not mutually exclusive, of course, but the exact amount of the overlap could not be determined with the information now available. Fifty eight percent of the approximately 3,000 admissions to state hospital programs for the mentally ill come into the hospital directly from their own homes.

Under the policy option discussed here, the goal is to divert some of these state hospital admissions to community-based programs. A 28 percent reduction in the annual admissions to state hospital programs for the mentally ill has been chosen as a goal for this policy option. In other words, this policy option assumes that roughly one-half the admissions which come to the state hospitals without prior contact with community mental health agencies could be diverted from the state hospitals. This reduction percentage was chosen because 1) it is feasible in terms of the development of community services necessary *to* support the policy, and 2) some experiments in Kentucky and Colorado

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indicate that screening of state hospital admissions results in over 50 percent of the admissions being diverted to other forms of care.

In terms of the state hospitals' mentally ill population, the above policy means that 850 admissions annually would be diverted from the state hospital programs for the mentally ill. This reduction in the number of admissions would result in a decrease in the average daily mentally ill population in state hospitals of 16 percent. Therefore, by 1984 the average daily mentally ill population would be about 1,17 8 residents, down from the 1,400 residents projected under the status quo Option A. Table VI-42 gives the total projected average population in state hospitals through fiscal year 1984 under Policy Option B.

TABLE VI-42

PROJECTED AVERAGE DAILY POPULATION
IN STATE HOSPITALS' MENTAL ILLNESS PROGRAMS
UNDER THE ADMISSIONS POLICY CHANGE

Fiscal Year	Average Daily Population
1980	1176
1981	1178
1982	1179
1983	1178
1984	1178

Source: Developed by Project Staff

IV. COST PROJECTIONS UNDER EACH POLICY OPTION

Policy Option A. Status Quo Cost Projections

Table VI-43 gives the projected total cost of programs for the mentally ill in state hospitals through fiscal year 1984, assuming that present policies of the state hospital system remain the same.

The following assumptions were made in order to develop the projections in Table VI-43,

- The annual increase in total cost was assumed to be 14 percent. That is, from one year to the next it would cost 14 percent more to serve the same number of patient days.

- Each patient day increased annually in the state hospital programs for the mentally ill can be served at 7 0 percent of the per diem cost estimated for that year. This is possible because of economy scale.

- For each patient day decreased in the state hospital programs for the mentally ill, 80 percent of the per diem cost associated with that day of service can be saved by the state hospitals.

- The above assumptions are based on historical data from fiscal years 1977 and 1978. See Section III of the full report, "Cost of Patient Care in a State Hospital," for an explanation of the procedure used to arrive at these numbers.

TABLE 43

TOTAL PROJECTED COST OF THE STATE HOSPITALS MENTAL ILLNESS PROGRAMS UNDER THE STATUS QUO POLICY OPTION A (dollars)

FISCAL YEAR	TOTAL COST	TOTAL PATIENT DAYS	PER DIEM COST
1977 (actual)	23,805,402	580,478	41.01
1978 (actual)	27,088,118	569,437	47.57
1979	31,799,945	593,659	53.57
1980	37,692,191	616,560	61.13
1981	43,012,074	617,441	69.66
1982	49,082,736	618,322	79.38
1983	55,922,395	617,881	90.51
1984	63,751,530	617,881	103.18

Source: Projections Developed by Project Staff.

Note: Approximately 15 percent of the state hospitals' mental illness program expenditures are reimbursed by non-state sources.

Policy Option B. Admission Policy Change Cost Projections.

When compared with the population projections under the Status Quo Policy Option A, the population projections given in Table VI-42 represent a total annual reduction of approximately 81,760 patient days in the state hospital programs for the mentally ill.

In estimating cost associated with reduced state hospital populations an adjustment must be made which changes the unit cost of hospital service to an incremental cost. Thus, while the average cost of a day of state hospital service may be $57.00, the actual savings if this day were removed would be less, say $45.00, minus any new costs incurred in the transfer. This difference is important since there are certain fixed costs, such as operations, maintenance and administration, which will not decrease as rapidly as the population decreases. As discussed previously1 approximately 80 percent of the per diem cost is saved by state hospitals on each patient day removed from the hospital. Table VI-44 presents the annual savings in the state hospitals' budget which would result from removing 81,760 annual patient days from the hospitals, taking into consideration fixed costs and inflation.

TABLE VI-44

REDUCTION OF STATE HOSPITALS' BUDGETS AND POPULATIONS DUE TO THE ADMISSIONS POLICY CHANGE

FISCAL YEAR	TOTAL PATIENT DAYS UNDER STATUS QUO POLICY OPTION	TOTAL PATIENT DAYS UNDER ADMISSION POLICY CHANGE	(dollars) TOTAL PROJECTED COST UNDER STATUS QUO POLICY OPTION	(dollars) TOTAL PROJECTED COST UNDER ADMISSION POLICY CHANGE	(dollars) REDUCTION IN STATE HOSPITAL BUDGET
1980	616,560	543,800	37,692,191	33,790,244	3,901,947
1981	617,441	535,681	43,012,074	38,565,398	4,446,776
1982	618,322	536,562	49,082,736	44,015,052	5,067,684
1983	617,861	536,121	55,922,395	50,144,167	5,778,228
1984	617,88I	536,121	63,751,530	57,201,961	6,549,569

Source: Developed by Project Staff

1 See Section III, "Cost of Patient Care in a State Hospital" the full report.

Table VI-44 indicates that under the Admission Policy Change, a reduction in state hospital patient days of approximately 13 percent could be achieved resulting in about 10 percent savings in the state hospitals budget.

Table VI-45 presents the total cost of the community-based programs needed for implementing this option. Under this option, 850 admissions annually would be diverted to some type of community programs. In estimating the annual cost of serving those 850 diverted admissions in community-based programs, the following assumptions have been made:

- All 850 admissions diverted from state hospitals would go into some type of community-based residential program. This assumption prevents the underestimation of cost.

- The community-based residential programs would be group homes, boarding care homes, foster homes, or safe houses.

- These persons would not be diverted to a more intensive level of residential care since by definition these persons were diverted from the state hospital because they needed a lower level of care.

- The average length-of-stay in these community residential programs would range from 14 days in a safe house to 5 months in a group home or boarding care facility. Since there is no available information to determine the proportion of persons who would go to each type of facility, an overall average length-of-stay of 3 months is assumed. This assumption will prevent the underestimation of the cost of community-based programs.

TABLE VI-45

ANNUAL COST OF SERVING 850 ADMISSIONS DIVERTED
FROM STATE HOSPITALS TO COMMUNITY-BASED PROGRAMS

		Total	Federal	State	County
1980	Residential Services	1,354,903	136,663	$69,874	649,366
	Medical Services	238.374	31,625	175,590	31,159
	Social SERVICES/CASE MANAGEMENT	231,591	85,689	12,042	133,858
	Vocational	236,193	177,145	59.048	0
	Day Treatment	$18,900	191,993	26,983	399,924
	Transportation	103,537	38,309	5,384	59,944
	TOTAL	$2,683,496	$661,424	$848,921	$1,173,151
1981	Residential Services	1,544,590	144,863	655,123	744,604
	Medical Services	271,746	36,053	200,173	35,520
	Social Services/Case Management	364,014	97,686	13,730	152,598
	Vocational	269,260	201,945	67,315	0
	Day Treatment	591.546	118,873	30,760	341,913
	Transportation	1,180,032	43.671	6,138	
	TOTAL	$3,059,188	S743,092	$973,239	$1,342,857
1982	Residential Services	1,760,833	153,555	752,635	354,643
	Medical Services	309,790	41,100	228,197	40,493
	Social Services/Case Management	300,976	111,362	15,652	173,962
	Vocational	306,956	230,217	76,739	0
	Day Treatment	674,362	249,515	35,066	389,781
	Transportation	134,556	49,786	6,997	77,773
	TOTAL	$3,487,473	$835,535	$1,115,286	$1,536,652
1983	Residential Services	2,007,350	162,769	864,146	980,435
	Medical Services	353,161	46,854	260,145	46,162
	Social *Services/Case Management*	343,113	126,953	17,843	198,317
	Vocational	349,930	262,447	87,483	0
	Day Treatment	768.773	284.448	19.975	444.350
	Transportation	153,394	56,756	7,977	88,661
	TOTAL	$3,975,721	1940.227	$1,277,569	$1,757,925
1984	Residential Services	2,288,379	172,534	991,638	1,124,207
	Medical Services	402,603	53,413	296,565	52,625
	Social Services/Case Management	391,148	144,726	20,341	226,081
	Vocational	398,920	299,190	99,730	0
	Day Treatment	876,400	324.270	45,572	506,558
	Transportation	174,969	64,702	9,093	101,074
	TOTAL	$4,532,319	$1,058,835	$1,462,939	$2,010,545

Source: Developed by Project Staff

Comparing Tables VI-44 and VI-45, one can see that diverting 850 admission annually from the state hospitals would result in savings of over one million dollars each year. From fiscal year 1980 to fiscal year 1984 this policy option will save over $8 million in the cost of caring for those diverted admissions. Furthermore, the cost of community-based programs is overestimated since it is assumed that 1) all the diverted admissions would go to community residential care, in other words, none would be handled as out-patients, and 2) the average length-of- stay in the community programs would be three months which means that roughly half of the diverted admissions would go to safe houses for short-term crisis management with an average length-of-stay of 14 days, and the other half would go to other types of group care with an average length-of-stay of five months. Based on incomplete evidence available from other states (Kentucky and California)[2] and the experience in the Minnesota state hospitals, it seems that the split between those going into short term care and those going to longer-term care is likely to be closer to 75 percent short-term and 25 percent long-term.

In order to interpret the estimates presented in Tables VI-44 and VI-45, an important consideration must be taken into account; that is, it may be difficult to target community programs specifically on potential state hospital admissions. One extreme approach to solve this implementation problem may be to provide enough services to serve both the potential state hospital admissions and persons who would not be admitted to state hospitals regardless of the existence of the programs. This approach would represent a substantial increase in the number of patient days that would have to be provided in the community. This approach would be particularly expensive if new programs such as safe houses are created. Definitive information on the proportion of community residential care services consumed by state hospital type residents is not available. However, based on data from a survey conducted in September, 1977, by the Department of Public Welfare and data from the Minnesota Department of Health, Quality Assurance Review, it seems that if an approach in which new residential services are created to serve a target subpopulation of the state hospitals is taken in the absence of any screening, it would be necessary to offer approximately three times the amount of services that would be consumed by the 'target subpopulation. The cost, therefore, would be approximately three times higher than the one estimated in Table VI-45 in the case of new services. This situation is usually referred to as the "woodwork phenomena" and simply stated it means that whenever new services are created for a known target population, the services will create a demand that goes beyond the target population and will draw from populations which are not included in the original needs assessment.

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2 Sundel, [Martin, Rhodes, Gary, Ferguson, Elizabeth, Hospital and Community Psychiatry "The Impact of a Psychiatric Hospital Crisis Unit on Admissions and Use of Community Resources". September, 1978, pp. 569-571.

One approach which may be used to minimize the effect of the "woodwork phenomena" would be to screen the potential admissions to the new services in order to assure maximum use of the services by the intended target population. In the specific policy option being considered, it means that only admissions coming to state hospitals from their own homes would be diverted into the new services for screening and intervention. For example, a crisis unit could be created as a joint venture of the area mental health center and state hospital to screen state hospital admissions. If this approach or a similar one is taken, then the community cost would approach the minimum cost computed in Table VI-45.

Between these two approaches, no screening versus elaborate screening, there are intermediate approaches that could be taken. The breakeven point, that is, the point at which the savings in the state hospitals budget equals the cost of the additional community-based program, occurs when 69 percent of the new service slots are taken by the target population of diverted state hospital admissions. In other words, persons coming from the "woodwork" must consume only 31 percent of the services in order for this policy option to be cost-effective.

POLICY OPTIONS FOR THE CARE OF THE CHEMICALLY DEPENDENT, POPULATION AND COST PROJECTIONS

This section compares the cost of caring for the chemically dependent persons in both state hospitals and community-based facilities. It is divided into four parts:

I. COST OF RESIDENTIAL CARE FOR THE CHEMICALLY DEPENDENT.

- .Cost of residential care in state hospitals.
- .Cost of residential care in community facilities.
- .Cost of non-residential services provided to residents of community facilities.

II. POLICY OPTIONS

III. POPULATION PROJECTIONS UNDER EACH POLICY OPTION

IV. COST PROJECTIONS UNDER EACH POLICY OPTION.

I. COST OF RESIDENTIAL CARE FOR THE CHEMICALLY DEPENDENT Cost of

Residential Care in State Hospitals

In an earlier section of this report figures are developed for the cost of caring for a chemically dependent resident in a state hospital. This analysis is based on 1977 data. Preliminary data for fiscal year 1978 shows a 16 percent increase. State hospital per diems for the chemically dependent are:

STATE HOSPITAL PER DIEMS	
Fiscal year 1977	$39.50
Fiscal year 1978	$45.82

Cast of Residential Care in Community Facilities

In an earlier section of this report the per diem cost of non-hospital based community residential facilities for the chemically dependent in each of the state hospitals receiving districts are given. These facilities include Department of Public Welfare Rule 35 facilities for primary, intermediate and extended care, free standing detoxification centers, and detoxification centers which are attached to licensed DPW Rule 35 primary care facilties.

The average per diem costs of non-hospital based community facilities for the chemically dependent are as follows (as of August, 1978):

	Statewide Average	Range
Non-Hospital Based Detox/Primary Care	$50.73	$35 - $70
Halfway House/ Extended Care	$20.39	$ 9 - $49

Cost of Non-Residential Services Provided to Residents of Community Facilities

Non-residential services offered to residents of community facilities vary widely depending on the philosophy of treatment and on the availability of other service resources. As a minimum, medical and social services are considered to be essential to any chemical dependency program. Employment services and vocational rehabilitation services are part of many programs, but their usage is more limited to

halfway house and extended care programs. The most probable pattern of non-residential service use was developed by interviewing selected facilities throughout the state and is summarized below:

MOST PROBABLE UTILIZATION PATTERN

Type of Care	Non-Residential Services
Primary Care	.Medical, dental, psychiatric and psychological services. .Social Services such as information and referral, placement, aftercare and family services.
Halfway/ Extended Care	.Medical, dental, psychiatric and psychological services. .Social services such as information and referral, placement, aftercare and family services. .Employment and vocational services. .Educational Services

The cost of these non-residential services is outlined in Table VI-46. The figures have been prepared by prorating the total cost of the service over the length-of-stay in the program and adjusting for the use of the service within each type of program. The figures were also checked against a three-county case record examination which provided additional information on use of medical and social services.

TABLE VI-46

THE COST OF NON-RESIDENTIAL SERVICES FOR CHEMICALLY DEPENDENT PERSONS IN COMMUNITY FATUITIES Fiscal Year 1978

PER DIEM COST IN DOLLARS

NON-RESIDENTIAL SERVICES	TYPE OF RESIDENTIAL COMMUNITY		
	Primary Care	Halfway House	Extended Care
Medical Services	4.25	2.06	2.06
(includes medical, dental, psychiatric and psychological services)	.82	.25	.25
Social Services			
Educational Services		.78	.78
Employment/Vocational Services	5.07		
TOTAL		.30	.30

Source: Telephone interviews with selected facilities and three-county, case record examination.

II. POLICY OPTIONS

Two policy options are presented in this section:

A.) Status Quo - Continuation of present chemical dependency policy through 198 4.

B.) Discharge Policy Change - Decrease the projected average daily population in the state hospitals chemical dependency programs by 11 percent by preventing persons that go through the state hospitals primary care program from staying in the hospital while receiving transitional {halfway house) services.

III. POPULATION PROJECTIONS UNDER EACH POLICY OPTION.

Option A: Status Quo Population Projections - Under Option A, the chemically dependent population in state hospitals is projected to increase slightly through 1984 (Table VI-47). This projection may not be an accurate indicator of demand for the state hospitals' chemical dependency services since the projection is constrained by availability of state hospital space and staff and administrative decisions that tend to limit the growth of state hospital programs.

TABLE VI-47
STATUS QUO POPULATION PROJECTIONS - CHEMICALLY DEPENDENT
(AVERAGE DAILY POPULATION)

	1977		1978		1979	1980	1981	1982	1983	1984
FACILITY	A.D.P.*	Admissions/ Discharges	A.D.P	Admissions Discharges	A.D.P.	A.D.P.	A.D.P	A.D.P.	A.D.P	A.D.P.
Anoka	74	710/698	88	703/690	90	90	90	90	90	90
Brainerd	41	537/526	42	591/561	44	45	45	45	45	45
Fergus Falls	103	885/876	128	965/944	129	130	130	130	130	130
Moose Lake	135	1214/1245	158	1590/1476	158	159	160	150	160	160
Rochester	30	405/428	37	512/463	50	60	50	50	50	50
St. Peter	39	400/393	42	374/375	44	46	48	49	50	50
Willmar	96	936/973	105	907/900	no	115	120	120	120	120
TOTAL	518	5092/5124	600	5561/5409	625	635	643	644	645	645
	← ACTUAL →					PROJECTED →				

Source; Developed by Project Staff.

* A.D.P. = Average Daily Population

Table VI-47 indicates that most chemical dependency programs in state hospitals will show no significant variation in size over the next five years. This projection, of course, assumes no changes in current policy.

Option B: Discharge Policy Chance Population Projections -Under this policy option the chemically dependent average daily population in state hospitals would be reduced by eliminating a percentage of the extended care beds. This option would reduce the total number of chemical dependency beds by 70 across the state hospitals and would eliminate 25,545 patient days of chemical dependency service in the state hospitals annually.

The rationale for Policy Option B is as follows:

.Transitional extended care programs in community-based facilities are less expensive than similar programs in state hospitals.

.Sixteen percent of the state hospitals chem-ically dependent residents participate in extended care programs with a duration of 3 to 6 months. It is estimated that 7 3 percent of these residents (i.e., those in residence for 3 to 4 months) could be appropriately served by community-based halfway residential care programs. If these residents were to be served in community programs, the average daily population in state hospitals would decrease by approximately 11 percent. It is important to clearly distinguish between extended care residents who are chronic alcoholics and need long-term treatment and those who have a need for several months of post-primary extended care while making the transition from primary care to the community. This policy option recommends that only persons who need transitional extended care would be moved into community-based facilties, that is, halfway houses.

.The state hospitals would continue to have viable extended care programs for nine percent of the resident population needing increased levels of medical care and supervision. It is estimated that for this group of extended care residents community-based facilities costs would not be significantly less expensive than the state hospitals' cost. Furthermore, there is currently a shortage of community-based facilities established to serve the chemically dependent persons in need of long-term care for a chronic disability.3

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3 .This was the position taken by the Residential Care Study Advisory Council and was repeated to the Project Staff by the Chief Executive Officers of state hospitals.

IV. COST PROJECTIONS UNDER EACH POLICY OPTION POLICY Option A:

Status Quo Cost Projections

The projected cost through 1984 for the status quo Policy Option A is presented in Table VI-48. In projecting these costs the following assumptions were made:

.State hospitals' cost would increase at an annual rate of 14 percent. Therefore, to serve exactly the same number of patient days will cost 14 percent more than the previous year.

.Each annual patient day increased in the state hospitals' programs for the chemically dependent would cost approximately 70 percent of the hospitals' per diem at that time. This is possible because of economies of scale.

.The state hospitals would save approximately 80 percent of the per diem when a person is discharged.

.These assumptions are based on historical data from fiscal years 1977 and 1978. See Section III of the full report, "Cost of Patient Care in a State Hospital," for an explanation of the procedure used to arrive at these numbers.

TABLE VI-48

PROJECTED TOTAL COST OF STATE HOSPITALS' CHEMICAL DEPENDENCY PROGRAMS UNDER STATUS QUO POLICY OPTION A
(dollars)

FICAL YEAR	TOTAL ANNUAL COST	TOTAL ANNUAL PATIENT DAYS	PER DIEM COST
1977 (actual)	9,217,523	233,355	39.50
1978 (actual)	12.384.917	270.295	45.82
1979	14.530.591	281.558	51.60
1980	16.763.653	286.385	58.54
1981	19.279.097	289.993	66.48
1982	22.002.096	290.444	75.75
1983	25.109.649	290.895	86.31
1984	28,624,999	290,895	98.40

Source: Developed by Project Staff

Note: A Legislative Audit Commission Report on Chemical Dependency Services in the State of Minnesota estimates that 15 percent of the total state hospital CD Cost is reimbursed by non-state sources.

The coat projections presented in Table VI-48 indicate that the total state hospital cost for chemical dependency services will double between 1979 and 1984. During the same period of time the chemically dependent population in state hospitals is projected to increase by three percent. Therefore, most of the cost increase projected is due to inflation.

POLICY OPTIONS FOR THE CARE OF THE MENTALLY ILL, POPULATION AND COST PROJECTIONS

This section compares the cost of caring for mentally ill persons in both state hospital facilities and in community-based facilities. It is divided into four parts:

I. COST OF RESIDENTIAL CARE FOR THE MENTALLY ILL.

- .Cost of Residential Care in State Hospitals.
- .Cost of Residential and Non-Residential Services in Community Facilities.
- .Total Cost of Residential and Non-Residential Services in Community Facilities.

II. POLICY OPTIONS.

III. POPULATION PROJECTIONS UNDER EACH POLICY OPTION.

IV. COST PROJECTIONS UNDER EACH POLICY OPTION.

Option B: Admission Policy Change Cost Projections

Under this policy option, there would be an estimated 25,545 fewer patient days of chemical dependency services in the state hospitals. The reduction in patient days would occur exclusively in the extended care programs. Since the cost of primary care is considerably higher than extended care cost, it is necessary to adjust the projected chemical dependency per diem upwards to reflect the higher cost which would result when the less expensive extended care patient days are subtracted from the total cost. However, since there would be fewer total patient days in the state hospitals, the total chemical dependency program cost in the state hospital would be less expensive under this policy option than under the Status Quo Policy Option. Table VI-49 presents the projected cost of the state hospitals chemical dependency programs under the Status Quo Policy Option and the Discharge Policy Change and the projected savings in the state hospitals' budgets resulting from implementing the Discharge Policy Change. The same assumptions employed for estimating cost under the Status Quo have been made in estimating the cost presented in Table VI-49.

TABLE VI-49

PROJECTED STATE HOSPITAL SAVINGS
UNDER THE DISCHARGE POLICY CHANGE

	A	B	C	D	E
FISCAL YEAR	PROJECTED TOTAL STATE HOSPITAL COST UNDER STATUS QUO POLICY OPTION	OVERALL PER DIEM STATUS QUO	PROJECTED TOTAL COST UNDER DISCHARGE POLICY CHANGE	OVERALL PER DIEM UNDER POLICY CHANGE	SAVINGS IN STATE HOSPITAL COST(A-C)
1980	16,763,653	58.54	15,589,805	59.76	1,173,848
1981	19,279,097	66.48	18,118,169	68.51	1,160,923
1982	22,002,096	75.75	20,679,368	78.06	1,322,728
1983	25,109,649	86.31	23,602,573	88.94	1,507,076
1984	23,624,999	99.40	26,908,333	101.40	1,715,666

Source: Developed by Project Staff.

Table VI-50 lists the estimated costs of moving the 25,545 extended care patient days to community halfway houses. Table VI-50 also projects the estimated federal, state and county costs which would be required to pay for the halfway house community costs. Unless the state is willing to finance a portion of the increased county costs under the Discharge Policy Change, it is highly unlikely that the counties would agree to implement this option. Therefore, in developing in implementation plan, careful attention would need to be given to increasing chemical dependency grant-in-aids to Community Mental Health Centers or other forms of state financial relief to counties for their increased extended care costs

TABLE VI-50

COST PROJECTIONS UNDER POLICY OPTION B
PLACING 25,545 EXTENDED CARE PATIENT DAYS
IN COMMUNITY-BASED HALFWAY HOUSES

YEAR	SERVICE	DOLLAR AMOUNT	UNIT COST	FEDERAL SHARE	STATE SHARE	COUNTY SHARE	PRIVATE FEES
FY 1980	Residential	$701,156	$24.69	$160,840	$96,432	$325,100	$118,784
	Medical Services	75,275	2.65		67,748	7,527	---
	Social Services	8,520	.30	3,153	443	4,924	---
	Voc. Rehab/Employment	24,139	.85	18,104	6,035	—	---
	Education	9,372	.33	4,828	3,692	852	
	SUBTOTAL	$818,462		$186,952	$174,350	$338,403	$118,784
FY 1981	Residential	$796,316	$27.14	$182,675	$109,517	$369,210	$134,912
	Medical Services	89,187	3.04	--	80,277	8,920	---
	Social Services	9,683	.33	3,583	503	5,597	---
	Voc. Rehab/Employment	27,287	.93	20,465	6,822	---	---
	Education	10,563	.36	5,442	4,161	960	---
	SUBTOTAL	$933,046	-	$212,167	$201,280	$384,687	$134,912
FY 1982	Residential	$903,575	$29.85	$207,279	$124,269	$418,943	$153,083
	Medical Services	105,672	3.49	---	95,105	10,567	---
	Social Services	10,900	.36	4,033	566	6,300	---
	Voc. Rehab/Employment	30,884	1.02	23,163	7,721	---	---
	Education	12,111	$ .40	6,239	4,771	1,101	--
	SUBTOTAL	$1,063,142	-	$240,714	232,432	$ 436,911	$153,083
FY 1983	Residential	$1,026,080	$32.84	$235,383	$141,117	$475,742	$173,838
	Medical Services	125,291	4.01	---	112,762	12,529	---
	Social Services	12,498	.40	4,625	649	7,224	---
	Voc. Rehab/Employment	34,994	1.12	26,246	8,748	---	---
	Education	13,747	44	7,082	5,415	1,250	---
	SUBTOTAL	$1,212,610	---	$273,336	$268,691	$496,745	$173,838
FY 1984	Residential	$1,164,211	$36.12	$267,071	$160,113	$539,737	$197,240
	Medical Services	148,588	4.61	---	133,729	14,859	---
	Social Services	14,182	.44	5,248	737	81,907	---
	Voc.Rehab/Employment	39,645	1.23	29,734	9,911	---	---
	Education	15,472	.48	7,970	6,095	1,407	
	SUBTOTAL	$1,382,097	----	$310,023	$310,585	$564,251	$197,240
TOTAL 1980-1984		$5,409,357		$1,223,165	$1,187,338	$2,220,997	$777,857

Source: Developed by Project Staff

VII. RECOMMENDATIONS

Comparison of Status Quo Policy Option to Discharge Policy Change

Table VI-51 gives the total cost for the Status Quo Option, the total cost (state hospital plus community cost) of the Discharge Policy Change, and the net savings resulting from implementing the Discharge Policy Change. The latter policy option would result in lower total cost to serve the same number of chemically dependent persons. Although the cost difference for any one year does not exceed $400,000, over the five years 1980-1984 the Discharge Policy Change has projected total costs which are $1,470,651 less than the cost under the Status Quo. Furthermore, only 15 percent of the state hospitals chemical dependency costs are reimbursed by non-state resources, when the focus of care is moved to community-based facilities, approximately 78 percent of the cost-of-care is reimbursed by non-state sources. These non-state sources are the federal government which would reimburse approximately 2 3 percent of the cost, private fees reimbursing approximately 14 percent of the total cost, and counties which would be responsible for approximately 41 percent of the total cost. Therefore, a shift to community-based programs would improve collections from non-state sources, but unfortunately a large proportion of the financial burden would be shifted to county governments.

TABLE VI-51

COMPARISON OF COST UNDER TWO POLICY OPTIONS

(dollars)

	OPTION A	OPTION B					
	STATE HOSPITAL COSTS UNDER STATUS QUO POLICY OPTION	STATE HOSPITAL COSTS UNDER DISCHARGE POLICY CHANGE	DIFFERENCE IN S.H. COSTS BETWEEN POLICY OPTION A & B	COST OF 25,545 EXTENDED CARE PATIENT DATS IN COMMUNITY	TOTAL COSTS OF POLICY OPTION A	TOTAL COST OF POLICY OPTION B	DIFFERENCE IN TOTAL COSTS BETWEEN POLICY •Options A + B
1980	16,763,653	15,589,805	1,738,848	818,462	16,763,653	16,408,267	355,386
1981	19,279,097	18,118,169	1,160,928	933,046	19,279,097	19,051,215	227,882
1982	22,002,096	20,679,368	1,322,728	1,063,142	22,002,096	21,742,510	259,586
1983	25,109,649	23,602,573	1,507,076	1,212,610	25,109,649	24,815,183	294,466
1984	28,624,999	26,908,333	1,715,666	1,382,097	28,624,999	28,291,430	333,569
TOTAL COST SAVING			6,880,246				1,470,651

Availability of Halfway House Beds in the Community

Under the Discharge Policy Change 25,545 patient days of extended chemical dependency care would be moved from state hospital programs to community-based facilities, specifically halfway houses. It is necessary to examine the number and utilization rates of halfway houses in the community in order to determine whether these additional extended care needs could be met by the existing community halfway houses.

In fiscal year 1978, the statewide occupancy rate of halfway houses averaged about 81 percent4, and approximately 183 persons were on the waiting list to be admitted to particular facilities. However, the concern under this policy option is that persons discharged from state hospitals' chemical dependency primary care programs in specific areas of the state have community facilities within a reasonable distance. Examining the number of persons in each hospital who composed the 11 percent of chemically dependent residents in fiscal year 1977 who would be discharged into the community under this policy, it can be determined that approximately the following numbers of people would be discharged from each state hospital each year from 1980 to 1984: Willmar-66; St. Peter-17; Rochester-21; Anoka-78; Moose Lake-83; Fergus Falls-35; and Brainerd-4.

Using the actual occupancy rate of halfway houses in 1978, the total number of halfway house beds which were not used was calculated. It was determined that approximately 134 beds of the 769 average number of halfway house beds in fiscal year 1978 were not occupied. It cannot be assumed that all of these unoccupied beds could be filled by state hospital discharges because of overlapping resident turnover which reduces the actual number of beds available for use. Also, because admission policies in halfway houses vary, it is not clear that all state hospital discharges would be acceptable to community halfway houses.

The number of unoccupied beds in halfway houses was calculated by state hospital receiving districts to determine which areas might have the greatest difficulty placing persons in community halfway houses given existing development of facilities. Based on the number of unoccupied halfway house beds, the following numbers of persons could be served annually in existing halfway houses in the state hospital receiving districts: Anoka-108; Brainerd-26; Fergus Falls-36; Moose Lake-7 month average length-of-stay.

Comparing the number of unused halfway house beds currently in specific state hospital receiving districts with the number of potential state hospital discharges needing transitional care, it can be seen that Moose Lake and Willmar State Hospitals' receiving districts are the only two receiving districts which fall considerably short of the half-

4Department of Public Welfare Chemical Dependency Program Division review of Community programs, July, 1978.

way house beds required to meet the estimated need resulting from an increase in state hospital discharges. The Fergus Falls State Hospital receiving district would probably need additional halfway house beds to serve the extended care needs of its state hospital discharges.

RECOMMENDATIONS: POLICY OBJECTIVES AND IMPLEMENTATION ACTIONS

The previous section of this report analyzed a number of policy options for the residential care of mentally retarded, mentally ill, and chemically dependent persons. The options presented do not exhaust all the possibilities, but they represent the most likely alternatives given constraints in funding and manpower and trends in treatment programs. Eight policy options were analyzed — four for the care of the mentally retarded and two each for the care of the mentally ill and the chemically dependent. Additionally, this study has identified certain implementation issues, such as the economic impact of the state facilities on the local economies, the dislocation of state hospital staff which may be caused by changes in resident population, and the state capital investment in the facilities, which must be taken into consideration when selecting a policy direction.

The recommendations which will be presented in this section are the result of reviewing and evaluating the policy options in the context of the following criteria:

- Most effective use of resources in both the private and the public sectors.
- Most effective treatment in the context of the least restrictive environment.
- No increase in the projected cost to state and county governments.

This section presents recommendations for each disability group in two areas:

1. Policy Objectives
2. Implementation Actions

Recommendations concerning special programs, staff issues, capital investment and monitoring are also presented.

. Accelerate discharges from state hospitals of fully-mobile, fully-ambulant severely or profoundly mentally retarded residents with no major behavior problems so that by 1984 few, if any, of these residents are served in state hospitals.

.Divert potential state hospital admissions of the target population to community facilities.

.Reduce the average daily population of mentally retarded residents in state hospitals to 1,897 residents, down from a projected 2,435 residents by fiscal year 1984 if the status quo were to prevail.

Implementation Actions:

.Target development of intermediate care facility-mentally retarded (ICF/MR) beds to state hospital receiving districts which will be affected the most by the acceleration in discharges, namely Faribault, Cambridge; Brainerd, and St. Peter. The following number of ICF/MR beds must become available for the target group statewide during the five year implementation period:

1980	1981	1982	1983	1984
290 beds	283 beds	266 beds	252 beds	246 beds

The Advisory Council recommendations regarding programs for the men-

These beds may be newly created or existing beds. It is estimated that new ICF/MR bed development must proceed at approximately 300 beds per year (current rate) through fiscal year 1984. If more existing ICF/MR beds become available, through, for example, the creation of a semi-independent living alternative, the number of new beds needed each year would decrease.

.The reimbursement mechanism under the Department of Public Welfare Rule 52 for ICF/MR's should be amended to allow the inclusion of day programming in developmental achievement centers as part of the residential per diem. This recommendation will serve to reduce the cost of' state and county government.

.Transportation services offered to ICF/MR residents participating in day programming at developmental achievement centers should likewise be included in the residential per diem reimbursed under DPW Rule 52. The cost of these services is currently being funded 100 percent by the state.

.Admission criteria to state hospitals should be revised in order to insure that fully-mobile, fully-ambulant severly or profoundly mentally retarded persons are admitted to community residents rather than to state hospitals whenever possible.

.A five year plan should be developed by each state hospital for the discharge of fully-mobile, fully-ambulant severely or profoundly mentally retarded state hospital residents.

RECOMMENDATIONS: MENTAL ILLNESS

This study recommends diverting from state hospitals all admissions which can be appropriately served in community-based programs and reducing the length-of-stay of mentally ill state hospital residents. This policy recommendation is analyzed in detail in Section VI of this report under Policy Option B for the residential care of mentally ill persons. These policy recommendations which require the screening of state hospital admissions and prompt discharge upon completion of treatment provide for better placement decisions and more effective use of limited mental health resources. Additionally, the recommendations coincide with the recommendations of the Residential Care Study Advisory Council.6

Policy Objectives:

.Divert from state hospitals all admissions which can be appropriately placed in community-based programs so that by 1984 1) there are 850 fewer annual admissions to the state hospitals programs for the mentally ill and 2) the average daily population of state hospital mentally ill residents is decreased to 1,176 residents, down from a projected 1,400 residents in 1984.

.Continue to minimize, the length-of-stay in the state hospitals programs for the mentally ill in order to prevent the development of unnecessary dependencies in the client.

.DEVELOP A fiscal relief plan for county governments which provides increased state participation in the cost of the critical services to the mentally ill which are outlines in the Implementation Actions.

Implementation Actions:

.The Mental Health Bureau of the Department of Public Welfare should establish as its priority the development of a) day programming, b) crisis management, c] case management services, and d) residential programs for mentally ill persons needing minimum supervision. The distribution of these services should conform to population needs in different areas of the state as measured by the use of state hospitals and the proportion of at-risk populations (see Section IV in the report). The goal of these services should be to prevent admission to more restrictive. treatment settings and to accelerate discharges from the residential care system. These services should be part of a local mental health plan, and state hospitals should deliver the services only if it is considered appropriate by the authority in charge of implementing the local plan.

[5] Ibid.

. *In order to achieve the reduction in average daily population recommended under the policy objectives, at least 20 beds in a safe-house or crisis home setting are needed statewide to provide services to 425 diverted state hospital admissions, assuming an average length-of-stay of 14 days per resident.*

. *Two hundred community residential care beds are needed statewide to provide services to another 425 diverted state hospital admissions with an average length-of-stay of five months per resident. The latter level of care IS needed for men-tally ill persons who require minimum supervision while they are acquiring those social skills essential for independent living. In order to sup-port these residential programs, it is estimated that 160 day treatment program slots are needed statewide.*[7]

In the absence of any screening, state hospital residents or potential residents must compete for community residential services with other mentally ill persons who would never use state hospital services. Based on limited information, two out of every three residential program slots created in the community for mentally ill persons are taken by persons who do not use the state hospital system. This data suggests that the level of service that must be created in the community in order to assure that the target population will be reached may be considerably higher (approximately 3 times higher) than the minimum level given above, unless screening for these services is available. The breakeven point, that is, the point at which the savings at the hospitals equal the expenditures in the community occurs when 69 percent of the community program slots go to the diverted state hospital admissions and 31 percent go to other non-state hospital groups. Since target effectiveness is such an important factor in future program cost, it is recommended that:

. *Community residential services created under this policy should give priority for admissions to persons who are directly referred by the state hospitals or* who *would otherwise go to a state hospital.*

. *The state hospital should institute intake procedures to review all cases prior to admission so that appropriate referrals to other less* restrictive *alternatives are made whenever possible. These screening services should pay special attention to individuals coming to the state hospital with no prior contact with community mental health agencies. The results of the intake screening should be made a permanent part of the patient's records, and future quality control reviews should comment on the hospital's performance in this area.*

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7. See Section VI of this report, "Policy Options for the Care of the Mentally Ill" for detailed description of these services and their cost.

.*The state hospitals should use their experience in the intake screening process to provide an annual report on mental health service gaps to the Department* of *Public Welfare and to regional and county authorities involved in mental health planning. This report should* be *taken into consideration by state, regional and county agencies responsible for mental health planning and resource allocation.*

. *In the context of a declining population, the Mental Health Bureau in the Department of Public Welfare should strengthen quality control mechanisms in order to monitor quality of CARE in state hospitals. There should be special emphasis on the appropriateness of the initial placement and the subsequent length-of-stay.*

The community services outlined in the recommended policy option would cost a minimum of $848,921 in state funds and $1.2 million in county funds in fiscal year 1980. In the same fiscal year, projected savings in the state hospital system under the recommended policy option would approach 53.3 million. It is recommended that:

.*The state develop a fiscal relief program which would effectively transfer a portion* of *those savings to the counties in order to assist in the funding of community residential and support services.*

RECOMMENDATIONS: CHEMICAL DEPENDENCY

This study recommends leaving present state hospital policies unchanged and projects an average daily state hospital census of 645 chemically dependent residents in 1984 (Policy Option A, Section VI). However, it is also recommended that community programs be strengthened, thereby preventing unnecessary growth in state hospital programs and helping to stabilize their size.

Since differences between the state hospital and the community programs are few, the comparative cost of service has been the primary consideration in making these recommendations. Specifically, state hospital-based primary care is considerably less expensive than similar programs in community hospitals. It is also competitive with non-hospital-based primary care programs in the community. Therefore, the state hospitals provide primary treatment programs that are cost effective and comparable to those offered in the community.

Under these recommendations the extended care programs in the state hospitals would remain unchanged. The state hospitals would continue to provide extended care services to the very disabled individuals for whom community placement has failed or is not cost effective. However, this study has found that the limited development of halfway house transitional programs in some receiving districts has impeded the rapid discharge from the state hospital system of those people ready to move into the community. In contrast with primary care treatment, halfway house services are less expensive in community settings, and programmatically it is generally more appropriate to provide these services in community-based programs where it is easier to use other community resources, such as employment services.

The recommendations presented here coincide with those developed by the Residential Care Study Advisory Council.[8]

Policy Objectives:

. *Maintain the state hospital's present involvement in chemical dependency pro-grams and promote the stabilization* of *the size of the programs at the project*-ed fiscal *year 1980 - 1984 average, dally population levels of 600 to 645 residents.*

These recommendations are contained in the "Report of the Residential Care Study Advisory Council" which may be requested from the Department of Public Welfare, Office of Policy Analysis and Planning.

Implementation Actions:

.The state hospitals chemical dependency programs should not act unilaterally in planning and executing new services, but should work in concert with related area mental health boards and county welfare departments in assessing needs and developing the re-sources necessary to meet those needs.

.Future allocation of chemical dependency funds for residential programs should have as their first priority the development of aftercare programs in the Moose Lake, Willmar and Fergus Falls State Hospitals' receiving districts. The design of those programs should take into consideration the difficulty of providing follow-up services to a widely scattered rural population which may require innovative approaches to assure that the programs are accessible.

RECOMMENDATIONS: SPECIAL PROGRAMS

Various special programs for different subgroups within each disability group are currently operated by the state hospitals. Some of these programs serve specific age groups such as geriatric and adolescent residents, others serve populations with specific problems such as dependency on narcotics. In some cases, the programs serve statewide populations with very specialized needs such as the behavior modification program at the Minnesota Learning Center in Brainerd State Hospital.

Without a detailed assessment of the specialized needs met through these programs, it is not possible to produce specific recommendations pertaining to each one of them. This study has identified, however, certain general guidelines necessary to assure the proper use of state resources when meeting special needs. Therefore, it is recommended that the Department of Public Welfare:

. *Review, in conjunction with state hospitals and local planning bodies, special programs currently operating in the state hospital system in order to deter-mine the target populations served, their need for the expansion or reduction of each program, their cost effectiveness, their programmatic appropriateness, and their accessibility to the population in need.*

.*Modify the special programs currently operated by the state hospital system to conform to the conclusions reached by this review.*

. *Institute administrative mechanisms to insure that the addition of new special programs and changes in the size of cur-RENTLY operated special programs in the state hospital system are the result of joint planning by the state hospital, the area board, and the county welfare departments affected by the program.*

. *Place emphasis on reviewing, following the above process, special state hospital programs for adolescents in order to determine the appropriateness of their size and program content, and their cost effectiveness. Insure that special programs for adolescents in state hospitals:*

-*Protect the adolescent's rights to treatment in the most appropriate setting to meet his/her needs as determined in the in-dividualized treatment plan.*

-*Promote continuity of care and integration of services to the adolescent and his/her family by requiring the state hospital staff to work closely with other community resources in the development and fulfillment of the individualized treatment plan.*

-*Insure that all adolescents placed in the state hospital system will be treat-ed in programs designed to meet the special needs of that population group.*

.*Evaluate the feasibility of developing state-operated or privately-operated geriatric psychiatric nursing homes to meet the special needs of aged mentally ill persons in need of long-term care for severe mental illness.*

Under the status quo and with no change in policy, it is projected that there will be a decline in the state hospital population. In 1984, even while meeting the more stringent staffing requirements of Welsh vs. Dirkswager and given no change in the staffing requirements of the mental illness and chemical dependency programs, 200 fewer employees will be needed than in 1978. With the changes in policy recommended here, the population decline will be accelerated. Under the policy options recommended for the three disability groups, 600 fewer employees will be needed by fiscal year 1984 than in fiscal year 1978. These estimates are not adjusted for the probable effect of attrition in the context of a change in hiring policy. Therefore, it is recommended that:

.The Department of Public Welfare should develop a plan to coordinate staff needs with the projected decline in resident populations at state hospitals.

.As a minimum this plan should specify the hiring policy to be followed by each state hospital when replacing employees who leave the hospital each year as part of the normal turnover. The normal turnover rate in state hospitals at the present time is approximately 10 percent. It is estimated that turnover replacement policy that allows an annual replacement hiring of approximately two-thirds of the turnover will resolve the staff surplus problem created by a declining patient population. However, since the turnover rate varies among employee classifications, the specific turnover rate for each employee classification must be taken into consideration when developing a turnover replacement policy.

The state hospital staff because of their specialized training and established relationship with the residents may be the most appropriate persons to provide aftercare services to discharged residents in certain cases. Taking into consideration the great benefits that may result to discharged residents in terms of continuity of care, it is recommended that the policies of the Department of Public Welfare:

. Allow state hospital staff to participate in the. provision of aftercare services when that participation is considered to be essential for the discharged resident's adjustment as determined in the individualized treatment plan.

In the context of a 27 percent decline in population in the state hospital system fay 1984 as a result of the policy recommendations, it may be possible to close one or more state hospital campuses. A discussion of closure, however, may be premature. The important issue is whether the existing facilities can efficiently phase down their operation to keep pace with the projected decline in resident population. This level of efficiency is generally expressed as the percent of the per diem saved when a day of service is removed from the hospital. This study has indicated that currently 80 percent of the state hospital per diem is saved, on the average, when a person is discharged from the state hospital system.

If a high degree of efficiency during the phase down can be maintained without affecting the quality of service, the issue of whether or not a facility should be completely closed need not be raised. At the same time, if any facility becomes inefficient it should be closed and the remaining residents transferred. Thus, it is recommended that the Department of Public Welfare:

.Develop a cost accounting system that clearly:

1. *identifies all cost associated with hospital services,*

2. *separates fixed costs from variable costs, and*

3. *attaches costs and services to disability groups and to sub-groups within the disability groups.*

.Establish an ongoing mechanism to insure that as a minimum the 80 percent per diem savings resulting from discharges is maintained in each state hospital. This mechanism should:

1. *specify the most efficient employee allocation patterns,*

2. *specify the most efficient campus size and use of facilities, and*

3. *specify future patterns of capital improvement and remodeling.*

RECOMMENDATIONS: MONITORING COMMUNITY PROGRAMS

With the anticipated increased demand for community-based programs resulting from the recommended policy changes, the protection of the residents' rights to quality care in the community is of paramount importance. Therefore, it is recommended that the Department of Public Welfare:

.Assure continued quality of community programs by emphasizing compliance with the Department's program rules.

.Allocate funds necessary for the Department of Public Welfare to monitor program outcomes and to define the concept of treatment success in residential facilities.

.Assure the availability of well publicized and readily accessible complaint mechanisms to all residents of community-based facilities. The complaint mechanism should provide for appeals to be heard by the Department of Public Welfare with final appeal to the courts.