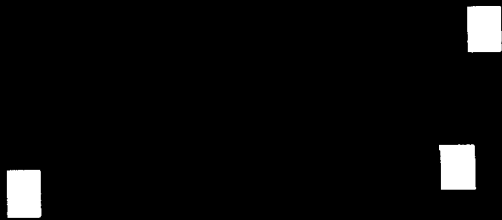
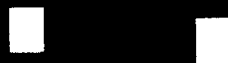


MINNESOTA'S STATE HOSPITALS



- mental retardation
 - mental illness
 - chemical dependency
-



MINNESOTA'S STATE HOSPITALS

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January 31, 1985

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FERGUS FALLS

BRAINERD

MOOSE LAKE

CAMBRIDGE

WILLMAR

ANOKA

ST. PETER

FARIBAULT

DEFINITIONS

Deinstitutionalization

(1) preventing admission of people to public residential facilities by finding and developing alternative community residential facilities; (2) returning to community residential facilities all public residential facility residents/patients who have been prepared through programs of habilitation and training to function in appropriate local settings; and (3) establishing and maintaining responsive residential environments which protect human and civil rights and which contribute to expeditious return of the individual to normal community living whenever possible.

Patients

people with chemical dependency or people with mental illness receiving services from state hospitals.

Residents

people with mental retardation living in state hospitals.

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BACKGROUND OF THIS REPORT

In 1984, the Minnesota Legislature established an "interagency board to be known as the institutional care and economic impact planning board" and directed the board to conduct a comprehensive study to provide information on topics to include, but not be limited to the following:

1. Projected displacement of state hospital employees because of deinstitutionalization by number, location, and job classification;
2. The extent to which displacement can be mitigated through attrition, retirement, retraining, and transfer;
3. The development of cooperative arrangements between the state and local units of government in the carrying out of these goals;
4. The necessary changes in the biennial budget to effect any fiscal and policy recommendations of the plan;
5. The necessary interagency agreements among and between appropriate departments and agencies as needed to effect recommendations contained in the plan; and
6. The energy efficiency of all state hospital buildings.

The Legislature also directed the interagency board to develop a plan for protecting the general interests of employees and communities affected by the reduction of state hospital population and specifying methods for assuring minimal impact on the economic life of communities affected by the changes.

These actions by the Legislature were based on a recognition that "closure and consolidation of state hospitals have negative economic effects upon public employees and communities." The Legislature stated, "It is the policy of the state that deinstitutionalization policies shall be carried out in a manner that ensures fair and equitable arrangements to protect the interests of employees and communities affected."

A series of recent actions preceded this decision and set the context:

- In 1980, the *Welsch vs. Noot Consent Decree* called for the placement of hundreds of mentally retarded residents in community-based facilities.
- In 1982, the Rochester State Hospital was closed as part of an effort to reduce state spending because of an economic recession.

- In December 1983, the Title XIX (Medicaid) home and community based waiver application was prepared which called for further reduction in the mental retardation population of state hospitals.

HISTORY OF THE STATE HOSPITAL SYSTEM

The care and treatment of Minnesotans with mental illness, mental retardation and chemical dependency has been an ongoing policy issue. The first institutions were developed as places to put people who were seen as "defective" or "insane." The intent was to isolate people and protect society from them. There were hopes that such actions would also result in treatment and cure. The number of hospitals and the number of Minnesotans placed in them continued to grow. By 1960, the State of Minnesota operated 11 state hospitals. On any given day, there were approximately 16,000 people who were residents and patients in those hospitals.

The development and evolution of the state hospital system have resulted in a complex organization involving many interest groups. Parallel developments in social policy and court decisions had a major impact on patients and residents and those with a direct interest in the future of the hospitals. The result has been:

- Local communities have become economically dependent on hospital operations.
- Employees of state hospitals organized to improve their working conditions and protect job security.
- Taxpayers expressed growing concern with government spending as costs of long term care increased rapidly.
- Statutes and court decisions called for patients and residents to be supported in the least restrictive environment.
- The community system of services has not been completely developed.

The current state of affairs—a large but much reduced state hospital system and the interaction of differing and sometimes competing interests—has resulted from 120 years of changes in philosophy, treatment approaches, and public policy.

1900 State Asylums for the Insane opened at Anoka and Hastings.

1861 Institute for the Education of the Deaf and Dumb established in Faribault.

1907 State Tuberculosis Sanatorium opened at Walker.

Minnesota State Institution for the Education of the Deaf & Dumb, and the Blind, Faribault ca 1870



Minnesota Historical Society

1863 School for the Deaf established in Faribault.

1911 The Asylum for the Dangerously Insane opened on the St. Peter State Hospital Campus (50 patients). Later, the name was changed to Minnesota Security Hospital.

"First Minnesota Insane Hospital," St. Peter ca 1868

1864 School program established in Faribault as the Institute for the Deaf, Dumb and Blind; 1902—name changed to Minnesota School for the Blind; 1940—Name changed to Braille and Sight Saving School.



Minnesota Historical Society

1866 Minnesota Hospital for the Insane established at St. Peter. Opened in December, 1867 for 50 mentally ill patients. State training school called House of Refuge established in St. Paul for boys and girls.

1879 Hospital for the Insane opened at Rochester (68 mentally ill patients transferred from St. Peter).

1911 Gillette State Hospital for Crippled Children opened in St. Paul.

1912 Willmar Hospital Farm for Inebriates opened.

1881 Legislature directed that the School for Idiots and Imbeciles be connected with the Institute for Deaf, Dumb and Blind. In 1887, the school was made a department of the Minnesota Institute for Defectives (largest state

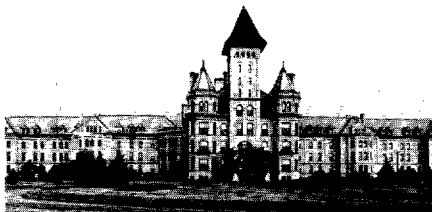
1917 Mentally ill patients admitted to Willmar State Hospital.

institution). Present name is Faribault State Hospital.

1925 Cambridge School and Hospital for Mentally Deficient and Epileptics opened.

1885 State School for Dependent Children established at Owatonna.

Fergus Falls State Hospital ca 1913



St. Paul Dispatch-Pioneer Press

1890 Fergus Falls Hospital for the Insane opened. (Eighty patients transferred from St. Peter.)

1938 Moose Lake State Hospital for the Insane opened.

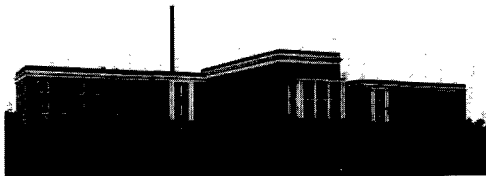
1950 Sandstone State Hospital for the Insane established. (It was converted into a federal prison 1959.)

1971 Rochester State Hospital designated as the surgical center for the Department of Public Welfare, and the only other remaining surgery unit in the state hospital system at Anoka closed.

1955 Lake Owasso Annex (to Cambridge State Hospital) established for mentally retarded children.

1972 Minnesota Residential Treatment Center for children at Anoka State Hospital closed.

Minnesota Colony for Epileptics, Cambridge ca 1925



Minnesota Historical Society

1973 Responsibility for Gillette Children's Hospital removed from the State Department of Public Welfare and transferred to the Gillette Hospital Authority.

1958 Brainerd School and Hospital for mentally retarded people opened.

Right to treatment in state hospitals established by state law.

1961 State geriatric facilities opened at Ah-Gwah-Ching and Oak Terrace, former tuberculosis facilities.

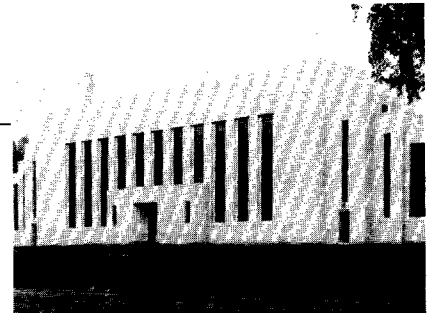
Mental retardation program opened at Willmar State Hospital.

1963 State residential treatment center for emotionally disturbed children opened at Lino Lakes.

1975 Sex offender treatment program established at Minnesota Security Hospital.

1968 Unit for mentally retarded people established at St. Peter State Hospital.

St. Peter State Security Hospital ca 1940



Minnesota Historical Society

1969 Mentally retarded residents from Faribault State Hospital transferred to a newly established unit at Rochester State Hospital.
Mental retardation unit opened at Moose Lake State Hospital.

1976 Lake Owasso Children's Home transferred from Cambridge State Hospital to Ramsey County.
Glen Lake Sanatorium no longer provided services for tuberculosis.

1970 Unit for chemically dependent people established at St. Peter State Hospital. Owatonna State School closed. Students not returned to the community were transferred to Brainerd State Hospital.

1977 The Minnesota School for the Deaf and the Braille and Sight Saving School, on the Faribault State Hospital campus, transferred to the Department of Education.

Minnesota Learning Center established at Brainerd State Hospital.
Minnesota Residential Treatment Center for emotionally disturbed children was transferred to Anoka State Hospital from Lino Lakes.

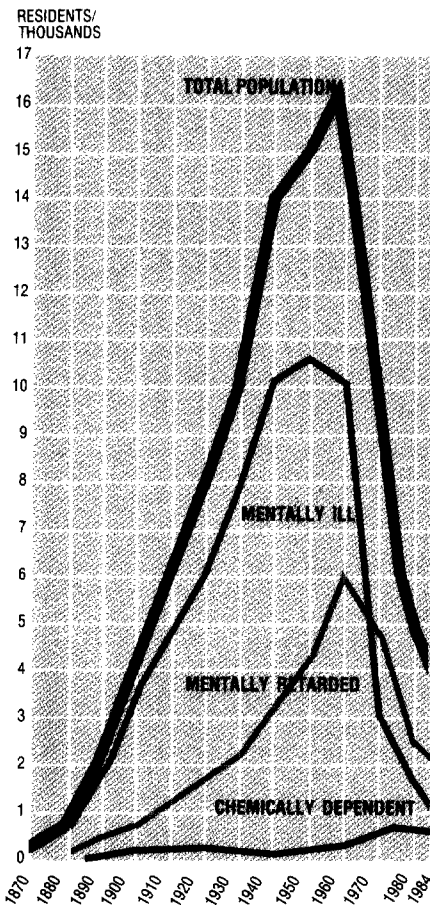
1978 Hastings State Hospital closed.
Legislature approved the construction of a new 165-bed security hospital on the St. Peter campus.

1971 Establishment of programs for mentally ill and chemically dependent people at Brainerd State Hospital.
Tuberculosis unit at Anoka closed.

1982 Rochester State Hospital closed.

FIGURE 1

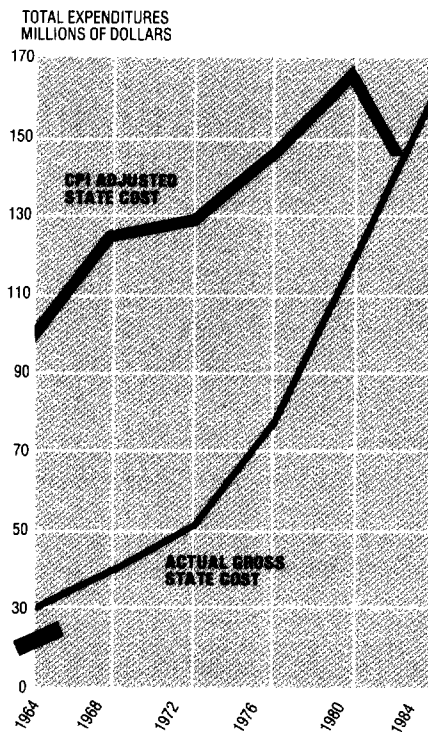
Changes in Mentally Ill, Mentally Retarded and Chemically Dependent State Hospital Populations, 1870-1984



SOURCE: Department of Human Services "Resident Population of State Institutions at End of Fiscal Years"

FIGURE 2

Gross State Cost for Minnesota State Hospitals 1965 through 1984 in Actual and CPI Adjusted Dollars (October 1983)



SOURCE: Department of Human Services

The Minnesota state hospital system can be put in historical perspective by summaries of 1) facility, organization and service development; 2) number of people served and 3) gross state cost of the state hospital system.

State institutions have had a dynamic history. Facilities have opened, closed, and reorganized. The types of programs offered as well as the geographic area served by each state hospital have also changed. Increasingly, hospitals have become multipurpose facilities, serving persons with acute and/or chronic mental illness, mental retardation, and chemical dependency. Minnesota currently operates eight state hospitals located in Anoka, Brainerd, Cambridge, Faribault, Fergus Falls, Moose Lake, St. Peter and Willmar.

The number of people with mental illness and mental retardation served by state hospitals grew rapidly and continuously until about 1960. (Figure 1) Recent patient/resident population trends indicate that:

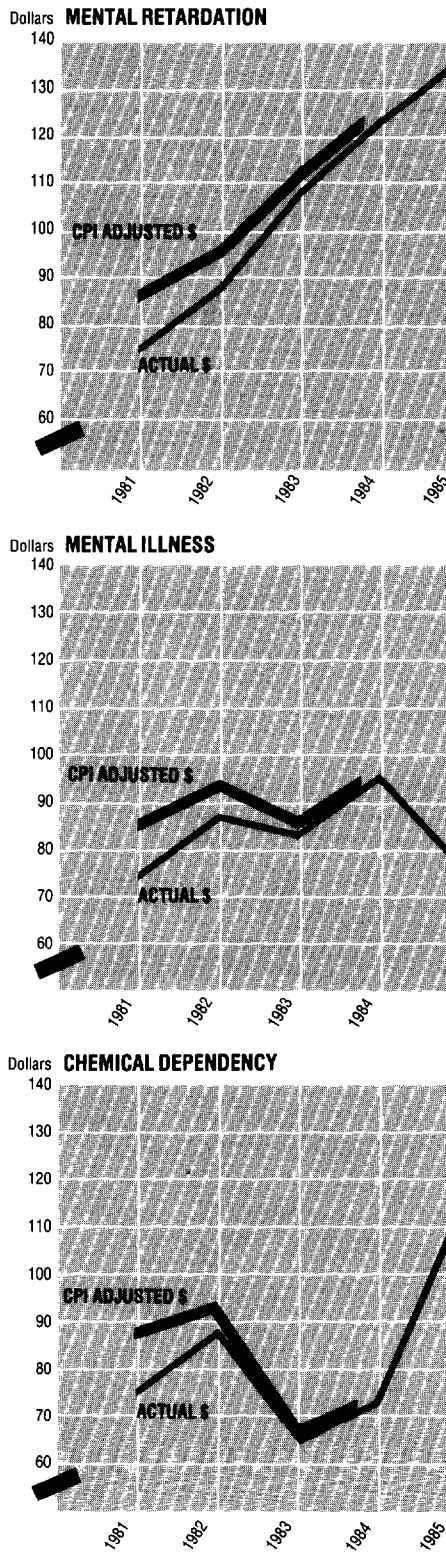
- Total state hospital population has dropped from 16,355 in 1960 to 4,006 in 1984, a decline of 75 percent.
- Patients with mental illness dropped from 10,093 in 1960 to 1,230 in 1984, a decline of 88 percent. Development of new drugs since 1950 has enabled many mentally ill people to return to their communities. In addition, greater attention has been paid to patients' rights and services in the community have developed.
- Residents with mental retardation dropped from 6,008 in 1960 to 2,182 in 1984, a decline of 64 percent. Reduction in the number of residents with mental retardation was required by the Welsch vs. Levine Consent Decree and facilitated by the availability of community-based facilities. Full implementation of the Consent Decree would further reduce the number of residents with mental retardation to 1,850 by 1987.
- The average daily population of patients with chemical dependency rose from 254 in 1960 to 594 in 1984, an increase of 134 percent. The average daily population with chemical dependency reached a peak in 1980 with 637 people. The increase in this group of patients is associated with heightened social and legal concern for alcohol and drug abuse and dependency.

Gross state cost combines all financial resources used by the state hospital system including operating expenditure, indirect expense, bond interest and depreciation. Offsetting cash receipts are not deducted from the gross cost. Annual gross state costs of the state hospital system are depicted for Fiscal Years 1965 through 1984 in Figure 2. Comparisons of actual gross costs from year to year are not valid because of the effects of inflation. The "constant" dollar trend line in Figure 2 shows actual gross costs adjusted to October 1983 values using the Consumer Price Index. Actual gross state costs increased from \$29,492,000 in Fiscal Year 1965 to \$159,045,000 in Fiscal Year 1984; with an average annual increase of 9.4 percent. With inflation taken into account, the state gross cost of the state hospital system grew at an average annual rate of 2.8 percent and increased about one and a half times during the period 1965 through 1984.

As population changes, unit costs become a second important measure in analyzing cost trends. Per diem rates are widely used cost measures in state hospital operations. They are calculated by dividing total program cost by the estimated daily population served multiplied by the number of days in the year. Separate per diem rates are currently calculated for service to persons with mental illness, mental retardation and chemical dependency to account for differences in care and treatment and to take advantage of federal reimbursement. Per diem rates for Fiscal Year 1984 were mental illness \$95.80, mental retardation \$123.25 and chemical dependency \$72.80. Actual per diem and adjusted per diem rates using the Consumer Price Index for Fiscal Years 1980-1984 are also presented in Figure 3. Per diem rates for Fiscal Year 1985 are mental illness \$108.60, mental retardation \$135.85 and chemical dependency \$77.05.

FIGURE 3

Minnesota State Hospital Per Diem Costs 1981 through 1985 in Actual and CPI Adjusted Dollars (October 1983)



SOURCE: Department of Human Services

Minnesota's State Hospital System Today

PATIENTS AND RESIDENTS IN STATE HOSPITALS

Minnesota's state hospitals exist to serve people with mental illness, mental retardation, and chemical dependency. While there are many factors which will influence the future of state hospitals, a very important factor must be the individuals for whom they exist. The issue to be addressed is—what is the general nature of the state hospital population which must be taken into account in planning for the future of the hospitals?

There are many ways of counting the number of people served by state hospitals, including the following:

1. a "census" gives the number of people who are patients or residents in the hospital on a particular day.
2. the "total patients/residents" count includes all people served during a year or other period of time.
3. the "average daily population" takes into account changes in population over a year, and provides a measure of operational size for comparison purposes.

The average daily population of all state hospitals during Fiscal Year 1984 was made up of 1,230 mentally ill (30.7 percent), 2,182 mentally retarded (54.5 percent) and 594 chemically dependent (14.8 percent) people.

Table 1 (see Appendix) indicates the number and percent of persons with mental illness, mental retardation and chemical dependency in each state hospital and the entire system during Fiscal Year 1984.

State Hospital Service Areas

All eight state hospitals do not provide the same services. Cambridge and Faribault State Hospitals serve only persons with mental retardation; Anoka serves only persons with mental illness and/or chemical dependency. The catchment areas differ for each condition by state hospital and are designated groups of counties. Figure 5 indicates the mental illness catchment areas. The mental retardation catchment areas are presented in Figure 4 and catchment areas for people with chemical dependency in Figure 6.

FIGURE 4
State Hospital Receiving Districts
Mentally Retarded

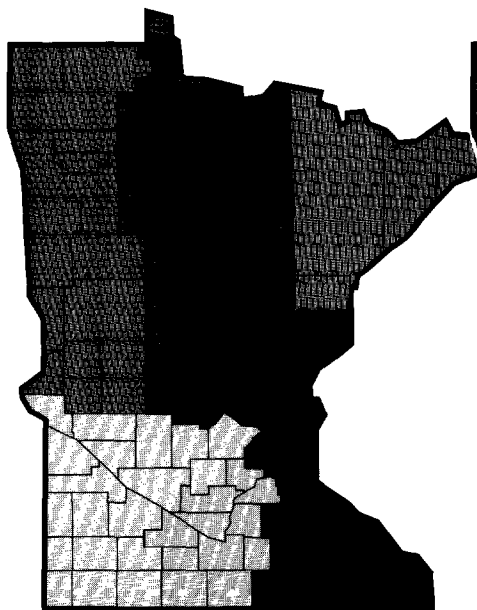


FIGURE 5
State Hospital Receiving Districts
Mentally Ill

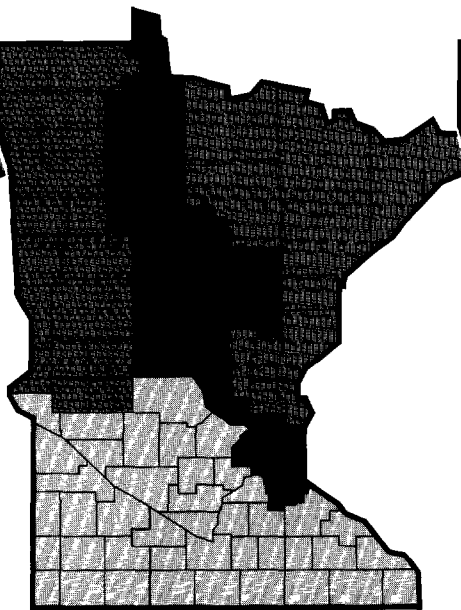
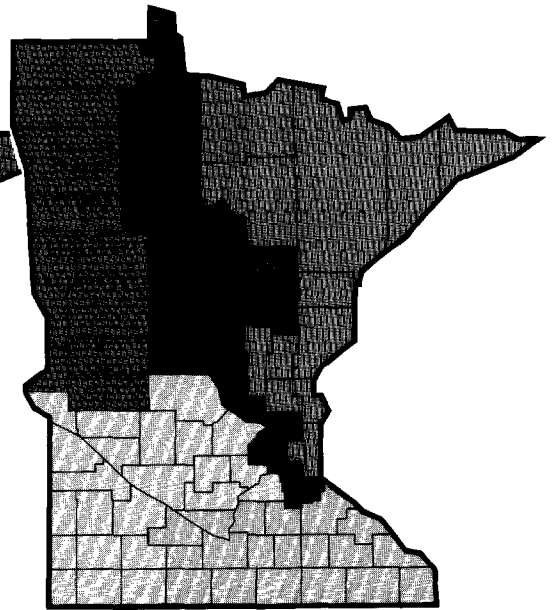


FIGURE 6
State Hospital Receiving Districts
Chemically Dependent



- KEY:**
- | | |
|-------------|----------------|
| ■ Anoka | ▨ Fergus Falls |
| ■ Brainerd | ▨ Moose Lake |
| ■ Cambridge | ▨ St. Peter |
| ■ Faribault | ▨ Willmar |

Characteristics of Patients and Residents

People with mental illness, mental retardation and chemical dependency are unique as individuals—each person has a unique set of strengths and needs, some of which are affected by the disability with which the person lives. As groups of people with specific disabilities, they require different kinds of services, treatment and/or care. Planning for the future of state hospitals and the individuals they serve requires an understanding of the special characteristics and needs of the patients and residents.

Patients with Mental Illness

Available information about persons with mental illness in state hospitals as of September 1984 was limited to patients classified in terms of five “levels” based on the severity of illness. (Table 2, Appendix)

- Level I patients comprise 9 percent of all patients with mental illness in state hospitals. “Level I” refers to the most severe mental illness. Symptoms include high risk of suicide, assaultive/threatening behavior toward others, and psychotic behaviors such as seeing or hearing things others do not. Persons classified in Level I are confused and disoriented, can be dangerous in the community, and may have a history of chemical dependency or abuse. In September 1984, 91 individuals were classified as Level I. At that time, all state hospitals with mental illness programs served some Level I patients. The largest number in any specific hospital was 38 at Anoka.
- Level II patients made up 27 percent of the state hospital population with mental illness. Persons classified as Level II have serious mental illness, but their behaviors are somewhat less severe. Symptomatic behaviors in this classification include disruption, requires protection from exploitation by others, suicidal tendencies, physical problems, chemical dependency and abuse, and psychotic episodes. In September 1984, 256 patients of state hospitals were classified as Level II. Anoka State Hospital served the highest number (80) of any single hospital.
- Level III patients accounted for 39 percent of the total state hospital population with mental illness. Symptomatic behaviors for Level III classification include deficient self-care skills, social isolation, lack of initiative for activities, difficulty in self control, needs monitoring for medical problems, and episodic substance abuse. In September 1984, 386 individuals were classified Level III in the state hospitals. The largest number in a single hospital was 143 in Willmar State Hospital.
- Level IV patients comprised 13 percent of the total. Behaviors indicating Level IV include limited ability to engage in the following—participate in groups, assume much self care, participate in work programs and use leisure time reasonably well. These individuals need a period of stabilization prior to discharge. In September 1984, 124 individuals were classified as Level IV, with the largest single hospital population being 33 at Willmar State Hospital.
- Level V is the lowest classification which requires hospitalization. It involves the least severe behaviors, such as confusion, disorientation, inability for self-care or daily living activities, may be assaultive, memory loss, and vulnerable to exploitation. In September 1984, 122 individuals were included in this classification within the state hospitals. The largest number in a single hospital was 42 at Moose Lake State Hospital.

Residents with Mental Retardation

State hospital residents with mental retardation have disabilities of varying severity. Many have multiple handicaps. In 1982, each resident was evaluated in terms of thirteen skill or trait areas listed in Table 3 (see Appendix). Programs are offered to residents based on their level of functioning in each area.

The numbers of residents rated at the various levels of functioning for each skill/trait area are reported in Table 3. The extreme levels ("highest" and "lowest") are reported and ratings between the extremes are combined as "other." These ratings indicate evaluations of current skill levels, not potential levels. In terms of these skill/trait areas, the 2,495 state hospital residents with mental retardation can be described in the following ways:

- *Orientation*: 27 percent are fully oriented to the world around them, while 23 percent are totally disoriented.
- *Self Preservation*: 43 percent were evaluated as mentally and/or physically unable to self preserve, while only 5 percent were judged to be independently able to self preserve.
- *Speech*: 31 percent are currently unable to speak, but 18 percent have normal speech.
- *Toileting*: 39 percent are independent in terms of toileting, while 22 percent are incontinent (bowel and bladder).
- *Behavior*: while 17 percent are evaluated as having no behavior problems, 43 percent have severe behavior problems.

- *Vision*: 61 percent have normal vision. About 7 percent are blind.
- *Hearing*: 84 percent have normal hearing. About 3 percent are deaf.
- *Walking*: 70 percent walk independently, while about 21 percent are currently unable to walk.
- *Bathing*: 45 percent require others to bathe them completely, but 8.5 percent bathe independently.
- *Bed Mobility*: About 12 percent must be turned and positioned in their beds, while 80 percent are independent in this area.
- *Eating*: 32 percent eat independently, while 13 percent are fed completely by others.
- *Grooming*: 46 percent currently require assistance in all areas of grooming, while 10 percent groom themselves.
- *Dressing*: 32 percent require complete assistance, but just over 16 percent can dress independently.

More up to date information about mentally retarded residents was recently collected and is being analyzed. Detailed reports will be issued in 1985.

Patients with Chemical Dependency

The amount of time individuals with chemical dependency spend in state hospitals is relatively short compared to persons with mental illness or mental retardation. While the average daily population of state hospital patients with chemical dependency was 594 during Fiscal Year 1984, a total of 5,327 such individuals were treated during the year.

General characteristics of patients with chemical dependency include the following: (See Table 4, Appendix)

- Most (54.8 percent) were diagnosed as being dependent on alcohol. Alcohol abuse involved 14.6 percent, while alcohol and drug dependency (13.6 percent), and alcohol and drug abuse (8.9 percent) accounted for fewer patients.
- The vast majority are males (85 percent).
- The vast majority are Caucasian (87 percent).
- Most are young adults 30 years of age or younger (55 percent), while 40 percent are between 31 and 60 years of age.
- Most (48 percent) have never been married and another 34 percent were divorced, separated or widowed.
- The vast majority (87 percent) have a high school education or less.
- The overwhelming majority (95 percent) were "informally" admitted but there was some court involvement prior to admission.
- Many (49 percent) had been arrested or convicted within the previous 6 months.
- 42 percent of 4,713 individuals left the program without completing it.
- Most are indigent based on the fact that 77.7 percent paid no or reduced fees (the state assumed the cost) and 8.8 percent had their fees covered by the counties.

COMMUNITY OPINIONS

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

- the convening of 9 town meetings, one in each area of the state served by a state hospital, and one in the Metro area;
- soliciting letters from the public and interested parties who would express their views; and
- receiving calls during a "toll-free call-in day."

In total, over 5,000 people attended and registered at the nine town meetings.

Over 80 separate organizations were represented and 362 individuals made presentations.

On October 16, 1984, 202 people called the toll-free number and made their views known. As of November 15, 1984, 178 letters and resolutions were received regarding state hospitals. After November 16, 1984, another 252 letters were received stating positive views about community services.

Transcripts of the town meetings, call-in messages and all letters were reviewed to identify information, concerns and points of view on specific issues. A speaker's presentation or a letter might contain more than one statement on issues. A total of 1,201 statements were identified in the views and sorted into 8 general categories. Table 5 (see Appendix) summarizes the type of statements made during the public process.

The contents of statements are summarized in the following themes or "messages."



Brainerd Daily Dispatch

Concerns About Patients and Residents

- The special needs of residents and patients should be the primary concern in planning the future of state hospitals.
- Persons most “difficult to place” because of severe behavioral, physical, medical, communication or multiple handicap problems are served by state hospitals.
- Persons who cannot afford private hospital and psychiatric care are served by state hospitals.
- Residents and patients need quality care and a base of support—state hospitals are the only home they have, they should not be made “homeless” nor “shuffled about.”
- The improvement of residents and patients has been documented. Individuals described the progress they have made. Some families prefer state hospital placement.
- The fact that state hospitals are geographically dispersed makes it easier for families to visit. Closure is viewed as forcing families to travel longer distances.
- During the call-in day, several callers cited incidents and criticized both state hospitals and community services because of inadequate or inappropriate treatment.
- Family members requested greater involvement and respect from staff.

Views on Community Programs

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

Quality of State Hospital Staff and Care

- State hospital staff and the care provided were described as caring, helpful, dedicated, the best, concerned, enthusiastic, skilled, loving, superior care, excellent care, warm, professional, and nationally recognized.
- Staff care about residents and patients, and provide a surrogate family relationship 24 hours per day.
- Staff are concerned about quality of care, continuity of care, standards, and a multi-disciplinary approach.
- State hospital staff salaries are justified because the residents/patients are the most difficult to serve. The salary levels in the community are low by comparison.
- Staff turnover rates are lower in state hospitals compared to community services.
- Staffing levels need to be increased in the mental illness units.

Suggestions for Improvement

- Change the policy and practice of community providers to a “zero-reject” approach to reduce the “revolving door” syndrome.
- Open the four buildings at Anoka State Hospital to handle demand of people with mental illness on the waiting list.
- Add more services to the state hospital such as halfway houses. Improve and expand state hospitals, do not close or reduce.
- Improve the security at state hospitals; improve the therapy and programs provided.
- Change the Commitment Act to let more people be admitted.
- Improve public education and attitudes about people with mental illness, chemical dependency and mental retardation.
- Resolve the conflict between state hospitals and the community. The Legislature needs to give direction and support. Counties have limited funds.
- More volunteers and visitors are needed.
- Use state hospitals as correctional facilities, veterans’ homes, elderly programs, and for dual diagnosis clients.
- Change state laws and make staff pensions portable (to other agencies).

- Any closure should be phased in over two to three years, not abrupt like Rochester.
- Create more outreach from state hospitals to provide services in the community, including training and therapy services.
- After-care needs to be improved.
- More emphasis must be placed on quality of care, dignity of residents and patients, monitoring of medications, consolidation of rules, and more surprise visits. State hospitals and community services must be improved.
- The state must operate with one set of rules. Currently state hospitals and community programs operate with two sets of rules. State operated services are not a good idea. Keep three state hospitals open—one each in North, Central and South.
- Develop pilot projects to try the Rhode Island approach of the State operating community services.
- Begin chemical dependency services for elderly persons who live alone.
- Begin a “Courage Center” operation at one of the state hospitals.
- Do not build any new state buildings until use of existing state hospital buildings has been considered.
- Move Faribault State Hospital residents who are deaf/blind to the State School.
- Open mental illness units at Faribault and Cambridge State Hospitals.
- More monitoring is needed to avoid patients bringing chemicals onto state hospital grounds.
- Cleanliness of buildings needs improvement.

Community Economic Impact on Hospital Closure

- The effect will be an economic chain reaction characterized by direct loss of hospital jobs, indirect loss of jobs because of slowed industrial growth, lowered gross community income, reduced retail sales, closed stores, fewer families, underutilized schools, increased taxes, higher utility costs, depressed housing market and rising unemployment.
- Several attempts to estimate the magnitude of the economic impact were presented.
- The economic impact of any future closing would be greater than that experienced by Hastings and Rochester hospitals because most of the remaining state hospitals are located in smaller, primarily rural communities.
- Decisions about two shopping mall developments have been delayed because of the uncertainty about the continued operations of state hospitals.
- Family members who come to visit individuals represent another source of retail trade.
- Volunteer time and donations should be included in calculations of economic impact.
- The economic gains from preventing deaths because of chemical dependency treatment cannot be calculated.
- Preference for economic development grants should be given to communities in case of closure.
- Public school districts working cooperatively with state hospitals said that closure would affect state aid, number of teachers and the tax base.

Interagency Relations

- Judges supported the continued operation of state hospitals because of the time involved in commitment proceedings. Judges believe closures would increase the time and costs involved.
- County sheriffs supported evaluation and treatment services provided by state hospitals. Sheriffs believe that closure would mean longer trips and extra costs for such services.

- Several county social services directors and county commissioners supported the state hospital system because it provides a necessary service.
- Local nursing homes cannot accommodate state hospital patients in the event of closure.
- Clergy described working relationships with state hospitals in terms of family issues—violence, incest and alcoholism.

Unique Programs Offered by State Hospitals

- The Brainerd State Hospital chemical dependency program for Native Americans serves four northern Minnesota reservations and has a higher success rate compared to traditional programs.
- The Security Hospital at St. Peter was described as a newly constructed facility that provides service state-wide.
- The Minnesota Learning Center at Brainerd State Hospital is nationally recognized.
- The Adolescent Unit at Willmar State Hospital was praised as a unique program.
- Fergus Falls State Hospital has several unique chemical dependency programs—women to women counseling, adolescent care and the 2x4 program.
- The nurses at every state hospital were described as having extensive experience in providing quality care.
- Specially controlled settings are required to serve dual diagnosis clients and those who are extremely difficult.
- Camp Confidence was described as a unique service which serves both the state hospital and community programs.
- Foster grandparents described the personal relationships they have developed with residents.

Other

- Closure means “banning people,” “economic catastrophe,” “human catastrophe,” “terrorizing patients,” and “uprooting people.”
- Several groups are held hostage by the indecision over state hospitals—residents and patients, staff, and communities.



Brainerd Daily Dispatch

- The League of Women Voters studied Anoka State Hospital in 1981 and concluded that the hospital was a benefit to the community.
- Frequent studies of state hospitals lower the morale of staff. Demoralization is at an all-time high.
- There is no justification for closure. Why are we assuming deinstitutionalization is a good thing?
- The Commitment Act needs revision according to relatives and judges.
- State hospitals are better and cheaper.
- The state will always assume responsibility for some residents and patients. The state has a moral responsibility.
- The communities extended a welcome to state hospitals when they were originally built and now the state wants to pull back on its commitment.
- Other town meetings should be scheduled to hear community concerns.
- Change is inevitable and so is closure.
- The adverse effects of the Rochester State Hospital closure included stress on families, divorce, unemployment, patients on the streets, three patient suicides, and higher use of hospital emergency rooms.
- Stop making the state hospitals the scapegoat.
- Closure does not save money.
- The advocacy system abuses parents' wishes.
- There are too many adversarial relationships among the state, counties, providers and state hospitals.

In translating all of these comments and opinions into state level policy-making the following limitations of the testimonial data should be kept in mind:

1. All town meetings were held at or near state hospitals and therefore might be expected to attract individuals and receive statements which support continued operation of state hospitals with a minimum of change.
2. There was no requirement that individuals making statements identify themselves. Based on information about people who did identify themselves, the largest group making statements tended to represent local government and community agencies: city and county officials, service providers, sheriffs, judges, clergy and school officials (27.6 percent). The second largest group of people making statements was state hospital employees (23.5 percent) followed by family and relatives (11.6 percent). Representation of business and groups was 11.1 percent, patients and residents 8.8 percent and advocates 2.5 percent.
3. Statements were not necessarily specific in terms of which group of people (mental illness, mental retardation, or chemical dependency) was of concern to the speaker. Statements about the needs of people in the hospital system, therefore, are not treated separately.

Based on the statements made during the public process, there is widespread support for the state hospitals, their role and function, and their impact on the communities in which they are located.

There are decidedly different views on the quality of care, treatment, and support provided to residents or patients in both the state hospitals and the community. There is no support for "dumping" people into the community without support.

The opinions expressed in the public process underscore the fact that whatever options are implemented in the future they must provide the following:

- support for people who are the "most difficult to place"
- affordable and accessible services
- services that respond to the special needs of each individual
- quality care and continuity
- good access to families and the opportunity for families to be involved
- a range of services in each area
- coordination, followup and monitoring
- staff who are competent and caring from several disciplines.

There is little doubt that any change in the state hospital system will have direct consequences on communities.

STATE HOSPITAL EMPLOYEES

State hospitals are a labor intensive industry. Over 5,900 people are employed in the state hospitals. Some have devoted a significant part of their working lives to service in state hospitals. Many are dedicated to the work they do and the lives of the individuals to whom they provide service.

For planning purposes in terms of protecting the interests of employees and determining ways of mitigating the impact of displacement during change, two issues are of paramount interest:

1. The characteristics of the workforce—numbers, retirement eligibility, length of service, separations, and profession insofar as it relates to the likelihood of obtaining employment elsewhere. This information was assembled from the files of the Department of Employee Relations, as authorized by statute; and
2. Career preferences and contingency plans of the workforce. An on-site questionnaire was completed by state hospital employees on a voluntary basis. During July and August 1984, 66 percent of the employees completed the questionnaire.

Workforce Characteristics

Following are the general characteristics of the state hospital workforce. (See Table 6, Appendix)

■ **Representation:** State hospital employees are assigned to 12 of the state's 16 bargaining units created by the Public Employment Labor Relations Act of 1971. The numbers in parentheses after job classifications in column 1 indicate bargaining unit. The employees are represented by six unions or employee associations—the American Federation of State, County, Municipal Employees; Middle Management Association; Minnesota Association of Professional Employees; Association of Institutional Dentists; Minnesota Nurses Association; and State Residential Schools, Education Association.

- **Job Classification:** The distribution of employees by job classification is indicated in Figure 7.
- **Sex:** State-wide, 63 percent (3,735) of the state hospital employees are female.
- **Age:** One-half (50.1 percent or 2,908) of the employees are under the age of 35. Just over 40 percent (42.9 percent or 2,489) are between 36 and 59 years of age, while 7 percent (411 individuals) are over 60 years of age.
- **Retirement:** About 6 percent (369 employees) were eligible for immediate retirement under the Rule of 85 at the time of data collection. An additional 12.5 percent (742) will be eligible for retirement within the next 5 years.
- **Separation:** 820 employees separated from the state hospital during fiscal year 1984.
- **Staff-to-resident Ratios:** The state-wide ratio is 1.48 employees for every patient or resident. This is based on 1984 average daily population information. For detailed planning purposes, this ratio must be analyzed further by job classification, hospital sub-population, and severity of condition of residents/patients.
- **Wages:** The state-wide average hourly wage for employees ranged from \$8.10 (for service workers) to \$22.70 (for managers). The largest group of workers (health care technicians and licensed practical nurses) averaged \$8.53 per hour.

FIGURE 7

Distribution of State Hospital Employees by Job Classifications

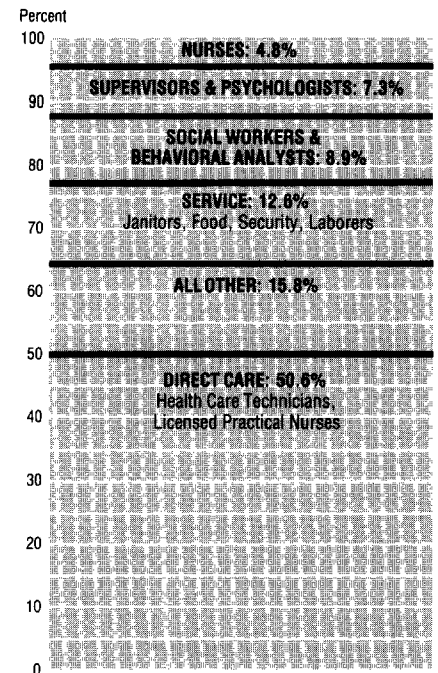
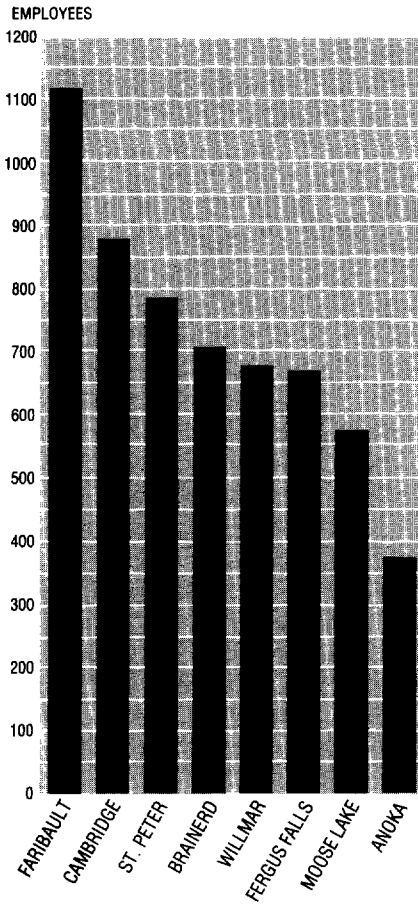


FIGURE 8

State Hospitals by Staff Size (Employees)



■ **Staff Variation Among Hospitals:**

There is little variation from one state hospital to another in terms of workforce characteristics except for staff size. Figure 8 rank orders the state hospitals by staff size. The range of variation on other characteristics is as follows:

Sex/Percent Females:

Low—61.1 percent (Brainerd)

High—69.3 percent (Cambridge)

Age/Under 35:

Low—37.8 percent (Anoka)

High—63.2 percent (Faribault)

Retirement/Within 5 Years:

Low—7.9 percent (Cambridge)

High—17.8 percent (St. Peter)

Average Length of Service:

Low—6.2 years (Anoka)

High—10.5 years (Fergus Falls)

Separations:

Low—63 (Anoka)

High—210 (Faribault)

(Sex, age, and separations refer to all employees while retirement and length of service refer to full time employees).

■ **Employee Separation Benefits:**

The collective bargaining agreements provide for severance pay and health benefits in the event of involuntary termination other than dismissal for cause. Federal and state laws require payment of unemployment insurance. These benefits have a monetary value that could become a cost to the state. Regular employees are eligible for severance pay at a rate of 40 percent up to 900 hours and a rate of 25 percent for the hours above 900 of unused sick leave at their last hourly wage. Total cost of severance pay by state hospital is presented in column 2 Table 7 (see Appendix).

State employees with three or more years of service receive six months of health insurance benefits paid by the state upon involuntary termination except in cases of dismissal for cause. Cost of health insurance varies by employee depending on coverage. The system-wide average is \$923 per employee for six months and the estimated total value of this benefit for each state hospital is reported in column 3 of Table 7. Unemployment benefits are paid to employees meeting specified eligibility requirements. Maximum benefits are \$198 per week for 26 weeks.

STATE HOSPITAL COSTS

The amount and use of financial resources for state hospitals can be analyzed in terms of operating expenditure by the hospitals, gross and net cost to state government, and unit costs. Cost is the amount of money or "money's worth" that is exchanged for services and property. Unit costs were discussed in Part I. Operating expenditure is an accounting term used for the cost of goods and services to carry on state hospital programs during a specified period of time, e.g., a fiscal year.

Operating Expenditure

Minnesota state hospital operating expenditures during Fiscal Year 1984 are presented in Table 8 (see Appendix). Expenditure reported by hospital indicates the relative size of hospital operations; reporting by object of expenditure indicates the use of financial resources. Total expenditures by hospital and by object were divided by the number of patients/residents in average daily population in all programs to give a per capita operating expenditure.

Total operating expenditure ranged from \$11,875,263 at Anoka State Hospital to a high of \$29,115,435 at Faribault State Hospital with a total operating expenditure of \$149,498,251 for the entire system during Fiscal Year 1984. Staff salaries, which include employee benefits, represented the largest object classification at \$128,433,135 or 85.9 percent of total operating expenditure. The second largest object classification for all hospitals was fuel at \$3,973,204 (2.7 percent) followed by food at \$3,576,272 (2.4 percent). While per capita operating expenditure by hospital is of interest, it is not a valid measure of comparative efficiency because of differences in composition of patient/resident population, staff seniority and other factors among the eight hospitals. Both total and per capita operating expenditure for Anoka State Hospital are somewhat overstated because \$357,210 for 11 positions with systemwide and central office responsibility are included.

While separate reimbursement rates are applied to services for mental illness, mental retardation and chemical dependency, the \$37,317 per capita indicates the statewide average hospital operating cost of care for one patient/resident for one year.

Gross and Net State Cost

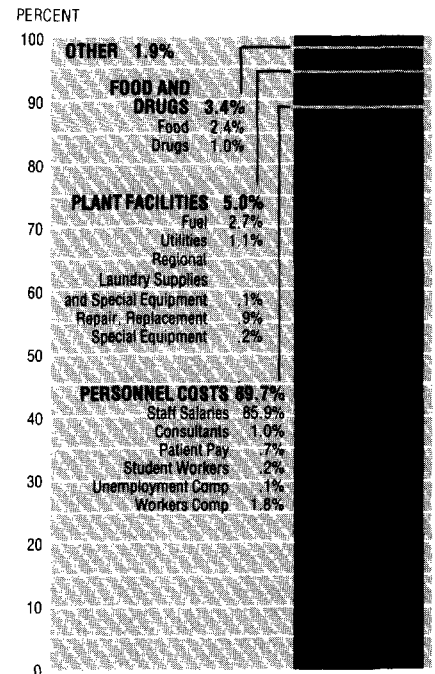
The gross state cost aggregates all financial resources used by the state hospital system: operating expenditure, indirect expense, bond interest and depreciation added together. Indirect expense includes expenditures for Department of Human Services operations associated with or prorated to state hospital operations including Fiscal Management, Reimbursement, Personnel, Information Systems and Mental Health Bureau. It also includes prorated expenditures for Departments of Administration, Employee Relations, Finance, Attorney General and other state agencies that provide services to the state hospital system. Bond interest is the cost of money borrowed to finance construction and improvement of plant facilities. Depreciation expense recognizes an amortized amount of capital expenditure for land, buildings and equipment. The depreciation expense is not placed in a reserve account, but it does recognize state capital costs and is an allowable item for federal reimbursement.

Table 9 (see Appendix) presents a breakdown of actual gross state cost for Fiscal Year 1984 and estimates for the next three fiscal years. The operating expenditure of \$147,755,064 is less than the total in Table 8 because: 1) offsetting receipts for regional laundry services, state hospital miscellaneous cash receipts and central office salaries paid on hospital line items have been deducted and 2) it reflects account balances as of August 1, one month after the end of the fiscal year, but before closing entries on or about September 1.

Actual indirect costs for Fiscal Year 1984 totaled \$3,970,098. Addition of \$2,284,951 for bond interest and \$5,035,366 for depreciation brought the gross state cost to \$159,045,479. Dividing the total gross cost by the 4,006 average daily population gives a per capita gross cost of \$39,702. In other words, \$2,385 or 6 percent of the state gross cost per patient/resident is made up of indirect, bond interest and depreciation expense.

FIGURE 9

State Hospital Operating Expenditures
Fiscal Year 1984



The Reimbursement Section of the Department of Human Services recovers state hospital costs from many sources through calculation of per diem rates and billing procedures. During Fiscal Year 1984, reimbursements totaled \$120,594,420 from all sources. The largest source was the federal share of Medical Assistance, \$52,656,694 or 43.7 percent of all reimbursements. The second largest source was the state's own share of Medical Assistance at \$46,825,724 or 38.8 percent followed by county payments for hold orders, poor relief and detoxification charges for \$6,362,510 or 5.3 percent of the total. Counties also pay a share of Medical Assistance that amounted to \$5,202,858 for state hospitals during Fiscal Year 1984.

The Legislature appropriates the gross state cost of the state hospital system. State hospital reimbursements are deposited into the State General Fund and designated as dedicated revenue for Medical Assistance, thereby reducing that appropriation. The presence of substantial reimbursement collection is the basis for computing net costs. Had eligible persons been treated in other settings, the state's share of Medical Assistance would clearly have been a "cost" to the state with no chance of cost recovery through the reimbursement process. In the case of treatment in state hospitals, reimbursement from the state's share of Medical Assistance functions more like an inter-agency transfer; state government helps individuals, but in doing so moves money from one account to another. From the state government's viewpoint, state hospital reimbursements from other than state sources are revenue receipts and, therefore, the gross state cost of state hospitals minus reimbursements from non-state sources yields a net cost. Following this procedure, the net state government cost for the state hospital system in Fiscal Year 1984 was \$85,276,783. If the net cost were divided by the 4,006 average daily population, the net state cost per capita becomes \$21,287, slightly more than half (53.6 percent) of the gross state per capita cost.

ECONOMIC IMPACT

A large industry, like a state hospital, contributes significantly to a community's economy. The smaller the community and less diverse its commercial or industrial base, the greater the impact. Determining a valid "bottom line" amount of economic impact by a particular state hospital is difficult because many factors are involved, some factors interact and there are many "unknowns." A detailed economic impact study was underway, but not completed at the time this report was prepared. This section highlights state hospital employment opportunity, payroll and local purchasing.

State Hospital Employment Opportunity

Jobs are a key factor in the vitality of a community's economy. Table 6 (see Appendix) indicated that the state hospitals provided 5,919 jobs (including part-time) distributed across eight communities. The number of full-time jobs by community ranged from 1,093 in Faribault to 378 in Anoka. Clearly, state hospitals are major employers. One way to assess the impact of these jobs is to determine what proportion they are of all jobs available in geographic areas surrounding each state hospital. "Community" was defined as the area in which state hospital employees live. Areas of employee residence were determined by aggregating postal zip codes into three zones. The primary zone was defined as that geographic area which included the zip codes of 50 percent of employees residing closest to the hospital. Primary and secondary combined zones were larger areas that included zip codes of 75 percent of employees living closest to the hospital. The regional impact areas are the largest of the three zones and include zip codes for 90 percent of a state hospital's employees. Geographic boundaries of these three zones are presented graphically in Figure 10.

The first three rows in Table 10 (see Appendix) indicate the percent state hospital jobs are of the total number of jobs in geographic areas surrounding each state hospital. When data for primary and secondary zones are identical, it means that the zip code area is not enlarged when the percent of employees is increased from 50 to 75 percent.

Data for the primary zones indicate that the greatest economic impact was in the immediate area of Moose Lake where 18.8 percent of the workforce was employed by the state hospital. Second and third ranked primary zone impacts were at Faribault and St. Peter where hospital employees represented 9 percent and 8 percent of the workforce respectively.

The U.S. Census Bureau has identified the total number of health or social services jobs in the state hospital regional areas. The percent of state hospital jobs of that total number was then calculated. The higher the percent, the lower the likelihood of finding another health or social services job. Fergus Falls (44 percent), Brainerd (37 percent) and Moose Lake (30 percent) are the areas in which finding another health or social services job would be most difficult.

Those areas in which state hospital jobs represent the largest proportion of total employment, Moose Lake, Faribault, Brainerd and Fergus Falls, also tended to have the highest county unemployment rates during July 1984. Highest unemployment rates were in Carlton County at 10.1 percent (Moose Lake State Hospital), followed by Crow Wing at 8 percent (Brainerd State Hospital), Otter Tail at 7.9 percent (Fergus Falls State Hospital) and Rice County at 7.1 percent (Faribault State Hospital).

State Hospital Payrolls

Salaries of state hospital employees may be the most significant factor in community economic impact. Table 8 (see Appendix) indicated that \$128,433,135 or 85.9 percent of total operating expenditure are for personnel costs. The amount ranged from \$9,809,295 at Anoka State Hospital to \$24,993,232 at Faribault. Patient pay totaling \$1,089,570 and student worker pay of \$340,120 could be added to staff personnel costs. Personnel operating expenditures overstate the direct community economic impact because it includes employee benefit costs, state and federal income tax, social security and other deductions that are not local transactions.

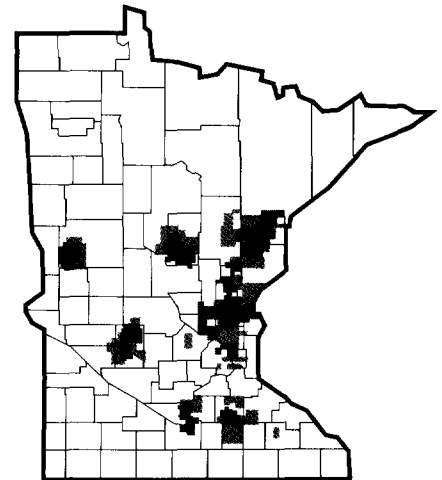
The amount of impact state hospital payrolls have on the local economy is difficult to estimate. While it is relatively easy to determine where the employees reside, it is more difficult to know where they spend their income. Persons working at Fergus Falls State Hospital and living in Fergus Falls are very likely to spend most of their money in or around Fergus Falls. Workers at Anoka State Hospital are very likely to shop in St. Paul, Minneapolis and suburban shopping centers outside the immediate Anoka area. The economic impact of salaries spent in the local community can be expected to "multiply" about one and one-half to two times in succeeding transactions.

The Department of Employee Relations and Demographer's Office provided information on state hospital payroll as a percent of total area income. Rows 5, 7 and 8 of Table 10 (see Appendix) provides this information for the three zip code based zones surrounding each state hospital.

In the primary zone, Moose Lake State Hospital's payroll represented 28.8 percent of total area income. Second highest was St. Peter State Hospital's payroll at 16.9 percent followed by Faribault State Hospital's at 12.5 percent.

FIGURE 10

Economic Impact Area for Minnesota State Hospitals



KEY:

- Primary Zone
- ▨ Secondary Zone
- ▨ Remainder of Impact Area

Local Purchasing

State hospital purchases of supplies appear to have a relatively minor impact on local community economies. The economic impact is reduced because most purchasing is accomplished through state offices in St. Paul. One of the issues in assessing the impact of hospital purchasing is whether or not fuel and electricity should be included. Money expended for electricity and gas from companies like Burlington Northern probably have little local economic impact, but a high local impact is possible when municipal power plants are involved. Purchasing information excluding fuel and electricity is reported in Table 10 (see Appendix).

Hospital purchases were analyzed to determine the amount and percent of total purchases that were made from local city and county businesses during Fiscal Year 1983. The largest amount of local city purchases ranged from \$230,384 or 18.7 percent of all purchases by Willmar State Hospital to \$14,526 or 1.8 percent by Anoka State Hospital. The amount at Willmar State Hospital was relatively high compared to the second-place amount of \$167,156 or 14.4 percent of total purchases at Fergus Falls State Hospital. Similar amounts and percents are reported for the counties in which the state hospitals are located. While amounts and percents of total local purchases increased as the area of impact was extended to the entire county, the major portion of impact for each state hospital tended to occur in the immediate city.

The magnitude of local state hospital purchases depends on what percentage those purchases are of total retail sales. In this context the largest economic impact occurred in St. Peter where \$96,194 in transaction constituted 1.25 percent of total retail sales reported by the Minnesota Department of Revenue. Moose Lake followed with \$72,905 in sales or 1.2 percent of total retail sales. Lowest impact of local purchasing occurred at Cambridge with \$27,056 in transactions representing .11 percent of retail sales.

If fuel and electricity are included, the percent of purchases made locally, amount of transactions and percent of retail sales all increase.

STATE HOSPITAL BUILDINGS AND ENERGY USE

Hospitals vary considerably in terms of the age of buildings, number of buildings, amount of land, and condition of buildings. Table 11 (see Appendix) summarizes information collected during a 1982 inventory of Minnesota state hospital plant facilities.

Anoka State Hospital

Anoka State Hospital has 22 main buildings on a 243 acre site. Total area of main buildings is 454,455 square feet and it has a licensed bed capacity of 347. Of the main buildings on which rating data are available, 9 are rated poor or poor to fair (4 are vacant and 2 are identified for demolition), 6 fair, 3 fair to good or good, and one, the chemical dependency unit built in 1980, is rated excellent. Seven of the buildings contain licensed beds and all are accessible to persons with handicaps. Anoka State Hospital is located in a high density suburban area. Ninety-five percent of its property is zoned single family residential and 5 percent is zoned multiple dwelling. Mixed zoning of property surrounding the hospital includes multiple dwelling, commercial and industrial.

Brainerd State Hospital

Brainerd State Hospital has 14 main buildings on a 198 acre site. The total area of main buildings is 698,178 square feet and its licensed bed capacity is 531. All buildings were constructed between 1958 and 1967. Thirteen of the buildings are rated good to excellent and one is rated poor to good. Eleven of the main buildings are residential facilities. The site is zoned "public" giving it the same classification as parks, hospitals, churches, colleges, etc. Surrounding area is zoned agricultural, rural residential, green space and some commercial.



Brainerd Daily Dispatch

Cambridge Star

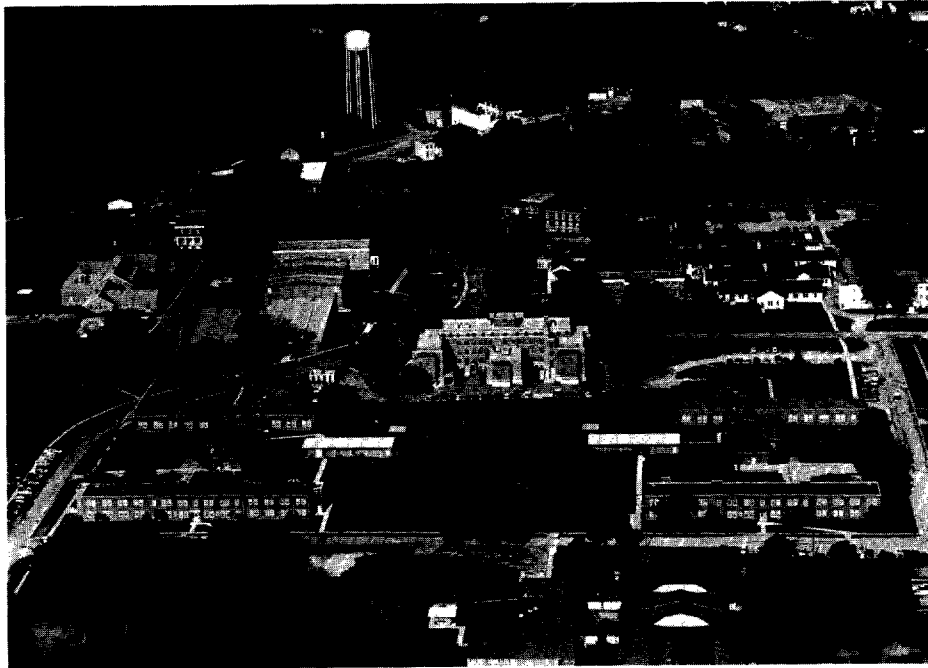


Cambridge State Hospital

Cambridge State Hospital has 26 main buildings on 245 acres. The majority of buildings were constructed between 1925 and 1937, but larger buildings constructed since 1953 account for over half of the 669,908 square feet of floor area. Of the main buildings, 18 (82 percent) were rated fair, fair to good or good, one was rated poor and 3 were rated excellent. Licensed bed capacity is 556 and 11 buildings are used as residential facilities; all meet life safety codes but 6 do not meet handicapped access requirements. The state hospital is zoned professional/medical. Zoning of surrounding area includes professional/medical, single family residential, multiple dwellings, flood plain and shore land.

Faribault State Hospital

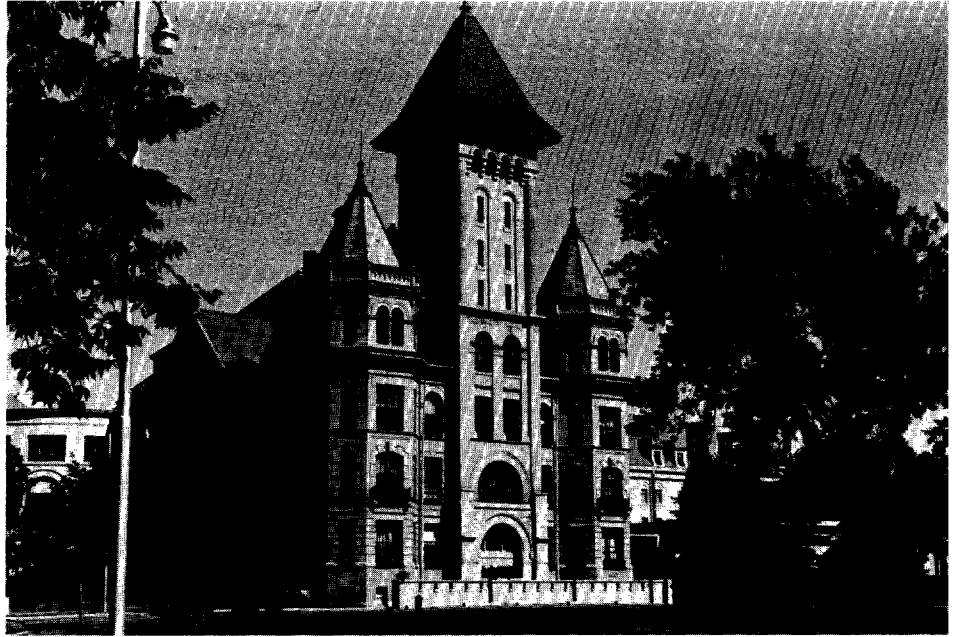
Faribault State Hospital has 52 main buildings on a 760 acre site; 593 acres are leased out. The oldest building is the power plant constructed in 1896; about half of the buildings were constructed between 1900 and 1937 and the remaining half between 1947 and 1964. Total floor area of the main buildings is 939,104 square feet and licensed bed capacity is 845. Of the 40 buildings for which ratings were available, 21 were rated fair to good or good, 14 were rated poor or fair to poor, and 5 were rated good to excellent. Fifteen buildings are used as residential facilities; all meet life safety codes but 3 do not meet handicapped access requirements. The state hospital is zoned high density residential. Surrounding property is zoned residential, agricultural and industrial.



Fairbault Daily News

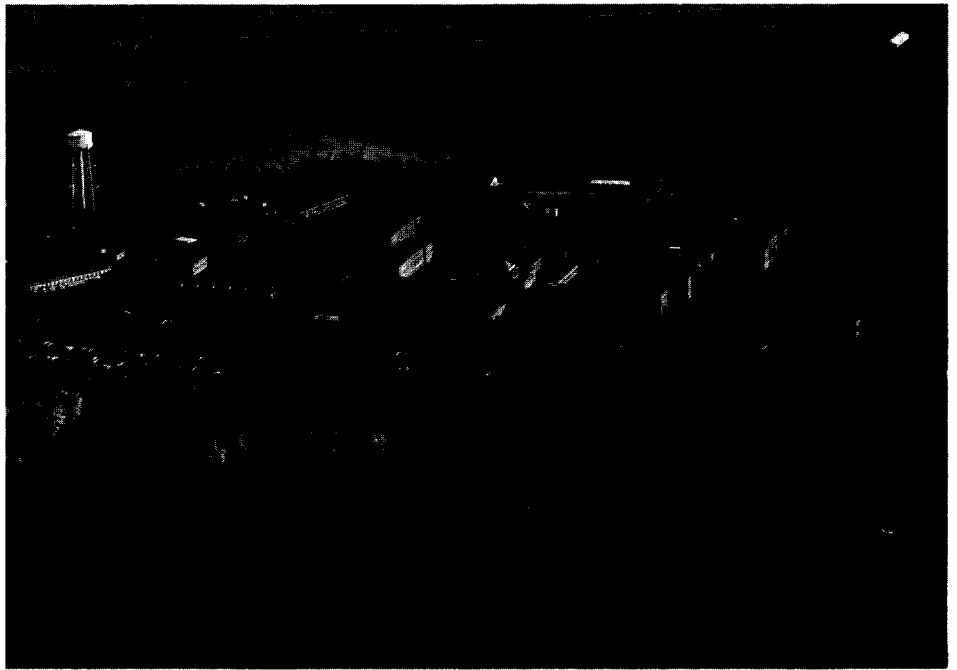
Fergus Falls State Hospital

Fergus Falls State Hospital has 40 main buildings on a 320.25 acre site; 164 acres of the site are leased out for farming. Total area of the main buildings is 867,010 square feet and licensed bed capacity is 561. Twenty-four of the main buildings were constructed between 1890 and 1923, 4 during the early 1930s and 12 between 1950 and 1964. Of the 27 buildings for which rating information was available, 10 were rated poor, fair to poor, or fair. Eleven buildings were rated fair to good or good and 5 were rated good to excellent or excellent. Eleven buildings are used as residential facilities. All residential buildings will meet life safety codes by March 1985; 10 are not in full compliance with handicapped access requirements. The hospital is zoned residential/agricultural and surrounding property is zoned multiple family residential, business district and industrial.

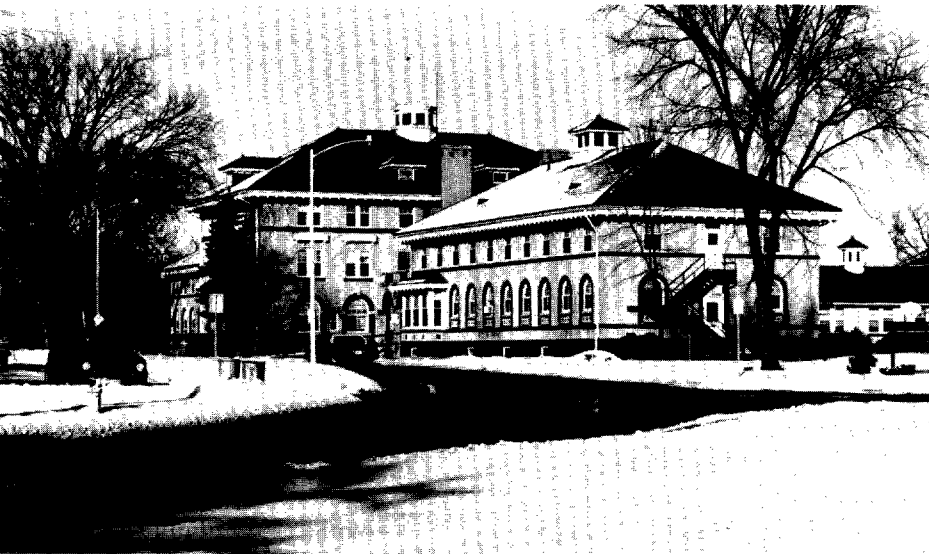
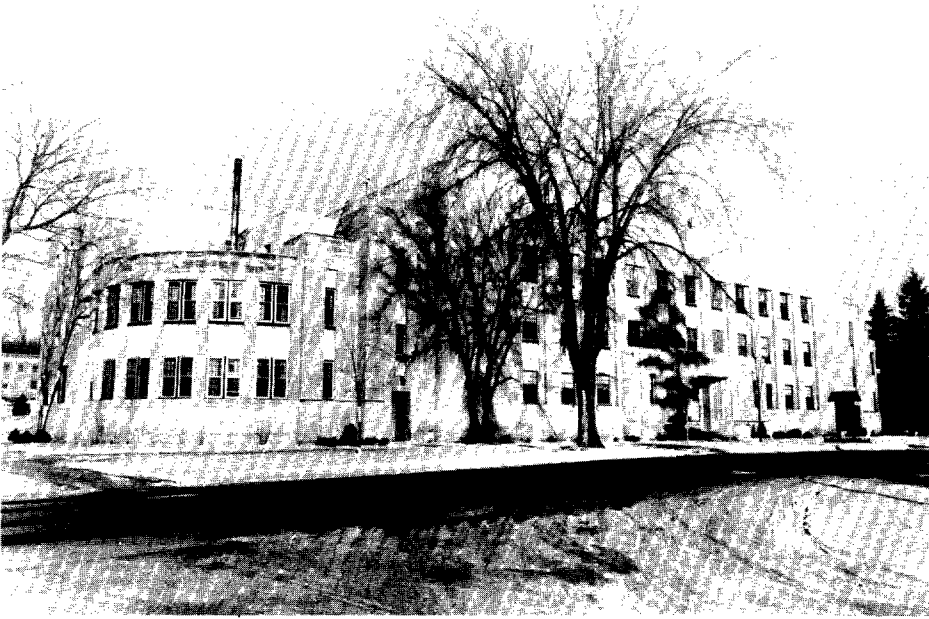


Moose Lake State Hospital

Moose Lake State Hospital has 23 main buildings on a 175 acre site. Main building area totals 518,815 square feet and licensed bed capacity is 645. Thirteen of the buildings were constructed in 1938 and the remaining 10 between 1949 and 1964. Of the 21 buildings with ratings, 7 were rated good to excellent or excellent and 14 were rated fair to good or good. Ten buildings are used as residential facilities; all meet life safety codes and nine meet handicapped access requirements. The hospital is zoned governmental/open. Surrounding property is zoned park, multiple dwelling and light industrial.



Moose Lake Star-Gazette



Michael Smith, Willmar

St. Peter State Hospital

St. Peter State Hospital has 35 main buildings on a 743.6 acre site of which 220 acres are leased out. A major renovation and replacement program during the past 20 years has transformed the first state hospital into one of the newest. Total area of main buildings is 857,404 square feet and its licensed bed capacity is 674 including the security hospital. Rating information indicates that 19 of the main buildings are fair to good, good, good to excellent or excellent, 4 are rated fair and 2 rated fair to poor. Eight buildings are used as residential facilities; all meet life safety codes and 6 meet handicapped access requirements. One of the main buildings is the Minnesota Security Hospital, started in 1981 and completed in 1982. It is a modern 117,072 square foot building with a licensed bed capacity of 236 and the only complete security building at any of the state hospital sites. The state hospital and surrounding property are zoned residential multiple dwelling.

Willmar State Hospital

Willmar State Hospital has 39 main buildings on a 158 acre site. Total area of main buildings is 562,151 square feet and licensed bed capacity is 644. Twenty-five of the buildings were constructed between 1912 and 1933; the remaining 14 were built between 1948 and 1979. Available rating data indicate the 18 buildings are in fair to good, good, good to excellent or excellent condition; 5 buildings were rated fair. Fifteen buildings are used as residential facilities; all will meet life safety code requirements when fire exits under construction are completed and 6 are in full compliance with handicapped access requirements. The state hospital is zoned governmental and institutional district with surrounding property zoned residential and agricultural.

State Hospital Energy Use

Many of the issues related to physical plant have implications for the future in terms of disposition of properties and possible consolidation. The same is true of energy costs. Energy consumption in buildings is affected by such factors as original construction features, efficiency of heating plant, severity of weather, and type of heating fuel used. Conversion from one fuel to another, installation of more efficient heating plants, replacing old windows and adding insulation are major capital expenditures in physical plants of state hospitals. Investment in major energy-saving modifications can be justified by estimated savings or "pay-back" over a period of time. Price of energy is a function of supply as well as state hospital location and access to energy suppliers.

Meaningful comparison of energy use at the eight state hospitals is difficult. Total usage and total energy cost data are informative, but do not take important variables such as size of plant, type of construction, price of energy and climate differences into account. Energy use and expenditure data per patient/resident are somewhat more useful because energy is essential to achieving the state hospital's purpose of serving people. However, the usefulness of per patient/resident energy use and expenditure data are limited by the fact that within a defined operating size, total energy expenditure is a fixed cost.

The adjusted total energy cost for all state hospitals was \$4,440,820 in 1983. Lowest energy consumption per square foot was .145 million BTU's and per patient was 164 million BTU's, both at Moose Lake. The smaller number of buildings and their relatively recent construction would contribute toward lower energy use. At the same time, Moose Lake State Hospital's cost of energy, \$.967 per square foot, ranks fifth and its \$1,057 per person cost ranks third lowest among the eight state hospitals. On the other hand, Fergus Falls has the lowest energy cost per square foot of \$.479 and the second lowest cost per person of \$746. Even with the lowest cost, Fergus Falls State Hospital had the highest energy consumption per patient/resident and the second highest use per square foot. (See Table 12, Appendix)

Alternative Use

There has been considerable experience across the United States concerning the conversion and disposal of state hospital properties. In discussion with other states, the following trends are evident:

- Generally speaking, state agencies report that they do not save money by using former state hospitals for other government uses rather than renting or building other facilities. This is due in large part to the condition and age of the buildings, energy costs, and renovation costs.
- Of the 31 institutions reported closed nationwide, none has been purchased by private industry. One has been converted to geriatric apartments, and one has been purchased by a religious organization.
- Over half of the former state hospitals in the nation have been converted to other types of institutions (correctional or veterans). Sixteen of them continue to be maintained by the state.
- Like Minnesota, all states surveyed (except California) have laws which give priority to state, county and local agencies before the property is offered to the general public.

In Minnesota, state hospital properties have been leased or sold for other uses. The following observations can be made based on the experience over the last decade:

- Most surplus buildings have been leased to other state, county and local agencies as well as to school districts. The annual rent charged to these agencies is minimal and may not cover the maintenance and/or energy expenses associated with the properties.
- Former staff homes have been sold at several locations.
- The closure of Hastings State Hospital was quickly followed by its conversion to a Veterans' Home.
- The Rochester State Hospital closure was different. The site was marketed for two years. The county purchased Rochester State Hospital for \$1.00, but was unable to utilize all the buildings on the campus. Eventually, the federal government bought it for use as a prison.

State hospital lands and buildings have been appraised by local assessors. In 1980, estimated market values range from \$7.5 million (Faribault) to \$37.3 million (Brainerd). As experience elsewhere has demonstrated, however, the estimated market value of the property may be less than actual market value.

Final Note

Dramatic change has taken place in Minnesota during the last two decades in terms of reducing the numbers of people served by state hospitals. There is increasing awareness that the system continues to change and that the changes directly affect the lives of patients, residents, employees and communities. The system has reached a point where decisions are required regarding the types and levels of services offered for people with mental illness, mental retardation and chemical dependency. The seven studies summarized in this report will assist the 1985 Legislature in the decision-making process.

Appendix

Tables 1-12

TABLE 1

*Average Daily Population by Type of Condition
Served in Minnesota State Hospitals During Fiscal Year 1984*

	ANOKA		BRainerD		CAMBRIDGE		FARIBAULT		FERGUS FALLS		MOOSE LAKE		ST. PETER		WILLMAR		TOTAL	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Mental Illness and others	237	75.0	65	14.4	0	0	0	0	99	21.1	169 ^a	38.9	365 ^b	62.0	295 ^c	53.4	1,230	30.7
Mental Retardation	0	0.0	325	72.2	483	100	712	100	231	49.3	107	24.6	170	28.9	154	27.9	2,182	54.5
Chemical Dependency	79	25.0	60	13.3	0	0	0	0	139	29.6	159	36.5	54	9.1	103	18.7	594	14.8
Total	316	7.9	450	11.2	483	12.1	712	17.8	469	11.7	435	10.9	589	14.7	552	13.7	4,006	100

^aIncludes 107 in Geriatrics Unit

^bIncludes 210 in Security Hospital

^cIncludes 42 in Adolescent Treatment Unit

SOURCE: Department of Human Services 1985-87 Budget Request

TABLE 2

*Selected Characteristics of Persons with Mental Illness
Served by Minnesota State Hospitals During September 1984*

	ANOKA		BRainerD		FERGUS FALLS		MOOSE LAKE		ST. PETER		WILLMAR		TOTAL	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
NUMBER	235	100	64	100	98	100	169	100	155	100	258	100	979	100
LEVEL I Suicidal, self-injurious, assaultive, psychotic, etc.	38	16	10	16	3	2	15	9	13	8	12	5	91	9
LEVEL II Disruptive, suicidal tendencies, chemical abuse, psychotic episodes, etc.	80	34	25	39	17	18	54	32	35	23	45	17	256	27
LEVEL III Requires daily supervision, lacks social skills, lacks self-control, etc.	80	34	20	31	21	21	39	23	83	54	143	55	386	39
LEVEL IV Limited ability to participate, some self-care, can work, needs stabilization, etc.	31	13	8	12	17	18	19	11	16	10	33	13	124	13
LEVEL V Confused, disoriented, requires supervision, withdrawn, etc.	6	3	1	2	40	41	42	25	8	5	25	10	122	12

SOURCE: Department of Human Services Survey of Mentally Ill People.

TABLE 3

*Selected Characteristics of Persons with Mental Retardation
Served by Minnesota State Hospitals During Fiscal Year 1982*

	BRAINERD		CAMBRIDGE		FARIBAULT		FERGUS FALLS		MOOSE LAKE		ST. PETER		WILLMAR		TOTAL	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
NUMBER	320	100	506	100	727	100	284	100	191	100	195	100	263	100	2,495	100
ORIENTATION																
Fully oriented	123	38.4	97	19.2	182	25.1	116	40.8	61	32.0	20	10.3	84	32.0	683	27.4
Other	160	50.0	276	54.5	328	45.1	120	42.3	77	40.3	118	60.5	140	53.2	1,228	49.2
Totally disoriented	37	11.6	133	26.3	217	29.8	48	16.9	53	27.7	57	29.2	39	14.8	584	23.4
SELF PRESERVATION																
Independent	16	5.0	29	5.7	11	1.5	20	7.1	3	1.6	15	7.7	30	11.4	124	5.0
Other	148	46.2	246	48.6	366	50.3	139	48.9	112	58.6	122	62.6	141	53.6	1,286	51.5
Mentally and physically unable	153	47.8	231	45.7	350	48.2	125	44.0	76	39.8	58	29.7	92	35.0	1,085	43.5
SPEECH																
Normal	59	18.4	53	10.5	88	12.1	72	25.4	46	24.1	58	29.8	82	31.1	458	18.3
Other	167	52.2	271	53.6	367	50.5	137	48.2	111	58.1	87	44.6	113	43.0	1,262	50.6
Unable to speak	94	29.4	182	35.9	272	37.4	75	26.4	34	17.8	50	25.6	68	25.9	775	31.1
TOILETING																
Independent	138	43.1	157	31.0	274	37.6	111	39.0	71	37.2	109	55.9	118	44.9	978	39.1
Other	116	36.3	203	40.1	290	40.0	122	43.0	72	37.7	52	26.7	100	41.8	974	39.1
Incontinent bowel and bladder	66	20.6	146	28.9	163	22.4	51	18.0	48	25.1	34	17.4	35	13.3	543	21.8
BEHAVIOR																
No behavior problem	63	19.7	94	18.6	119	16.3	54	19.0	30	15.7	22	11.3	43	16.3	425	17.1
Other	128	40.0	215	42.5	258	35.5	129	45.4	82	42.9	72	36.9	113	43.0	1,006	40.3
Assaulting/self-injurious	129	40.3	197	38.9	350	48.2	101	35.6	79	41.4	101	51.8	107	40.7	1,064	42.6
VISION																
No impairment	198	61.9	241	47.6	488	67.1	179	63.0	106	55.5	120	61.5	190	72.2	1,522	61.0
Other	93	29.1	240	47.4	168	23.1	89	31.3	75	39.3	71	36.4	62	23.6	807	32.3
Blind	29	9.0	25	5.0	71	9.8	16	5.7	10	5.2	4	2.1	11	4.2	166	6.7
HEARING																
Normal	271	84.7	422	83.4	635	87.4	232	81.7	134	70.1	153	78.4	242	92.0	2,089	83.8
Other	42	13.1	79	15.6	59	8.1	51	18.0	49	25.7	28	14.4	20	7.6	337	13.5
Deaf	7	2.2	5	1.0	33	4.5	1	0.3	8	4.2	14	7.2	1	0.4	69	2.7
WALKING																
Independent	220	68.8	340	67.2	492	67.7	208	73.3	130	68.1	161	82.6	206	78.3	1,757	70.4
Other	29	9.1	40	7.9	62	8.5	16	5.6	25	13.1	15	7.7	25	9.5	221	8.9
Does not walk	71	22.1	126	24.9	173	23.8	60	21.1	36	18.8	19	9.7	32	12.2	517	20.7
BATHING																
Independent	30	9.4	17	3.4	44	6.1	23	8.0	12	6.3	33	16.9	54	20.6	213	8.5
Other	119	37.2	226	44.7	373	51.3	141	49.7	75	39.3	108	55.4	110	41.8	1,169	46.9
Bathed completely	171	53.4	263	51.9	310	42.6	120	42.3	104	54.4	54	27.7	91	34.6	1,113	44.6
BED MOBILITY																
Independent	249	77.8	379	74.9	560	77.0	237	83.5	160	83.9	170	87.2	245	93.1	2,000	80.2
Other	29	9.1	57	11.3	58	8.0	20	7.0	11	5.6	8	4.1	6	2.3	198	7.9
Must be turned and positioned	42	13.1	70	13.8	109	15.0	27	9.5	20	10.5	17	8.7	12	4.6	297	11.9
EATING																
Independent	94	29.4	97	19.2	170	23.3	111	39.0	73	38.2	114	58.5	135	51.3	794	31.9
Other	174	54.4	349	69.0	427	58.8	143	50.4	89	46.6	64	32.8	115	43.7	1,370	54.9
Completely fed	52	16.2	60	11.8	130	17.9	30	10.6	29	15.2	17	8.7	13	5.0	331	13.2
GROOMING																
Independent	31	9.7	17	3.4	52	7.2	39	13.7	26	13.6	35	17.9	48	18.2	248	10.0
Other	149	46.6	196	38.8	337	46.4	132	46.5	63	33.0	100	51.3	117	44.5	1,103	44.2
Aid in all areas	140	43.7	293	57.8	338	46.4	113	39.8	102	53.4	60	30.8	98	37.3	1,144	45.8
DRESSING																
Independent	61	19.1	43	8.5	97	13.3	51	18.0	44	23.0	51	26.1	66	25.1	413	16.4
Other	151	47.2	265	52.4	399	54.9	142	50.0	75	39.3	108	55.4	145	55.1	1,294	51.9
Dressed completely	108	33.7	198	39.1	231	31.8	91	32.0	72	37.7	36	18.5	52	19.8	788	31.6

SOURCE: Quality Assurance and Review File (QAR).

TABLE 4

*Selected Characteristics of Persons with Chemical Dependency
Served by Minnesota State Hospitals During Fiscal Year 1984*

	ANOKA		BRAINERD		FERGUS FALLS		MOOSE LAKE		ST. PETER		WILLMAR		TOTAL	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
NUMBER	845	100	633	100	1,059	100	1,323	100	611	100	856	100	5,327	100
SEX														
Males	733	86.7	512	80.9	839	79.2	1,166	88.1	532	87.1	751	87.7	4,533	85.1
Females	112	13.3	121	19.1	219	20.7	157	11.9	79	12.9	105	12.3	793	14.9
RACE														
White	747	88.4	450	71.1	932	88.0	1,109	83.8	583	95.4	827	96.6	4,648	87.3
Native American	24	2.8	174	27.5	109	10.3	141	10.7	11	1.8	15	1.8	474	8.9
All Other	74	8.8	9	1.4	18	1.7	73	5.5	17	2.8	14	1.6	205	3.8
AGE														
Below 30	469	55.5	360	56.9	581	54.9	649	49.1	411	67.3	461	53.9	2,931	55.0
31-59	356	42.1	242	38.2	412	38.9	613	46.3	179	29.3	334	39.0	2,136	40.1
60 and older	20	2.4	31	4.9	66	6.2	61	4.6	21	3.4	60	7.0	259	4.9
MARITAL STATUS														
Single	423	50.1	308	48.7	471	44.5	577	43.6	323	52.9	452	52.8	2,554	47.9
Divorced, Separated, or Widowed	325	38.5	186	29.4	316	29.8	536	40.5	184	30.1	241	28.2	1,788	33.6
Married	97	11.5	139	22.0	272	25.7	210	15.9	104	17.0	163	19.0	985	18.5
EDUCATION														
High School or Less	724	85.7	559	88.3	871	82.2	1,173	88.7	550	90.0	746	87.1	4,623	86.8
College	120	14.2	74	11.7	188	17.8	150	11.3	61	10.0	110	12.9	703	13.2
EMPLOYMENT STATUS														
Employed	339	40.1	117	18.5	414	39.1	326	24.6	274	44.8	384	44.9	1,854	34.8
Unemployed	465	55.0	414	65.4	454	42.9	851	64.3	281	46.0	360	42.1	2,825	53.0
Other	41	4.9	102	16.1	191	18.0	146	11.0	56	9.2	112	13.1	648	12.2
ADMISSION														
Informal	811	96.0	617	97.5	966	91.2	1,264	95.5	578	94.6	806	94.2	5,042	94.6
Other	34	4.0	16	2.5	93	8.8	59	4.5	33	5.4	50	5.8	285	5.4
ARRESTED OR CONVICTED IN LAST 6 MONTHS	385	45.6	340	53.7	489	46.2	578	43.7	387	63.3	438	51.2	2,617	49.1
PRIMARY DIAGNOSIS														
Alcohol Abuse	55	6.5	204	32.2	306	28.9	29	2.2	134	21.9	52	6.1	780	14.6
Alcohol Dependency	450	53.3	218	34.4	511	48.3	926	70.2	286	46.8	528	61.7	2,910	54.8
Drug Abuse	10	1.2	5	.8	6	.6	2	.2	9	1.5	3	.4	35	.7
Drug Dependency	14	1.7	10	1.6	9	.8	16	1.2	8	1.3	55	6.4	112	2.1
Alcohol and Drug Abuse	92	10.9	112	17.7	136	12.8	21	1.7	84	13.7	30	3.5	475	8.9
Alcohol and Drug Dependency	107	12.7	60	9.5	54	5.1	311	23.5	14	2.3	178	20.8	724	13.6
Other	112	13.3	18	2.8	5	.5	6	.5	70	11.5	3	.4	214	4.0
Missing	5	.6	6	.9	32	3.0	12	.9	6	1.0	7	.8	68	1.3
DISCHARGED														
Program Completed	451	60.0	409	70.8	539	58.6	578	49.6	352	64.0	398	53.3	2,727	57.9
Program Not Completed	301	40.0	169	29.2	381	41.4	588	50.4	198	36.0	349	46.7	1,986	42.1
	N = 752		N = 578		N = 920		N = 1,166		N = 550		N = 747		N = 4,713	
PAYMENT														
Free or Reduced Fee														
State		86.5		77.7		65.6		78.2		81.2		79.9		77.7
County		9.5		7.5		8.2		8.9		9.9		8.9		8.8

SOURCE: Drug and Alcohol Abuse Normative Evaluation System File (DAANES).

TABLE 5

Summary of Town Meeting Statements

	Town Meetings									TOTAL	PERCENT
	ANOKA 9/6/84	BRAINERD 9/24/84	CAMBRIDGE 8/22/84	FARIBAULT 8/29/84	FERGUS FALLS ^a 9/25/84	METRO 10/9/84	MOOSE LAKE 10/4/84	ST. PETER 9/17/84	WILLMAR 9/13/84		
ISSUES PRESENTED											
Residents/patients	19	30	17	18	53	25	13	21	19	215	22.9
Community and individual economic impact	1	10	14	5	7	6	8	9	17	77	8.2
Quality of staff and care	14	19	9	19	34	8	15	12	27	157	16.7
Unique programs	3	8	0	0	11	1	3	4	9	39	4.1
Interagency relations	0	14	4	4	21	5	8	5	17	78	8.3
Suggestions for improvement	16	2	11	16	26	13	5	2	8	99	10.5
Acknowledgment/support of community programs	1	2	1	0	7	10	3	3	7	34	3.6
Shortcomings of community programs	4	17	11	16	40	14	10	11	17	140	14.9
Other	10	5	9	13	24	8	7	9	16	101	10.8
Total	68	107	76	91	223	90	72	76	137	940	100
REGISTERED ATTENDANCE	260	1500 +	425	750	300	105	605	550	350	4,845	—
ORGANIZATIONS REPRESENTED	20	85	36	59	29	33	68	40	52	422	—
COUNTIES OF RESIDENCE REPRESENTED	N.A.	9	13	21	11	4	N.A.	14	19	—	—
SPEAKER IDENTIFICATIONS											
Volunteers/citizens	5	2	3	5	6	0	2	5	4	32	8.8
Business/civic	3	12	4	4	1	0	3	6	7	40	11.1
Employees	7	12	12	7	24	2	5	12	4	85	23.5
Counties, cities, providers, clergy, sheriffs, judges, schools	2	24	5	6	14	7	13	9	20	100	27.6
Relatives/family	2	4	1	8	5	9	2	5	6	42	11.6
Residents/patients (inc. letters read into record)	15	3	0	0	12	0	0	1	1	32	8.8
Advocates	1	0	0	0	1	5	1	1	0	9	2.5
Legislators	2	3	3	2	1	0	3	4	4	22	6.1
Total	37	60	28	32	64	23	29	43	46	362	100

^aThe Fergus Falls Town Meeting was preceded by 8 separate local meetings.

SOURCE: Tabulation by staff.

TABLE 6

Numbers, Classifications and Selected Characteristics of Minnesota State Hospital Employees, 1984

	ANOKA		BRAINERD		CAMBRIDGE		FARIBAULT		FERGUS FALLS		MOOSE LAKE		ST. PETER		WILLMAR		TOTAL		STATEWIDE AVERAGE HOURLY WAGE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT		
JOB CLASSIFICATION (BARGAINING UNIT)																				
Craft/Maintenance (2)	22	5.8	20	2.8	23	2.5	38	3.0	19	4.6	26	4.6	28	3.6	21	3.1	197	3.0	\$11.54	
Service (3)	49	13.0	104	14.8	115	13.1	143	11.3	87	12.8	79	13.8	63	8.1	103	15.1	743	12.6	8.10	
Health Care Technicians, LPNs (4)	145	38.4	331	47.0	489	56.1	713	56.3	320	47.1	311	54.6	338	43.0	349	51.3	2,996	50.6	8.53	
Nurses (5)	47	12.4	37	5.3	22	2.5	36	2.9	35	5.2	27	4.7	45	5.7	30	4.4	279	4.8	12.52	
Clerical/Office (6)	18	4.8	31	4.4	26	3.0	27	2.1	31	4.6	26	4.6	44	5.6	35	5.1	238	4.0	8.39	
Technical Office Engineering (7)	6	1.5	7	1.0	5	.5	10	.7	8	1.2	8	1.4	11	1.4	7	1.0	62	1.0	9.66	
Doctors, Dentists (13)	3	.8	6	.9	5	.5	8	.6	5	.7	5	.9	3	.4	4	.6	39	.7	18.32	
Social Workers, Behavior Analysts (14)	44	11.6	67	9.5	62	7.9	88	7.0	46	6.8	37	6.5	125	15.9	59	8.7	528	8.9	11.30	
Teachers (15)	2	.5	10	1.4	3	.3	16	1.3	14	2.1	4	.7	23	2.9	5	.8	77	1.3	15.04	
Supervisors, Psychologists (16)	20	5.3	52	7.4	62	7.1	82	6.5	75	11.0	31	5.4	59	7.5	45	6.6	426	7.3	13.78	
Confidential Workers (17) ^a	7	1.9	9	1.3	11	1.3	12	.9	7	1.0	10	1.8	8	1.0	6	.9	70	1.2	12.12	
Managers (20) ^a	7	1.9	8	1.1	25	2.7	7	.6	4	.6	3	.5	5	.6	5	.8	64	1.0	22.70	
All Others (21) ^a	8	2.1	22	3.1	23	2.5	86	6.8	28	4.1	3	.5	34	4.3	11	1.6	215	3.6	NA	
TOTAL	378	100	704	100	871	100	1,266	100	679	100	570	100	786	100	680	100	5,934	100	—	
SEX^b																				
Female	233	61.6	441	61.1	590	69.3	824	65.1	419	61.7	350	61.5	455	57.8	423	62.2	3,735	63.1		
Male	145	38.4	269	38.9	261	30.7	442	34.9	260	38.3	219	38.5	331	42.2	257	37.8	2,184	36.9		
AGE^b																				
Under 35	143	37.8	323	45.5	453	53.2	730	63.2	280	41.2	261	45.9	380	48.3	338	49.7	2,908	50.1		
36-59	205	54.2	336	47.3	345	40.5	345	29.9	340	50.1	268	47.1	361	45.9	289	42.5	2,489	42.9		
60 and Older	30	8.0	51	7.2	53	6.3	80	6.9	59	8.7	40	7.0	45	5.8	53	7.8	411	7.0		
RETIREMENT ELIGIBILITY^c																				
Immediate	3	.8	61	8.7	31	3.5	49	3.8	30	7.2	38	6.7	68	8.7	59	8.7	369	6.2		
Within 5 Years	58	15.3	118	16.8	69	7.9	102	8.0	82	15.0	77	13.5	140	17.8	96	14.1	742	12.5		
AVERAGE LENGTH OF SERVICE (YEARS)																				
	6.2		7.6		8.0		9.0		10.5		9.1		6.7		7.7		—			
STAFF TO PATIENT/ RESIDENT RATIO^d																				
	1.20:1		1.56:1		1.80:1		1.78:1		1.45:1		1.31:1		1.33:1		1.23:1		1.48:1			

^aJob Classifications excluded from bargaining.

^bTotal numbers of employees by age (5,808), sex (5,919) and job classification (5,934) are not consistent. Original sources are confidential.

^cBased on Rule of 85 under which employees whose age plus years of service equals 85 are eligible for retirement.

^dAverage daily population for 1984 in Department of Human Services State Budget Request divided by hospital total by job classification.

SOURCE: Minnesota State Planning Agency.

TABLE 7

*Estimated Potential Cost of Severance and Health Benefits
for Minnesota State Hospitals as of August 1, 1984*

	ANOKA	BRAINERD	CAMBRIDGE	FARIBAULT	FERGUS FALLS	MOOSE LAKE	ST. PETER	WILLMAR	TOTAL
SEVERANCE	\$412,800	\$ 777,100	\$ 614,400	\$1,204,200	\$ 908,600	\$ 614,600	\$1,036,300	\$ 944,400	\$ 6,512,400
HEALTH	289,375	543,881	601,336	812,072	511,384	436,516	562,673	516,301	4,273,538
TOTAL	\$702,175	\$1,320,981	\$1,215,736	\$2,016,272	\$1,419,984	\$1,051,116	\$1,598,973	\$1,460,701	\$10,785,938

SOURCE: Minnesota Department of Employee Relations, August 1, 1984.

TABLE 8

Analysis of State Hospital Operating Expenditures During Fiscal Year 1984

	ANOKA ^a		BRAINERD		CAMBRIDGE		FARIBAULT		FERGUS FALL		MOOSE LAKE		ST. PETER ^b		WILLMAR		TOTAL		TOTAL OPERATING EXPENDITURE PER CAPITA	
	Amount	Per-cent	Amount	Per-cent	Amount	Per-cent	Amount	Per-cent	Amount	Per-cent	Amount	Per-cent	Amount	Per-cent	Amount	Per-cent	Amount	Per-cent		
Staff Salary^c																				
MI	\$ 4,208,224	—	\$ 991,981	—	\$ —	—	\$ —	—	\$ 2,200,722	—	\$ 2,905,017	—	\$ 8,597,031	—	\$ 5,058,762	—	\$23,961,738	—	—	—
MR	—	—	9,734,716	—	12,061,859	—	18,901,981	—	6,764,203	—	3,203,212	—	4,916,574	—	4,024,663	—	59,607,208	—	—	—
CD	930,700	—	641,996	—	—	—	—	—	2,353,674	—	2,350,885	—	712,024	—	1,258,322	—	8,247,601	—	—	—
General Services	4,670,371	—	4,434,429	—	4,862,308	—	5,283,838	—	3,647,714	—	3,238,912	—	3,696,847	—	4,590,344	—	34,424,763	—	—	—
Regional Laundry	—	—	563,117	—	461,180	—	807,413	—	—	—	—	—	126,032	—	234,083	—	2,191,825	—	—	—
Total	9,809,295	82.6	16,366,239	86.0	17,385,347	86.6	24,993,232	85.8	14,966,314	87.5	11,698,026	85.4	18,048,508	85.9	15,166,174	86.9	128,433,135	85.9	\$32,060	—
Food	275,671	2.4	399,465	2.0	425,149	2.1	635,593	2.3	445,740	2.5	386,281	2.8	525,265	2.5	483,108	2.8	3,576,272	2.4	893	—
Fuel	329,152	2.8	594,244	3.1	430,630	2.2	956,787	3.3	377,531	2.2	406,642	3.0	473,833	2.3	404,385	2.3	3,973,204	2.7	992	—
Utilities	160,021	1.3	261,334	1.4	257,851	1.3	256,006	0.9	140,463	0.8	175,671	1.2	257,098	1.2	103,633	0.6	1,612,077	1.1	402	—
Drugs	188,649	1.6	137,940	0.7	226,968	1.1	257,271	0.9	153,328	0.9	147,349	1.1	268,853	1.3	187,810	1.1	1,568,168	1.0	391	—
Repair, Replacement^d	156,584	1.3	139,765	0.7	102,830	0.5	304,835	1.0	170,469	1.0	83,444	0.6	184,123	0.9	130,222	0.7	1,272,252	0.9	317	—
Special Equipment	33,453	0.3	37,943	0.2	30,063	0.1	71,566	0.2	31,933	0.2	24,782	0.3	74,301	0.4	48,691	0.3	352,732	0.2	88	—
Regional Laundry Supplies and Special Equipment	—	—	28,824	0.2	26,019	0.1	72,016	0.2	—	—	—	—	8,998	—	15,471	0.1	151,328	0.1	38	—
Consultants	404,519	3.4	132,810	0.7	129,528	0.7	143,220	0.5	169,210	1.0	114,350	0.8	329,007	1.6	123,698	0.7	1,546,342	1.0	386	—
Patient Pay	136,739	1.1	128,984	0.7	36,718	0.2	85,024	0.3	131,329	0.8	148,344	1.1	239,131	1.1	183,301	1.0	1,089,570	0.7	272	—
Student Workers	6,977	0.1	71,080	0.4	—	—	128,999	0.4	51,203	0.3	22,901	0.2	—	—	58,960	.3	340,120	0.2	85	—
Unemployment Comp.	14,101	0.1	38,810	0.2	7,000	0.0	58,310	0.2	33,362	0.2	19,263	0.1	11,002	—	38,440	0.2	220,288	0.1	55	—
Workers' Comp	141,207	1.2	400,519	2.1	705,650	3.5	717,991	2.5	128,990	0.8	183,255	1.3	194,159	0.9	142,466	0.8	2,614,237	1.8	653	—
All Other^e	218,895	1.8	300,850	1.6	320,355	1.6	434,585	1.5	303,564	1.8	284,612	2.1	390,499	1.9	362,761	2.0	2,616,121	1.8	654	—
Rochester Adjustment^f																	125,473	0.1	31	—
Total	\$11,875,263	100	\$19,038,807	100	\$20,084,108	100	\$29,085,435	100	\$17,103,436	100	\$13,694,920	100	\$21,004,777	100	\$17,449,120	100	\$149,491,339	100	\$37,317	—
Average No. Patients	316		450		483		709		469		435		590		554		4,006			
Operating Expenditure per Capita	\$37,580		\$42,308		\$41,582		\$41,065		\$36,468		\$31,483		\$35,601		\$31,497		\$37,317			
Central Office Special Project																	6,912			
Total Operating Expenditure (Disbursements)																	\$149,498,251			

^aAnoka State Hospital operating costs are overstated by \$357,210 because of 11 positions that provide service systemwide.

^bIncludes Security Hospital.

^cIncludes employee benefits. Brainerd State Hospital MR salaries include Minnesota Learning Center. General Services include all activities other than direct care.

^dIncludes repair, replacement, and betterment of regular and special projects. Energy saving measures also included.

^eIncludes other current operating expenses for MI, MR, CD, MLC and general services.

^fIncludes \$23,391 for relocation and \$102,082 for Worker's Compensation.

SOURCE: Financial Management Division, Department of Human Services.

TABLE 9

Gross and Net State Cost of State Hospitals
Fiscal Years 1984 Through 1987

	FISCAL YEAR 1984 (Actual)	FISCAL YEAR 1985 (Estimated)	FISCAL YEAR 1986 (Estimated)	FISCAL YEAR 1987 (Estimated)
Hospital Operating Expenditure^a	\$147,755,064	\$154,662,055	\$159,952,300 ^k	\$160,385,100 ^k
Hospital Indirect Expense				
Central Office Support and Reimbursement ^b	2,395,743	1,737,538	—	—
Statewide Support ^c	1,444,517	1,435,484	—	—
Other ^d	129,838 ⁱ	2,710,725	—	—
Total Indirect	\$ 3,970,098	\$ 5,883,747	\$ 6,119,097 ^j	\$6,363,860 ^l
Bond Interest^e	2,284,951	2,078,545	1,891,476 ^m	1,721,243 ^m
Depreciation^f	5,035,366	4,566,573	4,141,882 ⁿ	3,756,687 ⁿ
Gross State Cost	159,045,479	167,190,920	172,104,755	172,226,890
Reimbursements				
Medicare ^g	1,847,435	—	—	—
Insurance ^h	2,024,030	—	—	—
Medical Assistance				
Federal	52,656,694	—	—	—
State	46,825,724	44,144,460 ^o	42,974,580 ^o	40,434,350 ^o
County	5,202,858	—	—	—
County ^f	6,362,510	—	—	—
Patients/families	5,675,169	—	—	—
Total Reimbursement	120,594,420	121,532,800	122,071,400	119,623,000
Net State Government Cost^f	\$ 85,276,783	\$ 89,802,580	\$ 93,007,935	\$ 93,038,240

^aIncludes salaries, employee benefits, food, fuel, drugs, supplies and all other current operating expense. FY 1984 net Reimbursement Section figure is less than total in Table 8 because 1) \$414,281 Regional Laundry receipts, \$417,422 miscellaneous cash receipts and \$394,430 central office salaries are excluded and 2) Reimbursement Section data are obtained from State Accounting as of August 1 while the Financial Management section data are as of September 1 when books are closed.

^bIncludes state hospital share of Department of Human Services costs for Institution Fiscal Management, Personnel, Information Systems, Mental Health Bureau and Reimbursement sections.

^cIncludes proration of costs for statewide Departments of Administration, Finance, Employee Relations, Legislative Auditor, Treasurer, Attorney General and others.

^dIn prorrations of Regional Laundry, Client Protection, Commissioner's Office, etc., actual amount for FY 1984 lower because offsetting receipts and other adjustments.

^ePortion of interest on state bonded debt chargeable to construction and improvements at state hospitals.

^fRecognizes prorated portion of long-term plant construction and remodeling costs.

^gIncludes Part A Inpatient Hospital Services, Part B Physicians Services and Ancillary Services.

^hIncludes all private health insurance carriers.

ⁱIncludes hold orders, poor relief and detoxification charges at Fergus Falls State Hospital.

^jGross State Cost minus Total Reimbursement excluding state share of Medical Assistance.

^kSame level funding department requests. Not included in these amounts are 1) a projected reduction of 644 MR staff positions to be accomplished by 6/30/87 2) projected increase of 125 MI staff.

^lAssumes a 4 percent increase over prior year.

^mAssumes a 9 percent decrease based on the change from FY 1984 to FY 1985.

ⁿAssumes a 9.3 percent decrease based on the change from FY 1984 to FY 1985.

^oBased on 44.73 percent state share.

SOURCE: Financial Management and Reimbursement Section, Department of Human Services.

TABLE 10*Selected Indicators of State Hospital Economic Impact*

	ANOKA (Anoka)	BRAINERD (Crow Wing)	CAMBRIDGE (Isanti)	FARIBAULT (Rice)	FERGUS FALLS (Otter Tail)	MOOSE LAKE (Carlton)	ST. PETER (Nicollet)	WILLMAR (Kandiyohi)
Hospital Employment as Percent of Total Employment^a								
Primary Zone ^b	.5	5.5	6.2	9.4	6.9	18.8	8.2	4.0
Primary and Secondary Zone ^c	.2	5.5	3.5	9.4	6.9	5.0 ^g	2.1	4.5
Regional Impact Area ^d	.1	4.8	1.5	1.6	4.2	2.3	2.2	3.9
State Hospital Jobs as Percent of Health Service Jobs in Entire Impact Area^e								
	1.0	37.0	16.0	8.0	44.0	30.0	26.0	26.0
July 1984 Unemployment Rate in County Hospital (Percent)								
	5.0	8.0	6.8	7.1	7.9	10.1	4.7	5.3
Hospital Payroll as Percent of Total Area Income^a								
Primary Zone ^b	.5	7.6	7.7	12.5	10.5	28.8	16.9	5.7
Primary and Secondary Zone ^c	.2	7.6	4.4	12.5	10.5	6.0	3.4	6.4
Regional Impact Area ^d	.1	6.7	1.7	1.9	10.1	5.2	3.5	5.9
Impact of Hospital Purchases (Excluding Fuel and Utilities)								
City								
Percent of Total Purchases	1.8	13.7	2.6	9.5	14.4	8.4	7.7	18.7
Amount	\$14,526	\$139,777	\$27,056	\$152,397	\$167,156	\$ 72,905	\$ 96,194	\$230,384
Percent of Total Retail Sales ^f	.18	.27	.11	.19	.30	1.2	1.25	.24
County								
Percent of Total Purchases	4.0	14.8	4.6	13.9	14.7	12.7	9.9	18.7
Amount	\$32,964	\$151,683	\$47,709	\$222,859	\$172,218	\$110,027	\$123,318	\$230,942
Percent of Total Retail Sales ^f	.09	.20	.45	.17	.15	.56	.66	.17

^aData provided by Minnesota Department of Employee Relations.^bArea consisting of zip code zones for 50 percent of personnel on state hospital payroll.^cArea consisting of zip code zones for 75 percent of personnel on state hospital payroll.^dArea consisting of zip code zones for 90 percent of personnel on state hospital payroll.^eBased on number of health and social service jobs counted in the 1980 U.S. Census.^fRetail sales data provided by Minnesota Department of Revenue.^gMoose Lake's secondary economic impact is being recalculated to exclude Cloquet.

TABLE 11*Descriptive Summary of Minnesota State Hospital Plant Facilities*

	ANOKA	BRAINERD	CAMBRIDGE	FARIBAULT	FERGUS FALLS	MOOSE LAKE	ST. PETER	WILLMAR	TOTAL
Dates of Construction and Additions	1905-1921 1930-1935 1950-1964 1980	1958-1964	1925-1935 1946-1961 1971 1981	1900-1937 1947-1966 1974	1890-1923 1930-1932 1950-1964	1938 1948-1954 1960 1964	1866 1919-1927 1937 1949-1954 1960-1974 1981	1912-1935 1948-1970	
Site Size (Acres)	243.5	198	245	760 593 acres leased out	320.25 164 acres leased as farmland	175	743.6 220 acres leased out	158	2,843.5
Number of Buildings									
Total Main Bldgs. ^b	22	14	26	52	40	23	35	39	250
Number unoccupied or in storage	14	3	22	15	14	12	20	13	113
Area of Main Buildings in Sq. Ft. ^c	454,455	698,178	669,908	939,104	867,010	518,815	857,404	562,151	5,567,025
Percent Area Vacant or in Storage^d	26	7	10	10	15	7	15	8	12.25
General Condition of Buildings^e	poor to excellent average to fair, needs much repair	good to excellent	fair to good	old buildings: fair to good; new buildings: good to excellent	fair to good: exterior repairs needed	good	excellent: major remodeling completed	good to excellent	
Resident Capacity 1984 Average Daily Population	316	450	483	712	469	435	589	552	4,006
Licensed Bed Capacity	347	531	556	845	561	645	674	644	4,988

^aIncludes Minnesota Security Hospital.^bIn addition to main buildings, there are small service structures such as storage sheds, garages, band-stands, backstops, etc. called "MC's."^cArea includes storage "MC's."^dSquare footage for partially vacated and partial storage buildings not available; actual areas and percents could be higher.^eRatings:**Good to Excellent:** Interior and exterior are in relatively good condition, relatively new or recently repaired or replaced. Needs little or no repairs.**Fair to Good or Good:** Between good to excellent and fair. Requires little or no repair.**Fair:** Currently meets code and is in operating order. May need some upgrading.**Fair to Poor or Poor:** In need of extensive repairs or replacements. May not meet code.**SOURCE:** Minnesota State Planning Agency, *Minnesota State Hospital Facilities and Alternative Use Report, 1985.*

TABLE 12

Adjusted Fuel Use and Energy Cost
in Minnesota State Hospitals, Fiscal Year 1983

	ANOKA	BRAINERD*	CAMBRIDGE*	FARIBAULT*	FERGUS FALLS	MOOSE LAKE	ST. PETER*	WILLMAR*	TOTAL/ AVERAGE
FUEL USE									
Source	Natural Gas	Natural Gas	Coal/Natural Gas	Natural Gas	Coal	Natural Gas	Natural Gas	Natural Gas	—
Total Energy Used (Million BTU)	76,468	105,101	148,200	195,884	173,454	72,408	126,520	88,889	986,924
Energy Per Square Foot (Million BTU)	.207	.159	.232	.238	.228	.145	.174	.175	(average) .195
Energy Per Resident (Million BTU)	257	227	306	273	363	164	229	163	(average) 248
ENERGY COST									
Total Energy Cost	\$397,676	\$658,165	\$521,165	\$958,050	\$364,460	\$481,681	\$654,635	\$404,988	\$4,440,820
Energy Cost Per Square Foot	\$1.078	\$.9974	\$.8156	\$1.1863	\$.479	\$.967	\$.9062	\$.7962	(average) \$.9032
Energy Cost Per Resident	\$1,185	\$1,378	\$1,083	\$1,365	\$ 746	\$1,057	\$1,126	\$ 742	(average) \$1,085

*Figures are adjusted to factor out the extraordinary cost of the regional laundry facilities. In addition, use and cost for Faribault were adjusted to reflect some short-term technical difficulties in the provision of steam to the Braille School.

SOURCE: Minnesota State Planning Agency. *Minnesota State Hospital Energy Use and Costs*, 1985.

